HEMPSONS

Key Legal Developments Update - Healthcare

October 2018

Priority **High** **Medium** **Low**

Area of Interest	Title	Significance
Withdrawal of care	*An NHS Trust and others (Respondents) v Y (by his litigation friend, the Official Solicitor) and another (Appellants)* [2018] UKSC 46	The Supreme Court upheld a decision made at first instance that there is no mandatory requirement for the Court to decide upon the best interests of every patient with a prolonged disorder of consciousness (PDOC) before withdrawing clinically assisted nutrition and hydration (CANH). The Court noted that it was sufficient for clinicians to follow the provisions of the Mental Capacity Act 2005 and relevant professional guidance (such as that provided by the General Medical Council and the Royal College of Physicians) before withdrawing CANH in patients with PDOC as long as the patient's family members were in agreement. An application to Court is required in situations where the family is in disagreement with the clinicians about the patient's best interests. (**Please find the case here**: http://www.bailii.org/uk/cases/UKSC/2018/46.html)
Inquests	*R (Maughan) v HM Senior Coroner for Oxfordshire and others* [2018] EWHC 1955 (Admin)	The High Court determined that a conclusion of suicide at an inquest can be determined on the balance of probabilities if the Coroner and/or Jury are satisfied that the deceased: 1) took his or her own life, and 2) they intended to do so. Before this judgement it was the criminal standard, beyond reasonable doubt. (**Please find the case here:** http://www.bailii.org/ew/cases/EWHC/Admin/2018/1955.html)

GDPR

Subject Access Requests

Unlike the scenario under the old Data Protection Act 1998, the new Data Protection Act 2018 (the DPA 2018) stipulates that individuals can no longer be charged for making subject access requests.

It remains possible to levy a reasonable fee in specified circumstances. The DPA 2018 provides that where requests are unfounded or excessive, in particular because of their repetitive character, the data controller may either:

(a) charge a reasonable fee taking into account the administrative costs of providing the information or communication or taking the action requested; or
(b) refuse to act on the request.

Please find the relevant provision here: (http://www.legislation.gov.uk/ukpga/2018/12/contents/enacted)

Health and Social Care

QCQ State of Care Report 2017/18

The QCQ State of Care Report 2017/18 is the annual assessment of health and social care in England. The report looks at the trends, shares examples of good and outstanding care, and highlights where care needs to improve. This year's report highlights:

- Quality of care is not consistent, and access to good care increasingly depends on where in the country you live and the type of support you need.
- Five factors that affect the sustainability of good care for people;
  (a) Access to care and support
  (b) Quality of care for people
  (c) Workforce to deliver care
  (d) Capacity to meet demand
  (e) Funding and commissioning

- Sustainable care is no longer just about whether individual organisations can deliver good care, but whether they can successfully collaborate with other services as part of an effective local system.

(**Please find the report here:** https://www.cqc.org.uk/sites/default/files/20171011_stateofcare1718_report.pdf)

Governance	*New CHC framework*	In March 2018, the Department of Health and Social Care amended the National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care ("CHC Framework"). The new version of the framework will be in effect from October 2018. It aims to reflect the implementation of the Care Act 2014. Main changes include: • updating the definition of social care need; • improvement of the annual CHC review process; • guidance on the continuing healthcare funding process; • emphasis on ensuring continuing healthcare process should not delay hospital discharge; • amended checklist so potential outcomes are clearer; and • revised guidelines to include a two-stage approach where an individual wishes to challenge a decision about CHC eligibility. **Please find the CHC Framework here**: (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/746063/20181001_National_Framework_for_CHC_and_FNC_-_October_2018_Revised.pdf)
Inquests	*Increased public funding for representation for bereaved families*	Guidance has been issued by the Lord Chancellor making it easier for families to obtain legal aid at Article 2 inquests. It is likely that legal aid will be awarded in most circumstances where a death is unnatural or due to the likely suicide of a person detained, whether in prison or a mental health unit or in police custody. (**Please find the guidance here:** https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/715441/legal-aid-chancellor-inquests.pdf)
NHS Resolution	*Learning from suicide-related claims - A thematic review of NHS Resolution data*	NHS Resolution published a report by Dr Alice Oates in relation to recurring issues in suicide cases.

It makes the following nine recommendations for improvement in care:

- referral to specialist substance misuse services for individuals with a diagnosis of substance misuse.
- systemic and systematic approach to communication and information sharing.
- risk assessments should form part of wider needs assessment.
- ensure staff undergo specific training in therapeutic observation.
- NHS Resolution continues to support both local and national strategies for learning from deaths in custody.
- Department of Health and Social Care should discuss with Healthcare Safety Investigation Branch (HSIB), NHS Improvement, Health Education England to consider creating a standardised and accredited training programme for all staff conducting SI investigations.
- Commissioners take responsibility for ensuring family or carers have been actively involved throughout the investigation process.
- Trust boards ensure those involved in arranging inquests for staff have an awareness of the impact inquests and investigations can have on individuals and teams.
- NHS Resolution supports the stated wish of the Chief Coroner to address the inconsistencies of the PFD process nationally.

Trusts are encouraged to consider how they will implement these recommendations.

(**Please find the report here:** https://resolution.nhs.uk/wp-content/uploads/2018/09/NHS-Resolution_learing_from_suicide_claims_148pp_ONLINE1.pdf)

Procurement

Lancashire Care NHS Foundation Trust & Blackpool Teaching Hospitals NHS Foundation Trust v Lancashire County

The Trusts successfully challenged the Council in relation to the award of a contract for the provision of Public Health Nursing services to persons aged 0 – 19.

	Council [2018] EWHC 1589	The Court concluded the procurement award decision should be set aside as the Trusts showed there was a material breach in the tender process. The reasons given by the Council for the scores awarded to the Trusts and the winning bidder for the quality evaluation questions were not sufficient to explain the scores given. (Please find the case here: http://www.bailii.org/ew/cases/EWHC/TCC/2018/1589.html)
Emergency Services	*Darnley v Croydon Health Services NHS Trust* [2018] UKSC 50	The Claimant attended A&E after suffering a head injury. He was told by the receptionist he would have to wait four to five hours to be seen. As a result, the Claimant left A&E after 19 minutes. He deteriorated shortly after arriving home and suffered permanent brain damage and disabling left hemiplegia. The evidence showed that the receptionist was incorrect, and the Claimant would have been seen by the triage nurse within 30 minutes. The Supreme Court overturned the judgements at the Court of first instance and the Court of Appeal. It found that as soon as the Claimant sought medical attention, there was a duty on behalf of the hospital (in his case the receptionist) not to provide misleading information. The Court was clear that it was applying existing legal principles regarding the duty of care. This case serves as a warning to Trusts that all employees (regardless of training) must provide information about care accurately if that information may be relied upon by the patient. (**Please find the case here:** http://www.bailii.org/uk/cases/UKSC/2018/50.html)
Mental Health Act	*Hewlett v Chief Constable of Hampshire* [2018]	The Court granted the Applicant permission under section 139(2) of the Mental Health Act 1983 to issue civil proceedings against police officers. The Applicant claimed police officers executed a warrant under section 135 to

		remove the applicant from his home. The applicant made an allegation of disability discrimination under the Equality Act 2010 on the grounds that the officers had been advised of the applicant's claustrophobia and aversion to being touched, but no reasonable adjustments had been made. The time limit for bringing a claim had passed, however section 118 of the Equality Act 2010 gave the Court discretion to extend time. The applicant had also satisfied the low threshold of showing a reasonable prospect of successfully obtaining an extension of time from the trial judge.
Assisted suicide	*R (Conway) v Secretary of State for Justice* [2018] EWCA Civ 1431	NC was diagnosed with Motor Neurone Disease in November 2014. He wished to end his life once his prognosis was six months to live. NC sought a declaration under section 4(2) of the Human Rights Act 1998 that section 2(1) of the Suicide Act 1961 is incompatible with his rights under Articles 8(1) (respect for private and family life and 14 (prohibition of discrimination) ECHR. In 2017, the Divisional Court refused his application to bring judicial review proceedings. In 2018, NC was unsuccessful in his appeal to bring judicial review proceedings. The Court of Appeal determine that a blanket ban was proportionate. (**Please find the case here:** http://www.bailii.org/ew/cases/EWCA/Civ/2018/1431.html)
Consent	*Gail Marie Duce v Worcestershire Acute Hospitals NHS Trust* [2018] EWCA Civ 1307	The Court of Appeal has provided further clarification on a doctor's duty to disclose material risks to a patient following the landmark ruling of *Montgomery v Lanarkshire Health Board*. It was held the trial judge was correct in his application of the test set out in *Montgomery* and the issue of whether a doctor should have been aware of the relevant risks is a matter for expert evidence.

The Court of Appeal clarified the application of the 'but for' causation test following *Chester v Afshar*, stating '*the majority decision in Chester does not negate the requirement for a claimant to demonstrate a "but for" causative effect of the breach of duty*'.

(**Please find the case here:** http://www.bailii.org/ew/cases/EWCA/Civ/2018/1307.html)

Clinical Negligence

£37 Million Clinical Negligence Settlement

In 2012, the Claimant contracted Herpes Simplex virus at birth which developed into a brain infection. Delays in prescribing and administering anti-viral medication at the Watford General Hospital led to the Claimant, sustaining a catastrophic brain injury and suffering from significant cognitive and motor impairment. The Claimant requires 24 hour care.

In 2017, West Hertfordshire Hospitals NHS Trust admitted liability and apologised to the Claimant and to his family. In 2018, an agreed settlement was approved by Mrs. Justice Lambert sitting in the High Court.

The Claimant will receive a lump sum together with annual, index-linked and tax-free payments to cover the cost of his care. The capitalised value of the settlement, calculated over the Claimant's lifetime, is around £37 million.

This is thought to be the biggest ever settlement for a clinical negligence case in the UK.

Mental Capacity

Mental Capacity (Amendment) Bill

Line by line examination of the Mental Capacity (Amendment) Bill (the "Bill") took place in the House of Lords on 22 October.

The Bill will amend the Mental Capacity Act 2005 in relation to procedures surrounding individuals that may be deprived of their liberty and lack capacity to consent.

For further information on any aspect of this Legal Update, please contact John Holmes (j.holmes@hempsons.co.uk) or Helen Claridge (**h.claridge@hempsons.co.uk**).