Can disciplinary sanction be increased on appeal?
McMillan -v- Airedale NHS Foundation Trust [2014] EWCA Civ 1031

This appeal concerned the issue of whether an injunction restraining an employer from imposing an increased sanction on one of its employees, namely dismissal, was appropriate.

The appellant NHS trust appealed against the grant of a permanent injunction restraining it from reconvening an appeal panel to consider the issue of sanction against the respondent employee.

The respondent was employed by Airedale NHS Foundation Trust. Following an adverse incident, the Trust initiated disciplinary proceedings against her which resulted in a final written warning, against which she appealed.

This led to a full re-hearing. Although the findings were upheld the panel reissued the final written warning. It became apparent that the Trust was calling for the claimant to be dismissed which is when she withdrew her appeal asserting that the panel had no further jurisdiction. After the Trust refused to allow her to withdraw her appeal she sought a Court injunction to restrain the Trust from increasing the sanction. This was upheld by the Court due to the disciplinary procedure (MHPS) being incorporated into the respondent’s contract. The procedure identified that an employee would have no further right of appeal therefore if the sanction had been increased this would be a breach of Mrs McMillan’s employment contract.

In principle an employer may maintain, increase or reduce a disciplinary sanction on appeal however it must be explicitly set out in the disciplinary policy and an employee must be afforded a further right of appeal.

The Trust could demonstrate neither; their own procedure did not make clear to the respondent that she risked a higher penalty if she chose to appeal and the procedure specifically stated that the claimant would not be allowed any further right of appeal. Consequently an injunction restraining her employer from imposing an increased sanction, namely her dismissal, was appropriate.
New legislation implements changes to the regulation of health care


The Regulations implement significant changes to the regulation of health care, the most significant of which is the introduction of a new statutory duty of candour which applies where patient safety incidents occurred. This much anticipated duty has been needed for some time according to many commentators. Robert Francis QC in the Mid Staffordshire NHS Foundation Trust Public Inquiry last year stated that ‘There seems to be near universal agreement that candour is an essential component in today’s healthcare.’

The Regulations also introduce a Fit and Proper persons test for directors. They provide that persons’ employed must:

- be of good character,
- have the necessary qualifications, skills and experience, and
- be physically and mentally capable to carry out to the work for which they are employed.

Part 3 of the Regulations seeks to enforce parts of the new requirements by creating a number of criminal offences for non-compliance. A criminal sanction may be imposed, amongst others, where there has been a failure:

- permit and encourage service users to make, or participate in making, decisions relating to their care or treatment to the maximum extent possible, where this is reasonably practicable, and
- to have sufficient quantities of suitably accessible equipment and medicines to ensure the safety of service users and to meet their assessed needs.

The offences created by the Regulations are punishable in the Magistrates Court only and by a fine but not imprisonment.

Wilful neglect to become criminal offence

Following additions to the Criminal Justice & Courts Bill care providers could be prosecuted for wilful neglect in 2015. The punishment for deliberate acts can be up to 5 years imprisonment and £5,000 fine for social care organisations in England and Wales in both public and private sectors.

The change in the law is aimed at closing the loophole which the Mental Capacity Act 2005 created, where prosecution can only happen where the victim lacks mental capacity or is in a setting such as a mental health institution.

However, there has been opposition to the idea. Nick Clements, Head of Medical Services at the Medical Protection Society, said the news was “extremely disappointing”.

Clements commented “This criminal sanction will have a huge impact on the professional lives of doctors, and it must be given time to receive the serious scrutiny it warrants; not just rushed through as an amendment to an existing bill.”

“…[The society] strongly opposes the new criminal sanctions as we believe the current regulatory, disciplinary and criminal framework is already effective at censuring unprofessional behaviour and there is no justification for new legislation.”
Act ‘will reform health and care’

The Care Act 2014 has received Royal Assent proposing the largest change in health and social care for the last 60 years with the aim to improve the quality and care for many people particularly the frail, elderly and those with disabilities and long-term care needs, as described by Health Minister Dan Poulter.

But the measures were labelled "modest" and a "Frankenstein Bill" by Labour. The Opposition continued to raise concerns about the "hospital closure clause", which it warned could result in well performing hospitals closing due to their proximity to failing ones.

The clause was put forward by the Government after the High Court ruled against a special administrator scrapping services at the financially sound Lewisham Hospital in an attempt to prop up South London Healthcare Trust, which was in financial difficulty.

Labour pushed one of its amendments on the Trust Special Administration (TSA) clause to a vote, which it lost as 294 MPs voted against it compared to 195 in favour, majority 99.

Continuing Healthcare Judicial Review:

R (on the application of Neal Dennison Administrator of the Estate of the late Lily Dennison) -v- Bradford Districts Clinical Commissioning Group [2014] EWHC 2552

The Court considered whether a clinical commissioning group had been wrong in refusing to retrospectively review a nursing home resident's eligibility for a continuing health care.

The claimant (D) applied for Judicial Review of a decision by the defendant clinical commissioning group refusing to assess the eligibility of his deceased mother (M) for continuing health care (CHC) between May 2007 and her death in October 2008.

M with nursing costs from May 2007, however M had to meet all her own residential costs during her time at the home. This was because the PCT did not assess M as eligible for CHC. Had she been assessed as eligible for CHC, those costs would have been covered. D contended that the two clinical assessments that took place during that period, one in 2007 and the other in 2008 were inadequate for determining M's entitlement to CHC because they had failed properly to consider whether she had a primary health need; this issue was key in determining CHC eligibility.

The NHS issued a process document concerning requests for assessments entitled NHS Continuing Healthcare Review Process in October 2012. 4.1.6 (ii) stated that if CHC eligibility had been properly considered before the Registered Nursing Care Contributions (RNCC) determination or annual review, a further assessment of the past period of care.

The application was granted in part. The assessment in 2007 had given no explanation as to the level of need the patient demonstrated. Neither did it include details on the appropriate level of funding. It was therefore impossible, from this assessment to come to a proper conclusion about whether a primary health need had been made out. The Court held that a reasonable CCG would have felt the need to review the period of care covered by this assessment.

The 2008 assessment however, had met the mandatory requirements for assessing CHC and there was no reason to revisit it.
X, Re [2014] EWCOP 25:

Sir James Munby, President of the Court of Protection recently handed down his judgment in Re X and others (Deprivation of Liberty). The purpose of the judgement was to set out the procedural and practical implications of the Supreme Court's decision in the Cheshire West case, which we reported on in Issue 10. In summary, the judgement states:

1) Deprivation of liberty (DoL) authorisations must be judicial and not administrative.

2) There are circumstances in which an authorisation for a DoL can be determined on the papers, but there must still be an unimpeded right to request a speedy review.

3) The 'triggers' for deciding whether an oral hearing is necessary include whether P is objecting to the DoL, whether there is any dispute around the care arrangements and whether there is any dispute around whether the patient lacks capacity to decide where to live.

4) Evidence in support of an application for a DoL authorisation must include professional medical opinion but should be "succinct and focussed" and the evidence and supporting material should not ordinarily exceed 50 pages.

5) Review of a DoL must take place at least annually and must be judicial, although it may not require an oral hearing.

6) It is not permissible to make 'bulk' DoL applications. Each application must be individual so that it can be considered separately and on its own merits.

A Mental Health Trust v DD [2014] EWCOP 11

The court was required to determine whether a patient (P) lacked capacity and if so, whether the applicant NHS trust should be authorised to perform certain medical assessments against her will. P was a woman in her mid-30s who suffered from an autistic spectrum disorder and had borderline learning difficulties.

P had five previous children, all of whom had been taken into care and adopted. Each pregnancy has caused health issues to P yet she continued to conceal her pregnancy. P was forcibly taken to hospital after obtaining a warrant for psychiatric assessment after which it was confirmed that P was pregnant. She was offered further treatment and appointments, but she did not attend them.

The Court authorised the trust to take necessary and proportionate steps to provide the medical treatment she required; The Mental Capacity Act 2005 s.48 enabled the court to exercise its powers on an interim basis if it was satisfied that it was in P's best interests, provided there was reason to believe that P lacked capacity, and that the matter was one to which its powers under the Act extended. The court was satisfied that there were reasonable grounds for believing that P lacked capacity to litigate and to make healthcare decisions in relation to whether to consent to the treatment.

The Court however, acknowledged that it was also of fundamental importance to take account of the wishes of P and her partner. P had made it clear that she did not want any engagement with professionals. Consequently, police were present throughout her treatment, as it had become apparent that P was willing to comply with medical assessments and interventions so long as she knew there was some associated structure and authority.
RB (A Patient) v Brighton and Hove City Council [2014] EWCA Civ 561

The Court of Protection had not erred in authorising the continued detention in a care home of a 37-year-old man with mental and physical disabilities. The deprivation of his liberty was necessary in order to protect him from seriously injuring himself, which had to be in his best interests.

Authorisation to detain B in care was granted under the Mental Capacity Act 2005 Sch.A1. B applied to terminate the standard authorisation however a jointly instructed psychiatric report concluded B did not have the capacity to decide where he should live.

Once B stopped participating in rehabilitation programmes it was apparent that B was not capable of independent living outside an institutional setting, therefore satisfying the mental capacity requirement set out in Sch.A1 para.15, due to the potential threat to himself and other residents. The local authority and the court were required to consider B’s wishes, under s.4(6), however it was not possible to comply with those wishes.

Constitution changes - update

It has been announced that NHS England are planning to extend the deadline for the submission of constitution changes by a month, to early December, to allow for the Legislative Reform Order to be passed, expected to be the end of October. It is expected that this will be confirmed in the next NHS E CCG bulletin.

It has been suggested that some agreed wording on joint committees would be helpful for CCGs, for example in the same vein as the model constitution wording was issued, to add into the constitution. A response is expected from NHS England shortly.

It is important to be aware of this as staff will be scheduling agreement of their changes with members and the Governing Body in what at present is a tight timescale.

R (Tracey) v Cambridge University Hospital NHS Foundation (2012) EWHC 3670 (Admin), (2012) MHLO 146

The Court of Appeal gave judgement on the consultation requirement of ‘Do Not Attempt Resuscitation’ (DNAR) notices. It found that there is a presumption in favour of patient involvement when placing “DNAR notices on patients' medical files and there needed to be convincing reasons not to involve the patient or family, such as physical or psychological harm being caused. Where this is not be shown, the patient is entitled to know that the clinical decision has been taken.

This ruling now means that trusts will now be acting unlawfully if they do not take steps to see that DNARs are discussed, unless there are convincing reasons not to do so.

Cabinet Office publishes consultation document on new UK Procurement Regulations

The Cabinet Office has recently published a consultation document on the transposition of the new EU Procurement Directive into UK Law which was finalised earlier this year. The consultation contains the proposed draft of the new Public Contracts Regulations 2015, which are due to take effect in 2015.

The consultation seeks views on those areas where the UK Government has discretion in the way in which it transposes the Directive. Of particular relevance to the healthcare sector is how the light touch regime will...
operate. It is notable that the current regime for healthcare services will continue until 18 April 2016.

Under the Cabinet Office proposals, public bodies would have freedom to determine the procedures that will be applied to procurements but generally require authorities to "conduct the procurement, and award any resulting contract" in conformity with the stated procedures. Healthcare commissioners have been afforded time to adapt to the new requirements of the light-touch regime, and the initial implementation was delayed. Practical guidance and support for commissioners is expected to follow.

There are some, limited, circumstances in which a CCG has a responsibility for patients outside its area, as provided for by the NHS Act 2006 (as amended by the Health and Social Care Act 2012) and the NHS Commissioning Board and Clinical Commissioning Group (Responsibilities and Standing Rules) Regulations. However the CCG disputes that any such exception applies.

The CCG, in its defence have highlighted a number of difficulties that it has encountered, including that the invoicing system used by the claimant is unreliable and confusing in that it is difficult or sometimes impossible for the CCG to ascertain which patient or patients the invoice relates to, or whether indeed the patient is one within the CCGs remit. When asked for further clarification as to which patients the invoices relate to, the claimant has not been forthcoming.

In any event, the general rule is that the CCG is responsible for commissioning services for patients who are registered with a GP who is a member of that CCG.

The matter was scheduled for a court hearing in September however a stay in proceedings was sought, in the hope that a settlement could be reached, without the need to progress to formal legal proceedings.

Steve Mason attended a meeting last week with all parties and their legal representatives and it is hoped that the matter will be settled shortly.

This ongoing matter concerns a patient who presents with complex health needs including epilepsy, diabetes and acquired a brain injury. The patient is currently in receipt of fully funded CHC package of care and a recent application was made by the patient to the Court to discharge him from his package of care, which in light of the recent Supreme
Court decision, amount to deprivation of liberty and which has been authorised under Sch 1 of the MCA 2005.

Reports opine that the care package put in place for L adapts to allow L more freedom while being under suitable supervision to monitor his health. L is highly influenced by other service users and a parent and therefore more conditions have been added to his care plan for when he is out in the community. This is due to the serious health hazards of L having excess amounts of alcohol and sugary substances. However, the less restrictive care arrangements have been suspended a few times but the staff will once again work towards a resumption of the package as part as a less restrictive option.

Various reports show that the benefits of the current accommodation outweigh the disadvantages. Therefore L will be better served by remaining in the care home. However despite this being explained to L, L has still brought a case to the Court of Protection.

The Court of Protection heard the case in August and came to the decision to adjourn the case until November so that independent expert evidence can be obtained along with the potential for L to be rehabilitated.

L does not accept that he lacks capacity and so disputes the jurisdiction of the Court, this matter will also be determined by the Court in the light of the expert evidence.