Key issues for healthcare organisations

#OneStepAhead
Welcome to Capsticks’ collection of key thoughts and commentaries in response to recent health stories in the press. We produce these on a regular basis and you can find them on the Insights page of our new website at www.capsticks.com.

Healthcare is our core sector and we have many friends and colleagues in organisations nationwide. Like them, and like you, we are proud to be celebrating the #NHS 70 birthday. Our centre pages reflect some real life experiences from our people on what the NHS means to them.

Here at Capsticks we have a unique position in working for both health and housing clients. We can see the mutual benefits for both sectors in working closer together in a variety of ways and we are working hard to start business conversations, introducing clients and contacts from both sectors to each other and supporting them as necessary. For example, in the last six months we have put seven NHS organisations in touch with RPs, who are active in their particular area, and who would be keen to work with them on specific projects. Do come and chat to us if you are interested in joint ventures or if you have any other ideas in mind.

We hope you find this booklet of interest and if you need any help with anything, feel free to let us know.
Fantastic example of joined up thinking by a Housing Association and the NHS

Swan Housing Association has launched an innovative new “Night Owl Service”, providing Care and Support services throughout the night in partnership with North East Essex Clinical Commissioning Group (CCG) and Anglian Community Enterprise (ACE). Covering Colchester, the 15-month pilot project supports the discharge of hospital patients who require assistance during the night.

careindustrynews.co.uk

The news this week of Swan Housing’s innovative new ‘Night Owl Service’ is an excellent example of how the housing and care sectors are coming closer together to meet the interests of vulnerable people and to reduce patient harm. This type of joined up thinking is very welcome as patients can be the most vulnerable in the first hours and days after discharge from hospital.

The pressures on the NHS are serious. I have sat in on patient-flow and bed management meetings with senior members of NHS management and have seen for myself how hard it can be to manage the constant demand on hospital services. There is pressure at the front end to treat patients admitted to the A&E department as soon as possible for obvious reasons. If these patients require hospital admission then a bed must be found. That bed can very often only be found if someone is discharged from hospital. It might sound unbelievable to an outsider but the reality is that, at times, is it is very much ‘one in, one out’. This same pressure can apply to extremely specialist beds such as ICU beds.

Any initiative which helps to ensure that those patients who can be discharged remain out of hospital is very much to be welcomed. After all, no-one wants to be sat in a hospital bed if they can avoid it but people often need support to make a discharge a success. The Swan initiative operates 7 days a week, 365 days a year, between 11pm and 7am. The Night Owl Service helps to ease the crucial transition period between hospital and home and is a shining example of the opportunities that exist in the space between housing and health.

As a specialist health and housing sector firm, I am sure we see more of these examples at Capsticks and I look forward to providing enabling advice which helps drive these projects forward.

Ian Cooper
Partner
ian.cooper@capsticks.com
0113 323 1060
Of the clinical negligence claims notified to us in 2016/17, obstetric claims represented 10% of the volume and 50% of the value.

resolution.nhs.uk

This NHS publication provides a helpful summary of the newly introduced Maternity Incentive Scheme. This is a great initiative to improve patient safety and to help reduce obstetric incidents.

Jeremy Hunt announced last year that the Government were bringing forward to 2025 the target of halving the numbers of stillbirths, neonatal and maternal deaths and severe birth-related brain injuries that was originally set for 2035.

NHS Resolution aims to incentivise the delivery of best practice in maternity services, through a link to CNST scheme contributions.

In order to qualify for a 10% (at least) discretionary rebate of CNST maternity contributions for 2018/19 under the new incentive scheme, progress will be measured against 10 criteria agreed by the National Maternity Champions.

The ten maternity safety actions agreed with the National Maternity Safety Champions and in partnership with NHS Digital, NHS England, NHS Improvement, Royal college of Obstetricians and Gynaecology, Royal College of Midwives, MBRRACE and CQC are:
1. Are you using the National Perinatal Mortality Review Tool to review perinatal deaths?

2. Are you submitting data to the Maternity Services Data Set to the required standard?

3. Can you demonstrate that you have transitional care facilities that are in place and operational to support the implementation of the ATAIN Programme?

4. Can you demonstrate an effective system of medical workforce planning?

5. Can you demonstrate an effective system of midwifery workforce planning?

6. Can you demonstrate compliance with all four elements of the Saving Babies’ Lives care bundle?

7. Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback?

8. Can you evidence that 90% of each maternity unit staff group have attended an ‘in-house’ multi-professional maternity emergencies training session within the last training year?

9. Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?

10. Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution’s Early Notification Scheme?

Rebecca Aldous
Senior Solicitor
Rebecca.Aldous@capsticks.com
0208 780 4926
Dr Bawa-Garba granted second appeal

Dr Bawa-Garba has been granted permission to appeal the judgment of the Divisional Court.

Pressure from the medical community rallying behind Dr Bawa-Garba, who was struck off following the GMC’s appeal of the MPT decision to suspend her for 12 months, may have swayed the Court of Appeal. Permission for a second appeal was granted on 28 March 2018 for Dr Bawa-Garba to appeal the judgment of the Divisional Court on 25 January 2018 to erase her from the medical register.

More than £360,000 has been raised to fund Dr Bawa-Garba’s legal challenge of the ruling.

Dr Bawa-Garba had been found guilty of gross negligence manslaughter at a criminal trial in 2015, following the tragic death of Jack Adcock in 2011 who had Down’s Syndrome and a heart condition, following undiagnosed sepsis leading to cardiac arrest. A series of errors included signs of infection being missed and erroneously believing he was under a DNR order.

Both the Department of Health and the GMC have published their terms of reference reviewing how doctors are investigated for gross negligence manslaughter.

Joanna Bowyer
Partner
Joanna.Bowyer@capsticks.com
0208 780 4805
Doctors ‘significantly over investigated’ for manslaughter, say medico-legal experts

The bar should be raised to ensure that doctors are only investigated for gross negligence manslaughter (GNM) in cases that are the ‘medical equivalent of driving down the wrong side of the motorway’, the Medical Defence Union (MDU) has warned.

GP online has quoted the MDU in advocating that the bar should be raised for investigating gross negligence (GNM) in cases that are the “medical equivalent of driving down the wrong side of the motorway”.

Following the high profile case of Dr Bawa-Garba, clarity is required as to how the GMC, Coroners and the criminal courts investigate doctors for GNM. The figures quoted are that more than nine in 10 cases currently investigated do not lead to a prosecution, yet doctors are often suspended and treated like criminals pending a lengthy investigation process. This is concerning at a time when doctors feel increasingly under pressure.

It is interesting to note that, in Scotland, there is apparently no known case where a doctor has been successfully prosecuted for an equivalent offence of GNM. It will be interesting to see if a Scottish model is followed.

I also welcome clarity for doctors as to how their reflections will be protected, which they do not believe is currently not the case. We have received a number of enquiries about this very issue from doctors following the Bawa-Garba case.

Joanna Bowyer
Partner
Joanna.Bowyer@capsticks.com
0208 780 4805
The case is the latest in a series of Court interventions about how NHS employers interpret the national framework for managing doctors, Maintaining High Professional Standards.

The High Court has handed down a judgment with important implications for any NHS employer managing a doctor facing a criminal investigation. The doctor in question was being investigated for gross negligence manslaughter. The High Court decision is:

(A) The implied term of mutual trust and confidence means that an employer should not conduct its internal disciplinary process before the CPS has reached a decision about prosecution, where the doctor’s position is that he has been advised not to participate and where the Trust cannot promise it will not pass on information from the disciplinary to the police.

(B) Where the doctor is subject to an interim suspension order by the GMC, preventing him from carrying out any work, his employer is not entitled to cease paying him.

(C) Significantly, the Court also interprets the national consultant contract (Schedule 19) in a way that suggests an NHS employer can dismiss a doctor without an internal hearing, for failure to maintain his or her registration (ie as a result of the interim suspension order).

Martin Hamilton
Managing Partner
Martin.Hamilton@capsticks.com
0208 780 4832
The Commission should make sure findings from hospital inspections are available to the public as soon as possible. It should write to us in April 2019 with an update on its performance. This should include whether it has achieved the commitment it made on publishing at least 50% of hospital reports within its timeliness target by 2018–19 and how it has balanced this with maintaining the quality of reports.

publications.parliament.uk

A consistent concern we hear from clients is the length of time CQC takes to produce inspection reports following inspection. This is particularly for hospitals. It can take months following an inspection for the draft report to even reach the provider, let alone be in final form for publication to the public.

In its annual report published in July 2017, CQC recognised that improvement was needed in ensuring that reports are published more quickly so that the public and the provider understand what the concerns are. After all, sometimes there can be a few issues lurking within the report that were never raised as issues during the inspection which comes as quite a surprise to a conscientious provider who wants to put things right immediately if something is found to be wrong. Shorter and more concise reports are part of CQC’s new strategy moving forward.

This month the Committee of Public Accounts in its report on how CQC is undertaking its regulatory duties, has also highlighted this as a problem specifically for hospitals – its states that there is too much of a delay in the public having information about the quality of care in a hospital. The Committee has recommended that CQC “should make sure findings from hospital inspections are available to the public as soon as possible”. CQC must update the Government in April 2019 reporting on whether performance has improved. CQC’s strategy moving forward will be to have shorter inspections and shorter reports which should make turnaround quicker.

Siwan Griffiths
Legal Director
Siwan.Griffiths@capsticks.com
0208 780 4887
Daniel Griffiths

I broke my spine when I was 19 and taken to Poole Hospital, I was then transferred to spinal surgeons in Dorchester where I had surgery and after care. The surgeons explained the process and were excellent, giving me the best chance possible to recover and completely free of any cost. The surgeons explained the process and were excellent, giving me the best chance possible to recover.

Alex Wilson-Jones

My #NHSstory is in 1994. I broke my arm roller skating, so badly the bone ripped through the muscle tissue. Pretty traumatic for a 9 year old, but I remember the staff at Kingston Hospital being beyond amazing – and I even got a Hedgehog Award for bravery!

Vicky MacDonald Hill

Thank you to the NHS ambulance crew who drove my father all the way from Pembrokeshire to Guy’s and St Thomas’, the surgeons who operated on him in the middle of the night and to the wonderful nurses who cared for him in the ICU.

Nimi Bruce

Last year my daughter suffered a head injury in the park and required corrective surgery to her face carried out at the Royal Surrey. She asked around a billion questions in advance of the surgery and when she came around from the anaesthetic was a bit delirious and demanded to know the identity of a Consultant she had not seen before! The care she received from the wonderful NHS team was outstanding from start to finish.

Rachael Heenan

Shout out to @leedshospitals @harrogatenhsft helping to bring my sons into the world and improve and extend quality of life for my dad ❤️

Daniel Griffiths

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#MyNHSstory

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#MyNHSstory
Ian Cooper

Thank you to the NHS and Newcastle General Hospital. When I was 10 years old my mum had to undergo serious neurosurgery to remove a tumour from behind her eye. The operation lasted over 6 hours and had serious risks associated with it. My mum had to undergo the same operation when the tumour came back 4 years later. I will always be grateful to the NHS for the expert care and treatment they provided to my mum.

Joanne O'Rourke

I worked on a children’s ward for a week (many years ago) at Kingston Hospital. They really did a fantastic job in trying to keep children entertained before going to surgery or if they were long-stay patients. It’s really important that the children are distracted from whatever treatments or surgeries they are undergoing and the staff work really hard to make sure they have a good memory of their time in hospital.

Andrew Rowland

In 2008, our first baby was diagnosed with a lump on her lung in pregnancy. After her birth she was referred to Great Ormond Street. A world expert on her condition decided that keyhole surgery was needed. A large team operated on Tess at 10 weeks and after 4 hours an egg-shaped lump was removed. The only lasting effect is three keyhole scars. The staff at the hospitals were incredible and we will always be grateful to them.

Ron Simms

My NHS Story is from the late 1950s when the NHS was first actively recruiting from overseas, and so attracted two people from two completely different countries to work for them as a porter and a care assistant. Those two people were my Dad and Mum, so without that recruitment drive, I literally wouldn’t be here.

Martin Hamilton

21st December 2007: my daughter delivered by the amazing UCLH maternity team. Crumbling Victorian building (now demolished!), 21st-century medicine.
Claims to employment tribunals have soared by 90% since the abolition of fees, latest official figures show. The government’s latest quarterly statistics, for October to December 2017, show 8,173 single claims were brought, up from 4,200 in the same period in 2016.

Claims were 16% up on the previous quarter and are at the highest level since 2013, when employment fees were introduced. The backlog of single claims has increased by 66%.

The latest figures from the Ministry of Justice show a big increase in the volume of employment tribunal claims. The number of single claims issued in the period October-December 2017 increased by 90% from the same period 12 months earlier. Further the backlog of single claims has increased by 66%. This is the biggest increase since employment tribunal fees were abolished in the summer of 2017, although as yet the number of claims issued each month remains well below pre-fee levels.

The huge increase in claims will come as no surprise to those of us who regularly deal with the employment tribunal. The backlog of claims means that cases are being listed for hearing many months into the future, and the tribunals are clearly struggling to cope with the increased demand. Employers and employees, not to mention those that advise them, will be hoping that the tribunals are granted increased resources to cope with this surge in claims.

Sarah Parkinson
Professional Support Lawyer
Sarah.Parkinson@capsticks.com
020 8780 4756
The Health Secretary has published a letter to private providers in light of a critical CQC report on the independent health sector. Measures and issues outlined in his letter include:

1. Exploring an ‘inadequate’ regime for private hospitals;
2. Greater transparency (data collection) obligations;
3. The possibility of cost recovery for NHS treatment provided in consequence of negligent private treatment;
4. Addressing a lack of supervision and governance of consultants.

The sector was asked to reply within two weeks.

Andrew Latham
Associate
Andrew.Latham@capsticks.com
020 8780 4674
NHS Providers will no longer have to pay 50% of any sale profits from the disposal of the primary care estate back to the Department of Health and Social Care (DHSC). The DHSC can now retain the sum to fund STP capital priorities.

capsticks.com

Some NHS Trusts are still not aware that they can reclaim overage currently payable to the Department of Health and Social Care on the disposal of old PCT properties.

The Government has recently responded to many NHS Trusts’ frustrations of being unable to retain and re-use the full sale proceeds arising from the disposal of ex PCT properties.

Therefore if your Trust is planning to dispose of any ex-PCT properties, be sure to seek early approval from DHSC that any overage can be reclaimed and used for other Trust premises investments.

Henry Matveieff
Partner
Henry.Matveieff@capsticks.com
0121 262 6568

Government response to the Naylor Review – What are the opportunities for you?
Health and Housing – new partnerships, new challenges

The Naylor report has acted as a catalyst for health and housing sectors to work together but there are inherent issues around raising awareness of the potential benefits, speaking the same language and having a forum to debate future policies. In addition to the report there are other drivers such as the financial constraints within the health sector, the lack of affordable housing nationwide and the bleak picture around all types of social care.

Large numbers of housing associations would readily sign up to a deal with a health body, for example investing in the development of keyworker accommodation, but the perception in recent times is that the health sector is not as interested in this avenue as it might be and projects are slow to get going. However, innovative ideas can get off the ground and Capsticks is working with several joint partnerships, facilitating discussions and dealing with issues such as procurement, land sales, workforce and commercial contracts. Housing Associations are not for profit organisations with surplus money to invest and view the NHS as a ‘sister’ organisation, working for public service and ploughing money back into their sector. There is a natural affinity between the two sectors and together they can help support the public in the best way possible.

Capsticks has a unique position, working for both health and housing clients, and can provide both the means for these two sectors to come together as well as the requisite legal advice. We talk the language of both these sectors and can assist at all levels. Our specialist healthcare and housing teams are working closely together, with our clients, to understand the challenges of cross-sector working and to provide simple solutions. All this means that we won’t be reinventing the wheel for your project, and instead will be offering tried and tested solutions that we know will work. Getting it right first time, every time, without any nasty surprises is crucial to the success of these projects.

We are currently involved in cross-sector research culminating with a report on how the NHS could benefit from working with housing sector in order to achieve the outcomes outlined in the Naylor report and we are involved in several ground-breaking projects that highlight the wide range of benefits available to both sides – e.g., shared revenue streams; the provision of new facilities or staff accommodation; step-down facilities and patient hotels; and estates reconfiguration. In some cases, these projects are cross-subsidised by the sale of new residential units – delivering ambitious capital projects within tight budgets. For example, we are working with a housing association and an NHS Trust who are looking to deliver keyworker accommodation in a new way, that allows for the NHS to share in the revenue stream without taking void risk. We are also working with another NHS organisation on the proposed delivery of a care home facility on part of a site, and the disposal of the remainder for housing.

If this is of interest to your health organisation, come and talk to us and we can help put you in contact with the right people, guiding you at every stage.

Susie Rogers
Partner
Susie.Rogers@capsticks.com
020 8780 4829
New CQC guidance on combining Ratings for Quality and Use of Resources

Introduction of combined trust-level quality and use of resources ratings

Published: 5 March 2018

Categories: Public

Last November and together with NHS Improvement, we asked for your views on how we should report on and rate how well non-specialist acute NHS trusts are using their resources to provide high quality, efficient and sustainable care.

Following feedback from members of the public, healthcare providers and other stakeholders we have updated our guidance, which confirms our joint approach and summarises the responses you shared with us.

cqc.org.uk

The CQC has this week published up-to-date guidance setting out a new methodology for awarding overall ratings to NHS Trusts. The guidance explains that the CQC will now combine the ratings given to NHS Trusts for Use of Resources with the Quality ratings that we are now used to (safe, effective, caring, responsive and well-led).

We have moved on from 'shadow ratings' and as from 5 March 2018, Trusts will received a new combined rating (on the scale of outstanding, good, requires improvement or inadequate) which will be arrived at by aggregating the ratings on the five key questions plus the Use of Resources rating.

The CQC consulted on these proposals but only 16 out of 240 or so NHS Trusts took the time to respond (or had the time to respond?).
The CQC’s new guidance (http://www.cqc.org.uk/sites/default/files/20180228-how-CQC-regulates-NHS-trusts-updated-March-2018-final.pdf) addresses one of the concerns raised during the consultation that a negative rating for Use of Resources could lead to a disproportionate number of Trusts being rated as Requires Improvement overall. The usual aggregation rule is that if, within a set of 4 to 8 ratings, there are 2 requires improvement ratings then the overall rating will be limited to requires improvement (sometimes known as ‘the rule of two’). The new guidance has lifted the tolerance level to 3 so a trust can have 2 requires improvement ratings on the overall ratings for safe, effective, caring, responsive, well-led and use of resources and still achieve a ‘good’ overall rating, provided that the other 4 ratings are all ‘good’ or better. If the same Trust were to have 3 requires improvement ratings out of the 6 ratings then this will lead to an overall rating of ‘requires improvement’ as illustrated by the image above.

What should we take from this?

1. The Use of Resources inspection is important and will have a bearing on the overall Trust rating. At the moment, only non-specialist acute trusts get inspected by NHSI on use of resources but it will be rolled out more widely to other trusts in the future. Learn more about how to prepare for a UoR inspection here: https://improvement.nhs.uk/uploads/documents/Brief_guide_to_UoR_assessments_23oct.pdf

2. The new aggregation rules apply to all inspections undertaken after 5 March 2018. When considering the factual accuracy of draft reports (from CQC and NHSI) consider how the findings will merge to create the overall rating.

3. As with existing rules, all ratings need to be displayed on Trust premises for patients and the public to see.

Ian Cooper
Partner
ian.Cooper@capsticks.com
0113 323 1060
The Capsticks health team

We have over 200 specialist solicitors – below are some of our key contacts:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Email</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joanna Bowyer</td>
<td>Partner, Litigation</td>
<td><a href="mailto:Joanna.Bowyer@capsticks.com">Joanna.Bowyer@capsticks.com</a></td>
<td>0208 780 4805</td>
</tr>
<tr>
<td>Catherine Bennett</td>
<td>Partner, Clinical Law</td>
<td><a href="mailto:Catherine.Bennett@capsticks.com">Catherine.Bennett@capsticks.com</a></td>
<td>0208 780 4731</td>
</tr>
<tr>
<td>Mike Clifford</td>
<td>Partner, Head of Commercial</td>
<td><a href="mailto:Mike.Clifford@capsticks.com">Mike.Clifford@capsticks.com</a></td>
<td>0121 230 1513</td>
</tr>
<tr>
<td>Abi Condry</td>
<td>Partner, Litigation</td>
<td><a href="mailto:Abi.Condry@capsticks.com">Abi.Condry@capsticks.com</a></td>
<td>0208 780 4719</td>
</tr>
<tr>
<td>Ian Cooper</td>
<td>Partner, Clinical Law</td>
<td><a href="mailto:Ian.Cooper@capsticks.com">Ian.Cooper@capsticks.com</a></td>
<td>0113 323 1060</td>
</tr>
<tr>
<td>Jamie Cuffe</td>
<td>Partner, Commercial</td>
<td><a href="mailto:Jamie.Cuffe@capsticks.com">Jamie.Cuffe@capsticks.com</a></td>
<td>0208 780 4657</td>
</tr>
<tr>
<td>Peter Edwards</td>
<td>Partner, Clinical Law</td>
<td><a href="mailto:Peter.Edwards@capsticks.com">Peter.Edwards@capsticks.com</a></td>
<td>0208 780 4761</td>
</tr>
<tr>
<td>David Firth</td>
<td>Partner, Litigation</td>
<td><a href="mailto:David.Firth@capsticks.com">David.Firth@capsticks.com</a></td>
<td>0208 780 4785</td>
</tr>
<tr>
<td>Lisa Geary</td>
<td>Partner, Real Estate</td>
<td><a href="mailto:Lisa.Geary@capsticks.com">Lisa.Geary@capsticks.com</a></td>
<td>0113 322 5561</td>
</tr>
<tr>
<td>Siwan Griffiths</td>
<td>Legal Director, Clinical Law</td>
<td><a href="mailto:Siwan.Griffiths@capsticks.com">Siwan.Griffiths@capsticks.com</a></td>
<td>0208 780 4887</td>
</tr>
<tr>
<td>Martin Hamilton</td>
<td>Managing Partner</td>
<td><a href="mailto:Martin.Hamilton@capsticks.com">Martin.Hamilton@capsticks.com</a></td>
<td>0208 780 4832</td>
</tr>
<tr>
<td>Philip Hatherall</td>
<td>Partner, Clinical Law</td>
<td><a href="mailto:Philip.Hatherall@capsticks.com">Philip.Hatherall@capsticks.com</a></td>
<td>0208 780 4717</td>
</tr>
<tr>
<td>Rachael Heenan</td>
<td>Senior Partner</td>
<td><a href="mailto:Rachael.Heenan@capsticks.com">Rachael.Heenan@capsticks.com</a></td>
<td>07538 680 529</td>
</tr>
<tr>
<td>Sam Hopkins</td>
<td>Partner, Head of Real Estate</td>
<td><a href="mailto:Sam.Hopkins@capsticks.com">Sam.Hopkins@capsticks.com</a></td>
<td>0208 780 4776</td>
</tr>
</tbody>
</table>