

Silent revolution in the NHS

We explain the new laws and legislation that are happening in the NHS. We review their impact and what you need to do.

Kennedys

Healthcare advice in black and white

**Healthcare
Briefing**

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Welcome to **Kennedys' Healthcare** briefing. In this edition, we look at some topical issues to coincide with our attendance at this year's NHS Confederation Conference including the Mental Capacity Act 2005 and the much publicised Freedom of Information Act 2000 which finally came into force in January 2005. In addition, we discuss the impact on Trusts of a number of high profile Court cases concerning the Coroners office and Health & Safety Executive.

This month we will run seminars on the proposed Corporate Manslaughter Bill and its impact on Trust Executives. If you are interested in attending please come and see us on stand C14 and let us know.

The past year has again seen the NHS make the front pages of our daily newspapers although it seems to be only 'bad news' that sells papers despite the fact we have much to celebrate about our NHS.

I hope you find these articles interesting and wish you all a good conference in Birmingham.





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Inquiries after death

What sort of investigation should follow a death in a hospital?

There have recently been several high profile court cases involving deaths in custody. In one of these cases, Middleton, the decision of the House of Lords has helped to clarify – and widen – the scope of a coroner’s inquiry when such deaths have occurred.

But does this approach apply to deaths in hospitals? What exactly is the scope of the coroner’s inquiry into deaths arising from clinical negligence? According to the recent High Court decision in *Goodson v HM Coroner for Bedfordshire & Luton*, the inquest following most deaths in hospital will be much more limited.

What happened in *Goodson* ?

In *Goodson*, the deceased was undergoing a diagnostic test for gallstones when his duodenum was accidentally perforated. He developed peritonitis and was being resuscitated in HDU when he suffered a cardiac arrest and died.

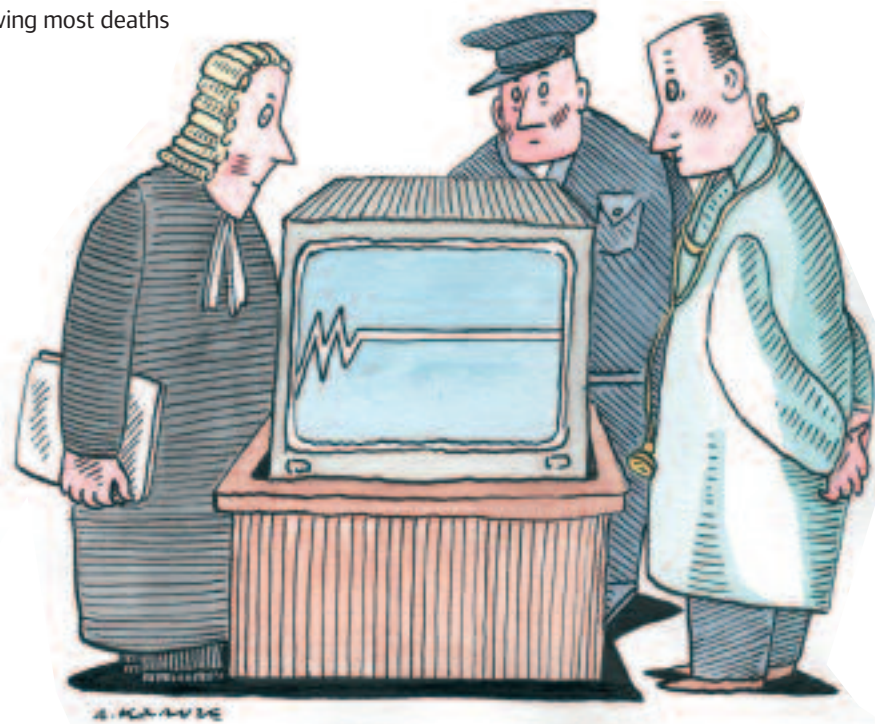
The family’s solicitor – relying on ECHR’s article 2, which concerns the right to life – asked the coroner to seek a report from an independent expert witness. The coroner refused because he was already calling evidence from an independent pathologist and from the relevant clinicians. He went on to record a verdict of misadventure.

Effective investigation

The family sought judicial review, arguing that an independent medical report was essential to meet the criteria laid down for an effective investigation under article 2.

This argument was founded on well rehearsed principles. It is generally accepted that any potential violation of article 2 means that the state must carry out an effective public investigation into the circumstances of the death. This helps to keep state agents accountable for deaths occurring in their areas of responsibility. In many cases, the inquest is the means by which the state will carry out this duty.

Exactly what is required during the investigation depends on the circumstances of the case;



where there is an allegation of the use of lethal force by an agent of the state (for example, the “death on the rock” shootings) this must be treated with the utmost seriousness. This kind of death would require a far more detailed investigation than one which was the result of alleged “simple negligence” in hospital.

In *Middleton*, the House of Lords held that the state’s obligation to investigate deaths could be met by widening the scope of the inquest so that the question of “how” the death occurred should be interpreted to mean not just “by what means” but also “in what circumstances”.

Hospital deaths

In *Goodson*, the judge held that there is “no separate procedural obligation to investigate under article 2 where a death in a hospital raises no more than a potential liability in negligence”. Indeed, he found that simple negligence in itself does not amount to a breach of the state’s positive obligations to protect life under article 2. He said that there should still be an effective investigation but the inquest should only play one part in this, along with other means for inquiring into liability, such as criminal, civil and possibly disciplinary proceedings.

The judge went on to find that, even if there was a procedural obligation under article 2, on the facts of this particular case, the coroner’s inquiry would still have been sufficient to satisfy the requirements of an effective investigation.

What is more surprising is that the coroner made clear in his evidence to the High Court that, in deciding whether an article 2 inquiry was necessary, he had considered whether there had

been negligence. He would not need to come to any conclusion on this point; but many in hospital may feel uncomfortable that the question is even on the coroner's agenda.

Appeal

Permission has been granted for an appeal in Goodson and this is currently scheduled for October.

If it is upheld, it seems that the inquest will not be seen as the only means of inquiry into a hospital death. There will be no one-stop investigation and families will have to look to a range of judicial remedies – criminal, civil and even disciplinary hearings – for a complete inquiry.

Uncertainties

Intriguingly, some of the comments in Goodson might suggest that the decision could possibly have been different if the family had provided the coroner in advance with an independent expert report showing credible evidence of negligence. This point was not explored in the judgment but it may perhaps encourage solicitors representing a

bereaved family to obtain an expert report well in advance of an inquest. If so, will NHS trusts feel obliged to do the same?

Uncertainty continues for both NHS trusts and bereaved families as to what they can expect from an inquest into a hospital death. And it is hard to be reassured by the further delay of the proposed white paper on coronial reforms.



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Violence in the workplace

Health trusts that fail to safeguard their employees face criminal penalties.

The Health & Safety Executive has been working to raise the issue of workplace violence in hospitals and other healthcare establishments over the last few years. Significantly, South West London and St George's Mental Health NHS Trust recently pleaded guilty to an offence under section 2 of the Health and Safety at Work etc Act 1974 at a hearing at the Central Criminal Court. This is the most high-profile instance to date of an NHS trust being prosecuted under the Act in relation to workplace violence. Section 2 imposes a duty on every employer "to ensure ... so far as reasonably practicable, the health, safety and welfare of all his employees".

Facts of the case

The case arose out of the death of one of the hospital's psychiatric nurses, who was killed by a schizophrenic patient of the hospital. The trust

admitted it had breached its section 2 duty to the psychiatric nurse who was killed. The court was told by the HSE's counsel that the nurse had been working alone, without clear procedures and with inadequate measures in places to check on his safety. It was described as a "significant management failure".

In sentencing the trust, Mr Justice Gordon concluded that leaving the nurse alone without appropriate support from staff on other floors was unacceptable. The judge went on to say that the holding area for the patient had been unsuitable and that, while the nurse had been told not to attend to this particular patient without other staff being present, he was effectively left to deal with the patient on his own.

The trust was fined £28,000 and ordered to pay the HSE's costs of £14,000. The judge admitted he found sentencing difficult, as the trust was non-profit making and publicly funded. The judge made it clear that a much larger fine would have been appropriate had the trust been a for-profit organisation.

General lessons

While the case involved the actions of a schizophrenic patient in a hospital, the need to manage workplace violence is the same for any healthcare provider. Trusts should now undertake risk assessments of individual patients and an evaluation of the location in which they are treated. They must ensure that staff are appropriately trained in breakaway techniques, including how to defuse and de-escalate situations. They must also have emergency procedures on how to raise the alarm if a violent situation develops. In addition, they should have systems in place to deal with staff who have suffered verbal or physical violence.

Level of violence

At the big picture level, incidents of violence at work have fallen significantly in the last decade. A recent Home Office report ("Violence at Work: Findings from the 2002/2003 British Crime Survey" published in the first quarter of this year) reveals that, overall, the incidence of physical assaults at work has fallen by 35% since 1995. Sadly, however, health and social welfare professionals (including doctors, nurses and dentists) still face a significant risk of violence when carrying out their job.



Tackling the problem

A number of initiatives have been launched to tackle workplace violence. In 2000, the

Health & Safety Commission began a three-year campaign aimed specifically at reducing the number of violent incidents at work: that campaign's effectiveness is now being

evaluated. The government has also launched a clutch of programmes – for example, the NHS zero tolerance campaigns, “Working Together: Securing a Quality Workforce for the NHS” and “Improving Working Lives” – these programmes are designed to tackle the problem in the healthcare sector in particular.

In addition, the HSE has issued various guidance documents (including “Violence and aggression to staff in health services” published by HSE books ISBN: 0717614662). Such guidance is not compulsory. But if employers have not implemented the recommended steps, then an HSE inspector may well conclude that not all “reasonably practicable” measures have been taken to reduce or minimise the risk of violence in the workplace. In a separate initiative, the HSE has also commissioned

research into the effectiveness of training in the management of violence and aggression in the healthcare industry.

Bad publicity

The hope is that the successful prosecution of South West London and St George’s Mental Health NHS Trust will have a strong effect on other healthcare providers who will not only want to ensure the safety of their staff but also avoid the type of prosecution brought against the trust in the St George’s case. While the fine and the costs incurred by South West London are significant, perhaps the biggest sanction available against an NHS trust is the negative publicity and the stigma of having been found to be criminally responsible for the breach of the HSWA.

Knowing me, knowing you

Over the last six months,
NHS bodies have become
acquainted with the effects
of the “right to know”.

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On 1 January 2005, the Freedom of Information Act 2000 came fully into force. The Act provides a general right to request information held by public bodies – including NHS organisations.

When information is requested, it must be disclosed unless it comes within an exemption. Many exemptions are available and they fall broadly into two categories: qualified and absolute.

If a qualified exemption applies, information can only be withheld if this is also in the public interest: the public interest in withholding the information must be greater than the public interest in disclosing it. If an absolute exemption applies, the information can be withheld without considering the public interest test.

There are two areas of particular concern to NHS bodies: commercial information and information about deceased patients.

Commercial information

Many problems have arisen through companies seeking commercial information about competitors – often given to a public body during a tendering process. The Act is retrospective and public bodies will already be holding confidential and commercially sensitive information about private organisations that may have contracted with them in the past.

The relevant exemptions are in section 4.1 (information provided in confidence) and section 4.3 (commercial information).

Section 4.1

Although the confidence exemption is absolute, it is limited in two ways:

- It will not be triggered merely by saying that information is “confidential” it applies only where, if the public body disclosed the information, it could be sued for breach of confidence.
- It only applies where information has been provided to the public body: it cannot be used to protect the body’s own confidential information.

Section 4.3

Where disclosing the information is unlikely to lead to legal action for breach of confidence, section 4.3 may apply. This is a qualified exemption and so the public interest test applies here.

Section 4.3 provides an exemption for trade secrets. The Information Commissioner has said that “trade secret” may have a fairly wide meaning: the term can sometimes extend to customers’ names or a company’s pricing structure, where these are not generally known and if they give a company “competitive edge”.

This section also gives an exemption for information that may prejudice the commercial interests of either the public body or another person or organisation. This will be a matter of degree and each case must be considered on its facts.

Even if disclosure is thought to prejudice someone’s commercial interests, the public

interest test must apply as well. In the NHS, the question of ensuring a Trust’s public accountability for spending decisions would be an important factor.

Consulting the company

Under the Act, there is no obligation for the public body to consult the company in question when a request for information is received. But the Department for Constitutional Affairs’ Code of Practice states it is “highly recommended” for public bodies to tell the affected organisations of these requests and, where necessary, consult with them.

In practice, this allows the public body to ask the company to justify why the information should be withheld. Although the ultimate decision is for the public body, the company can do some of the hard work in weighing considerations under the exemption and the public interest test.

Increasing numbers of contracts with the private sector are likely to include a duty to liaise when a request occurs. But the Information Commissioner has made it clear that public bodies may not go so far as effectively to “contract out” of their obligations under the Act by agreeing to withhold information that does not fall within one of the exemptions.

Deceased patients

Section 4.0 provides an absolute exemption from disclosure information which constitutes personal data under the Data Protection Act 1998. This will cover most health records.

However the Data Protection Act defines “personal data” as data relating to a living individual who can be identified from that data there could be difficulties about:

- records of patients who have died, perhaps in circumstances of interest to journalists;
- data which does not identify a patient, such as anonymised data used for clinical audit purposes.

Information given to a doctor is likely to be provided in confidence and so section 4.1 of the Act may assist here; but would this cover information that was not “provided” to the public body, for example the details of a hospital post mortem report?

Section 3.1 covers circumstances where it is not possible to make a disclosure without breaching other legislation. The Human Rights Act 1998 (article 8: right to private and family life) or the Access to Health Records Act 1990 (which provides that a deceased patient’s records can only be accessed by a personal representative or someone with a claim arising out of the death) may both be relevant.

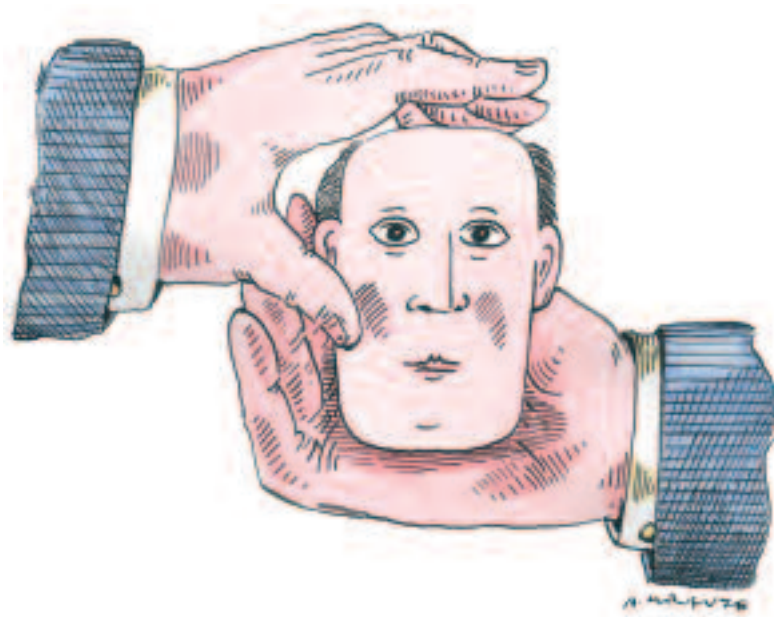
Further guidance may be obtained from the Information Commissioner and the Department of Constitutional Affairs.



Mental Capacity

The Mental Capacity Act 2005 (MCA) significantly alters the way in which healthcare decisions relating to patients without capacity can be made.

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For the first time, there is a statutory definition of adult incapacity. Under the Act, an adult is unable to make a decision for themselves if they cannot:

- understand the information relevant to that decision;
- retain that information;
- use or weigh the information as part of the process of making the decision; or
- communicate their decision.

Best interests

Previously, where an individual could not give consent, then he or she could be treated under the common law doctrine of necessity, according to which treatment necessary to preserve life or prevent serious deterioration in the patient's condition could be given in accordance with the individual's best interests. However, it was never entirely clear what constituted "best interests".

Under the new Act, several questions have to be resolved in arriving at a decision about what is in a person's best interests:

- Will the individual in future have capacity regarding the matter in question?
- If yes, when is that likely to be?
- What are the individual's past and present wishes and feelings?
- What directions are contained in any advance decision (see further below)?
- What beliefs and values might influence the individual's decision, if they had capacity to consent to treatment?
- Are there any other factors that the individual would consider if they were able to do so?

For the first time, the Act now requires consultation, if practicable, with the following:

- anyone named by the person lacking capacity as someone who should be consulted on the issue(s) in question;
- anyone caring for – or who is interested in the welfare of – the person without capacity;
- any donee of a lasting power of attorney (see below) granted by the person lacking capacity; and
- any deputy appointed under the Mental Capacity Act.

The MCA now provides two routes to obtaining consent to treatment in cases where the adult does not have capacity:

- (1) via a lasting power of attorney; or
- (2) via a court-appointed deputy.

Lasting powers of attorney

The Mental Capacity Act has repealed the Enduring Power of Attorney Act 1985 and introduced the concept of a lasting power of attorney. The two powers are similar, but the range of a lasting power of attorney is greater than that of an enduring power. Lasting powers, like enduring powers, need registration with the Court of Protection before they are valid.

The lasting power of attorney allows the donee (the person to whom the power has been granted) to make decisions relating to the healthcare treatment of the donor (the individual granting the lasting power) if the donor lacks capacity. This is new. However, if the donor wants the donee to make life-or-death decisions in the event that the donor becomes incapable of making such decisions for himself or herself, this must be specified in the lasting power.

Advance decisions

The Act also formalises the position in relation to what are now known as “advance decisions” (previously “advance directives”). Advance decisions can only be made by individuals with capacity who are 18 or over. They must be in writing, signed by the individual making the advance decision and witnessed by at least one other person. An advanced decision is defined in the MCA as:

“a decision that if

- (a) at a later time and in such circumstances as [the individual] specifies, a specified treatment is proposed to be carried out or continued by a person providing healthcare for [that individual], and

- (b) at that time, [the individual] lacks capacity to consent to the carrying out or continuation of that treatment,

the specified treatment is not to be carried out or continued”.

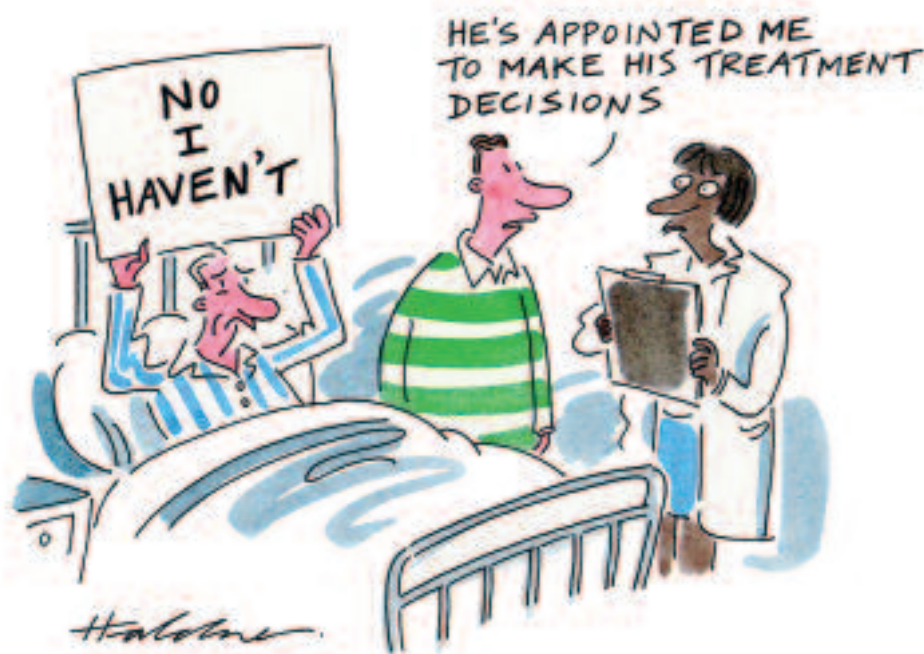
However, the advance decision will not apply in certain circumstances. For example, it will not apply to life-sustaining treatment unless the advance decision is backed up by a statement from the individual that, even if life is at risk, the decision does indeed exclude the particular treatment being considered.

Anyone treating the donor who is ignorant of an advance decision will not incur any liability. Nor will they be liable if they withhold or withdraw treatment in the reasonable belief that an advance decision exists which is valid and applies to the treatment in question.

Greater freedom of choice

We have yet to see how the Mental Capacity Act will work in practice, but the statutory definition of incapacity is to be welcomed. For some time, the law regarding individuals without capacity has been complicated, and responsibility for treatment has traditionally rested with the doctors. The Act now gives patients a sound legal basis for appointing another individual to make medical care decisions in the event that they become incapable of consenting to such treatment themselves.

This Act has not yet come into power.





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Pay protection for junior doctors

The rebanding of medical posts has arguably generated more questions than answers.

Safeguarding junior doctors against unexpected fluctuations in earnings is a noble principle. In practice, however, there are significant difficulties in applying it to long rotations, involving a series of posts or placements in a training programme. The identity of the posts – and their banding – may well not be clear at the outset, so it can be difficult to determine whether or not the earnings expectations of the doctor(s) involved are reasonable.

In deciding if (and to what extent) pay protection applies, a key issue is identifying the moment at which a post has been 'accepted' by the doctor. Does there have to be a binding legal acceptance, where both parties have formally agreed all the details of the job, or will a simple acceptance in principle be enough? Following a recent Court of Appeal decision, the courts seem likely to take a common sense approach when deciding on the meaning and timing of a doctor's acceptance of a post, which then triggers pay protection.

A post will probably be treated as having been accepted once the doctor knows when and where they will take up that particular job, irrespective of whether the information is given by the employing health trust, the Deanery or the programme director. It is debatable, however, whether doctors on rotation accept all the posts on the rotation list from the outset, or, alternatively, only accept them as and when they are notified of each individual post during the course of the rotation. An NHS trust will improve its position in this regard by ensuring that all communications from it, the Deanery or the programme director state clearly when making job offers that the pay band for the relevant post(s) has not been determined for the period of the doctor's occupancy of that particular job.

Difficulties over rotation

The biggest problems are likely to be with posts in a long rotation that currently come within Band 2A of the New Deal for Junior Doctors but which, within five years, will drop back into Band 1A, with a significant reduction in the number of unsocial hours worked. In this context, the key underlying provisions are paragraphs 21(h) and (i) of the national terms and conditions of service (NTCS).

Paragraph 21(h) deals with the (now, largely historical) question of pay protection for single posts on their transition to the New Deal. But it can be construed as saying that a person occupying a rebanded post is entitled to pay protection while they continue to do that particular job.

Paragraph 21(i) applies paragraph (h) to doctors on a rotation. Consequently, paragraph 21(h) will protect the pay for a particular rotational post if, before a doctor takes up the job:

- (1) it has been assessed for a New Deal-compliant pay band; and
- (2) the duties of the post have been changed before the doctor takes it up. But for paragraph 21(i) to apply, the relevant post must have been assessed as New Deal compliant at the 'time of appointment' to the rotation. At present, however, it is unclear whether this means the actual beginning of the rotation, or the acceptance in principle of the series of posts or placements making up the rotation.



Assessments

There are difficulties too about what is meant by a New Deal pay band assessment. On one view, there must be a link between the assessment and the change in duties; on another, if the assessment is made before the doctor accepts the post, then any subsequent changes in duties will also be pay protected. Arguably, paragraph 21(i) will only be triggered if a New Deal assessment of a post is carried out before the rotation begins, and that assessment changes the duties of the post after the rotation has begun but before the job is taken up by a particular doctor. The wording of paragraph 21(i) appears to anticipate only one New Deal assessment in relation to each post on the rotation. Accordingly, it is questionable whether it affords pay protection following a second assessment that takes place between the doctor's joining the rotation and their taking up the rebanded post.

Start of protection

For doctors who are not aware of the timing or location of a post at the outset of the rotation, pay protection may only bite when they accept that particular post. Inevitably, this will be at the lower band then applicable, and will reflect any subsequent rebanding between the doctor joining the rotation and their acceptance of the post.