

Change and reflection: a view from here

Kennedys

Healthcare advice in black and white

Healthcare
Briefing

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Welcome to **Kennedys' Healthcare Briefing**. The past year has again been another challenging one for the NHS and in this issue we look at some topical issues which have occupied all of us. These include the increase in Equal Pay Act claims, the impact of legislative rules on the problem of delayed discharge or "bed-blocking" as it is called, as well as examining what NHS Trusts can do to protect themselves from construction claims. In addition we examine the inquest system and discuss the workings of the Mental Capacity Act including a recent case in which an NHS Trust instructed an Independent Mental Capacity Advocate. Finally, we look at the progress of the Corporate Manslaughter Bill.

I hope you find the Briefing thought provoking and interesting and that you will feel free to raise these and other topics when you visit us on our stand.

Finally may I wish you a good conference and look forward to welcoming and meeting as many of you as possible.



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NHS and equal pay

A look at the basic principles underpinning Equal Pay Act claims

The number of equal pay claims presented to employment tribunals in the past 12 months has more than doubled compared with the previous year. Many of these claims have been made against public sector employers, including the NHS. This article revisits the basic principles underpinning such claims.

Claims under the Equal Pay Act 1970 for backpay following the introduction of the NHS pay grading system Agenda for Change, are being made to an employment tribunal. A claim will be well-founded if an employee can show that he or she has not received comparable pay to a comparator of the opposite sex performing similar work or work rated as equivalent.



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Questionnaires

Such Equal Pay claims will usually be preceded by a questionnaire. Under section 7B of the Act, an employee can submit a list of questions to their employer seeking information that may help him to decide whether or not to start proceedings and, if so, how to present his case in the most effective manner. The questionnaire will usually seek details about pay, terms and conditions appropriate to other staff, and is aimed at identifying appropriate comparators.

The employer is required to respond to the questionnaire within eight weeks. Its responses may be admissible in evidence in later proceedings. If the employer fails to respond – or if its replies are evasive or equivocal – an employment tribunal may later draw inferences adverse to the employer.

Grievances

Under the Employment Act 2002, a claim to an employment tribunal must be preceded by the complainant submitting a grievance under the employers' grievance procedure.

A grievance must be in writing and identify the basis for the grievance in sufficient detail for the employer to be able to understand – and respond to – the complaint. An employment tribunal will not deal with a claim if the claimant has not submitted a grievance at least 28 days before presenting his complaint to the tribunal. If the grievance procedure is not completed because of some failure by the claimant, the employment tribunal will reduce any compensation award by between 10% and 50%. Equally, a failure by the employer to comply with the grievance procedure will result in an increase in compensation in the same percentage range.

Tribunal procedures

The tribunal procedure for dealing with equal pay claims is set out in Schedule 6 to the



Employment Tribunals (Constitution and Rules of Procedure) (Amendment) Regulations 2004. The procedure specific to NHS equal pay claims is subject to the tribunal's protocol for management of multiple claims. Currently, such claims are being processed through the employment tribunal at Newcastle. The procedure provides for Stage 1 and Stage 2 hearings

prior to a final hearing to determine the case. The Stage 1 hearing deals with the identification of relevant comparators, their job descriptions and any other relevant issues. It also gives directions relevant to the provision of independent expert evidence and the facts on which the expert may rely in preparing their report.

The Stage 2 hearing determines the facts on which the parties have been unable to agree, and which relate to the questions on which the independent expert is required to report. The procedure encourages agreement about the essential facts of the case, with the tribunal determining the facts that cannot be agreed. The case will then proceed to a full hearing, where the tribunal may admit the report of the independent expert and hear further expert evidence submitted on behalf of the parties. The set timetables provide for a claim to be heard within 25 weeks of the claim being presented in a case where independent expert evidence is not involved, and 37 weeks when it is.

Under the protocol for multiple NHS equal pay claims, a lead party's claim will be pursued to a final ruling, which will then determine the outcome of all the other supporting claims based on similar facts.

End result

- Successful claimants will be entitled to:
- an equality clause in their employment contracts securing the same pay in the future as their comparator;
 - backpay from the date of lodging the tribunal application to the date of the equality clause;
 - backpay of up to six years running from the date that the tribunal application is lodged; and
 - interest on the backpay.

Compensation for injury to feelings cannot be recovered.



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Beating inflated claims

When it comes to construction projects, the healthcare industry needs to keep better records.

Nobody in the healthcare industry can fail to have noticed the significant – many would say, long overdue – level of new construction work that is going on. It is inevitable, though, that such investment will lead to more legal claims. What should you be doing to safeguard your position?

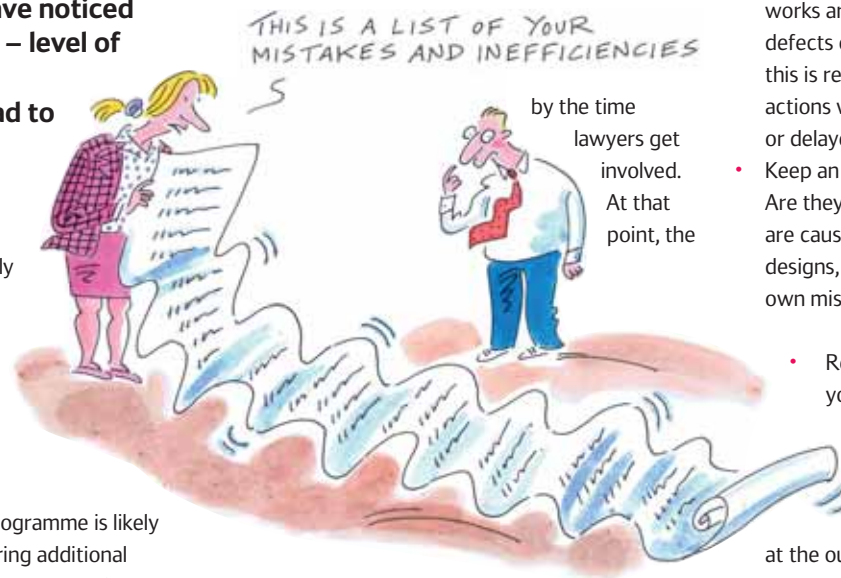
Construction is inherently risky and if an existing facility is being modified or extended, the risks can be substantial. One never really knows for certain what services lay buried beneath the ground or where hidden cables or pipes run until the work is underway. Unforeseen circumstances, changes to what is required, restrictions on access or variations in the timing of work can all have a significant impact on the smooth progression of construction work.

Anything that interferes with the orderly running of a building programme is likely to lead to the contractor being delayed and, consequently, incurring additional costs. Not surprisingly, the contractor will want to recover these costs in order to preserve its profit margin. Even where a partnering approach is adopted, contracts for construction work will almost always make provision for a contractor to be paid additional sums if the work is varied or impeded, and for the date by which works must be completed to be deferred.

Paperwork not memory

The contractor's claims for additional time or money are often disputed, either because the claim is seen as being inflated or because there is insufficient justification for the payment or additional time sought. Contracts frequently provide for a structured process under which submissions are made and evaluated. Discussions at increasingly senior levels then take place before the dispute is referred to a third party (an adjudicator, or perhaps an arbitrator or court) to decide the issue.

Consequently, if an amicable solution to a contractor's claim cannot be reached, any legal action to resolve the dispute may not happen until a considerable time after the events in question. By then, the individuals who were heavily committed to the original construction scheme may well have moved on to other projects. Their memories will have faded too. It is not uncommon for key figures to have no recollection whatever of correspondence they wrote – or even the circumstances in which agreements were reached –



contemporaneous records become critical in establishing what happened and its effect on the construction works.

In these circumstances, whoever has the better paper trail is likely to come out on top. Contractors know this well, and many will have a team of people making sure they have diary entries, memoranda, minutes and correspondence to enable their claims to be presented in the best possible light. In addition, many are adept at identifying opportunities to make legal claims backed by ambiguous or misleading documents. Designed to maximise the contractor's recovery, this paperwork may present a distorted

picture of what really happened.

Protecting yourself

If you want to protect your position against inflated claims, a few practical tips may be helpful:

- Keep better records. This is paramount. Do not rely on oral agreements or memories. Keep your own notes of meetings, and check any formal minutes. Respond to correspondence. If a distorted account is given, make sure you rebut it, or at least indicate that the account is disputed. Do not allow the contractor to write a self-serving history of events.
- Keep track of mistakes or inefficiencies that are your contractor's responsibility. For example, if works are delayed by the need to make good defects or because materials are late, make sure this is recorded. You may need to prove that your actions were not the real cause of increased costs or delayed completion.
- Keep an eye on your own professional team. Are they blaming the contractor when in fact they are causing problems by failing to issue or approve designs, or are they perhaps covering up their own mistakes?
 - Recognise that if you make changes to what you want or the sequence in which you want it to be carried out – or if you prevent the contractor from working efficiently – then you will have to pay for this. Try to establish what you want at the outset and then stick to it.
 - Where changes are necessary, try to agree or, at least, record their impact. A contractor may well argue, years later, that an insignificant change – for example, the diversion of an access route – caused weeks (or even months) of delay. If the impact is actually minimal, make sure you have evidence to demonstrate this to an adjudicator or judge.

As the old saying goes, it's not what you know, it's what you can prove.



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A question of capacity

The Mental Capacity Act 2005 (MCA) seeks to protect the most vulnerable members of society and to ensure that medical treatment and welfare decisions are made in their best interests, following consultation with interested parties.



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The Act is supported by a code of practice, designed to help those making best-interest decisions. Under the MCA, mental capacity is presumed unless the contrary is established. However, where a person does lack capacity, the Act empowers their carers, family members and healthcare professionals to assist in the resolution of issues on their behalf. While only prescribed people can actually make decisions for those lacking mental capacity, the Act makes it clear that a number of interested individuals ought to be consulted before any final resolution is made.

If an individual believes that there may come a time when they will lose the capacity to make decisions, the Act enables them to plan ahead and to ensure that someone is put in place to decide matters on their behalf. Such advanced decisions (as they are known) will then be taken into account if and when the envisaged circumstances do finally arise.

The MCA encourages medical practitioners to support individuals in making decisions on their own. For example, if such a person is in hospital, and a doctor is explaining a recommended treatment option to them, the doctor should be aware of the potential anxiety and stress the patient may be under. This may affect the patient's ability to think rationally and all reasonable means should be used to make them feel as comfortable as possible before making treatment decisions.

If there are communicational or linguistic problems, the doctor should try to overcome these by using, for example, an interpreter or consulting a member of the family. Medical professionals will also need to take into account any cultural, ethnic or religious factors that may have a bearing on a person's thinking.

Assessing capacity

It is not enough for a doctor to suspect that a patient lacks capacity. A two-stage assessment must be undertaken:

- (1) It must be established that there is an impairment of – or a disturbance in the functioning of – the patient's mind or brain.
- (2) It must be established that the impairment or disturbance is sufficient to render the person incapable of making a decision. That is to say, as a result of the impairment or disturbance, the patient must be unable to:
 - understand the information relevant to the decision;
 - retain the information;
 - use or weigh that information as part of the process of decision-making; and
 - communicate their decision to others.



When establishing capacity, a medical practitioner should consider talking to the patient's friends or family. When discussing personal details, the importance of confidentiality must be taken into account. If the person lacks the capacity to agree to the information being shared, and/or refuses to consent at the time, a balance must be struck between public and private interests in deciding whether or not to permit disclosure.

Best interests

When considering a person's best interests, the following factors should be assessed:

- the individual's past and present wishes and feelings (including, for instance, any relevant written statements made by the individual when they had mental capacity);
- any beliefs and values that may influence the person's decision if they had capacity; and
- any other factors the patient would consider if they were able to do so.

The MCA encourages discussion by practitioners with all interested parties, whenever that is both practicable and appropriate. One interested party might be a donee under a lasting power of attorney (LPOA).

Lasting power of attorney

For the first time, the Act allows a prescribed individual to consent to treatment on behalf of another adult. An LPOA makes provision for any subsequent loss of capacity. It is a mandate signed by a donor who has mental capacity at the time of signature. The mandate allows the person named – the attorney – to act on the donor's behalf in those matters listed in the power from the time when the donor loses their mental capacity. With such lasting power comes lasting responsibility.

Anyone can make a LPOA. It is thought that elderly people – perhaps with a prognosis of dementia or who have a diagnosed degenerative condition – are the most likely people to make this kind of arrangement. LPOAs will come into force as from October 2007.

A donee must be authorised under a LPOA, which must be registered. The donee must make decisions that are in the best interests of the donor, having carried out a reasonable assessment of the options available and of the patient's best interests in the light of those circumstances. The donee must take account of the decision they believe the patient would have made if they had mental capacity. This may be a very complicated exercise, particularly if there are many different treatment options.

Before a donee considers what decision to make, they should make sure they understand the patient's personal circumstances. They should then take advice from doctors and carers as to what they think is the best course of action. Where appropriate, the donee should seek advice on alternative courses of action – just as the patient would do, if they had capacity.

There may be conflicts between donees and doctors over what is in the patient's best interests. If those conflicts cannot be resolved, then the Court of Protection should be consulted. Similarly, there may be conflicts of interest between the donee and donor. For instance, a donee under a LPOA may have a vested interest in the donor's property, if they are also a beneficiary under the will. That may constitute a conflict of interest, when it comes to making end-of-life decisions. Again, this may necessitate an application to the Court of Protection.

All decisions made under a LPOA must be reached after taking reasonable steps to determine that the patient really does lack capacity. The donee must

believe the patient lacks capacity and then make a decision in the patient's best interests. If a court later rules that a decision made on behalf of a patient was not a reasonable one – or that the patient was ill-treated or wilfully neglected – the decision-maker can be held criminally liable. As from April 2007, that offence carries a maximum sentence of five years imprisonment.

Independent advocates

Where no family or next of kin can be found and the patient is incapacitated, the NHS Trust can instruct an independent mental capacity advocate (IMCA) to act on the patient's behalf. Such an advocate cannot make decisions on behalf of the patient, but they can step into the shoes of the patient's next of kin and discuss treatment options with doctors. If they disagree with the doctor's assessment of the patient's best interests, an IMCA can apply to the Court of Protection for a declaration. IMCAs came into existence in April 2007 and Kennedys were involved in what we believe to be the first case of this kind, involving a patient on life support who had no known family. Before a definitive

treatment plan was agreed, an IMCA was instructed to advocate on behalf of the patient and discuss his best interests with the medical staff.

Court of Protection

From October 2007, the new Court of Protection will be staffed by judges and have a broad jurisdiction regarding matters relating to incapacity. The court will be able to make:

- declarations about whether a patient has capacity;
- declarations about whether an act was done lawfully;
- decisions regarding a patient's property, business and financial dealings, and general welfare; and
- decisions on LPOAs and whether donees have acted appropriately.

It will be able to determine the validity and scope of advance decisions.

Summary

- When a person is undergoing medical treatment, it is presumed that they have mental capacity.

- If it is thought they may lack such capacity, all reasonable means should be used to make them feel as comfortable as possible before a practitioner decides this.
- Where treatment is proposed, the patient must give consent. If the patient lacks the capacity to give such consent, treatment must be given in line with their best interests, following consultation with all relevant individuals, including donees under an LPOA. If there is no next of kin the healthcare body should consider instructing an IMCA.
- During any such consultation, the confidentiality of a patient's personal details must be taken into account.
- An act carried out in relation to a patient's care and treatment is not authorised if it conflicts with the decision of an attorney acting within the scope of their power.
- The Court of Protection may be consulted if required.



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Looks like carelessness

Perhaps the most contentious verdict in a coroner's court is one of neglect.

The inquest system has been described as (at its best) an investigation of the facts of how a person died and (at its worst) an archaic system which invests the power of investigation in one individual, namely the coroner, to rule on the cause of death.

This conclusion, or verdict, will often attract the most attention. Ultimately, though, an inquest is important in helping bereaved families assess the circumstances surrounding the death of their relative, which may then lead to a subsequent civil claim.

Submissions to the coroner

Once the evidence has been heard, the lawyers or interested parties are allowed to make submissions to the coroner (although these are not always welcomed) as to the appropriate verdict. These submissions may only be on issues of law. But some coroners do still allow references to the facts, as it is very difficult to make submissions about the appropriate conclusion without referring to the facts of the case or to the evidence heard during the course of the inquest.

Other coroners, on the other hand, take a tougher line. For instance, at one inquest – where a nurse

injected the wrong patient with a dose of insulin, thereby causing her death – the nurse gave evidence confirming that she had confused the deceased with another patient, and conceded that she had made a significant error. The family's lawyer, however, was not allowed to refer to the nurse's actions. The most they could do was to point out to the coroner that it was open to him to find that death had occurred as a result of neglect.

Form of verdict

There has never been any obligation on the part of the coroner to use a particular form of verdict, although currently there appears to be a move towards a "narrative" or "longer-form" verdict (which sets out in narrative form how the person died) rather than the "shorter-form" verdict (such as death due to natural causes, accident or misadventure) suggested in the Coroners' Rules 1984.



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Deaths in hospitals settings are most usually shorter-form verdicts. A verdict of misadventure does not suggest any form of wrongdoing and, in a coronial sense, is no different to an accidental verdict (*R v HM Coroner for Portsmouth ex parte Anderson* (1987) 1WLR 1640). The coroner will often reach a conclusion of misadventure if a medical procedure was in some way involved in the death, but this is not to suggest that the medical procedure was unnecessary or performed in a substandard manner.

Finding of neglect

One of the most contentious verdicts is neglect. Case law has established that neglect means something very different in a coroner’s court to negligence in a civil court, although it can be hard to rationalise this distinction.

The most often quoted authority on what constitutes neglect remains *R v North Humberside Coroner ex parte Jamieson* (1995) QB 1. In that case, the Court of Appeal confirmed that (in the context of medical treatment) “neglect” means a gross failure to provide adequate nourishment or liquid, or to provide (or procure) basic medical attention, shelter or warmth for someone in a dependent position. Potentially, a failure to provide medical attention for a dependent person whose physical or mental condition reveals an obvious need for such help may amount to neglect. But neglect is not usually appropriate as a freestanding conclusion. It is normally only attached as an adjectival finding to the verdict of natural causes or accident/ misadventure, or as part of a narrative verdict.

More recent case law (*R (Middleton) v West Somerset Coroner* (2004) UKHL 10) has arguably extended the approach laid down in *Jamieson* so that a jury can now



therefore averted death, the test for causation will be satisfied and a neglect rider may be given.

But if the lawyer can show (or is allowed by the coroner to demonstrate) in the context of their submissions that treatment was not obviously necessary, then they may be successful in persuading the coroner that, despite the failure to provide treatment, neglect is not an appropriate finding.

incorporate a finding of neglect in a broader range of circumstances in cases where the verdict relates to systemic neglect.

However, neglect should never form any part of any verdict unless a clear and direct causal connection is established between the conduct so described and the cause of death.

Some coroners have adopted the test applied in *R v HM Coroner for Coventry ex parte the Chief Constable of Staffordshire Police* (2000) 164 JP. In that case, Mr Justice Tomlinson said: “The touchstone in the present case is, I believe, the opportunity of rendering care, in the narrow sense of that word, which would have prevented the death. The question is whether [the person providing medical care] had the opportunity of doing something effective”. In other words, if there was a real and missed chance of doing something that would *probably* have been effective (as opposed to might have made a difference) and



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Corporate Manslaughter Bill – Crunch time

Getting the new proposals onto the statute book is going to be a close run thing.

Much has been heard about the proposed new offence of corporate manslaughter but how does this differ from the law as it currently stands and what are its implications for NHS Trusts?

The corporate manslaughter and corporate homicide bill, if enacted, is designed to make it easier to prosecute organisations when their gross negligence leads to death. Currently, a corporate body (including NHS Trusts) can be prosecuted at common law for manslaughter and there have been a number of high-profile attempts to do so – most notably, the prosecutions following the Herald of Free Enterprise ferry disaster, the fire at the North Sea Piper Alpha oil

platform and the Hatfield train crash. All these attempts failed, however.

In fact, very few prosecutions for corporate manslaughter have ever been successful: over the past 10 years, there have only been seven such convictions. The main reason for this meagre success rate is that, in each case, the prosecution has to prove:

- An individual has been guilty of gross negligence resulting in a person’s death.
- That individual is so senior that he or she is to be regarded as the “directing or controlling mind” of the company.

This is known as the identification principle. The successful prosecutions have all been against small



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companies where it has been easier to fulfil the “directing or controlling mind” test. In a large company or organisation, the prosecution will always find it difficult to identify a senior company official who acted as the directing or controlling mind, was grossly negligent and caused a person’s death. In such companies, the individuals responsible for a tragic incident may be far removed from those who represent the directing mind. Alternatively, the company’s negligence may well have been the result of the collective errors of a number of officials.

The new offence

If the new bill becomes law, it will abolish the common law offence of corporate manslaughter and replace it with a statutory offence that creates a new framework for finding an organisation guilty of corporate manslaughter. The current wording of the bill states that an organisation will be guilty of an offence if the way in which its activities are managed or organised:

- (1) causes a person’s death; and
- (2) amounts to a gross breach of a relevant duty of care owed by the organisation to the deceased.

An organisation is only guilty if the way in which its activities are managed or organised by its senior management are a substantial element in the breach of its duty of care. “Senior management” is defined as the individuals who play significant roles in:

- (1) the making of decisions about how the whole or a substantial part of the organisation’s activities are managed or organised; or
- (2) the actual managing or organising of the whole or a substantial part of such activities.

NHS Trusts are included in the class of organisations covered by the proposed legislation and the term “senior management” covers both those in the direct chain of management as well as those in, for example, strategic or regulatory compliance roles.

For an NHS Trust to be prosecuted successfully, two things will have to happen:

- (1) the Trust must be found to have owed a duty to take reasonable care for a person’s safety; and
- (2) the way in which the Trust’s activities have been managed or organised must amount to a gross breach of that duty and caused the person’s death.

How the activities were managed or organised by senior management will have to be a substantial element of the gross breach. This new test differs from the one under the common law in a number of ways but, most importantly, it will no longer be necessary for an individual to be convicted of manslaughter. The new offence allows for the failings of senior management to be aggregated, bringing in the concept of collective failure. In addition, the second part of the definition of senior management will catch people much further down the management chain.

Consequently, the authorities will now look at a far wider section of the workforce when considering whether to prosecute an organisation.

Relationship with health and safety offences

Since the case of R v Southampton University Hospitals NHS Trust (2006), a Trust has already had to face up to a potentially wider liability for health and safety offences. In Southampton, two senior house officers were convicted of manslaughter by gross negligence with regard to the treatment of a patient. Regular observations of the patient’s pulse, temperature and blood pressure revealed striking abnormalities but the two house officers failed to make an appropriate diagnosis or to seek senior medical advice. There were also failures in the implementation and maintenance of the Trust’s management systems, in particular the supervision of senior house officers in the trauma and orthopaedic department.

The Trust pleaded guilty to an offence under section 3(1) of the Health and Safety at Work Act 1974 (HSWA) for failing to discharge its duty towards persons not within its employment. The fine originally imposed on the Trust was reduced on appeal from £100,000 to £40,000.

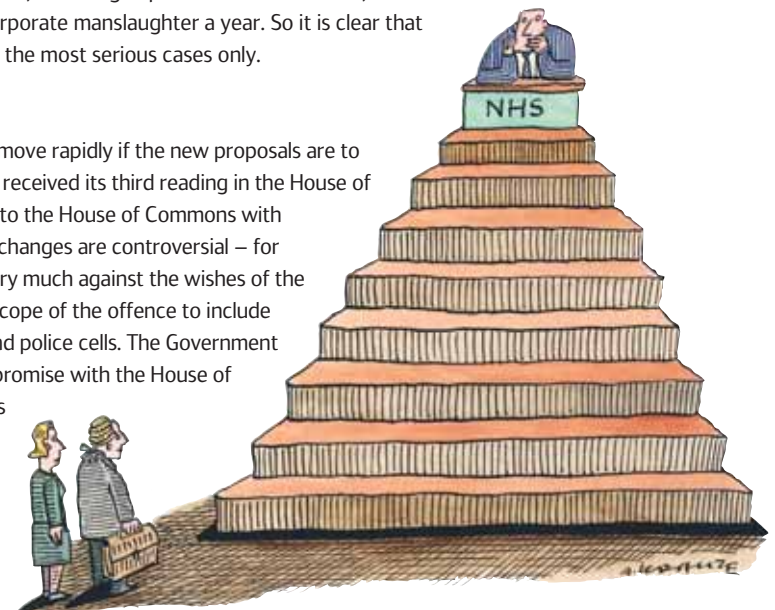
Summary

There has been widespread criticism of the current law of manslaughter. Not surprisingly, the criticism is loudest in the worst cases of corporate liability, where a conviction for corporate manslaughter is seen by the public as more appropriate than a conviction for a HSWA offence. However, it will still be easier to prosecute under HSWA because all that has to be established is that an organisation failed to take all reasonably practicable measures. By contrast, in a manslaughter case, the prosecution has to prove gross negligence and causation – that is to say, that the grossly negligent actions of the defendant have led to the victim’s death. In addition, fines for HSWA offences in the Crown Court (which will deal with any cases involving death) are already unlimited.

The Home Office estimates that, following implementation of the bill, there will be 10-13 additional cases of corporate manslaughter a year. So it is clear that prosecution will be limited to the most serious cases only.

Need for speed

The government will have to move rapidly if the new proposals are to become law. The bill has now received its third reading in the House of Lords and has been returned to the House of Commons with amendments. Some of these changes are controversial – for example, the amendment (very much against the wishes of the government) extending the scope of the offence to include deaths in custody in prison and police cells. The Government is now trying to agree a compromise with the House of Lords. Crucially, if the bill does not obtain Royal Assent by 20 July 2007, it will fail and the current common law offence based on the identification principle will remain in force.





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Is bed-blocking a thing of the past?

While the legislative rules seem to be failing, joint working initiatives between local authorities and voluntary organisations remain effective.



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It was hoped by many in the NHS that the problem of delayed discharge – or “bed blocking” as it is called – would be greatly reduced by the introduction of fines for local authorities who failed to co-operate in the rapid transfer of patients from acute wards.

In December 2003, there were 3,220 patients in England unnecessarily occupying beds in such wards, often due to delays by local authorities in the assessment of patients’ needs.

The Community Care (Delayed Discharges) Act 2003 (the Act) came into force in January 2004 and enables NHS Trusts to compel local authorities to undertake an assessment of a patient’s social care needs by serving a formal notice. Failure to comply with such a notice results in a fine of £100-£120 per day. At the same time, extra financial help has been given to local authorities to help them co-operate quickly.

But the Act is restricted in its use. It only applies to patients receiving acute care on the NHS – but not palliative, rehabilitative, intermediate, mental health or maternity care – and it does not permit notices to be served upon NHS bodies even if the delay is caused wholly or partly by the NHS.

Implementation

In many areas where primary care trusts (PCTs) and local authorities had pooled budgets, it was felt that the NHS was expected to impose fines

with one hand while building up joint working programmes with the other. In these cases, the Act was hardly ever used and the government grants were used to encourage joint working initiatives such as appointing dedicated discharge co-ordinators to plan discharges from the point of admission. Across the board, the initial signs seemed encouraging. By December 2004, only 2,190 patients in acute care in England were affected by delayed discharge – a 32% decrease from the previous year.

Where are we now?

There is anecdotal evidence that the Act alone is not working. For example, according to the Health Service Journal, United Lincoln Hospitals NHS Trust had 90 beds blocked in December 2006, compared to 76 in December 2005. Brighton and Sussex University Hospitals NHS Trust also reported a significant rise in April 2007 on the comparable 2006 figure, with 65 beds blocked.

Even where improvements have been made, it seems these may be attributable to the additional funding rather than any use of the Act.

There are a number of possible reasons why the Act is no longer working:

- The grants to local authorities ceased in 2006 and services now have to manage bed-blocking within their usual budget.
- When delayed discharges drop in number, emergency readmissions go up, suggesting that some discharges are made prematurely or without a suitable care package in place.
- A higher number of patients are being admitted to hospitals through A&E departments and there is pressure on NHS Trusts to meet A&E targets.
- There is virtually no spare capacity in the acute hospital system, due to the payment by results system.
- Reconfiguration has left many areas without social and community services.
- Delays are now less likely to relate to local authorities’ behaviour and are more likely to be the consequence of patients awaiting further non-acute NHS care.

Delays will also probably arise for patient-related reasons because of the impact on patients, carers and families of assessments for continuing care. If a patient is assessed as having a primary health need, then continuing NHS care is arranged, at no cost to the patient. However, if a patient is assessed as having primarily social care needs, continuing care is arranged subject to financial assessment, and may even result in the patient having to fund their own care, even if this means selling the family home.

In January 2006, the government’s eligibility criteria for these assessments were legally challenged in the case of *R Grogan v Bexley NHS Care Trust* (2006). As a result, PCTs, local authorities and strategic health authorities were asked to review their eligibility criteria and to look again at cases where patients in social care had received a high level of health care. This review of procedures and individual cases may well have affected how quickly acute patients have been assessed for continuing care.

The Mental Capacity Act 2005 (which came into force in April 2007) could also affect discharges from acute care, as carers and families are now more likely to challenge treatment and care decisions.

The future

The Act has had a limited effect in reducing the number of blocked beds and is having even less impact now in the light of the changing nature of the NHS.

The responsibility for addressing the problem appears to have been thrust on those working in the NHS without the support of extra resources. However, joint initiatives with local authorities and voluntary sector organisations continue to be effective and the Department of Health now provides a plethora of materials on the practicalities of dealing with delayed discharge (see <http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/IntegratedCare/Delayedischarges/index.htm>). At least, the government seems to acknowledge that fines alone are not enough.

