



Health legal update

Introduction2

 Training.....2

 Health group news.....3

 Healthcare Resource Centre.....3

NHS management – improving productivity3

 King's Fund publishes 'Improving NHS productivity'3

NHS management – reconfiguration.....4

 Department of Health provides guidance on tests for service reconfiguration.....4

NHS management – regulation.....4

 How will regulation work together in the liberated NHS?.....4

Contracts5

 More good reasons to sign a contract before performance starts.....5

 Beware – claims for interest and adjudication – they don't necessarily go together!6

List management6

 First tier tribunal finds that GP should remain on performers list despite not performing for two years .6

Professional regulation7

 Fitness to practise adjudication – where now?.....7

 Department of Health to take action on language testing for European Economic Area doctors.....8

 End to competence tests for EU nurses8

Procurement – rules and guidance.....9

 Revised PRCC and Procurement Guide published.....9

Procurement – co-operation and competition panel cases10

 CCP finally gets its first procurement appeal!.....10

 CCP case: conduct complaint against North West Specialist Commissioning Team11

Patient matters – deprivation of liberty11

 Review of DOLS by the Mental Health Alliance11

Patient matters – NICE quality standards12

 NICE announces the development of further quality standards12

Patient matters – cancer treatment.....12

 New £50million interim cancer drugs fund announced.....12

Patient matters – mixed sex wards13

 Plans to eliminate mixed sex wards13

Patient matters – Care Quality Commission14

 Care Quality Commission publishes its first report.....14

 CQC publishes guide for patients on NHS standards15

Patient matters – social care grants16

 Department of Health consultation on changes to the allocation of the Learning Disability
 Commissioning Transfer, Preserved Rights and Aids Support Grants.....16

Patient matters – mental health.....17

 Guidance in respect of tribunal references following revocation of a Community Treatment Order (CTO)
 17

 Salaried mental health judges to chair restricted First-tier Tribunal cases17

Patient matters – the Court of Protection.....17

 Court emphasises the importance of concentrating on the 'plain words' of the Mental Capacity Act17

briefing continued

Patient matters – children.....	18
Working group to produce new guidance for doctors involved in child protection	18
Vital signs monitoring of children.....	19
The court process.....	19
Judgment considers collective responsibility of jury.....	19
Decisions of the Upper Tribunal are subject to judicial review	20
Employment	21
Equality Act: preparing for October implementation.....	21

Introduction

A warm welcome....

.... to the September edition of the *Health legal update*. As I sit here with a sneak preview of this month's edition, I am struck by the distinct feeling of change in the air and there is a definite chill about and the morning fog is not lifting at all quickly.

As we wrap up warm for the cooler evenings, we are all still trying to get to grips with the proposed changes to the NHS and the sheer volume of new guidance, proposals and consultations. In this edition we highlight some of the key issues including matters such as improving productivity, reconfiguration and the proposed new regulatory framework.

In addition to this update Mills & Reeve have produced and will continue to produce a lot of helpful guidance. Please check out the following:

- 1 easy access to important papers and our briefings on the proposed changes on our [Healthcare Resource Centre](#);
- 2 an outline of the help we can give as we prepare for GP commissioning; and
- 3 our briefing on [GP commissioning](#).

Some issues and questions are becoming clearer and will be offering our thoughts and guidance in due course. It seems we are moving in the direction that foundation trusts will operate in the health "marketplace" like (and with the same status as) any other provider of healthcare looking to receive commissions from the NHS. We plan to respond to the DH to many of the consultations currently in progress and you may wish to take this opportunity to have your say.

Of course, as we are taking on board the proposed fundamental changes to the way the NHS operates, you will also see in this issue, that there is plenty to keep us busy on other matters, including revised guidance on the procurement rules which will apply to shadow GP commissioning consortia. We also offer some insight into a review of the Deprivation of Liberty safeguards; the implementation of the Equality Act 2010; guidance on community treatment orders and the first report of the CQC.

As the CQC adopts a new "patient-centred" approach to regulation, it will certainly be interesting to see how the regulation of quality is affected by the Mid-Staffs public inquiry which will look at the operation of the commissioning, supervisory and regulatory bodies responsible for the trust.

Training

We have a full autumn programme of free training seminars held across the country. These include a special seminar on GP commissioning with the latest developments affecting healthcare professionals, and their implications. You can see the whole programme and book places [here](#).

briefing continued

We are happy to offer in-house training if you think that might help. For more information just get in touch with [me](#).

Health group news

I am delighted to say that we have talented new lawyers joining our expanding health group advising the NHS and health sector – as well as some well-deserved promotions. I know they will help us to deliver the best service to you during these challenging times.

Congratulations to our trainee solicitors who, on completion of their training, join the Mills & Reeve health group as newly qualified solicitors. **Emily Brown** joins the health team in Cambridge working with Gill Thomas and Arzu Ozel joins the Birmingham healthcare team led by Jill Mason. **Anna Youngs** becomes an Associate in our health employment team in Birmingham and **Kathryn Haigh** becomes an Associate working with Stuart Craig in the Cambridge employment team. **Katrina McCrory** is also promoted to an Associate based in the Birmingham healthcare team. **Emma Pattenden** (Cambridge employment) and **Lee Parkhill** (Birmingham healthcare) are both newly promoted to Senior Solicitors.

Healthcare Resource Centre

Last but not least, I would just like to take this opportunity of reminding you about our [Healthcare Resource Centre](#). It is designed to help you and your team save money on legal costs - so please take advantage! It contains a wealth of up to date basic legal advice and guidance offered to help you with some common every day problems. Take a look. Simply type in your NHS email address to log in. You might find the answer to your question and it's free!

If you have any suggestions for information or help you would like to see on the Healthcare Resource Centre, just let [me](#) know.



Stuart Knowles
Consultant
0121 546 8461
stuart.knowles@mills-reeve.com

NHS management – improving productivity

King's Fund publishes 'Improving NHS productivity'

On 22 July the King's Fund published their latest report under the "quality in a cold climate" theme [Improving NHS productivity: More with the same not more of the same](#).

This report is a combination of policy and health economic research into the scale of the financial issues surrounding the NHS and wider health economy over the next few years combined with input from the King's Fund leadership and health care improvement teams on what NHS leaders and others need to do to address the issues.

It includes strategies for improving productivity: "doing things right and doing the right thing". As the NHS grapples with significantly smaller increases in funding from 2011, there is a danger that the necessary focus on improving productivity becomes, at best, an end in itself and, at worst, a misunderstanding that the NHS needs to dramatically cut budgets, reduce services for patients and sack staff.

briefing continued

The NHS will need to carefully select the strategies which, together, produce “more value” from the same or similar resource – “not” the same for less.

For further information or advice please contact [Tania Richards](#) on 01233 222476.

NHS management – reconfiguration

Department of Health provides guidance on tests for service reconfiguration

On 21 June 2010, the Secretary of State published the revised [Operating Framework for 2010/2011](#) which sets out four tests against which reconfiguration processes need to be assessed. The Framework requires existing and future reconfiguration proposals to demonstrate:

- support from GP commissioners;
- strengthened public and patient engagement;
- clarity on the clinical evidence base; and
- consistency with current and prospective patient choice.

On 29 July 2010, the Department of Health (DH) released [guidance](#) on the application of these four tests. The guidance asks local GP commissioners, supported by PCTs, to lead reconfiguration processes locally and to assure themselves, and their SHAs, that any proposals pass the four tests. The guidance grants flexibility on how to gather the evidence of support. The DH argues that the process needs to be locally-led and designed and so does not define specific thresholds for any of the tests.

For further information or advice please contact [Alison Maw](#) on 0121 456 6454.

NHS management – regulation

How will regulation work together in the liberated NHS?

When the White Paper was published it was clear that regulation for the NHS would be changing significantly in the future. Greater roles for Monitor, Care Quality Commission (CQC) and the National Institute for Clinical Excellence (NICE) were apparent but the detail of how the regulators would work together was less than clear.

There has now been a consultation published, [Liberating the NHS: regulating healthcare providers](#) which provides some insight into how the Government sees regulation in the future. Our briefing on the consultation can be accessed [here](#).

The consultation document has provided some further clarification on the proposed role of Monitor and how this will link with the CQC. It is proposed that Monitor will regulate health and social care in three core functions, namely the regulation of price, promotion of competition and to support service continuity. Monitor will also have the function of licensing NHS providers in addition to CQC registration. There will be the possibility of enforcement action with removal of the licence or fines if terms of the licence are breached. For NHS organisations this will mean registration with two regulators and the payments of two sets of registration fees with the possibility of enforcement from two regulators.

Social care providers and private health providers will not require a Monitor licence on the basis that these are mature markets with a range of choice between alternative providers. CQC will retain the registration function for both health

briefing continued

and social care providers and will provide quality assurance in respect of levels of quality and safety for both health and social care.

Despite the broad heading of the consultation document, there is no real detail about the role of CQC or NICE in the future landscape. CQC will regulate the NHS and social care providers based on the “essential standards of quality and safety” which have been drafted to inform providers how they can ensure compliance with the section 20 regulations of the Health and Social Care Act 2008. So far we have not been informed how the 150 quality standards of care from NICE will fit in with the new CQC standards. Will a breach of NICE standards mean enforcement action from CQC, have consequences for the Monitor licence, or result in no action at all?

The consultation document states that the Government is committed to reducing the overall burden of regulation across the health and adult care sectors. Once we have more detail about how the proposed regulatory bodies will work together in the future, we will see if this commitment is likely to be achieved.

For further information or advice please contact [Katrina McCrory](#) on 0121 456 8451 or [Tim Winn](#) on 0121 456 8355.

Contracts

More good reasons to sign a contract before performance starts

The recent High Court case of [GHSP Inc v AB Electronic Ltd](#) concerned a “battle of the forms” dispute. Such disputes arise when the contracting parties have commenced performance of the contract without formally agreeing whose contract terms apply (ie, the supplier issues the purchaser with a copy of its standard terms and conditions and vice versa). In this case, a dispute around liability ensued following supply of defective products which resulted in a third party incurring significant consequential losses. The third party claimed against the purchaser and the purchaser claimed against the supplier.

The significant fact in these circumstances was that it was not clear which party’s terms applied. If the purchaser’s terms applied, this meant that the supplier would have unlimited liability and if the supplier’s terms applied this meant that it would have almost no liability. As liability was potentially very high this was really important.

Following an examination of the parties’ behaviour and communications both, in the negotiation stage and following commencement of supply, the court held that neither parties’ standard conditions applied. Although most contract discussions referred to the purchaser’s terms, the supplier had made it clear that it did not accept the liability in them. It was therefore impossible for the court to determine the liability position. Rather, the court held that arrangements between the parties were governed by implied terms of the Sale of Goods Act 1979 and in particular, the requirement under that Act that goods supplied are of satisfactory quality. The significance of this is that the implied terms of the Act meant that the supplier’s liability under the contract was unlimited (subject to the common law rules on recovery of damages).

Whilst limitations and exclusions of liability are one of the most negotiated areas of all commercial contracts, parties should only commence performance of contractual obligations once liability is agreed and a contract is entered into. In this case, the parties proceeded without agreement assuming nothing would go wrong or if it did, they could reach agreement. But the stakes were too high. This decision by the High Court demonstrates the significant risks involved in not signing contracts before starting to perform them.

For further information or advice please contact [Gill Thomas](#) on 01223 222237 or [Emma Tully](#) on 01223 222485.

briefing continued

Beware – claims for interest and adjudication – they don't necessarily go together!

The courts (and arbitrators) have the power to decide whether a party is entitled to interest on its claim.

An adjudicator does not have this power. In adjudication, a party does not have the right to claim interest unless the contract expressly allows it to do so, or unless there is a specific statutory right.

For example, the JCT forms of contract provide for interest where payment of a certified sum is late. However, there is no express right to interest in the JCT forms where a tribunal decides that a contractor is entitled to loss and expense.

A judge can award interest relating to a loss and expense claim using his or her discretion under section 35A Senior Courts Act 1981. Arbitrators can also award interest at their own discretion pursuant to section 49 of the Arbitration Act 1996. There is no equivalent statutory provision in relation to adjudication.

The recent consultation regarding the proposed changes to the Scheme for Construction Contracts asked the construction industry whether adjudicators should have the discretion to award interest in adjudications brought under the scheme. This would seem fair. We will have to wait to see whether it is implemented.

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

List management

First tier tribunal finds that GP should remain on performers list despite not performing for two years

This was the finding of the first tier tribunal in the case of [Dr Sido John v Stockport Primary Care Trust](#). Dr John appealed against the decision by Stockport Primary Care Trust (the PCT) to remove him from the PCT's Medical performers list on the basis that he had not performed services within the PCT's area during the preceding 12 months. This decision was taken pursuant to regulation 10(6) of the NHS (Performers Lists) Regulations 2004 (as amended) (the regulations).

Dr John was receiving treatment for a head injury which he had sustained after falling down some stairs in December 2007. He hoped to return to work but there was no certainty as to if and when he would be able to do so. The PCT waited until 11 February 2010 before taking the decision to remove him from the list on the basis that he could reapply once he had recovered. In the interim, Dr John was suspended by the GMC on 20 January 2010 for a period of 18 months.

The tribunal found that it should be read into regulation 10(6) that any decision taken should be reasonable and proportionate in all the circumstances. They found that Dr John should not be removed from the performers list because such a step would be significantly more than the minimum required in order for the PCT to meet its objective. This was because:

- The PCT was able to keep the list up to date by noting that Dr John was the subject of special circumstances which for the time being meant he could not practise.
- On the available evidence, a point had not been reached where Dr John's prospects of rehabilitation and remediation were not reasonable and there was no concluded view as to Dr John's ability to return to work as a GP in the future.
- Dr John's likelihood of return to practice would be significantly reduced if he were removed from the list.

briefing continued

- In terms of protecting the public, Dr John had insight into his condition and there was no suggestion that he would do anything other than comply with the advice of the professionals as to whether he is fit to practise. Furthermore, his suspension from the GMC means that he is unable to work as a doctor and if the PCT considers it appropriate, it could take action to contingently remove him.
- The evidence available to the tribunal was not sufficiently detailed or wide ranging so as to enable the tribunal to come to a properly considered view with regard to contingent removal.

The tribunal also criticised the PCT's decision making process on the basis that the decision to remove had been made during a conversation which was not documented and of which no minutes were taken. This made it difficult for the tribunal to consider the evidential basis for the PCT's decision.

For further information or advice please contact [Alison Maw](#) on 0121 456 8454.

Professional regulation

Fitness to practise adjudication – where now?

The fifth report of the Shipman Inquiry voiced concerns about the independence of adjudication by the General Medical Council (GMC) in Fitness to Practise (FTP) cases. Reviews were undertaken and reports published concerning the regulation of doctors and of other health professionals.

A programme of reform followed, with a move towards more independent adjudication on FTP matters planned. The Health and Social Care Act 2008 provided the legal framework for an independent body – the Office of the Health Professions Adjudicator (OHPA). The plan was that the OHPA would provide adjudication for the GMC and General Optical Council with other regulators to follow. The OHPA became a legal entity in January 2010 with hearings due to go live in April 2011.

As part of the current Government spending review further implementation of OHPA is being re-examined. At the time of publication of the fifth Shipman report the GMC had already made changes and further change has taken place since. The Department of Health has just published a consultation document [Fitness to Practise Adjudication for Health Professionals: assessing different mechanisms for delivery](#), which sets out quite how far things have moved on.

The Government now says that the rationale for moving to adjudication on FTP matters through OHPA is less clear cut and say there may be the opportunity to realise substantially the same benefits without the additional cost to the public purse of proceeding with OHPA. Projected costs in the short term have escalated, though it is recognised that OHPA offered some future economies of scale.

The Department of Health is consulting on three options:

- 1 continue with OHPA as planned;
- 2 repeal the legislation establishing the OHPA, and legislate to make adjudication more independent and to modernise existing processes at the GMC; and
- 3 repeal the legislation establishing the OHPA and take no further action.

Option 2 is stated to be the preferred one. The consultation concludes on 11 October.

briefing continued

For further information or advice please contact [Fiona Hawker](#) on 0121 456 8284.

Department of Health to take action on language testing for European Economic Area doctors

The Government has published its [*Response to the House of Commons Health Committee report into the use of overseas doctors in providing out of hours services*](#), (the response) which was commissioned following the death of David Gray, a patient of Dr Ubani from Germany who was working as an out of hours doctor, despite having previously failed a language test to work in this country. Dr Ubani administered diamorphine to Mr Gray which was twenty times the recommended dose.

The response recognises that as the law is governed by the European Directive 2005/36/EC on mutual recognition of professional qualifications, any changes to that legislation will need to be effected as part of the European Commission's review of the implementation of the Directive. There is no guarantee that the review will result in changes to the EU law and in any event any changes are likely to take several years to implement.

There is therefore a need to focus on what can be done to strengthen language checks with the current law. The response confirms that the Government is working with the GMC to jointly explore a strengthened system of language checks.

The response also confirms that the Government is considering the possibility of the NHS commissioning board taking over responsibility for ensuring that there is a more effective process for undertaking language knowledge checks on primary care practitioners.

From April 2012, out of hours providers will be required to register with the Care Quality Commission (CQC) and as the response points out, from that time they will be required to meet CQC registration requirements which include a requirement that staff are suitably qualified, skilled and experienced. In its guidance on compliance, the CQC confirms that this includes a requirement of being able to communicate effectively with patients, the inference being that they are able to speak the patient's language.

With regard to the contractual arrangements for out of hours care generally, the response stresses that those commissioning out of hours care should ensure that contracts with providers detail rigorous standards in respect of recruitment, induction and training of doctors and that this will apply to future commissioners including GP commissioning consortia.

For further information or advice please contact [Katrina McCrory](#) on 0121 456 8451 or [Kevin Duce](#) on 0121 456 8263.

End to competence tests for EU nurses

The constraints placed on the UK by EU law in relation to the employment of EU nationals, can be demonstrated by the recent decision of the Nursing and Midwifery Council (NMC) to agree to the end of competency tests for workers from the European Union (EU) after being told it could be sued by the European Commission for breaching EU law on "the freedom of movement" for workers.

Under the current system, if nurses from the EU want to register with the NMC and work in Britain, they have to demonstrate that they have practised as a nurse or midwife in their home country for 450 hours in the last three years, or they must undertake a "return to practice" course, which includes stringent testing. This requirement will still apply to nurses outside the EU.

The NMC's council paper on EU registration requirement can be accessed [here](#).

briefing continued

For more information or advice please contact [Katrina McCrory](#) on 0121 456 8451 or [Kevin Duce](#) on 0121 456 8263.

Procurement – rules and guidance

Revised PRCC and Procurement Guide published

The new Government has issued revised versions of the [Principles and Rules of Co-operation and Competition](#) (PRCC) and [Procurement Guide](#), amended in light of the recent White Paper and the revised Operating Framework.

PRCC

A revised PRCC (published March 2010) was already due to come into force on 1 October 2010. The further revised version will come into force on the same date, although that date is still stated to be subject to consultation by Monitor on appropriate changes to the Foundation Trust Compliance Framework.

A key change is that the new principle 7, which concerns access to essential services, will not come into force on 1 October as previously planned. Instead, it will operate as guidance only for the time being.

The new principle 7 states that providers may not refuse to supply essential services or to use services supplied by others, where this restricts patient or commissioner choice against patients' or taxpayers' interests. This is controversial, as in practice it will involve things like providing the services of hospital consultants to new providers (this is the example given in the PRCC document). In addition, it may mean that providers have to give third parties access to their facilities and equipment (although this is under further consideration by the Department of Health, Monitor and the Co-operation and Competition Panel). Providers will be relieved by the delay in implementing this principle, as this recognises that further work is needed to ensure that it is workable before it is introduced.

The other main change is to principle 5, which relates to patient choice. This has been amended so that commissioners have to "promote" rather than "encourage" patient choice, and to reflect the increasing importance of the any willing provider model. The principle now expressly states that promoting patient choice will include, where appropriate, choice of any willing provider.

The third key change to note is that there is express reference to the PRCC applying to shadow GP commissioning consortia. This clears up any doubt as to whether GP commissioners will be caught by this area of NHS policy.

Looking forward, the revised document notes that the status of the PRCC is expected to change in light of further developments flowing from the White Paper, including the responses to the consultation documents. In the longer term, the PRCC is expected to continue to apply until the new competition regime is established in 2012. The new regime will be overseen by Monitor in its new role as Economic Regulator.

Procurement Guide

The revised Procurement Guide has been renamed from the *PCT Procurement Guide* to the *Procurement Guide for commissioners of NHS-funded services*. This is a clear change in emphasis and so it is no surprise that the guide now expressly states that it applies to shadow GP commissioning consortia.

In applying to shadow GP consortia, the Procurement Guide introduces a number of responsibilities that GP consortia may not have anticipated. For example, all commissioners are expected to state their short/medium term commissioning intentions on their website, all procurements and contract award notices must be published on NHSSupply2Health and all commissioners must use the NHS standard contracts. This gives some clarity around

briefing continued

expected arrangements for GP commissioning at this stage. However, in relation to governance, the guide simply states that the arrangements may need to be changed to reflect changes to accountability arrangements resulting from the White Paper.

As with the PRCC, the revised Procurement Guide places more emphasis on increasing patient choice, and in particular the use of the any willing provider model to achieve this. Further guidance is to be issued on this in the context of community services.

It is also worth noting that the new guide expressly states that no advantage must be given to any market sector. This clears up any doubt left by the previous Government's references to the "NHS as preferred provider", which is no longer mentioned.

The revised Procurement Guide is applicable to procurement activity commencing from August 2010 and will be revised further as the White Paper reforms progress. In particular, it will be revised substantially for 2011-12 to reflect the transition to shadow GP consortia and establishment of the shadow NHS Commissioning Board.

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

Procurement – co-operation and competition panel cases

CCP finally gets its first procurement appeal!

The Co-operation and Competition Panel (CCP) has taken on its first procurement appeal, more than 18 months after it was set up. Procurement appeals can only be referred to the CCP once local dispute resolution at PCT and SHA level has been exhausted.

The case involves a tender by NHS North of Tyne for specialist orthodontic services. An unsuccessful tenderer is challenging the process as being in breach of the following parts of the Principles and Rules of Co-operation and Competition (PRCC):

- principle 1: commissioners should commission services from the providers best placed to meet the needs of their patients and populations; and
- principle 3: commissioning and procurement should be transparent and non-discriminatory.

The complainant alleges that the process treated bidders unequally and was not transparent. In particular, it is alleged that one of the panel members for the procurement discriminated against the complainant, that there have been serious errors in the scoring and that there has been a lack of transparency in areas such as failing to allow bidders to ask questions and failing to keep proper records of scores.

Although the dispute resolution at local level found that there was no breach of principles 1 or 3 of the PRCC, the CCP has decided that there are sufficient concerns to investigate the alleged breaches. The complainant is asking for a recommendation that the award decision be set aside. A decision is due by 7 October 2010.

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

briefing continued

CCP case: conduct complaint against North West Specialist Commissioning Team

The Co-operation and Competition Panel (CCP) has recently decided to progress this case to Phase II, in other words a detailed investigation.

The commissioner ran a procurement process for the award of a four year framework agreement for certain mental health services. The complainant provider was excluded from the procurement at pre-qualification questionnaire (PQQ) stage due to their financial standing. They have been told that the next opportunity to get onto the framework is when it comes up for re-tendering in 2013.

The complainant has brought a conduct complaint, alleging that the conduct of the Specialist Commissioning Team prevents it from competing in the market for the next four years.

This is an interesting case because although it is a conduct case, some of the key issues are procurement points. A procurement case could only be appealed to the CCP if it had exhausted local dispute resolution processes at commissioner and SHA level first. This did not happen in this case. However, the CCP has made it clear that it feels that in this case it was not possible to separate out the conduct and procurement issues in order to allow the procurement points to go through local dispute resolution first. Helpfully, the CCP does clarify that combined procurement and conduct complaints will not generally obviate the need to go through the procurement dispute resolution process in relation to procurement issues.

What is also particularly interesting is that from a procurement perspective, you would expect the next opportunity to be appointed to a framework agreement to be when the current term expires and the service is put back out to tender. There is not usually an opportunity for providers to be appointed to a framework mid-term, particularly where it is appropriate to appoint providers via a procurement process (as distinct from an “any willing provider” model). The fact that this could potentially be considered as conduct which distorts the market will come as a surprise to many commissioners and so it will be important to see what decision the CCP reaches. The decision is due in November 2010.

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

Patient matters – deprivation of liberty

Review of DOLS by the Mental Health Alliance

The Mental Health Alliance, a coalition of 75 organisations including clinicians, lawyers and patient user groups, has now published the first [review](#) following the introduction of the Deprivation of Liberty Safeguards (DOLS) in April 2009 under the Mental Capacity Act 2005.

The review expresses concern that these important safeguards are not being properly implemented. Applications for authorisations have totalled only one third of the rate originally predicted by the Government when DOLS were introduced. There are also some large disparities in use between different local authorities and primary care trusts.

The review concludes that there is widespread misunderstanding and confusion regarding the legislation that has led to the safeguards being introduced, prompting concerns for the human rights of individuals confined in hospitals and care homes.

This confusion is felt to be partly due to the absence of a specific legal definition of what constitutes a “deprivation of liberty”. At present practitioners must refer to previous case law, much of which is referred to in the DOLS code of

briefing continued

practice, in order to make their decisions as to whether the evidence suggests a deprivation or merely a restriction of liberty. Only if it is concluded that a person is deprived of their liberty must an authorisation be sought.

The Mental Health Alliance is calling for an urgent investigation into why so few applications for authorisation have been made, updated guidance on DOLS which is more accessible to staff and refresher training.

If you have any concerns regarding the legal issues surrounding DOLS or require any training for your organisation then please do not hesitate to contact us.

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

Patient matters – NICE quality standards

NICE announces the development of further quality standards

Dr Fergus Macbeth, Director of the Centre for Clinical Practice at the National Institute for Health and Clinical Excellence (NICE), has announced the development of nine further Quality Standards for 2010/11. These were referred to NICE from the Department of Health on advice from the National Quality Board, and relate to the management of:

- breast cancer;
- diabetes (types I and II);
- chronic kidney disease;
- end of life care;
- glaucoma;
- depression;
- chronic heart failure;
- alcohol dependence (treatment, not primary prevention or causation); and
- chronic obstructive pulmonary disorder.

Focusing on outcomes of care, patient experience and cost effectiveness, and derived from the best available evidence, the standards will be used to assess existing practice and to improve future delivery.

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

Patient matters – cancer treatment

New £50million interim cancer drugs fund announced

Ministers have announced a £50million interim cancer drugs fund ahead of the creation of the fully-fledged fund giving effect to the Conservative election manifesto promise, expected to be implemented in April 2011.

briefing continued

Prior to the election, the Conservative Party indicated that raising the threshold for employers' national insurance contributions would free up £200million from the NHS budget to create a fund to ensure that no cancer patient would be refused access to drugs licensed since 2005, if their clinicians recommended them, even where the National Institute for Health and Clinical Excellence (NICE) had decided the drugs were not cost-effective. However, Quality Minister for Health, Earl Howe, has now said that the Government is unable to guarantee that the fund will have the £200million budget initially pledged.

The interim fund, resourced with the money originally destined for Labour's Personal Care at Home Act, will be put in place in October 2010 and will be made available through clinically-led regional panels. The anticipation is that existing PCT funding routes, including individual funding requests, will have been explored and exhausted before a call is made on the regional funds. Strategic Health Authorities have already been informed of the likely allocation by region based on the weighted capitation formula, with figures varying between 2.8m for the North East and 7.6m for London.

The National Clinical Director for Cancer, Professor Sir Mike Richards, in presenting his recent report on international variations in drug usage and noting that the usage of new cancer drugs was relatively low in the UK compared with international averages, said that he welcomed the additional £50million being made available this year. Critics of the fund however, have said that it both undermines the work of NICE and the current emphasis on evidence-based allocation of scarce resources and instils a huge funding bias towards cancer care, to the detriment of patients suffering from motor neurone disease, multiple sclerosis, dementia and other chronic and degenerative conditions.

A consultation on the final scheme is scheduled to begin in the autumn and final details will be released after the conclusion of the spending review.

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

Patient matters – mixed sex wards

Plans to eliminate mixed sex wards

Health Secretary, Andrew Lansley, has announced his determined and robust plans to ensure that NHS organisations are accountable for managing their beds and facilities to eliminate mixed sex accommodation where there is no clinical justification. His commitment follows a similar pledge made by the incoming Secretary of State in 1997.

In an effort to ensure patient dignity is preserved, NHS organisations will have clear standards spelling out when they should report a breach. Patients and members of the public will be made aware of any breaches and fines against NHS organisations will be strengthened.

Mr Lansley's commitment follows new data released by the Department of Health evidencing a failure to capture data consistently across the country. This data listed a number of breaches by NHS organisations of their commitment to "virtually eliminate" mixed sex accommodation. In the first quarter of 2010-11, NHS organisations reported 8,028 breaches where patients were accommodated in mixed sex wards without clinical justification. It appeared, from the data, that patients were being placed in mixed sex wards for operational reasons.

January 2011 will see the introduction of new measures to eliminate mixed sex wards. The measures will include the following:

- the elimination of mixed sex wards, except where it is clearly in the best interest of the patient, or reflects their personal choice;

briefing continued

- mixed sex occurrences should always be considered as exceptions rather than the norm and staff must always be able to provide clinical justification for any mixed sex occurrences;
- publication of data so that poor performing trusts have nowhere to hide;
- “breach” will be defined consistently;
- each breach, whether clinically justified or not, will be reported;
- commissioners will apply sanctions to NHS organisations who declare a breach: it will be a matter for the commissioner to determine whether a breach is clinically unjustified; and
- reports will be made publicly available for the first time so that patients requiring elective care will be able to choose not to be treated at the worst performing organisations.

It remains to be seen whether these measures will achieve what the previous government failed to achieve in 13 years.

The DH announcement can be accessed [here](#).

For further information or advice please contact [Lorna Shastri-Hurst](#) on 0121 456 8400.

Patient matters – Care Quality Commission

Care Quality Commission publishes its first report

The Care Quality Commission (CQC) has published its first ever report to Parliament on the state of health care and adult social care in England, [The State of Care](#).

The report states that there has been an overall improvement in health and social care with 63 per cent of NHS trusts, 77 per cent of adult social care providers and 95 per cent of councils having been rated “good” or “excellent”. It is also reported that rates of MRSA and C-difficile have reduced by 34 per cent and 35 per cent respectively and the number of serious incidents reported to the National Patient Safety Agency has reduced.

However, the report highlights that not everything is rosy: some organisations are lagging behind in relation to safety, safeguarding and workforce training.

The report also argues that “joined up” health and social care could deliver both better care and greater efficiency, for example:

- better intermediate care in the community for patients over 75 years could reduce emergency admissions to hospital and result in a saving of about £2billion a year for NHS hospitals;
- better communication between professionals: GPs and hospitals need to send the right information to each other on time and care homes and hospitals need to routinely providing high-quality information on infections to each other in a co-ordinated way;
- councils and primary care trusts should adopt mechanisms for working in partnership such as local area agreements, local strategic partnerships and joint strategic needs assessments.

briefing continued

The CQC has said that it will play a part in driving improvements to make care joined up, but providers should also use the findings in their report to drive change.

A more joined up approach with health and social care is a recurring theme and one that is also reflected in the NHS White Paper. With closer links between the NHS and local authorities anticipated, on the basis of this report these are changes that the CQC will no doubt embrace.

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

CQC publishes guide for patients on NHS standards

The Care and Quality Commission (CQC) has just published a new paper entitled [*What Standards to expect from the regulation of your NHS Hospital: An introduction to important changes to the regulation of NHS Hospitals*](#).

It is a patient guide for those receiving hospital treatment and sets out:

- the important changes to the way in which NHS hospitals are regulated;
- a summary of the new essential standards of care that NHS hospitals must keep to and how these standards are monitored; and
- the standards of care patients can expect when they use NHS hospital services.

What patients can expect from NHS hospitals

NHS hospitals are now legally responsible for making sure they meet new essential standards of quality and safety when delivering patient care. Broadly these essential standards go to the heart of the Government's objective of providing safe patient centred care.

The guide confirms that patients can expect:

- to be involved and told what's happening at every stage of their care. They will be involved in discussions about their care and treatment. Their privacy, dignity and independence respected and consent obtained for each procedure.
- expect care, treatment and support which meets their need. Their personal needs will be assessed to ensure care is safe and supports their rights. Where more than one provider is involved there will be a co-ordinated flow between different services.
- to be safe and protected from the risk of abuse. They will be treated in a clean environment which is protected from infection and both safe and accessible to facilitate recovery. Medicines will be administered safely with suitable equipment.
- to be cared for by qualified staff. They will be treated by adequate numbers of staff who will be well managed and have the chance to develop and manage their skills.
- hospitals to constantly check the quality of its services to ensure patient safety.
- their personal records to be accurate and kept securely.

briefing continued

- their complaints will be acted upon properly.

The new approach of the CQC

In order to meet these new essential services the CQC has remodelled its delivery of regulatory functions and will:

- look at the care the patients are getting rather than at systems and processes;
- listen to what patients have to say;
- check how NHS hospitals are meeting essential standards now rather than in the past;
- put into practice their wide range of powers to target failing hospitals; and
- update their website when there are changes to report about checks, improvements or concerns.

For further information or advice please contact [Lorna Shastri-Hurst](#) on 0121 456 8400.

Patient matters – social care grants

Department of Health consultation on changes to the allocation of the Learning Disability Commissioning Transfer, Preserved Rights and Aids Support Grants

The Department of Health (DH) has recently issued a [consultation](#) on options for distributing three social care grants: learning disability commissioning transfer, preserved rights and aids support, in each case from 1 April 2011.

Responses are requested by email by 5pm on 6 October 2010. The Government will make its response available by the end of 2010.

Although the consultation does not prejudice the outcome of the spending review, which will consider whether these grants should continue in their current form or whether they should be brought into formula grant, the DH is considering changes to the way the grants are calculated.

The consultation paper provides useful summaries of the history of both the Learning Disability Commissioning Transfer and Preserved Rights Grants and is worth a read for this alone.

The DH is also asking PCTs to check the data it has used as the basis of its calculations, ie locally reported learning disability commissioning transfers between PCTs and local authorities; and preserved rights caseload data reported in the 2009 survey.

In each case the DH proposes two options, one of which uses an appropriate relative need formulae (RNF) to allocate the grant. However, in the case of each of these grants, the RNF option has been rejected and the alternative stated as the preferred option.

This preference is based on the finding that for some local authorities moving to a formula based grant allocation would produce allocations which are radically different from the current pattern of caseload and costs and would cause very large changes in the grant received. In addition, the RNF option would not reflect the local authorities' actual responsibilities for younger adults with learning disabilities, the cost of providing services to particular individuals with preserved rights or where people with HIV/AIDS currently live and the costs of services for them.

briefing continued

Having already reached that conclusion, the main purpose of the consultation seems to be to get PCTs to check their figures again.

For further information or advice please contact [Julie Jordan](#) on 01223 222478.

Patient matters – mental health

Guidance in respect of tribunal references following revocation of a Community Treatment Order (CTO)

When a CTO patient is recalled and the order is subsequently revoked the hospital managers, under section 68(7) have a duty to refer the case to the First-tier Tribunal. However, more often than not, by the time the tribunal has been listed, the patient is back in the community again on a CTO. The Deputy Chamber President, Mark Hinchcliffe, has issued [guidance](#) on how to deal with tribunals in this scenario. The guidance states:

If a CTO patient is recalled and the CTO is revoked under section 17F, Hospital Managers must continue to refer cases to the tribunal pursuant to section 68(7) ***but must notify the tribunal immediately if the patient is placed on a new CTO***. Following such notification the referral will be treated as having lapsed, the parties should be notified and the file will be closed unless there are other outstanding references or applications, in which case consideration will be given to the management or consolidation of any continuing proceedings, under case management powers.

This will not prevent the patient making an application if they wish to contest the CTO.

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

Salaried mental health judges to chair restricted First-tier Tribunal cases

On 26 July 2010, the Lord Chancellor and Secretary of State for Justice, Kenneth Clark, agreed to a proposal that salaried mental health judges with suitable experience can be selected to chair restricted patient tribunal cases. Previously, restricted cases could only be chaired by a circuit judge, a retired circuit judge or a recorder QC. As there are now full time experienced salaried judges the pool of chairs for restricted cases will increase. Circuit judges and recorder QCs will, however, continue to deal with the majority of restricted tribunal cases.

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

Patient matters – the Court of Protection

Court emphasises the importance of concentrating on the ‘plain words’ of the Mental Capacity Act

The High Court has ruled on the capacity of a vulnerable adult, T, to decide on two issues: where she should live, or whether she should have contact with family members. The case, [RT and LT v A Local Authority](#) was complex. Persons with T's IQ would normally have capacity to decide on such issues. T had only a mild learning disability but a significant disorder of social functioning and interaction. While she could discuss relevant issues, she had very fixed views on certain matters. An expert jointly instructed by the parties described how T was only able to identify the arguments on one side of these issues, trying to get her to discuss contrary arguments was "the wall through which you could not pass".

The court emphasised that the "individual capacities" set out in section 3(1) of the Act are not cumulative. An individual lacks capacity if any of paragraphs (a) to (d) apply, ie, that the person is unable:

- (a) to understand the information relevant to the decision;

briefing continued

- (b) to retain that information;
- (c) to use or weigh that information as part of the process of making the decision; or
- (d) to communicate that decision (whether by talking, using sign language or any other means).

The court accepted the expert's evidence that T fell under paragraph (c), and ruled that she lacked capacity to decide on the issues of residence and family contact.

In a postscript to the judgment, the court stressed that, where possible, the plain words of the Act should be applied to all cases. Trawling through old case law to interpret the statute will usually not be helpful.

For further information or advice please contact [Philip Grey](#) on 01223 222463 or [Helen Burnell](#) on 020 7648 9237.

Patient matters – children

Working group to produce new guidance for doctors involved in child protection

In a [press release](#) published on 15 July 2010, the General Medical Council (GMC) announced that Rt. Hon. Lord Justice Thorpe, Deputy Chair of the Family Justice Council, and Lord Justice of Appeal, will chair a working group to produce new guidance for doctors involved in child protection.

The working group will:

- review the content of relevant GMC guidance against significant developments regarding doctors' roles in child protection;
- identify and consider any guidelines that other organisations have published on issues related to doctors in child protection work and how this might inform or complement GMC guidance;
- engage with a range of experts on the challenges and practical difficulties doctors face undertaking child protection work, and to seek the views of key interested parties;
- decide the scope and structure of new guidance, taking account of other GMC guidance;
- recommend a draft of the guidance to the GMC;
- oversee and analyse the outcome of a formal consultation exercise; and
- consider and advise on ways in which the new guidance could be disseminated, promoted, and used, and its impact evaluated.

The group has been asked to produce the new guidance by the end of 2011, and will begin the process by issuing a call for evidence this summer.

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

briefing continued

Vital signs monitoring of children

On 18 August 2010 a report on primary care trust and NHS trust performance against the NHS Operating Framework was published.

Data in relation to Child & Adolescent Mental Health Services (CAMHS) is included within the report and provides some useful data with regard to the provision of the service. Readers will be aware that the requirement to ensure patients aged under 18 admitted to hospital for mental disorder are accommodated in an environment that is suitable for their age was introduced via the Mental Health Act 1983 on 1 April 2010.

In relation to CAMHS, the report provides data regarding:

- the amount of time patients under 18 years spend on CAMHS wards and adult psychiatric wards; there is a breakdown for those aged under 16 and those aged 16-17;
- the rating of local CAMHS services including whether:
 - a full range of CAMHS services for children and young people with learning disabilities has been commissioned; and
 - 16 and 17 year olds who require mental health services have access to services and accommodation appropriate to their age and level of maturity;
- arrangements are in place to ensure that:
 - 24 hour cover is available to meet urgent mental health needs of children and young people;
 - a specialist mental health assessment is undertaken within 24 hours or the next working day where indicated; and
 - a full range of early intervention support services is delivered in universal settings and through targeted services for children experiencing mental health problems commissioned by the local authority and PCT in partnership.

The figures show some marked differences across England. The figures can also be used to compare with data published for the period January to March 2010 which can be accessed [here](#).

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

The court process

Judgment considers collective responsibility of jury

NHS employees do not often come face to face with a jury, but you might if faced with a difficult inquest hearing or a serious criminal matter.

A recent case has focused on the role and responsibility of the jury. The collective responsibility of the jury is not confined to the verdict but begins as soon as the jury is sworn. It places an obligation on each juror to ensure the conduct of all members is consistent with the jury oath and that the directions of the trial judge about the discharge of their responsibilities are followed.

briefing continued

This was the judgment of Lord Judge CJ in the Court of Appeal, Criminal Division when deciding the joined appeals of [R v Thompson; R v Crawford; R v Gomulu; R v Allen; R v Blake and R v Kasunga](#) against their convictions claiming jury irregularity.

The general rule is that legal inquiries into jury deliberation are prohibited except for a couple of technical exceptions.

It is expected that where there is any irregularity this will be addressed and remedied during the trial itself. Only in exceptional cases will the court examine jury deliberations after the verdict and even then are very reluctant to question their validity, which is demonstrated by the fact that all but one of these cases were dismissed.

The material sent to potential jurors before trial and the directions commonly given by judges at trial were examined and although they were found to be neither “unfair or deficient” the judge believed the guidance could be strengthened in the following ways:

- a full and comprehensive explanation of collective responsibility be included when giving a general introduction to the jury;
- it be made clear that any irregularity be brought to the attention of the trial judge immediately and not after the verdict;
- specific guidance be given about the use of the internet which makes clear that in order to preserve fair conduct of trial the internet must not be used to either research or discuss the case; and
- where written directions are given to the jury they should be discussed with counsel first and a copy kept on the court file; however, it remains a matter for the judge as to whether they may be helpful and are not a requirement.

For further information or advice please contact [Philip Grey](#) on 01223 222463.

Decisions of the Upper Tribunal are subject to judicial review

The Upper Tribunal is a newly created court of record with jurisdiction throughout the United Kingdom. It has been established by Parliament under the Tribunals, Courts and Enforcement Act 2007. Its main functions are:

- to take over hearing appeals to the courts and similar bodies from the decisions of local tribunals;
- to decide certain cases that do not go through the First-tier tribunal;
- to exercise powers of judicial review in certain circumstances; and
- to deal with enforcement of decisions, directions and orders made by tribunals.

In the recent case of [R \(on the application of Cart\) v The Upper Tribunal and others](#), the Court of Appeal has ruled that decisions of the Upper Tribunal (UT) can still be challenged by judicial review, but only on the grounds of outright excess of jurisdiction or denial of procedural justice. This particular case concerned child maintenance but this decision will have implications for all decisions of the UT which can include mental health matters.

The examples given where the High Court might need to step in were:

briefing continued

- if the UT made an order giving a money judgment which it had no power to give;
- if a member of the UT were to sit when ineligible or disqualified; or
- if the UT conducted a hearing so unfairly as to render its decision a nullity.

They explained that this list was not exhaustive but illustrated the kind of error, although likely to be rare, that would take the UT outside the range of its decision-making authority.

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

Employment

Equality Act: preparing for October implementation

There has been a flurry of activity since last month's announcement that the implementation of the core provisions of the Equality Act 2010 will take place on 1 October. Both the [Equality and Human Rights Commission](#) and [ACAS](#) have published guides on these measures, which will bring all Britain's main anti-discrimination and equal pay measures together into a coherent whole. The [associated codes of practice](#), currently available in draft, are expected to be finalised shortly.

The provisions introducing a new public sector equality duty across all the main discrimination strands will not be commenced in October. Until this happens – and the timetable is still uncertain – the existing gender, race and disability duties will continue to apply, with some minor updating. When implemented, the new equality duty will apply to most NHS bodies, as well as many other public authorities.

There is more background information on the employment provisions of the Act in our [briefing](#), which was published earlier this year, before the Coalition Government was elected.

For further information or advice please contact [Charles Pigott](#) on 01223 222411.



Jacqueline Haines
Senior Solicitor
for Mills & Reeve LLP
+44(0)121 456 8404
jacqueline.haines@mills-reeve.com

www.mills-reeve.com T +44(0)844 561 0011

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.

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 will process your personal data for its business and marketing activities fairly and lawfully in accordance with professional standards and the Data Protection Act 1998. If you do not wish to receive any marketing communications from Mills & Reeve LLP, please contact Suzannah Armstrong on 01603 693459 or email suzannah.armstrong@mills-reeve.com