Brunswicks' Healthcare Review

Volume 7 Issue 42
7 November 2012

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Volume 7 Issue 42
7 November 2012

This week's article

There is no article this week.

Parliamentary Business

05.11.2012 – HoL – Oral Question - Proposed NHS inquiry into the Liverpool Care Pathway - Baroness Knight of Collingtree

06.11.2012 – HoC – Adjournment - Polycystic kidneys - Mrs Madeleine Moon

Continued on page 58

Editorial

I have been acutely aware of the tensions and pressures on a range of organisations, especially charities and members' associations and similar over the past two years or so.

In this issue of BHCR we report the sad and imminent closure of the Social Care Association a body which has done a tremendous amount of work of benefit to the social care sector which has benefitted those receiving care. A body worth supporting. A body worth developing.

I am also aware of SCA's great work in supporting individual care workers wrongly targeted by regulators for disciplinary proceedings.

On looking at the accounts of SCA lodged with the Charity Commission one can see that in the year to 30.06.2007 there was income of £1.65m, the global economic crisis struck and income steadily fell, year on year, until last year – just four years later - when the income stood at less than 10% at £139,000. Of course the managers and the board of trustees have controlled expenditure which was similarly, and dramatically, brought down during the period.

For any organisation closure is a disaster.

For those who work for such a body it is a personal crisis - when income is lost and perhaps the prospects of other work are not great.

Timing can never be good, but such an announcement before Christmas will be particularly painful for everyone.

However, for a body which has been engaged in wide-ranging work and training in the sector for 63 years it is particularly tragic.

SCA was the first body to formulate Codes of Practice setting out the standards which its members were expected to adhere to. For such a forward-thinking and creative body it must be a bitter blow to have taken the decision to wind-down operations and close.

It's demise will, I believe, leave the sector much the poorer.

Bodies like SCA deserve support...its membership have provided that.

Is it time for Government to step in, as it did with the Nursing and Midwifery Council and offer a one-off lifeline? The NMC got £20m. To preserve SCA will require a much more modest injection of funds.

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The Actuarial Profession Mortality Seminar Series: Dementia research – where are we and what are the gaps?

An Actuarial Profession and ILC-UK joint meeting

28 November 2012—16:55 – 19:30
(Registration from 16:30)

The Actuarial Profession, Staple Inn Hall, High Holborn, London, WC1V 7QJ

The Prime Minister's challenge on dementia launched in 2012 stated: "Dementia is one of the biggest challenges we face today – and it is one that we as a society simply cannot afford to ignore any longer. We have made some good progress over the last few years, but there's still a long way to go. Our research knowledge on dementia lags behind other major diseases such as cancer or heart disease".

The continued gains in longevity, with life expectancy at birth in 2010 reaching 78.2 years for men and 82.3 years for women, are a particular challenge for conditions like dementia which increase rapidly with age. Dementia affects around 1 in 100 people aged 65-69 years of age but 1 in 6 of those aged 80 and over.

This event will bring together speakers from academic, charity and policy sectors to address the current state of knowledge and the gaps in key areas for dementia service provision:

- **Early prevention**
- **Challenges facing general practitioners and the NHS**
- **Care homes and end-of-life care**
- **Costs of dementia care**

This is the first in a series of events being organised by the Actuarial Profession under the theme 'The Actuarial Profession Mortality Seminar Series: Exploring the future; defining the questions'.

This event is free of charge but does require registration. Register for this event here. Places are limited so book now to secure your place.

End to Independent Voice in Social Care

01 November 2012 - Social Care Association

Social Care Association and the Social Care Association (Education) have reluctantly decided to close. The Association has been the independent voice of the social care workforce that has campaigned and acted to promote high quality social care for children and adults. It is of particular sadness that this is happening at a time when social care for children and adults really needs well informed independent action free from fluster and posturing.

The Association was started in 1949. Members created the first codes of practice to set the expectation on staff of safe and professional behaviour. Practice Guides also set the pattern of how to introduce information to the sector, using a clear and well-grounded evidence base.

Membership fees have been modest reflecting the low pay endured by most social care staff. To keep the organisation going it has relied on training and consultancy work, never having been given any government funding for the organisation.

Over the last few years, cuts in spending have meant that staff training has been severely restricted. In seeking paid work the SCA has found it is now competing with government funded organisations that are dealing with their own financial difficulties by offering training, consultancy and recently membership.

Government has not accepted suggestions and bids for development work on sustainable improvement to social care services.

There has been on-going reluctance of the Government in England to back words with action and to recognise and properly support the staff in the social care sector. Professional registration is now being introduced in other parts of the UK and the rewards are beginning to emerge as staff take on responsibility for their own competence. In England there is no prospect of registration despite legislation being passed in 2000, we think that the general public will be shocked to understand that such staff are not required to be properly professionally registered.

The SCA has survived and continued to contribute to policy and improving practice despite living in ‘a hand to mouth’ manner for many years. Now, despite the magnificent efforts of the staff led by Nick Johnson, we have to accept that closure is the only course available. We are grateful for the support from other social care organisations and in particular the British Association of Social Workers and the College of Social Work, who have offered to take members who fulfil their conditions. For others, no serious option is available.

We hope and intend that the core aims of the association will be picked up and carried forward.

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Abuse/Dignity

1. New agony for care home victims

29 October 2012 - Daily Mail

I exposed this scandal – now it's happening all over again

29 October 2012 - Daily Mail

Two pages – 19 of the 51 patients moved from Winterbourne View Hospital have suffered injury in other care settings, including by Joe Casey the man who worked undercover for Panorama at the hospital.

2. Winterbourne View patients in new care safety alerts

29 October 2012 – BBC News

'No excuse' for care service failures, says health minister

29 October 2012 – BBC News

NHS figures show safeguarding alerts have been issued for at least 19 of Winterbourne View's 51 former patients since they were moved to other care homes, and of those, at least one has been assaulted and one criminal inquiry is under way.

However, not all of the alerts mean that someone was harmed.

http://www.bbc.co.uk/news/uk-20070437
http://www.bbc.co.uk/news/uk-20123238

3. Care home abuse is a national scandal - Norman Lamb

30 October 2012 – BBC News

Health Minister, Norman Lamb, has told MPs that care home abuse, such as that which had taken place at Winterbourne View, is a "*national scandal*" that "*has to end*".

"What has been exposed by Panorama is utterly intolerable and has to come to an end," Mr Lamb told the Commons.

The Government's full response to the abuse at Winterbourne View will be published in November,

He told MPs, in response to an urgent question tabled by shadow health minister Liz Kendall that the Government's full response to the abuse at Winterbourne View will be published in November.

http://www.bbc.co.uk/news/uk-20140421

4. 'I failed to protect my child from Winterbourne View'

30 October 2012 – BBC News

Ann Earley, the mother of Simon Tovey, a man with learning difficulties who was the victim of abuse at Winterbourne View speaks about her anguish.

In secret footage filmed by Panorama, Mr Tovey, 38, was slapped, physically restrained and mentally abused.

Eleven of his former care workers were sentenced for either mistreatment or neglect and six were jailed for between two years and six months.

http://www.bbc.co.uk/news/uk-england-wiltshire-20135757

5. 'Challenging restraint in a children's home made my life hell'

30 October 30, 2012 – Community Care

In this article, a residential care worker shares a dilemma he faced at work - how to challenge a colleague who seems to use physical restraint as a way of exerting authority.

http://www.communitycare.co.uk/blogs/childrens-services-blog/2012/10/dilemmas-in-residential-child-care-use-of-restraint.html

6. Historical abuse inquiry: 101 apply to take part

01 November 2012 – BBC News

A total of 101 people have applied to take part in the inquiry into abuse in care institutions in Northern Ireland between 1922 and 1995, which include Catholic religious orders, state and voluntary groups.

Most applicants, 72%, want to meet with both the acknowledgment forum and the statutory inquiry.

http://www.bbc.co.uk/news/uk-northern-ireland-20169984

7. Abuse probe at Katie Kares respite care centre for children

01 November 2012 – BBC News

The privately-run Katie Kares at Torbreck on the outskirts of Inverness has closed temporarily while abuse allegations are being investigated. The respite care centre caters for children with special needs in the Highlands.

At this stage no-one has been charged.

http://www.bbc.co.uk/news/uk-scotland-highlands-islands-20169527

8. Public health approach to violence prevention outlined

02 November 2012 - DH

A public health approach to preventing violence is set out in a new report.

Protecting People, Promoting Health – A public health approach to violence prevention in England draws on the latest evidence to show that many of the key risk factors that make individuals, families and communities vulnerable to violence are changeable. The report also contains new figures on the cost of violence, estimating national costs to the NHS and a wider cost to society.

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The Department of Health commissioned the North West Public Health Observatory (NWPHO) to produce the high level report to provide information and evidence for policy makers and commissioners to use in developing preventative approaches with strategic partners.

The report aims to increase awareness and strengthen commitment to prevention across government, NHS, local authorities, private and voluntary sectors as well as education, employers and other agencies.

9. Petitioning Government

03 November 2012

I'm asking @DHgovuk to close institutions like #winterbourne & help stop the abuse of ppl with a learning disability http://ow.ly/eMlYi

Business News

10. Care home group to sue Barclays for up to £37m in Libor-rigging test case

30 October 2012 - The Times

Barclays LIBOR case to go to trial

30 October 2012 - Reuters

First Libor damages trial set to proceed

30 October 2012 - Financial Times

Libor: Judge forces Barclays to reveal names of staff involved in rate rigging

30 October 2012 - The Telegraph

Barclays became the first bank to be ordered to stand trial in a British court over damages arising in part from manipulation of the Libor interest rate in a claim brought by Guardian Care Homes, a residential care home operator based in Wolverhampton, is suing Barclays for up to £37 million over the alleged mis-selling of interest rate hedging products known as swaps.

Guardian Care Homes' chief executive Gary Hartland said after the hearing on 29.10.2012 of a 'strike out' application by Barclays before Mr Justice Flaux *"Today is a huge milestone with a trial now going forward to determine whether these financial products should be declared void..."* The Barclays application failed and Flaux J said *"Your clients know jolly well what is being alleged. The real issue is that they are trying to shut it out at this stage because they don't like it."*

The case might lead to new revelations about the Libor scandal after Guardian Care Homes asked for documents relating to the affair to be disclosed.

The trial will be a test case for thousands of small British firms which assert that they were mis-sold such swaps and it raises the prospect of other companies linking future claims to interest rate rigging by banks.

The country's biggest four banks agreed in June 2012 to review past sales of interest-rate hedging products to small businesses and to compensate customers for mis-selling loan insurance after the Financial Services Authority said it had found "serious failings" in the way that they were sold.

However, the compensation scheme subsequently set up by the FSA, which allows banks to appoint an independent arbitrator to assess claims, has been criticised by businesses for being too slow and for lacking transparency. Companies also have the option of bypassing the FSA scheme and pursuing banks directly through the courts.

Guardian Care Homes, which operates 27 homes providing care for 1,000 elderly or vulnerable patients, says it has lost £12 million after being sold two swaps in 2007 and 2008 against two loans it took from the bank which combined were worth £70 million.

The hedging contracts tied in the company for 20 years even though the two loans, of £41 million and £29 million, were taken out for only 10 years and five years, respectively. To get out of the arrangement, Guardian Care Homes would have to pay break fees of £25 million.

Barclays, which has set aside 450 million pounds to compensate customers mis-sold interest rate swaps, said after the decision that it didn't believe the case had merit. It said Guardian had entered into the swaps with "*sufficient understanding*" as to whether they met its business objectives.

Britain's financial regulator has estimated that about 44,000 interest rate swaps have been wrongly sold to UK companies since 2001.

The swaps were supposed to protect companies against rates going up by making their future repayments more predictable, but many borrowers didn't realise they would pay far more if lending rates fell significantly and would face substantial fees to get out of the arrangements

11. AstraZeneca-MRC deal gains UK funding boost

31 October 2012 – Pharma Times

The UK's Medical Research Council has just pledged an extra £7 million worth of funding for research projects surrounding a number of drug compounds being shared by AstraZeneca.

A year ago the firm announced it would make 22 of its compounds available free of charge to UK academia in 2012, as part of a tie-up with the Medical Research Council.
http://www.pharmatimes.com/Article/12-10-31/AstraZeneca-MRC_deal_gains_UK_funding_boost.aspx

12. Circle planned cut of 20pc of staff at Hinchingbrooke

02 November 2012 - Health Service Journal

HSJ reports that a document which it has seen indicates that Circle's original business plan for its running of Hinchingbrooke Healthcare Trust outlined a cut in the hospital's workforce of 20%.

13. Vaccine sales hit Pfizer

02 November 2012 - The Times

A 16% fall in revenue at Pfizer said that there had been a sharp drop in sales of Pevnar – a vaccine against pneumococcal bacteria and sales of Lipitor – cholesterol lowering – had also been lower than projected.

Care Homes

14. Care home patients 'sent to wrong kind of institution'

29 October 2012 – BBC News

New fears have been raised over what has been happening to a large number of the people who were put in other homes when Winterbourne View was closed down: at least 19 of the 51.

Mark Goldring, chief executive of learning disabilities charity Mencap, said that Winterbourne View patients were moved without proper consideration and planning.
http://news.bbc.co.uk/today/hi/today/newsid_9764000/9764357.stm

15. Poor care providers must face 'corporate law', says MP

29 October 2012 – BBC News

Former Care Services Minister, Paul Burstow, says that negligent care service providers which fail their patients should be "*corporately accountable*" by law, along with their staff.

The Lib Dem MP said there was "*now a case for corporate wilful neglect*" to be added to the UK's statute book, just as fresh fears are raised for the safety of patients moved from a failed Bristol care home.
http://www.bbc.co.uk/news/uk-20120661

16. Greencroft Nursing Home scrutinised after death of resident

29 October 2012 – BBC News

A Flintshire nursing home has been placed under special scrutiny after the death of a resident last month.

Beatrice Morgan, 88, died in hospital while being treated for scald injuries and she had been a resident at the private Greencroft Nursing Home at Shotton at the time of the incident.

Flintshire council said it was working with other agencies to "*address performance issues*" at the home.
http://www.bbc.co.uk/news/uk-wales-20125235

17. Young people with spinal injuries face discharge to homes for elderly people

30 October 2012 – The Guardian

New research from the spinal injury charity, Aspire, has suggested that one in five people with spinal injuries are likely to be discharged into residential or nursing homes for older people because of a lack of appropriate housing options.

Apparently the average stay is two years but in some cases, young people with spinal injuries languish in care homes for more than three, even though most people with spinal injuries are in hospital for three to five months, allowing plenty of time for planning before they are discharged.
http://www.guardian.co.uk/society/2012/oct/30/spinal-injuries-discharge-homes-elderly-people

18. Winterbourne View: MP calls for action against Castlebeck

31 October 2012 – BBC News

An MP is calling for the owner of a care home near Bristol where staff abused vulnerable patients to be prosecuted for corporate negligence.

Six ex-workers were jailed for the ill treatment and neglect of residents at the Winterbourne View private hospital.
http://www.bbc.co.uk/news/uk-england-bristol-20157881

19. Care provider Associations unite to condemn NHS London

01 November 2012 - ECCA

The English Community Care Association, *The National Care Association*, *The National Care Forum* and *The Registered Nursing Home Association* have united to condemn NHS London's unilateral imposition of a fee of £700 for continuing healthcare.

The care provider associations had been given assurances by NHS London that there would be proper negotiation and both the contract and the price, would be mutually agreed and would reflect the assessed needs of the patient.

Martin Green Chief Executive of ECCA said:

"Despite these assurances, NHS London have behaved in a totally unacceptable and despotic manner

and they have reneged on agreements and wasted a lot of the provider sector's time and stolen our expertise to cover their ignorance.

"What was also clear from the process was the duplicity and dishonesty of NHS London and their lack of any understanding about how the market works. They did not justify their decision on costs, they just unilaterally imposed it.

"We are strongly urging all providers to ignore the AQP process and to give NHS London a taste of its own unilateralism. It is important that nursing home providers in London act in unison in order to force NHS London to respect the actual cost of care of an acceptable quality. If a person were to stay in hospital his/her care would be costing approximately £400 per night or £2,800 per week. To ask nursing homes to provide quality care at one quarter of this cost is unacceptable."

Ed. This follows a similar step taken by NHS bodies across the North West of England last year where the amount the NHS said it was prepared to pay was extraordinarily low – perhaps too low to enable care providers to fully discharge their obligations.

The NHS appears to be abusing its monopsany, it is a short sighted policy which will deliver financial savings in the short term, but, will probably result in something of a 'train-wreck' further down the line. Contracting parties who achieve the best long-term relationships do so in an environment of mutual respect and seeking to both derive benefits, not, by a dominant party 'stuffing' the other party to the contract.

20. Suffolk County Council care homes transfer decision upheld

01 November 2012 – BBC News

A decision to transfer Suffolk's 16 local authority care homes to a private firm has been endorsed by the scrutiny committee.

The Conservative-run council's plan was to hand the centres to Care UK, which would build 10 replacement homes.

Committee members upheld the original decision, saying it was not convinced by Labour's arguments that financial information was inadequate.

The transfer of the homes was due to take place on 01.11.2012 before the decision was called in.
http://www.bbc.co.uk/news/uk-england-suffolk-20166633

21. The young patients wasting away in old people's homes

03 November 2012 - The Times

Sue Ryder, the health and social care charity says that many young people who have neurological conditions are "condemned to live in old people's homes without specialist care" it also says just 5% of local authorities know how many people with neurological conditions they provide care for.

Case study – 'If she had gone there she would just have existed and not lived' – about Romana Ali a young mother who suffered a brain haemorrhage four months into her second pregnancy in 2004.

Case Reports

Law Reports

22. A, B and C v X, Y and Z

Summary

In this important case, Hedley J was required in respect of an elderly gentleman called X to consider his capacity to:
(1) marry;
(2) make a will;
(3) revoke or grant an enduring or lasting power of attorney;
(4) manage his affairs; and
(5) litigate.

Hedley J was also required to consider whether he had capacity to decide with whom he had contact, although that last issue was not for immediate determination.

Whilst the judgment is of importance for the approach taken to the questions of capacity, they can only properly be understood against the (Tolstoyan) background set out by Hedley J.

The first of two key events in the case occurred in April 2008, when X's former wife died. They had been married for 56 years. It is clear that her death was not only a great shock to X and to the whole family, but it forced into the open a state of affairs which had hitherto been managed within the family. The immediate family consisted of three adult children known as A, B and C, all of whom were themselves married with children. Hedley J found that, even making all allowances for family loyalty and respect, it was quite clear that this was a close and trusting family, in which X held a revered role as a loved and respected hus-

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band, parent and grandfather. It is also the case that he was a man of significant means deriving from the family business. X was clearly a skilled and highly intelligent man.

However, he was bored by, and therefore not very effective at, routine business administration, which he usually entrusted to others, whether a secretary, a professional or a family member. However, by 2007, the family were becoming anxious because of X's increasing tendency to forget things and to get lost; so much so that, in November 2007, Mrs B took over the running of his affairs. However, personal relations within the family appeared to be unaffected by these matters. In May 2008, after the death of his wife, X was diagnosed with dementia. In September 2008, he executed lasting powers of attorney in favour of A, B and C.

In 2010, Z came on the scene. Hedley J found that this marked the second key shift in events in this case. In July 2010, she was employed as a full-time carer. In October 2010, X said that he would like to marry Z. From that point on, relationships within the family deteriorated badly quite rapidly and ultimately found expression in litigation brought by A, B and C.

Hedley J was quite satisfied that all three of A, B and C were wholly honourable in their intentions towards X, and sought his best interests in all matters. Unfortunately, that had not always been recognised by X. He was also satisfied that Z was honourably disposed towards X; however, she was "a persistent, effective and somewhat strident woman with a style that the others have come to resent. She and A were designed to clash, and clash they did; a clash made more toxic by each entertaining serious doubts about the good faith of the other towards X.

X was therefore put in an impossible position. He clearly believed himself to be in love with Z, and indeed they were cohabiting. He looked to her to help him, and became (in Hedley J's view) highly influenced by her and increasingly dependent upon her, taking in consequence her side on many issues. In consequence of a conflict which he could neither understand nor control, he apparently became estranged from his children (albeit, in the absence of Z, Hedley J accepted that he enjoyed a warm and close relationship with his family, as he did with Z in the absence of A, B and C; "[r]e*move the conflict and you remove many of X's problems*" (para 15).

Hedley J had medical evidence before him from three experts, one instructed by each of the sides, and the other (whose instruction had been recommended by the other two) jointly instructed. Hedley J expressed his regret that (in part because of the differences in the practice of the two psychiatrists), "*each appeared as one instructed by the side whose views they supported*" (para 16), albeit that he emphasised that he recognised that this was not in fact so. He had no such reservations about the impression given by the evidence of the neuropsychiatrist. He made clear, however, that in reaching his views, he had not relied upon the conclusions expressed by the experts, but "*only on the steps of reasoning and the factual basis which led them to their views*" (para 20).

Having analysed the evidence in some detail, Hedley J declared himself satisfied – by way of general background – that *"in respect of some issues of capacity the areas of complex thought abilities may play a more significant role than in others. Moreover, I am satisfied that in some respects X's capacity may fluctuate. That explains differences in experience that are, as I find, accurately reported and assessed by the three forensic experts*" (para 27). Hedley J then turned to the specific issues in respect of which he had to determine X's capacity to take decisions, and found thus:

Marriage

As regards the capacity to marry, Hedley J expressed himself in complete and respectful agreement with the approach taken by Munby J (as he then was) in the (pre MCA 2005) case of Sheffield City Council v E & Anr [2005] 2 WLR 953, and specifically associated himself with the final observation made by Munby J (at paragraph 144) that:

"*There are many people in our society who may be of limited or borderline capacity but whose lives are immensely enriched by marriage. We must be careful not to set the test of capacity to marry too high, lest it operate as an unfair, unnecessary and indeed discriminatory bar against the mentally disabled*."

Asking himself whether A, B and C had satisfied him that X lacked the capacity to marry (i.e. to give effect to the presumption of capacity in s.1(2) MCA 2005), he found that they had not:

"*32. … Although I accept that X has suffered a significant decline in executive function, he retains many aspects of his intelligence in the fundamental level and it is at that point that it is important to have in mind that the requirements of capacity to marry are comparatively modest. I actually think it highly probable that he retains an understanding of the marriage contract and that his 56 years of beneficent experience of marriage has firmly etched upon his understanding the duties and responsibilities that go with it. Certainly I am not satisfied to the reverse and I decline to make any declaration that he lacks capacity to marry. I add only this, inevitably. Whether any decision that he might take to marry is wise or unwise,*

whether it leads to happiness or regret, is simply none of my business and I am simply unable to take into account any specific plans he might have in that direction."

Capacity to make a will

Turning to X's capacity to make a will, Hedley J reminded himself that the law was long-established, derived from the decision in *Banks v Goodfellow* [1870] LR 5 QB 549. Applying the principles to the facts before him, he confessed that he had found answering the question whether the Applicants had discharged the burden upon them "*quite difficult*." He continued:

"*36. On the one hand, if one looks at X's statement, he demonstrates an understanding of his obligations and makes perfectly sensible and proper proposals as to what should be in his will. On the other hand, I am impressed by the medical evidence, which points out a dramatic decline in executing functioning in the context of further inevitable deterioration, and that seems to me to raise serious concerns as X's own affairs are relatively complicated. I have also borne in mind the differing impressions of the doctors in relation to this question of testamentary capacity and the factors that I set out earlier in this judgment which may have the affect of retarding on the one hand or accelerating on the other the deteriorating progress of this disease.*

Hedley J came to the conclusion that he could not make a general declaration that X lacks testamentary capacity, "*but that* [conclusion] *needs to be strongly qualified*. "*There will undoubtedly be times when he does lack testamentary capacity. There will be many times when he does not do so. The times when he does lack such capacity are likely to become more frequent. It follows that, in my judgment, any will now made by X, if unaccompanied by contemporary medical evidence asserting capacity, may be seriously open to challenge. I draw attention, if I may, to a helpful passage in Heywood & Massey, provided by Counsel for the Applicants, at paragraph 4046, which deals with borderline capacity. It seems to me that the advice contained in that is very much applicable to this case*" (para 37).

Capacity to revoke or create enduring or lasting powers of attorney

Hedley J found with relative ease that the Applicants had not satisfied him that X lacked capacity to revoke a power of attorney in their favour (if, indeed, that was a live issue as the revocation had been accepted and the registration cancelled). The question of whether X had the power to create an EPA much more difficult for the same reasons as applied in relation to testamentary capacity. Unsurprisingly, perhaps, he reached the same conclusion, namely that he could not make a general declaration that X lacked the capacity, but that this was qualified "*the exercise of such a power, unless accompanied by contemporary medical evidence of capacity, would give rise to a serious risk of challenge or of refusal to register. It seems to me, for exactly the same reasons as I endeavoured to set out in relation to testamentary capacity, that X's capacity is likely to diminish in the future and there will be times when undoubtedly he lacks capacity, just as there will be times when he retains it*" (para 38)

The management of affairs

Applying, in particular, the approached adopted by Kennedy LJ in *Masterman-Lister v Brutton & Co & Ors* [2003] 1 WLR 1511 (paragraph 18-20), Hedley J found (on the basis of the evidence of the neuropsychiatrist) that, on balance, X lacked the capacity to manage his own affairs. However,

"*41… In so finding, I acknowledge, as I have done in relation to the other matters, that there would be times when a snapshot of his condition would reveal an ability to manage his affairs, but the general concept of managing affairs is an ongoing act and, therefore, quite unlike the specific act of making a will or making an enduring power of attorney. The management of affairs relates to a continuous state of affairs whose demands may be unpredictable and may occasionally be urgent. In the context of the evidence that I have, I am not satisfied that he has capacity to manage his affairs.*"

Litigation capacity

Hedley J identified the heart of the test as being that formulated by Chadwick LJ in *Masterman-Lister* at paragraph 75, as being whether:

"… the party to the legal proceedings is capable of understanding, with the assistance of proper explanation from legal advisers and experts in other disciplines as the case may require, the issues on which his consent or decision is likely to be necessary in the course of those proceedings. If he has capacity to understand that which he needs to understand in order to pursue or defend a claim, I can see no reason why the law – whether substantive or procedural – should require the interposition of a next friend."

Importantly, Hedley J noted that, whilst the question of capacity to litigate "*inevitably follows closely*" on the question of the management of one's own affairs, it required (at least on the facts of the case before him) separate consideration because "*it does operate in a separate and more restricted time frame, but a time frame quite different to the decision to make a will or to grant a power of attorney*" (para 44).

Hedley J noted, but discounted, X's hearing difficul-

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ties, because they were irrelevant to the question of capacity (the hearing difficulties having been addressed and X in consequence having been able to "*hear the essence of what has gone on in this hearing*" (para 44).
However, he found that, on balance, and looked at in the round, X lacked the capacity to conduct the litigation, made in light of the factors identified already in the judgment.

Hedley J noted that he would not have wished to make any decision upon X's capacity to decide with whom he should have contact if a finding had been sought, emphasising that "[t]*he idea that this distinguished elderly gentleman's life should be circumscribed by contact provisions as though he was a child in a separated family is, I have to say, deeply unattractive. I believe that, on reflection, the parties may be inclined to think so too*" (para 46). He concluded with an injunction to the parties to take stock of the fact that the greatest gift that anyone could bestow upon X would be to bring the conflict between them to an end so as to allow the time that was left to X to be one that could be enjoyed by family old and "*if circumstances so decide*" new as well (para 48).

Practice points
At the outset of his judgment (para 3), Hedley J identified two case management lessons which he believed the case taught: "[t]*he first is the need in the Court of Protection for a much greater emphasis on the importance of judicial continuity and, secondly, for the need for a pre-hearing review in respect of any case which is estimated to last three days or more. Either or both of those matters may have had the effect of avoiding the rather bruising experience of the first afternoon, when it seemed at least to me, rightly or wrongly, that there was a lack of clear direction in terms of the trial*." In the event, the parties conducted themselves in such a way that it was possible to overcome the difficulties caused by late filing of quite substantial amounts of evidence and bring about a focused and relatively expeditious hearing.

Comment
It is slightly ironic that we have reported previously the judgment of Hedley J in *LB Haringey v FG & Ors (No. 1)* [2011] EWHC 3932 (COP) in which he decried undue citation of first instance judgments upon questions of capacity, because (at the risk of sounding unduly deferential), the judgments given in both this case and that of *NYC v PC and NC* (discussed elsewhere in this newsletter) represent paradigms of the approaches that should be taken to the assessment of capacity. It is, further, of particular significance for the following reasons:

Its confirmation that the approach adopted by Munby J in Sheffield *City Council v E* to the capacity to consent to marry remains the right one, and its endorsement of the clear principle that the bar must not be set too high (to similar effect in the latter regard, see also the judgment of Baker J in *PH v A Local Authority and Z Limited and another* [2011] EWHC 1704;

(2) The 'qualified' declarations made by Hedley J regarding X's capacity both to make a will and to create an EPA. Such declarations (which really amount to declarations which must be read together with the accompanying passage of the judgment) may not find an express place in the scheme of the MCA 2005, but they represent a way in which the immensely complicated questions of borderline/fluctuating capacity can pragmatically be answered in such a way as to preserve P's autonomy to the maximum extent possible compatible with the protection of their interests;

(3) The approach taken to the question of managing X's affairs, and the distinction drawn there between an ongoing state of affairs and the doing of a specific act (or acts). We might also suggest that this distinction could appropriately be drawn in respect of other ongoing states of affairs – for instance, as to whom X wishes to have living in their house – where, at times, a snapshot of their condition would suggest that they had the capacity to take the decision, but otherwise they lacked the capacity to do so. As such, it potentially provides a further way in which to cut the otherwise philosophically Gordian knot of fluctuating capacity;

(4) The approach to the expert evidence, and the (re) emphasis upon the point – made also by Baker J in *PH* and *CC v KK* [2012] EWHC 2136 (COP) – that it is for the Court, and not for the experts, to determine whether the individual in question has the material capacity;

(5) The case management points made at the outset of the judgment – lack of judicial continuity, in particular, being a matter which plagues applications before the Court of Protection given the length of time they can take to resolve. Whether Hedley J's plea for greater emphasis to be placed upon such continuity will be capable of being addressed remains to be seen.

23. Re AS

Summary
With the permission of Senior Judge Lush, we can reproduce here the background to and the material passages from a judgment given in December 2011 upon an objection to the application for the appointment of a panel deputy, to which our attention has

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recently been drawn.

The Court summarised the background to the application, brought by a solicitor, SH (on the approved panel), that she be appointed property and affairs deputy for an elderly lady suffering from dementia, with specific authority to undertake the sale of a property. AS' niece, LC, objected to the appointment of the solicitor, proposing instead that she be appointed deputy. Before addressing the specific application before it, the Court set out the following as regards the appointment of a deputy:

"***The law relating to the appointment of a deputy***
Sections 1, 2, 3 and 4 of the Mental Capacity Act 2005 provide that, once it has been established that a person lacks capacity to make a particular decision at a particular time (such a person is referred to as "P" in the Act), then any act done or decision made by someone else on P's behalf must be done or made in her best interests.

The Act does not define "best interests", but section 4 provides a checklist of factors that anyone making the decision must consider when deciding what is in P's best interests. These are:

• whether they are likely to have capacity in relation to the matter in question in the future;

• the need to permit and encourage them to participate, or to improve their ability to participate in the decision-making process;

• their past and present wishes and feelings (and, in particular, any relevant written statement they made when they had capacity), the beliefs and values that would be likely to influence their decision, and any other factors they would consider if they were able to do so;

• if it is practicable and appropriate to consult them, the views of others, such as family members, carers, and anyone else who has an interest in their welfare; and

• whether the purpose for which any act or decision is needed can be as effectively achieved in a manner less restrictive of their freedom of action.

If a person lacks capacity in relation to a matter or matters concerning his or her property and affairs or personal welfare, the Court of Protection may make any decision on her behalf, or may appoint a deputy to make decisions on her behalf in relation to the matter or matters (section 16(2)).

Section 16(4) provides that, when deciding whether it is in P's best interests to appoint a deputy, the court must have regard to the principles that:

(a) a decision by the court is to be preferred to the appointment of a deputy to make a decision; and

(b) the powers conferred on a deputy should be as limited in scope and duration as is reasonably practicable in the circumstances.

Section 19 contains further provisions relating to the appointment of deputies, concluding at section 19(9) as follows:

'The court may require a deputy –

(a) To give to the Public Guardian such security as the court thinks fit for the due discharge of his functions, and

(b) To submit to the Public Guardians such reports at such times or at such intervals as the court may direct.'

When it appoints a deputy, the Court of Protection exercises its discretion. It has to exercise this discretion judicially, and in P's best interests. Many of the old authorities that used to govern the appointment of a receiver under Part VII of the Mental Health Act 1983 are probably still relevant with regard to the appointment of deputies.

These authorities generally acknowledged that there was an order of preference of persons who might be considered suitable for appointment as a receiver. I have called it an order of preference, rather than an order of priority, to avoid giving an erroneous impression that certain people were in the past automatically entitled to be appointed as receiver, or are automatically entitled now to be appointed as a deputy. They aren't. The Court of Protection has discretion as to whom it appoints. However, in the past, when appointing a receiver, it traditionally preferred relatives to strangers.

Generally speaking, the order of preference is:

• P's spouse or partner;

• any other relative who takes a personal interest in P's affairs

• a close friend;

• a professional adviser, such as the family's solicitor or accountant;

• a local authority's Social Services Department; and finally

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• a panel deputy, as deputy of last resort.

To some extent this is borne out by the statistics. The Office of the Public Guardian supervises 34,000 deputies, 99% of whom are deputies for property and affairs. There are only 342 personal welfare deputies. 53% of deputies are family members; 26% are local authorities, and 21% are professional deputies, though not necessarily panel deputies of last resort. The court prefers to appoint a family member or close friend, if is possible. This is because a relative or friend will already be familiar with P's affairs, and wishes and methods of communication. Someone who already has a close personal knowledge of P is also likely to be better able to meet the obligation of a deputy to consult with P, and to permit and encourage him to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him. And, because professionals charge for their services, the appointment of a relative or friend is generally preferred for reasons of economy.

In an unreported case, In the matter of B (No. 11579443), in which I handed down judgment on 15 August 2011, I made the following observations about the idea of deputyship of last resort:

'There is, however, another reason why I am allowing this application, which neither side really touched on at the hearing. It involves the whole concept of deputyship of last resort, and in this respect the history of these proceedings is relevant. Originally, IB applied to be appointed as his mother's deputy for property and affairs. His brother JB opposed the application and there were mutual allegations of financial abuse. A hearing date was set, but shortly before the hearing was due to take place, the brothers agreed a compromise and invited the court to appoint a panel deputy - or deputy of last resort – which court eventually did.

There is no longer any dispute between IB and JB and, as I understand it, the entire family unanimously supports IB's application to be appointed as deputy in place of Mr C. The question arises, therefore, whether there is still really a need for a deputy of last resort.

In Re P [2010] EWHC 1592 (COP) Mr Justice Hedley suggested that 'the court ought to start from the position that, where family members offer themselves as deputies, then, in the absence of family dispute or other evidence that raises queries as to their willingness or capacity to carry out those functions, the court ought to approach such an application with considerable openness and sympathy.' Michael Kirby, the President of the Court of Appeal in New South Wales, said much the same thing in Holt v. The Protective Commissioner (1993) 31 NSWLR 227. His remarks are even more pertinent because, whereas Hedley J was commenting on the court's discretion on an initial application for the appointment of a deputy, Kirby P was considering the somewhat different discretion that arises on an application to remove a deputy.

In some Common Law jurisdictions there is even an obligation on a deputy of last resort to seek a less restrictive alternative to his or her own appointment. For example section 744.704 of the 2010 Florida Code, in which the deputy of last resort is referred to as a 'public guardian', provides as follows:

(1) A public guardian may serve as a guardian of a person adjudicated incapacitated under this chapter if there is no family member or friend, other person, bank, or corporation willing and qualified to serve as guardian. ….

(6) The public guardian, when appointed guardian of an incapacitated person, shall seek a family member or friend, other person, bank, or corporation who is qualified and willing to serve as guardian. Upon determining that there is someone qualified and willing to serve as guardian, either the public guardian or the qualified person shall petition the court for appointment of a successor guardian.

I would not go so far as to suggest that a similar positive obligation arises in English Law, but there is a general principle in section 1(6) of the Mental Capacity Act 2005, which states that:

'Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.'

Generally speaking, from P's point of view, the appointment of a family member as a deputy will be a less restrictive alternative to the appointment of a panel deputy, though the question remains as to whether the appointment of a family member will achieve the desired objective as effectively as the appointment of a panel deputy.

There are, of course, cases in which the court would not countenance appointing a family member as deputy. For example, if there has been financial abuse or some other kind of abuse; if there is a conflict of interests; if the proposed deputy has an unsatisfactory track record in managing his own financial affairs; and if there is ongoing friction between various family members. This list is not exhaustive."

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Upon the evidence before the Court, the Court considered that the application of SH would be "*one of last resort, and there is simply no need in this case for an appointment of that nature*," and accordingly appointed LC as AS's property and affairs deputy. As regards the question of costs, the Court did not depart from the general rule laid down in rule 156 of the Court of Protection Rules 2007.

Comment
There is still a paucity of decisions upon the appointment of deputies, and it is therefore very useful to have another indication of how applications are being considered in practice. This judgment is of particular interest as an indication of the order of preference that is likely to be adopted when the Court has decided to appoint a deputy. The question of *whether* to appoint a deputy (discussed in both *G v E* and *SBC v PBA* as well as *Re P*) is quite a different one, and the *total* figure of 342 for health and welfare deputies perhaps speaks for itself.

24. Bureš v. the Czech Republic [

Summary
The European Court of Human Rights was asked to consider a claim brought against the Government of the Czech Republic alleging that the Applicant (Mr Bureš) had been ill-treated in a sobering-up centre in violation of Article 3 of the Convention and further had been detained in a psychiatric hospital in violation of Article 5 of the Convention.

The applicant had been diagnosed as having a psycho-social disability. He had previously been treated in Italian psychiatric hospitals as a voluntary patient and was using psychiatric medication. On 9 February 2007 he inadvertently overdosed on his medication and left his home wearing only a sweater. He was picked up by a police patrol who took him to a hospital. He was then transferred to a sobering up centre. The precise events which then occurred at the sobering up centre were in dispute. The Applicant's case was that he had been strapped tightly and left unchecked overnight causing a reduction in blood circulation to his arms. The Government alleged that he had been initially restrained for two hours as he was restless but was checked. Subsequently his behaviour had become destructive requiring further restraint.

On 10 February 2007 the applicant was transferred to the Intensive Psychiatric Care Unit where, according to the admission record, he had visible abrasions on the front of his neck, both wrists and both ankles, caused probably by friction against textile, and abrasions of an unspecified different type on his knees. He complained about his treatment in the sobering-up centre to the hospital authorities, but they did not take any action. On 15 February 2007 the applicant was examined by a neurologist, who stated that as a result of the use of straps the applicant suffered severe paresis of the left arm and medium to severe paresis of the right arm. He began a course of intensive treatment at the Rehabilitation Unit. The applicant remained in the hospital involuntarily until released on 13 April 2007. However, because of his two-month hospitalisation, he was confused and was not able to fully take care of himself. He voluntarily returned to the hospital on 14 April 2007 and remained there until 1 July 2007.

The Claimant subsequently made a complaint to the police which was investigated but no prosecution was brought. He challenged his detention in civil proceedings but the Constitutional Court rejected his appeal on the ground that he had not exhausted all remedies before the Regional Court.

The European Court of Human Rights noted that whilst they had doubts as to the Government's version of events at the sobering up centre, the Applicant's description was also not fully supported by the evidence. Accordingly, they proceeded to consider the claim on the basis that the Government's account was accurate.

The Court nevertheless proceeded to uphold the claims of both a violation of the substantive rights protected by Article 3, and also a violation of the procedural right to an effective investigation. In particular, the Court held the following:

(1) The medical staff in the sobering up centre should be regarded as agents of the State such that their actions could be attributed to the State – the Centre was a public body and the applicant was subject to the complete control of the Centre's staff. Further, the key issue was not the applicant's injury as an unintended negative consequence of medical treatment, as submitted by the Government, but rather the use of the restraints itself. The applicant's injury was only incidental to the intentional treatment. Accordingly, medical negligence case precedent relied upon by the Government was not relevant but cases concerning the use of restraints on persons in detention, which the Court has always considered from the point of view of negative obligations, were;

(2) The Court had previously recognised the special vulnerability of mentally ill persons in its case-law and the assessment of whether the treatment or punishment concerned is incompatible with the standards of Article 3 has, in particular, to take into consideration this vulnerability (see *Keenan v. the United Kingdom*, no. 27229/95, § 111, ECHR 2001 III, *Rohde v. Denmark*, no. 69332/01, § 99, 21 July 2005 and *Renolde v. France*, no. 5608/05, § 120, ECHR 2008 (extracts));

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(3) In respect of persons deprived of their liberty, recourse to physical force which has not been made strictly necessary by their own conduct diminishes human dignity and is in principle an infringement of the right set forth in Article 3 of the Convention (see *Krastanov v. Bulgaria*, no. 50222/99, § 53, 30 September 2004). In the context of detention in a sobering-up centre, it is up to the Government to justify the use of restraints on a detained person. Aggressive behaviour on the part of an intoxicated individual may require recourse to the use of restraining belts, provided of course that checks are periodically carried out on the welfare of the immobilised individual. The application of such restraints must, however, be necessary under the circumstances and its length must not be excessive (see paragraph 86);

(4) The position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with. Nevertheless, it is for the medical authorities to decide, on the basis of the recognised rules of medical science, on the therapeutic methods to be used, if necessary by force, to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves and for whom they are therefore responsible. The established principles of medicine are in principle decisive in such cases; as a general rule, a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading. The Court must nevertheless satisfy itself that the medical necessity has been convincingly shown to exist (see *Herczegfalvy v. Austria*, 24 September 1992, § 82, Series A no. 244) (see paragraph 87).

On the facts, the Court found that the strapping of the Applicant reached the minimum degree of severity required to engage Article 3. As to the justification for the use of restraint, in line with domestic and international guidance, the Court found that strapping a patient to a bed for two hours could not be justified by "mere restlessness." Whilst aggressive behaviour could justify restraint in principle, strapping should be a mechanism of last resort. Patients who are restrained must be kept under close supervision. Further, European and national standards require proper recording of every use of restraints, which, among other things, facilitates any subsequent review of whether their use was justified. In the applicant's case, restraint had been applied as a matter of routine and the Government had not justified its use as proportionate in the circumstances of the case. There was therefore a substantive breach of the Applicant's Article 3 rights. The Court also found that there was a breach of the procedural aspect of Article 3, for reasons which need not detain us here.

The complaints of alleged breaches of Article 5 of the Convention were rejected as inadmissible on the grounds that the Applicant had not exhausted domestic remedies.

Comment
This case provides a useful synopsis of the jurisprudence of the European Court of Human Rights in relation to the treatment of mentally ill patients whilst they are being deprived of their liberty. Whilst the judgment focuses on the use of restraint, which on the facts resulted in a significant and permanent injury to the applicant, it serves equally as a reminder that additional attention should be paid by state authorities to ensure that the Article 3 rights of mentally ill individuals are upheld in hospital settings where they are particularly vulnerable. As such, it serves as a useful parallel to the case of Col Munjaz, discussed in a previous edition of the newsletter, in which the ECtHR emphasised the importance of Article 8 rights to those who are deprived of their liberty and in consequence the greater part of their autonomy.

25. Re Clarke

Summary
These three cases are reported together. They bear note not so much for any principles to be derived from them, but as a (relatively rare) insight into the management by the Court of a contested property and affairs application, an insight granted by virtue (if such is the word) of the fact that, whilst the proceedings took place in private, "*the manner in which* [the applicant] *Mr Michael Clarke has breached his mother's entitlement to privacy has been so comprehensive and long-standing that nothing is now to be gained by delivering the judgments in private for Mrs Clarke's benefit. On the contrary, in the light of Mr Michael Clarke's conduct, it is better that the court's reasons are made known*" (judgment of 9.10.12 at paragraph 4).

Mr Clarke sought to discharge the property and affairs deputy appointed on behalf of his mother, who had received some time previously a substantial sum of damages in compensation for injuries sustained in road traffic accident (including brain injuries). By the time the matter came before the Court, she had one substantial asset, a property in Blackpool, and her remaining free capital had in effect run out; her income consisted of a state pension and DLA, together with payment of a household allowance and living expenses from her capital fund. Her son, with whom she lived for most of the time in Spain in rented accommodation, was receiving c. £60,000 p.a. for care he was providing to her, although this sum was reduced in late 2011 because the current level of expenditure was deemed to be unsustainable by the Deputy. This led (Peter Jackson J drily noted) to an 'escalation' in the internet campaign that Mr Clarke

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had started to wage against the Deputy, the Office of the Public Guardian and the Court of Protection, and (it appears). Subsequent to the issue of proceedings, Mr Clarke's activities had escalated to the point where the Deputy had obtained an injunction restraining him from further harassment of the Deputy or his firm. The application to discharge the Deputy was resisted by Mr Clarke's other children on the basis that if she were not protected, he would spend her money on himself. He filed counter allegations against his siblings and the Deputy.

Expert evidence was directed by way of a s.49 MCA 2005 report as to Mrs Clarke's capacity (inter alia) to (1) manage her benefits; (2) make a will; and (3) decide whether to retain or sell the property in Blackpool. That evidence tallied with earlier evidence obtained (it is not clear by whom) by a consultant clinical psychologist to the effect that Mrs Clarke had the ability to make a will; there was apparent divergence on other matters.

At the hearing in July 2012, Peter Jackson J declined to embark upon a wide-ranging investigation of the issues between the family members or between Mr Clarke and the Deputy as being inconsistent with the overriding objective in Rule 3 COPR 2007. He also declined to embark an attempt to narrow the issues in dispute between the doctors by way of requiring a meeting between them and/or putting further questions to them; rather, he moved straight to a consideration of whether Mrs Clarke had the capacity to take the three decisions which arose at that stage.

At paragraph 35 of his July judgment, Peter Jackson J declined to find whether or not Mrs Clarke had capacity to manage her benefits, because he considered that it was in any event clear that it was in her best interests that they be managed on her behalf by her carer, who happened to be Mr Clarke. He found that she did have capacity to make a will, albeit that (as with the s.49 expert) he could "*not exclude the possibility that Michael Clarke exerts influence on Mrs Clarke, but I do not find that this currently invalidates her general testamentary capacity. Whether any particular will that she may make could subsequently be challenged is not a matter for this court at this time*" (paragraph 36). He found, by contrast, that she lacked the ability to weigh up the financial and welfare risks involved in each of the courses of action implicit in the decision whether or not to sell the property in Blackpool (paragraph 38). He found that he could not decide at that point whether to order a sale of the property in Blackpool because he did not have sufficient information before him. He therefore directed further evidence to be filed upon Mrs Clarke's best interests as regards the sale of the property and how her future income and housing needs were to be met.

Peter Jackson J considered the matter further in early October 2012. In the interim, a will had been prepared which (as he noted at paragraph 21) "[bore] *the hallmarks of having been prepared by Mr Michael Clarke*," contained provisions "*designed to prevent the sale of the property during Mrs Clarke's lifetime and to ensure that it comes into the hands of Mr Michael Clarke upon her death*" (paragraph 21). The Deputy and the other children wished the property to be sold (placing reliance upon observations made by Senior Judge Lush in *Re JDS* to the effect that it is not the function of the Court to "*anticipate, ring fence or maximise any potential inheritance for the benefit of family members upon the death of the protected party*." Mr Clarke firmly opposed the sale of the property.

Peter Jackson J noted that there was no satisfactory solution to the present situation, in which "*the difficulty of identifying where Mrs Clarke's best interests lie is compounded by the family situation. For better or for worse, Mrs Clarke's future is inextricably bound up with Mr Michael Clarke, whose strident voice threatens to drown out all others*" (paragraph 30). He noted that, if it were a purely financial question, the case for the sale of the property would be unanswerable. However, because the property was not merely an asset but was also (even if for only part of the time) a home for Mrs Clarke and Mr Clarke, as her carer, a sale would lead to the loss of their home. That outcome could not be justified from Mrs Clarke's perspective unless it was apparent that her daily needs were not in fact being met. Whilst Peter Jackson J found that the figures before him were not encouraging as regards the making up of a gap between her income and her outgoings, he did not consider that it was right at the present time to order her to sell her home to make up an income shortfall which could be made up in other ways. He noted that Mr Clarke would have the opportunity to manage her finances and to support her, but that if her way of life were to be deteriorating unacceptably as a result of inadequate income, a fresh application could be made for the sale of the property. He noted, though, that:

"38. Whatever the side-effects of my decision, it is no part of my purpose to 'anticipate, ring-fence or maximise any potential inheritance for the benefit of family members'. Not can my decision be influenced by the dismay of the other family members that Mr Michael Clarke's questionable sense of entitlement to his mother's property has, at least at this stage, prevailed. I have been guided only by my assessment of Mrs Clarke's best interests at the present time."

In light of his conclusion as to Mrs Clarke's best interests, Peter Jackson J directed that the Blackpool property not be sold or charged during her lifetime without an order of the Court; the deputyship being redundant in the circumstances, he therefore discharged it.

The family members other than Mr Clarke and the Deputy then made an application that their costs be charged to Mrs Clarke's estate. Mr Clarke asked the court to postpone a decision and in the interim to make orders for disclosure and for the production of further accounts by the Deputy and the Office of the Public Guardian. He opposed the other parties' applications.

Declining to depart from the general rule in property and affairs cases (Rule 156), Peter Jackson J noted that:

"*5. In this case there is no basis for departure from the general rule. My overall conclusions in relation to Mrs Clarke's capacity did not favour any party. While a sale of the Blackpool property has not been ordered at this time, the manner in which Mr Michael Clarke has conducted the proceedings more than wipes out any weight that might be attached to that factor. I identify his use of his mother's case as a vehicle for his political views, his aggressive disrespect towards anyone with whom he disagrees, and his complete lack of regard for his mother and family's right to privacy.*

6. In contrast, the conduct of the proceedings by the family members and the Deputy has been entirely reasonable in trying circumstances. Their costs shall be charged to Mrs Clarke's estate and become payable upon her death."

Comment
As noted above, this case is of interest not because of its outcome, but rather as an insight into the management of an application which (regrettably) is not entirely unusual in either the issues raised or in the attitude adopted by a litigant in person. Reading between the lines of the three judgments, it is clear that this was a case in which the patience of the Court was sorely tried, and that it was not without a very considerable degree of reluctance that Peter Jackson J came to the conclusion that he did as to where Mrs Clarke's best interests lay as regards the sale of the property in Blackpool.

One minor point to note in passing is that Peter Jackson J presumably did not approach questions of the management of Mrs Clarke's benefits on the basis that he had any jurisdiction to decide who should be her appointee to receive them on her behalf. Contrary to something of an urban myth, the Court of Protection has no jurisdiction to make such a decision, which lies solely in the gift of the DWP (whose guidance upon the question of appointeeship can be found at: http://www.dwp.gov.uk/docs/part-05.pdf).

26. Kedzior v Poland

Summary
The (relative) flurry of decisions from Strasbourg upon deprivation of liberty in the context of care homes continues apace.

This case (as with *Stanev v Bulgaria* and *DD v Lithuania*) concerned the placement of a person in 'an adult social care home.' Mr K's brother, in his role as Court-appointed guardian, asked that he be placed in a social care home, where he remained for a decade from 2002. It would appear that, under Polish law, his admission was considered voluntary and did not require approval by a court. He made repeated attempts both to challenge the lawfulness of his detention, and also to have his capacity restored, the latter it would seem primarily so that he would be allowed to leave the home. His attempts proving fruitless, he made an application to Strasbourg. Upon the application, the ECtHR had cause to consider the following:

(1) whether he was deprived of his liberty at the care home;

(2) if so, whether the deprivation of his liberty was lawful for purposes of Article 5(1)(e) ECHR;

(3) whether he had at his disposal a procedure complying with the requirements of Article 5(4) ECHR to challenge the necessity for his continued stay in the social care home and to obtain his release;

(4) whether his right of access to a court had been breached contrary to Article 6(1) ECHR.

The application also raised an issue under Article 8, but the Court did not consider it separately.
We address each of the four main issues in turn.

Whether Mr K deprived of his liberty
The submissions of the parties (including an intervention from the admirable Mental Disability Advocacy Centre) took a form that is now familiar, in particular in the reliance by the Polish Government upon the decision in *HM v Switzerland* ((2002) 38 E.H.R.R. 314).

At paragraphs 54-6, the Court noted the general principles at play in a form very similar to that set out in *DD*, noting that it had in that case and in *Stanev* "*had the opportunity to examine placements in social care homes of mentally incapacitated individuals, and to*

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find that it amounted to deprivation of liberty within the meaning of Article 5 § 1 of the Convention." Applying those principles, the Court held thus as regards the objective element:

"*57. As concerns the circumstances of the present case, the Court considers that the key factor in determining whether Article 5 § 1 applies to the applicant's situation is whether the care home's management has exercised complete and effective control over his treatment, care, residence and movement from February 2002, when he was admitted to that institution, to the present day (see paragraph 44 above and D.D. v. Lithuania, cited above, § 149). The applicant was not free to leave the institution without the management's permission. Nor could the applicant himself request leave of absence from the home, as such requests had to be made by the applicant's official guardian. Accordingly, and as in the Stanev case, although the applicant was able to undertake certain journeys and to spend time with his family the factors mentioned above lead the Court to consider that the applicant was under constant supervision and was not free to leave the home without permission whenever he wished (see Stanev, cited above, § 128). Moreover the Court notes that it would appear that the applicant's extended visits to his family were only authorised during the last few years of his stay in the Ruda Różaniecka Home.*

Finally, the management of the care home controlled the remaining 30% of the applicant's disability pension. The Court observes in this respect that the facts of the applicant's situation at the home were largely undisputed."

As regards the subjective element, the Court adopted a similar approach to that in *Stanev* and *DD*, concluding that:

"58 … In sum, even though the applicant had been deprived of his legal capacity, he was still able to express an opinion on his situation, and in the present circumstances the Court finds that the applicant had never agreed to being placed in the social care home."

The Court found that, although the applicant's admission was requested by his guardian, a private individual, it was implemented by a state-run institution (the care home), and hence the responsibility of the authorities for the situation complained of was engaged; and that he was deprived of his liberty for purposes of Article 5(1) with effect from February 2002 (paragraph 60).

Whether deprivation of liberty lawful for purposes of Article 5(1)(e)

Taking a very similar approach to that adopted in *DD*, the Court reiterated the need to go beyond a mere compliance with formal compatibility with the procedural requirements of the domestic law in question to examine whether those procedures provided sufficient guarantees against arbitrariness. The Court therefore examined the procedures in Poland to see whether they complied with the criteria set down in *Winterwerp v Netherlands* (1979) 2 E.H.R.R. 387 at 39. It reiterated in so doing that the mental condition of a person must have been established at the time of the deprivation of liberty (paragraph 66); in the case before it, an assessment conducted a little over a month previously could be considered sufficiently current (paragraph 67). However, the Court found that the assessment had been solely for purpose of determining the issue of his legal protection, rather than to decide whether his state of health required his detention, such that it could not stand as evidence that the mental disorder in question warranted detention (paragraph 68), and that there had been a "*total lack*" of continued assessment of his disorder (paragraph 71), such that his placement in the home was not ordered in compliance with a procedure prescribed by law and was hence not justified by reference to Article 5(1)(e)(ibid).

Article 5(4)

Turning to the applicant's complaint under Article 5(4) ECHR, the Court reiterated the 'mantra' from *DD* as to the relevant principles in the context of those detained as being of unsound mind thus:

"75. Among the principles emerging from the Court's case-law on Article 5 § 4 concerning "persons of unsound mind" are the following:

(a) a person detained for an indefinite or lengthy period is in principle entitled, at any rate where there is no automatic periodic review of a judicial character, to bring proceedings "at reasonable intervals" before a court to put in issue the "lawfulness" – within the meaning of the Convention – of his detention;

(b) Article 5 § 4 requires the procedure followed to have a judicial character and to afford the individual concerned guarantees appropriate to the kind of deprivation of liberty in question; in order to determine whether proceedings provide adequate guarantees, regard must be had to the particular nature of the circumstances in which they take place;

(c) the judicial proceedings referred to in Article 5 § 4 need not always be attended by the same guarantees as those required under Article 6 § 1 for civil or criminal litigation. Nonetheless, it is essential that the person concerned should have access to a court and the opportunity to be heard either in person or, where necessary, through some form of representation (see Megyeri v. Germany, 12 May 1992, § 22, Series A no.

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237-A; see also Stanev, cited above, § 171).

76. This is so in cases where the original detention was initially authorised by a judicial authority (see X v. the United Kingdom, 5 November 1981, § 52, Series A no. 46), and it is all the more true in the circumstances where the applicant's placement in the care home has been instigated by a private individual, namely the applicant's guardian, and decided upon by the municipal and social care authorities without any involvement by the courts (see D.D. v. Lithuania, cited above, § 164)."

The Court noted that the framework in place in Poland fell notably short of the requirements of Article 5 (4), in particular because there was no provision for automatic judicial review of the lawfulness of admitting a person to, and keeping him in, an institution such as a social care home, and a review could not be initiated by the person concerned if that person has been deprived of his legal capacity, such that Mr K was prevented from independently pursuing any legal remedy of a judicial nature to challenge his continued involuntary institutionalisation.

Article 6

The Court noted that it had, in *Stanev*, in respect of partially incapacitated individuals, that given the trends emerging in national legislation and the relevant international instruments, Article 6(1) of the Convention must be interpreted as guaranteeing a person, in principle, direct access to a court to seek restoration of his or her legal capacity. It reiterated (paragraph 89) that "*the Court reiterates that the right to ask a court to review a declaration of incapacity is one of the most important rights for the person concerned, since such a procedure, once initiated, will be decisive for the exercise of all the rights and freedoms affected by the declaration of incapacity, not least in relation to any restrictions that may be placed on the person's liberty*." On the facts before it, and in particular given that there had been a judgment from the Polish Constitutional Court to the effect that lower courts should not limit procedural rights of incapacitated adults even before legislation to that end had been completed, a judgment which had been signally ignored prior to the enactment of the legislation in question, the Court concluded that there had been a breach of Article 6(1).

The Court awarded Mr K the sum of €10,000 in respect of non-pecuniary damage to reflect the breaches of his rights under the Convention.

Comment

Even if it could be said previously that the English Courts were required to deduce the relevant principles applicable to the deprivation of liberty of incapacitated adults in care homes from Strasbourg jurisprudence which was not directly on point (for instance, *HL v United Kingdom*, concerned with informal admission to psychiatric hospital), that cannot be the case now. In *Stanev, DD* and now *Kedzior*, we have a trinity of cases which are expressly concerned with the placement of those without the relevant capacity in care homes. Unsurprisingly, perhaps, the approach adopted in each of the cases to the determination of the objective element of the deprivation of liberty is both internally consistent and consistent with that adopted in *HL*. None of the cases (with the possible but ambiguous exception of dicta in *Stanev*) rely upon questions of purpose, reason or motive; none proceed by reference to a comparator in the way adopted by the Court of Appeal in *Cheshire West*.

The divergence between the path adopted in England and Wales and that set down by Strasbourg would seem only to be widening. The need for the Supreme Court to grapple with the question of what constitutes a deprivation of liberty for purposes of the MCA 2005 only becomes more urgent; it is therefore all the more regrettable that we understand that the case is not listed until the autumn of 2013.

Kedzior is also of significance for confirming – if such confirmation was required – that the *Winterwerp* criteria are directly in play when it comes to consideration of those to be deprived of their liberty under the DOLS regime. To that extent, therefore, *Kedzior* (and *DD* before it, which addressed the matter more briefly) therefore answers the Court of Appeal's complaint in *G v E* [2010] EWCA Civ 822 [2010] COPLR Con Vol 431 that the "*European* jurisprudence *derives exclusively from the fact that in the cases which have reached the ECtHR, the issue has involved alleged mental illness and detention in a psychiatric hospital*" (paragraph 59). The steps required to ensure that a person satisfies the mental health requirement of Schedule A1 would appear to meet the requirements set down by Strasbourg, albeit that *Kedzior* does sound as a powerful reminder that it is necessary that (save in the case of emergency) the evidence upon which reliance is placed to justify detention must be (1) current at the point of detention; (2) prepared with a view to identifying why the disorder warrants detention; and (3) kept under regular review.

27. An NHS Trust v Mr and Mrs H & Ors

Summary

In these proceedings the Court was asked to consider an application by an NHS Trust for best interests declarations approving a medical treatment plan relating to KH.

KH was a three and a half year old boy. When he was just over a month old he contracted a Herpes virus infection which caused viral encephalitis. As a result,

he sustained a serious brain injury and now functions below the level of a new born baby. He had a number of complex additional medical complications, is unable to communicate and was entirely dependent on his foster carer.

The medical treatment plan at issue provided that life sustaining treatment should be withheld from KH when (as inevitably it would), his medical condition deteriorated on the basis that it would not be in his best interests aggressively to treat him in those circumstances. The plan was supported by the Trust and his foster carer. His parents lacked capacity to make decisions about his medical treatment and were represented in the proceedings by the Official Solicitor. They were unable to support the plan fully. The plan was opposed by the Children's Guardian and the Local Authority who were unable to support a medical treatment plan which proposed to withhold life sustaining treatment.

The NHS Trust invited the Court to declare that it was lawful and in KH's best interests "*to have medical treatment withheld in the circumstances as described in the attached Advanced Care Plan*."

In his judgment, Peter Jackson J summarised the state of the law in relation to the withdrawal of or withholding of medical treatment from children, endorsing in so doing the guidance produced by the Royal College of Paediatrics and Child Health upon "Withholding or Withdrawing Life Sustaining Treatment in Children: A Framework for Practice" (Second Edition) May 2004. He also indicated that he found some guidance as to how best to approach the question of the "best interests" test applicable by reference to s.4 MCA 2005 (although it had no legal application with regard to the Court's inherent jurisdiction in this regard).

As regards the fact that KH's parents lacked litigation capacity, he had this to say:

"10. In this case, KH's parents have been found to lack litigation capacity and it is understood that they are to be represented by the Official Solicitor as next friend. In these circumstances it is submitted that to be consistent with the Mental Capacity Act 2005 as amended, and in particular section 4(6) of that Act, regard should be had to the parents' wishes and feelings, but only to the extent that these relate to KH's best interests, which are for the Court to assess objectively. As stated by Holman J at 8x) above, 'Their own wishes, however understandable in human terms, are wholly irrelevant to consideration of the objective best interests of the child save to the extent in any given case that they may illuminate the quality and value to the child of the child/parent relationship'. A fortiori, this caveat must apply more forcefully to the views or wishes of parents without capacity who are not themselves looking after the child in question. The Official Solicitor, acting as litigation friend for KH's parents, should of course seek to advance a position in the 'best interests' of KH's parents rather than KH himself. It is important to note, therefore, that whilst the Official Solicitor's views in this regard may well elide with the 'best interests' of KH, there is this distinction to be made. This contrasts with the Official Solicitor's usual role in Court of Protection proceedings, where he seeks to advance P's best interests (rather than those of other Respondents to such proceedings).

[…]

16. My only other comment relates to the statement in paragraph 10 of Mr Hallin's summary that: 'A fortiori, this caveat [i.e. the irrelevance of the wishes of others, save to the extent that they cast light on objective best interests] must apply more forcefully to the views or wishes of parents without capacity who are not themselves looking after the child in question.' I readily accept that an involved and capacitous parent may be better placed to express views that assist in assessing best interests than one who is less involved or capacitous, but that is a matter of evidence and not one of principle. Parents who lack capacity may still make telling points about welfare and it would be wrong to discount the weight to be attached to their views simply because of incapacity. It is the validity of the views that matter, not the capacity of the person that holds them. In the present case, I have not discounted the views of the mother on the ground that she is represented by a litigation friend (the Official Solicitor) who does not oppose the declarations sought by the Trust, but have tried to approach her views on their merits."

Peter Jackson J held that it was appropriate that the matter had been brought to Court whilst KH was in relatively good health such that the issues could be fully explored in a way which would not have been possible if the parties had waited until he had deteriorated and been forced to make an urgent application. However, the corollary of that approach was that the medical issues had not fully crystallised. He went on to hold that there were difficulties with the request that the Trust had made, as the Court's function was to make decisions about specific issues on the basis of a factual substrata.

Accordingly, open ended declarations should be avoided by Judges as they might need to be revisited in the future: *Wyatt v Portsmouth Hospital NHS Trust* [2005] EWCA Civ 1181 at paragraphs 117 and 188 per Wall LJ. Accordingly, his approach was to identify the treatment issues that needed to be determined

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and that were not likely to change over time and in respect of which declarations can be made.

On the facts of KH's case, those treatment issues were clear as his condition was well understood, the scope for improvement was almost nil, and the prospect and manner of deterioration was inevitable. Had there been a major issue over which there was uncertainty, it would not have been possible to resolve it in theory ahead of it crystallising in reality.

Comment
This case provides a useful overview of the current state of the law in relation to withholding life sustaining medical treatment from children, as well as a careful analysis of the approach to be adopted where one or more parent is (because of their own difficulties) unable to act for themselves in such proceedings. As such, it serves as an interesting counterpart to the Strasbourg decision in RP, discussed elsewhere in this newsletter. We would also suggest that the dicta "[i]t is the validity of the views that matter, not the capacity of the person that holds them" are dicta that are of general application, rather than confined to the specific instance of the case before Peter Jackson J.

The case also serves to highlight the difficulties in ensuring an appropriate balance between bringing an application before the Court timeously and waiting until such time as the medical issues have crystallised. In this regard, practitioners should note the approach the Court took to the declarations that were sought and, specifically, the focus on treatment options as opposed to the granting of an open ended declaration.

28. An NHS Trust v (1) K and (2) Another Foundation Trust

Summary
K had cancer of the uterus. She could be cured by a potentially life-saving operation. However, because of other co-morbidities (in particular her obesity) and other factors there was a considerable risk that she could die during the operation or in the post-operative recovery period. Because of chronic and long-standing mental illness, she lacked the capacity to make an informed decision, denying that she had cancer at all. She opposed and was resistant to the operation. The medical team at the hospital considered that she would benefit from the operation and would like to perform it. K's three adult sons (who were not formally represented, but from the Court heard) all strongly desired that she should have the operation and felt that the potential benefit outweighs the risk. The Official Solicitor, relying upon the evidence of an independent intensivist/anaesthetic expert, considered that the operation was too risky because of the risk that she would die during the overall operative period, in particular during the recovery phase, a risk that the expert placed at some 40-50%.

Holman J was therefore asked to determine whether it was in K's overall best interests to have the operation or not. Having set out in detail the evidence as to risk during the post-operative period, he noted (paragraph 36) that the operation had previously been scheduled for a date in July 2012, but on that occasion she had become so agitated and resistant while in the ward prior to anaesthesia that it had to be abandoned (this being the event that triggered the application to the Court of Protection).

This raised the "*very serious issue and concern as to how, even if the court determines that the operation is in her best interests, it can actually be achieved without her pre-operative compliance…*" Holman J accepted that it would be objectively in K's best interests to be "*less than frank*" with her so as to achieve her admission to hospital; and that whilst such a course of action "*might appear to offend the legal requirement of section 4(4) of the Mental Capacity Act 2005* [that the person be permitted and encouraged to participate in the relevant decision/act] *but that is qualified by the words 'so far as reasonably practicable*" (paragraph 37). However,

"*38. Greater difficulties arise… once she is at the hospital and the operation is scheduled to begin. She must be told in sympathetic and straightforward language what is proposed. Mr. J himself would not be willing to operate without having first told her. The sons and others predict, however, that no sooner is she told this than, just as in July, she would become physically resistant. This has led to much discussion during the evidence and the hearing as to the legality, ethics and medical impact of the use at that point of physical restraint so that she could be sedated and later anaesthetised.*

39. I can, however, cut through it. There is medical evidence, to which I have already referred, to the effect that it could be very risky to apply physical restraint to Mrs. K in view, in particular, of her prolonged QT interval. It would be particularly risky immediately prior to anaesthesia. No one now advocates the use of physical restraint and it would not be employed at any stage pre-operatively.

40. A separate and discrete issue is, however, whether she might first be lightly sedated before being told, so that, it is hoped, she is compliant and not resistant as in July. This, too, has been the subject of considerable discussion and evidence. In the upshot, the declaration which the applicant Trust invite me to make on this issue (if I consider that the operation as

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a whole may take place) is that 'it shall be lawful for sedation to be administered by, and thereafter continuously monitored by, a qualified anaesthetist before Mrs. K is informed that it is proposed to carry out the [proposed] surgery and anaesthesia'.

41. Again, the sons have pressed upon me the logical argument that if it is in her overall best interests to have the operation, it must be in her best interests to have the sedation, unless medically contraindicated at the time, to enable the operation to take place. If I do decide to make an order permissive of the operation, the Official Solicitor does not oppose a consequential declaration in the above terms.

42. As to the lawfulness of doing so, my attention has been drawn to a decision of Sir Nicholas Wall, President, in DH NHS Foundation Trust v PS [2010] EWHC 1217 (Fam). In that case a hysterectomy was in the best interests of a patient who had agreed on previous occasions to undergo the operation, but had been overcome on the day by fear and needle phobia. The President made an order which approved a plan which included provision for covert sedation at the patient's home with a sedative drug mixed with a soft drink such as Ribena. (In that case there was provision also for the use of force if necessary to sedate her and convey her to hospital - see paragraph 19 of the judgment - but there were not the medical risks associated with co-morbidities that there are in this case.)

43. Although there are many factual differences between that case and this one, that authority does satisfy me that if it is in Mrs. K's overall best interests to have the operation, it can be lawful, and in her best interests, to sedate her to enable it to take place, and lawful to do so before she is told, after sedation but before anaesthesia, what is planned. There must be a qualified anaesthetist (not necessarily at that stage Dr. VB herself) throughout.

44. I do consider that an ethical issue may arise as to the degree of sedation and whether the surgeon can ethically proceed to operate unless he has given to the patient an adequate account of what he proposes to do while she retains sufficient awareness to hear it and take it in. But that is an ethical matter for him. I am satisfied that a declaration in the terms I have just quoted would, on the issue of sedation, be in her best interests and is lawful."

Turning to the question of K's overall best interests, Holman J found that the only really significant countervailing factor to place in the balance sheet against the benefits of carrying out the operation was the risk of death in the overall operative period. Having reviewed the evidence on this point, he concluded (paragraph 50) that, viewing the evidence as a whole, the independent expert whose views were relied upon by the Official Solicitor "*may have been unduly pessimistic. The evidence as a whole supports that the actual risk of mortality peri-operatively for this patient, if there is no attempt at lymphnodectomy, is closer to 5% than to 40 or 50%. Even if the risk is of the order not of 5% but of 10%, it seems to me to be a risk worth taking. I differ, therefore, from the Official Solicitor not because I would regard a 40 to 50% risk as acceptable, but because it seems to me, on all the available evidence, that although the risk of post-operative mortality is high, it is not so high as the assessment and position of the Official Solicitor assumes*." Given the considerably more speculative benefit to be derived from a lymphnodectomy, the Trust was ultimately not pressing for a declaration to extend to authorising such a procedure.

Holman J then turned to who should have a power of 'veto,' discussing the question thus:

"*52. No one, nor any court, can order or require any doctor to take any step. The court can only permit it. It follows, of course, as I wish to make crystal clear, that my intended order will permit and render lawful the procedures described, notwithstanding the lack of consent of the patient. Right up to the last moment, however, it must remain a matter for the individual professional judgement of Dr. VB* [the consultant anaesthetist] *and Mr. J* [the consultant gynaecological surgeon] *whether they think it justifiable to embark on the sedation, the anaesthesia and the surgery. Each of them has, therefore, a practical power of veto. I intend, nevertheless, to make it express on the face of the order that the proposed declaration ceases until further order to be of any effect if at any stage prior to the actual sedation, anaesthesia or surgery either Dr. VB or Mr. J notifies her/his colleagues that she/he considers it should not take place.*"

Given the particular nature of Mrs K's case and of her multiple co-morbidities, together with the high risks of post-operative complications and of post-operative mortality Holman J considered that a temporary power of veto should also extend to Dr W, the intensivist (paragraph 54) if she considered that the risk of post-operative mortality had simply become too great; because of her particular psychiatric complications and needs, he also considered that the professor of psychological medicine who would be in charge of her psychological wellbeing whilst she was at the hospital should also be given an effective power of veto (paragraph 55). Turning to the position of the sons, Holman J had this to say:

"*56. I wish to stress very clearly that the power and duty to make the best interests decision and consequential declarations is vested in the court alone. It is*

my duty to take responsibility for my decision, and although it is a heavy burden I, and I alone, do so. But in reaching that decision I have paid considerable regard to the position and views of the three sons, which I respect. They are not doctors but they know their mother well and each of them would be heavily involved during her recovery and convalescence. I do not make the declarations because they ask me to do so; but I might well have refused to make the declarations if they had raised any reasoned opposition to them.

57. Circumstances may change. They may reassess issues, such as the mental state of their mother or her likely post-operative compliance. For that reason, although the operation does not require their consent, there must be a temporary brake upon it if any of them notifies the doctors, making reference to the relevant part of the court order, that he no longer considers that the operation should take place. I stress that all these powers of veto or brakes are temporary, not absolute. They would halt the process but would not preclude further consideration by the court (myself if possible) in the light of the changed circumstances."

Comment

This case could properly stand as a case study of a medical treatment application in the COP, because it shows the careful application of the provisions of the MCA 2005 to the very particular facts before the Court, and, in particular, the close analysis of the evidence of the risks that would present themselves if the operation went ahead. Section 4 does not prescribe an outcome in any given case, but s.4 (and the 'balance sheet' approach) allows the Court to take a structured approach to identifying what outcome can properly be said to be in P's best interests.

That having been said, it would be interesting to learn the basis upon which the NHS Trust had not sought the authorisation of the Court prior to making the abortive attempt to undertake the operation in July 2012. Whilst Holman J made no criticism at all of the Trust in this regard, it would seem from the face of the judgment to have been a case in which the Practice Direction 9E would have mandated an application to be made, not least given the fine balance between the benefits to Mrs K of the operation and the burdens and risks that it was likely to entail.

29. NYC v PC and NC

Summary

This case concerned a 48 year old woman with mild learning disabilities called PC. She lived independently in the community, and had previously formed a relationship with NC. NC was then convicted and imprisoned for sexual offences. While he was in prison, PC and NC married. PC did not accept that NC was guilty of the offences for which he was convicted and wanted him to live with her on his release. As NC's release date approached, the local authority applied to the court for a declaration that it was in PC's best interests that she resumed her married life with NC when he was released from prison, on the basis that the risk he posed to her was outweighed by the likely distress that would be caused were they to be prevented from continuing their relationship. The court was asked to determine whether PC had capacity to decide to have contact with NC and to live with him, and if she did not, whether it was in her best interests to resume her married life with him.

Hedley J was confronted with legal submissions as to whether a decision about contact should be viewed as person-specific or not – perhaps PC lacked capacity to decide whether to spend time with NC, but had capacity to make decisions about contact with other people. Hedley J set out his approach to the issue in the following way:

"*19. There has been considerable debate as to whether the issue of capacity to decide on contact should or should not be person specific, that is to say whether it should or should not in this case focus on NC. This is in part derived from the terms of section 17 of the Act. However, it seems to me that what the statute requires is the fixing of attention upon the actual decision in hand. It is the capacity to take a specific decision, or a decision of a specific nature, with which the Act is concerned. Sometimes that will most certainly be generic. Can this person make any decision as to residence or contact or care by reason of, for example, their dementia? Or does this person have any capacity to consent to sexual relations by reason of an impairment of mind which appears to withdraw all the usual restraints that are in place? Such generic assessments will often be necessary in order to devise effective protective measures for the benefit of the protected person, but it will not always be so. There will be cases, for example, in relation to medical treatment where attention is centred not only on a specific treatment or action but on the specific circumstances prevailing at the time of the person whose decision making capacity is in question. The hysteric resisting treatment in the course of delivering a child is an example from my own experience. Accordingly, I see no reason why in the construction of the statute in any particular case the question of capacity should not arise in relation to an individual or in relation to specific decision making relating to a specific person. In my judgment, given the presumption of capacity in section 1(2) this may indeed be very necessary to prevent the powers of the Court of Protection, which can be both invasive and draconian, being defined or exercised more widely than is strictly necessary in each particular case.*

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20. It follows that in my judgment, rather than making a general finding about whether the question to be considered should or should not involve in it any particular individual, my task, as I understand it, is to articulate the question actually under discussion in the case and to apply the statutory capacity test to that decision. The question in this case surely is this: should PC take up married life with NC now that, in terms of imprisonment and licence, he is free to do so? It is a decision which any wife in her position would be required to take and it is a decision that does not admit only of one answer. Thus, the question of capacity is important. All the other issues raised, care, residence and contact, are peripheral, save insofar as they bear on the question of the resumption of the long interrupted cohabitation of PC and NC. Although that is a narrow issue it is, in my judgment, a seriously justiciable issue to which the court should give its proper attention and make a decision."

Applying that approach, the court concluded that PC lacked capacity to make the relevant decision. Because of her mental impairment, she was "*unable to weigh the information underpinning that potential risk so as to determine whether or not such a risk either exists or should be run, and should, therefore, be part of her decision to resume cohabitation*."

PC's social worker considered that, notwithstanding the risks that NC posed to PC in light of his offending history, it was in PC's best interests for them to resume their married life. The alternative, of restraining PC from seeing NC, would have been seriously distressing for PC.

The court agreed, observing that it would be impractical and effectively unenforceable because of PC's strongly held wishes. Hedley J expressed the view that "*faithfulness to the policy behind section 4(4), and potentially behind section 4(6), is that it may be necessary from time to time to leave open to the protected person the option of taking an unwise decision which others, who are fully capacitous in her position, may themselves have taken*."

Comment
This is an illuminating and instructive judgment which, in our view sets out in clear terms the correct approach to the assessment of capacity under the MCA. Capacity is decision-specific, not issue-specific, situation-specific or person-specific, although factors such as the situation in which a decision falls to be made, and the identity of people involved in the decision may well be relevant. It must be correct that a person could have capacity to decide to see A but not B where the information relevant to each decision is different because of the different risks posed by A and B, provided that the reason why the person cannot understand or weigh that information is their mental impairment.

The acceptance by the court that it can be in P's best interests for an unwise or risky decision to be made is similarly welcome, and could usefully be applied to decisions about the return home of elderly people whose physical care needs would be better met in a residential setting, but who have a strong desire to live in their own homes.

30. RP v UK

Summary
This case arose from family proceedings in which the Official Solicitor was appointed to act as litigation friend to a mother who lacked litigation capacity. The points of principle raised upon the application to Strasbourg were identical to those which arise in Court of Protection proceedings, and thus the case merits consideration in some detail.
The mother argued, among other points, that her rights under Article 6 ECHR had been breached because:

(1) There had been no determination by the court of her litigation capacity – the Official Solicitor had accepted an expert report on the issue, and had not put the matter before the court for resolution.

(2) The Official Solicitor had taken the view that he could not challenge the local authority's argument that the mother's children should be taken into care, as the merits of the mother's case were too weak. As a result, the outcome she wished for was not argued.

The Court started its examination of the issue by recalling that the right of access to the courts guaranteed by Article 6(1) was not absolute, but may be subject to limitations. Whilst a certain margin of appreciation was left to member states in this regard, the Court recalled that:

(1) the limitations applied must not restrict or reduce the access left to the individual in such a way or to such an extent that the very essence of the right was impaired; and

(2) a limitation would not be compatible with Article 6 (1) if it did not pursue a legitimate aim and if there was not a reasonable relationship of proportionality between the means employed and the aim sought to be achieved.

As regards those with disabilities, the Court recalled that it had permitted domestic courts "*a certain margin of appreciation to enable them to make the relevant procedural arrangements to secure*

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the good administration of justice and protect the health of the person concerned (see, for example, Shtukaturov v. Russia, no. 44009/05, § 68, 27 March 2008). This is in keeping with the United Nations Convention on the Rights of Persons with Disabilities, which requires States to provide appropriate accommodation to facilitate the role of disabled persons in legal proceedings. However, the Court has held that such measures should not affect the very essence of an applicant's right to a fair trial as guaranteed by Article 6 § 1 of the Convention. In assessing whether or not a particular measure was necessary, the Court will take into account all relevant factors, including the nature and complexity of the issue before the domestic courts and what was at stake for the applicant (see, for example, Shtukaturov v. Russia, cited above, § 68)" (paragraph 65).

In the instant case, the Court accepted that the proceedings were of the utmost importance to the mother, who stood to lose both custody of and access to her only child. Moreover, "*while the issue at stake was relatively straightforward - whether or not R.P. had the skills necessary to enable her successfully to parent K.P. - the evidence which would have to be considered before the issue could be addressed was not. In particular, the Court notes the significant quantity of expert reports, including expert medical and psychiatric reports, parenting assessment reports, and reports from contact sessions and observes the obvious difficulty an applicant with a learning disability would have in understanding both the content of these reports and the implications of the experts' findings*" (paragraph 66).
"I*n light of the above*," the Court continued *"and bearing in mind the requirement in the UN Convention that State parties provide appropriate accommodation to facilitate disabled persons' effective role in legal proceedings, the Court considers that it was not only appropriate but also necessary for the United Kingdom to take measures to ensure that R.P.'s best interests were represented in the child-care proceedings. Indeed, in view of its existing case-law the Court considers that a failure to take measures to protect R.P.'s interests might in itself have amounted to a violation of Article 6 § 1 of the Convention (see, mutatis mutandis, T. v. the United Kingdom [GC], no. 24724/94, §§ 79 - 89, 16 December 1999)*" (paragraph 67).

The Court therefore examined the appointment of the OS in the case before it to see whether it was proportionate to the legitimate aim pursued or whether it impaired the very essence of RP's right of access to a court. It found as follows:

(1) The OS was only invited to act following the commissioning of expert evidence from a clinical psychologist as to RP's capacity to conduct the litigation in question, and that, whilst there was no formal review, in practice further assessments were made of her litigation capacity during the course of the proceedings (paragraph 69);

(2) Whilst there was no formal right of appeal against the appointment of the OS, RP was informed of her ability to contact either her solicitor or the Official Solicitor (or a complaint's officer) if she was unhappy with the conduct of the litigation; the OS also gave evidence to the domestic courts that "*R.P. could have applied to the court at any time to have him discharged. Alternatively, he indicated that if it had come to his attention that R.P. was asserting capacity, then he would have invited her to undergo further assessment*." These, the Court considered, constituted an "*appropriate and effective means by which to challenge the appointment or the continued need for the appointment of the Official Solicitor*" (paragraph 70);

(3) It would not have been appropriate for the domestic courts to conduct periodic reviews of RP's litigation capacity, as this would have caused unnecessary delay and would have been prejudicial to the welfare of her daughter. There would also have been no purpose served in encouraging her to seek separate legal advice at this juncture (paragraph 71);

(4) Any means of challenging the appointment of the OS, however effective in theory, would only be effective in practice and thus satisfy the requirements of Article 6(1) of the Convention if the fact of his appointment, the implications of his appointment, the existence of a means of challenging his appointment and the procedure for exercising it were clearly explained to the protected person in language appropriate to his or her level of understanding. On the facts of the case, her solicitor had taken proper steps to ensure that she was aware of the nature of the involvement of the OS and of his role (and she had only complained some 10 months after his appointment and two days before the final hearing), such that adequate safeguards were in place to explain the nature of proceedings to her and to enable her to challenge the appointment of the OS (paragraphs 72-4);

(5) As regards the conduct by the OS of the proceedings, the Court noted RP's concerns that the OS had focussed 'on what was best' for RP's daughter. However, it accepted that the best interests of the daughter were the touchstone by which the domestic courts would assess the case, such that in determining whether a case was arguable or not, it was necessary for the OS to consider what was in K.P.'s best interests. Bearing in mind what was best for the daughter did not therefore constitute a breach of the mother's Article 6(1) rights (paragraph 76).

Furthermore, and in a passage which will resonate

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with those appearing before the Court of Protection, the Court noted that it did "*not consider that 'acting in R.P.'s best interests' required the Official Solicitor to advance any argument R.P. wished. On the contrary, it would not have been in R.P.'s - or in any party's - best interests for the Official Solicitor to have delayed proceedings by advancing an unarguable case. Nevertheless, in view of what was at stake for R.P., the Court considers that in order to safeguard her rights under Article 6 § 1 of the Convention, it was imperative that her views regarding K.P.'s future be made known to the domestic court. It is clear that this did, in fact, occur as R.P.'s views were referenced both by the Official Solicitor in his statement to the court and by R.P.'s counsel at the hearing itself*" (paragraph 76).

Noting finally that RP had appealed to the Court of Appeal (refusing the assistance of pro bono Counsel which the OS had secured for her) and that during the course of her appeal she was afforded ample opportunity to put her views before the Court, the Court concluded that the very essence of her right of access to a Court was impaired, and therefore found there to have been no breach of Article 6(1).

The Court further found manifestly ill-founded allegations of breaches of Articles 8 and 13 for reasons which need not trouble us here.

Comment
The outcome in this case is perhaps not hugely surprising. If it had been otherwise, the system of representation in England and Wales for those lacking litigation capacity and who do not otherwise have the benefit of a litigation friend would have collapsed. However, three points of significance arise:

(1) This is only the most recent of the cases involving incapacitated adults discussed in our newsletter in which the Court has construed the ECHR by reference to the UN Convention on the Rights of Disabled Persons;

(2) The Court placed considerable emphasis upon the steps taken to explain to RP the ways in which she could seek to challenge the appointment of the Official Solicitor; it therefore left open the possibility that a failure on the part of the particular individuals appointed to act on the part of the protected party (whether that be P or another party to the litigation) to convey the necessary information in an appropriate form would give rise to a breach of Article 6(1);

(3) The endorsement of the proposition that 'acting in the best interests' of a protected party does not require advancing every argument that party wishes to be relayed to the Court is of assistance, although it is necessary to ensure that where the protected party has a particularly important stake in the outcome of the proceedings that their views are appropriately conveyed to the Court. This is particularly so where the protected party is P him or herself (rather than, as in *RP*'s case, a protected party other than the subject of the litigation). In such circumstances, it is suggested that, even if not formally advanced by way of argument to the Court, P's views must clearly and fully put before the Court so as to comply the duty to safeguard their rights under Article 6(1) ECHR.

31. SCC v JM & Ors

Summary
To the best of our knowledge, this case is the first judgment in the public domain recording the sentencing of someone to prison for breaches of orders made by the Court of Protection (*PM v KH and HM* [2010] EWHC 2739 concerning breaches of orders made under the inherent jurisdiction).

The facts of the underlying case are not relevant to the contempt proceedings; suffice it to say that they related to the residence of JM, an elderly man suffering from Alzheimers and a degree of vascular dementia. The conduct of one of JM's children, WM, had given rise to substantial concern on the part of the Court during the course of the proceedings, albeit that HHJ Cardinal was at pains to point out (paragraph 2) that the way in which she had behaved in that litigation was in no way reflected in the judgment to which he came upon the committal application.

In 2011, injunctive relief had been granted by first a District Judge and then HHJ Cardinal:

a. to the effect that the respondents should not encourage JM to leave or to ask to leave his placement, or discuss with him the possibility of moving back home, or remove him from the jurisdiction of the court. The reason why that order was made was because there was a history on one occasion of JM being removed from the care home where he was situated and, indeed, taken to Turkey for a short period;

b. restraining WM from using or threatening violence against her father or any employee of the applicant or the AH home, or instructing, encouraging or in any way suggesting any other person should do so. She was further forbidden from intimidating, harassing or pestering her father or any employee of the applicant Local Authority or the AH home.

Notwithstanding these injunctions, which had been served upon WM (who had attended nearly every hearing), WM took the following steps which HHJ Cardinal found to constitute contempt of court:

a. WM and IM (her brother) took JM to see a solicitor in Birmingham to discuss his placement. They did so

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by WM persuading or causing IM and his partner to collect JM for what was initially reportedly a contact visit and to bring him from the Local Authority home to Birmingham to see a solicitor;

b. WM produced and distributed a leaflet prior to and during the final hearing giving details of the case, containing a photograph of her father and other information so as to identify him and that is in breach of rule 90/91 of the Court of Protection Rules;

c. speaking to her father on numerous occasions about the proceedings, even though she has been told that in doing so she has caused him distress. She also gave her father a wooden cross at a visit, saying that he should keep it with him at all times to prevent the evil in the home hurting him;

d. abusing and threatening Ms LW (the practice lead social worker of the older person's mental health team for the local authority), contrary to the court's orders (the abuse including abusive emails and voicemails);

e. bringing her father to Court on the day of the judgment upon the welfare application, a journey of some 50-60 miles, in circumstances where it was necessary for the clerk to HHJ Cardinal and court security to be involved to remove JM from her and IM, and where it was found that JM was unwell upon his return to the care home "*thanks in no small part to the stress involved in attending court unnecessarily*" (paragraph 3).

HHJ Cardinal found, perhaps not surprisingly, there had been a considerable number of breaches, and that WM had no intention, "*unless restrained by a severe measure by this court, of obeying the orders herself*" (paragraph 12). He also found that she had been seeking to evade service of the application for committal for contempt and in the circumstances considered it appropriate to proceed to sentence her in her absence. In light of the paucity of consideration by the Court of contempt applications, the relevant paragraphs of his judgment merit setting out in full:

"*15. … I look at the terms of punishment. Miss Khalique has properly reminded me that the court's purpose is not to express outrage, but simply to express the court's concern as to breach of its orders and not in fact to punish unnecessarily, it is not a criminal court. I bear in mind the guidance given by the leading case of Hale v Tanner [[2000] 1 W.L.R. 2377], but in the circumstances it seems to me that there is no alternative other than to commit this lady to prison. I realise, of course, that in doing so I would be punishing JM to a degree because in some small way he still appreciates visits from his daughter, although she seems to ruin part or all of most of the visits and telephone calls, but the court cannot allow this situation to continue whereby she abuses LW, she abuses staff at AH Home and she defies the court order by bringing her father to court. She is causing him very considerable grief. In those circumstances it seems to be only right she should go to prison.*

16. I have thought very carefully about the punishment. Last time I proposed imprisonment for five months. There have been other incidents, but I am satisfied that those incidents took place simply because she had not appreciated that I was going to send her to prison for breaches and she just continued her behaviour. I do not think it is a case for increasing the punishment so in the circumstances for each and every one of the breaches I will send her to prison for a further period of five months to be served concurrently. I am not sure I have said so clearly, but I make it clear that the telephone calls by WM have been not just to LW, but, of course, also to staff at AH Home and I want to make it clear that this order is made to protect them just as much as it is to protect staff of the Local Authority direct."

Comment
It is, unfortunately, not uncommon for those before the Court of Protection to show themselves (by word or deed) reluctant to heed the declarations or decisions of the Court; this judgment is helpful confirmation that the standard principles applicable to contempt in civil proceedings will apply if and when their reluctance reaches the level of contempt.

32. R (Sunderland City Council) v South Tyneside Council

Summary
Although this concerns the free after-care provisions of s.117 of the Mental Health Act 1983, it provides an opportunity to mention the ordinary residence provisions surrounding the identity of the relevant supervisory body for DOLS.

The main issue for the Court of Appeal was whether patient SF was "resident" in a Sunderland hall of residence or a South Tyneside hospital for the purposes of determining which authority was responsible for paying for her after-care services. The parties agreed that SF was resident in Sunderland at the time when she was informally admitted to the South Tyneside hospital on 7 October 2009 having attempted suicide. She suffered from atypical Asperger's and a borderline personality disorder and consented to the admission, *"but it is likely that if she had not given her consent, compulsory powers would have been used*" (para 6). However, just over two weeks into her two-month informal hospital stay, her licence to live in the Sunderland hall of residence was terminated,

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along with her college placement. After absconding from the hospital on 9 December 2009, she was detained for assessment and then for treatment under the Mental Health Act.

At first instance, Langstaff J had applied the test for ordinary residence in *R (Shah) v Barnet LBC* [1983] 2 AC 309 (adopting a place voluntarily and for settled purposes as part of the regular order of one's life for the time being), and noted that the informal admission was not a voluntary surrender: it was closely analogous to a compulsory admission, with the powers to detain in the background. Moreover it was not for a settled purpose; nor was it part of the regular order of her life. Accordingly SF remained resident in Sunderland.

Allowing the appeal, the Court of Appeal held that *Shah* was not a helpful guide and *Mohamed v Hammersmith and Fulham LBC* [2001] UKHL 57 was to be preferred. Although the period of hospital *detention* must be disregarded, regard could be had to the preceding two-month informal stay. The question *"is not only that of physical presence*" and "it may be relevant to consider why the person is where he or she is, and to what extent his or her presence there is voluntary" (para 31). Crucially, once the Sunderland hall of residence had ceased to be available to her, there was no place where SF could be said to be *"resident*" other than the hospital. It followed that South Tyneside was responsible for her after-care.

Comment
It is important to emphasise that where someone "resides" for MHA 1983 s.117 purposes involves a different test to deciding where they "ordinarily reside" for the purposes of the National Assistance Act 1948. Section 117 is freestanding and contains none of the deeming provisions referred to in the 1948 Act.

When identifying which supervisory body is responsible for dealing with a DOLS application, the Mental Capacity Act 2005 relies upon the "ordinarily resident" approach of the 1948 Act, and not the "resident" approach of the 1983 Act. Thus, the fact that a person can be said to "reside" in hospital for s.117 purposes, between losing their community placement and being detained under the MHA, may not impact greatly in non-MHA situations.

No mention is made in the judgment of SF's capacity to consent to the informal admission and the deprivation of liberty safeguards were not used. However, let us imagine an incapacitated person is ordinarily resident in area A where they are accommodated by local authority A under Part 3 of the National Assistance Act 1948. If they are placed in a care home in local authority B, s.24(5) of the 1948 Act deems that person to still be "ordinarily resident" in area A. Thus, local authority A remains the supervisory body for any DOLS application.

If the person is admitted to hospital in area B under a DOLS authorisation, s.24(6) of the 1948 Act similarly deems them to be "ordinarily resident" in area A and so the Primary Care Trust in area A will be the supervisory body. If, however, they were detained in that hospital under MHA s.3, PCT B and local authority B will be responsible for their s.117 after-care because area B is where they were "resident" prior to the detention. That was the position prior to this decision and does not appear to be altered by it.

What remains to be seen is the extent to which the *Shah* test will continue to be used when determining ordinary residence for the purposes of the 1948 Act (and therefore DOLS). Indeed, clause 32 of the draft Care and Support Bill retains the term "ordinarily resident" so the issue seems set to continue.

Ed. My thanks go to the team of specialist barristers Alex Ruck Keen, Victoria Butler-Cole, Josephine Norris and Neil Allen all of 39 Essex Street Chambers, London for the above case summaries and the comments. Especial thanks to Senior Judge Lush for permissions mentioned above.

Disciplinary cases

33. Nurse denies misconduct over book about murder

30 October 2012 - The Times
Kathleen Pugh, 53, appeared before the NMC on charges that her fitness to practice is impaired by selling a book to a patient which she had written about a health visitor seducing a dying patient before killing him. She also handed out promotional literature about the book to patients and staff at Royal Oldham Hospital.

34. Doctor suspended over claims he lied about qualifications

03 November 2012 – Daily Record
Dr Muhammad Ishaque is being sued by a US university over the alleged lies about his qualifications.

He told health chiefs at NHS Grampian he had a master's degree from a research university in America and claimed he was a member of the Royal College of Surgeons, when he was not entitled to join until he had passed all relevant exams.

Dr Ishaque will appear at a General Medical Council hearing to face the allegations later this month.
http://www.dailyrecord.co.uk/news/scottish-news/doctor-suspended-over-claims-he-lied-1414078

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Cases in the news

35. Council fined for lawyer's error

26 October 2012 - Law Society Gazette - John Hyde

Stoke-on-Trent has been fined £120,000 after one of its solicitors sent a series of emails relating to a child protection legal case to the wrong address.

The Information Commissioner's Office (ICO) found Stoke-on-Trent Council in serious breach of the Data Protection Act after 11 emails were sent in December 2011.

They included highly sensitive information relating to the care of a child and further information about the health of two adults and two other children.

The emails should have been sent to counsel instructed on a child protection case. The wrong address was a valid address but the recipient failed to respond when asked to delete the emails. The ICO's investigation found the solicitor was in breach of the council's own guidance, which confirmed that sensitive data should be sent over a secure network or encrypted.

However, the council had failed to provide the legal department with encryption software and knew that the team had to send emails to unsecure networks. The council had failed to provide relevant training.

The fine followed an undertaking by the authority in 2010 when data relating to a childcare case was lost after being stored on an unencrypted memory stick.

Ed. We all use email more and more frequently for our business and commercial transactions. We are all prone to error and mistakes. This decision serves as a warning to us all to exercise as much care as we possibly can.

36. PIP breast implant boss Jean-Claude Mas leaves custody

29 October 2012 – BBC News

Jean-Claude Mas, the founder of the scandal-hit French breast implant company PIP has been released from custody pending trial.

He spent eight months in detention after his company's breast implants were revealed to be prone to rupturing and is due to go on trial in April. He will have his movements restricted in the meantime.
http://www.bbc.co.uk/news/world-europe-20126546

Children

37. Actress teams up with police to raise awareness of child sex-ploitation

29 October 2012 - ACPO

Sex abuse film to help police spot victims

30 October 2012 - The Times

A new training film to help front-line police officers spot the early signs of group-associated grooming, and support vulnerable children being sexually exploited, has been launched. The 19 minute film can be seen on YouTube.

38. Care leavers data pack

30 October 2012 – Department for Education

Care leavers' charter must guarantee more support for young people

30 October 2012 – The Guardian

A data pack analysing in detail the attainment outcomes of care leavers when set against other aspects of their lives. The data pack will be updated as new statistics become available.

The aim is to improve the quality of support as they make their transition to adulthood.
http://www.education.gov.uk/childrenandyoungpeople/families/childrenincare/a00216209/care-leavers-data-pack
http://www.guardian.co.uk/society/2012/oct/30/care-leavers-charter-young-people?newsfeed=true

39. NICE guidance on vulnerable children

31 October 2012 - NMC News

NICE (National Institute for Health and Clinical Excellence) have published new guidance on the social and emotional wellbeing of vulnerable children under five.

The guidance aims to ensure that both universal and targeted services provide the additional support all vulnerable children need to ensure their mental and physical health and wellbeing.

Recommendations relevant to nurses and midwives include that:

- Midwives should offer intensive home visits by an appropriately trained nurse to parents assessed to be in need of support.
- Those in antenatal and postnatal services should identify factors that may post a risk to a child's social and emotional wellbeing
- Midwives should consider evidence-based interventions to improve maternal sensitivity and mother-infant attachment.

See the guidance

Conferences & Courses

40. Dignity: A Tale of Two Wards

12 November 2012 - Cardiff University

Cardiff University together with Fiona Phillips will be hosting an event to formally launch the training DVD 'Dignity: A Tale of Two Wards' which has been dis-

tributed to all acute NHS facilities in England and Wales and to universities teaching health professionals. The content draws upon real life examples of care that is sometimes dignified and sometimes not – intending to create feelings of empathy with the people receiving care, and how they are likely to feel. The DVD is intended to connect to emotions.

For further information about the DVD contact wtadd@mac.com

Ed. I have not yet seen the DVD myself, however, I have read some rave reviews from a number of people whose opinion I respect.

Consultations

41. Consultation on the role of Monitor

Consultation opens 14 August 2012
Consultation closes 08 November 2012
Monitor launched the draft Commissioner Requested Services and Protected Services Guidance for consultation.

The guidance sets out a process for commissioners to follow to ensure that key NHS services remain available for patients if a provider gets into serious financial difficulty.

Commissioner Requested Services are services that will be considered by the commissioner for protection should a provider fail. The system will form part of Monitor's Continuity of Service framework which aims to make sure patients continue to have access to the services they need in their local area.

As part of the Continuity of Service framework, Commissioners will decide which services should be designated Commissioner Requested Services and the guidance helps them to do this. Providers of Commissioner Requested Services will be subject to additional licence conditions in the proposed NHS provider licence, which was released for consultation on 31 July 2012.

Jason Mann, Transition Policy Director at Monitor said,

"*We need a continuity of service framework that protects patients whilst allowing commissioners and providers to work together to deliver the right services for their local community.*

"The guidance is an important part of the continuity of service framework which is our primary means of making sure key services continue to be available to patients should a provider experience serious difficulties.

"It is very important that we get the guidance right and we urge people to get involved with the consultation to help the NHS continue to deliver high quality services for patients in the future."
http://healthandcare.dh.gov.uk/category/nhs/sector/
http://www.monitor-nhsft.gov.uk/consult
http://www.nationalcareforum.org.uk/forums/forum_posts.asp?TID=5196&PN=1

42. Health and Safety Executive: Proposed regulations to implement Council Directive on preventing sharps injuries in the hospital and healthcare sector - A consultation

Consultation opens 08 August 2012
Consultation closes 08 November 2012
HSE would like your views on proposals to introduce new regulations to protect healthcare workers against the risk of injury from sharp medical instruments. The regulations are provisionally titled The Health & Safety (Sharp Instruments in Healthcare) Regulations 2013.

You can view and respond to the consultation by going to: ***http://www.hse.gov.uk/consult/condocs/cd244.htm***

43. Consultation on proposed changes to the governance arrangements for controlled drugs

Consultation opens 27 September 2012
Consultation closes 15 November 2012
DH is consulting on proposed changes to the governance arrangements for controlled drugs in England and Scotland, including the role and functions of Controlled Drugs Accountable Officers (CDAOs).

The Health and Social Care Act 2012 has introduced significant structural changes for the NHS in England from next April. These have important ramifications for the overall governance of controlled drugs and in particular, for the role and functions of primary care trust CDAOs. Consequently, 'the Controlled Drugs (Supervision of Management and Use) Regulations 2006' require revision.

This consultation describes the proposed new regulations and seeks views and comments from all interested parties on a number of proposed changes to the current arrangements.

The proposed new regulations have been devised with the support and help of a small multi-disciplinary working group chaired by Dr Keith Ridge, Chief Pharmaceutical Officer for England.
http://www.dh.gov.uk/health/2012/09/controlled-drugs/

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44. Developing the culture of compassionate care: creating a new vision for nurses, midwives and care-givers - A consultation

Consultation opens 21 September 2012
Consultation closes 16 November 2012
An opportunity to help create a new strategy for nursing, midwifery and care-giving that embeds a culture of compassionate care.
http://www.commissioningboard.nhs.uk/files/2012/09/nursing-vision.pdf

45. Public consultation (MLX 379): Transposition of Directive 2011/62/EU ("the Falsified Medicines Directive") into UK legislation

Consultation opened 18 October 2012
Consultation closes 19 November 2012
This consultation sets out, under sections that address the key topics addressed in the Falsified Medicines Directive, a brief summary of the way in which the Directive will change the current regime. It invites comments on the proposals for implementation. The draft legislation is also provided and you are strongly advised to read this in conjunction with this summary document.
http://www.mhra.gov.uk/Publications/Consultations/Medicinesconsultations/MLXs/CON195906

46. CQC sets out plans to drive improvements in health and adult social care

Consultation opens 06 September 2012
Consultation closes 06 December 2012
The Care Quality Commission (CQC) is asking for views on its plans for the next three years.

In a consultation paper on its strategy for 2013-2016 published today, the national regulator for health and adult social care sets out proposals for what it thinks it should focus on and what the public and others can expect from it.

CQC's new Chief Executive David Behan said: "*For CQC, being successful means that more health and care services meet quality and safety standards – and improve quickly if they don't.*

"I want people to know that together with Healthwatch as the consumer champion we will listen to them and use their experiences to help inform the judgements we make about services.

"And I want to ensure providers of services understand what good looks like and what is unacceptable so they can improve the services they provide.

"CQC is now in its fourth year. As we enter the next stage of our development I am clear that our role is to check that health and care services meet national standards and in that way drive improvements in the quality and safety of services.

"Perhaps the most significant of our proposed changes is that we'll tailor the way we regulate different types of organisations based on what has the most impact on driving improvement. We will put people's views at the centre of what we do.

"We also recognise we need to work more effectively with others. We have a common goal with other organisations to improve the quality of health and care services. By sharing information and acting together we will be more effective in driving improvement."

The consultation paper also says that over next three years CQC will improve the way it uses information to help it spot and address poor care faster. It will highlight what works well so the people who run health and care services can improve the quality of the care they provide. And it will make it easier for people to access and understand its information.

At the same time, it will continue to carry out thousands of regular unannounced inspections and go in at any time where there are concerns about poor care.

CQC Chair, Dame Jo Williams said: "*A clearer strategy for CQC will make a vital contribution to improving the care that people have a right to expect. It will enable us to focus our action where there is greatest risk, to become an authority on the state of care, tackle poor standards, work with others to drive improvements in the quality of health and adult social care more decisively than ever. It gives us a real opportunity to make a difference and we are determined to do so.*

"We talked to hundreds of people in preparing these plans and we're hoping hundreds more will share their views with us."

The consultation paper asks for people's views on seven specific questions about the proposed approach. These cover how CQC regulates services, how it manages its independence, its relationship with the public and with organisations that provide care, its role in the complaints system, its responsibilities in relation to mental health services and on how it can measure its own impact.

Full details of the proposals and how to respond are on CQC's web site at **www.cqc.org.uk/thenextphase**

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47. HCPC launches new consultation on service user involvement in approved education and training programmes

Consultation opens 03 September 2012
Consultation closes 07 December 2012

The Health and Care Professions Council (HCPC) has launched a new consultation today to seek the view of stakeholders on a proposal to amend the standards of education and training (SETs) to require the involvement of service users in programmes approved by the regulator.

The SETs, the standards that an education and training programme must meet before it can be approved by the HCPC, already support and encourage education providers to provide evidence of service user involvement in their programmes. However, the involvement of service users is not currently a requirement of the standards themselves. Therefore, the proposed amendment to the SETs would make service user involvement in approved training programmes a formal requirement.

Michael Guthrie, Director of Policy and Standards at the HCPC, said:

"We have been actively reviewing our approach in this area for a number of years. Research we commissioned earlier this year into existing involvement of service users found a number of benefits to both service users and students.

"The majority, if not all, HCPC-approved programmes already involve service users in some way. We are proposing to amend the SETs to require service user involvement because this would recognise the involvement activities that are already taking place and encourage education providers to think about how best to involve service users in their programmes.

"This sends out a strong message that service user involvement has an important contribution to make to public protection by ensuring that anyone successfully completing a programme has the skills necessary for safe and effective practise."

The consultation will be of interest to a wide range of stakeholders, particularly education providers offering programmes approved by the HCPC, professional bodies, advocacy organisations and service users. Once the consultation closes, the HCPC will consider the responses and decide whether the proposals should be amended.

The consultation is available here:
www.hpc-uk.org/aboutus/consultations/index.asp?id=150

48. 'Three people, one baby' public consultation begins

Consultation opens 17 September 2012
Consultation closes 07 December 2012

A public consultation has been launched to discuss the ethics of using three people to create one baby.

The technique could be used to prevent debilitating and fatal "*mitochondrial*" diseases, which are passed down only from mother to child but means that the resulting baby would contain genetic information from three people - two parents and a donor woman.

Ministers could change the law to make the technique legal after the results of the consultation are known.
http://www.bbc.co.uk/news/health-19597856

49. Consultation on national performers list for GPs, dentists and ophthalmic practitioners

Consultation opened 19 October 2012
Consultation Closes 14 December 2012

A consultation proposing that in future, there is one national list of general practice doctors, dentists and ophthalmic practitioners approved to provide NHS primary care services has been opened. Medical, dental and ophthalmic practitioners may not perform NHS primary care services in England unless they are included on a performers list held by a primary care trust (PCT). The performers' list system provides PCTs with powers to manage these performers and protect the public from any performers that fall below the required standards.

The consultation also considers recommendations made by two reviews that looked at the performers list system. It discusses the three different options that could be pursued and the option that has been chosen.

It seeks responses on proposed changes, including:

- the introduction of national lists
- changes to the 'minimum service' that performers on the list will need to perform
- changes to suspension powers, including, immediate suspension and additional powers at suspension hearings
- changes to the requirement to submit criminal records checks.

- respond to the consultation on line
- performers lists regulations 2013 consultation overview including annex B
- annex A draft regulations

- annex C summary of the recommendations of the performers list review
- annex D provides a word copy of the consultation questionnaire

50. The following section/document has been added/updated

Consultation opens 19 October 2012
Consultation Closes 30 November 2012
This consultation seeks views on proposals to introduce some new fees, simplify some fees and increase some fee levels charged by the MHRA for the regulation of medicines, including herbal and homeopathic medicines.
Public consultation (MLX 377): Fees legislation for 2013

51. Consultation on ensuring fair and transparent pricing for NHS services

Consultation opens 05 October 2012
Consultation closes 21 December 2012
A consultation to help ensure fair and transparent pricing for NHS services has been opened by the Department of Health.

From April 2014, Monitor and the NHS Commissioning Board will take over responsibility for pricing NHS services from the Department. They will do this through the national tariff. These arrangements will place responsibility for pricing with the bodies best placed in the new system to undertake it.

This consultation seeks views on the Department of Health's proposals for:

- which providers can formally object to Monitor's way of calculating prices
- what level of objections from commissioners and/or providers would require Monitor to: reconsider how it calculates prices, or refer its way of calculating prices to the Competition Commission, who will then decide whether or not it is appropriate.

- Respond to the consultation online
- Read Fair and transparent pricing for NHS services – A consultation on proposals for objecting to proposed pricing methodology
- Download consultation response form

This consultation should be considered alongside current consultations on a new licensing regime for providers of NHS services and procurement regulations for NHS commissioners.
http://consultations.dh.gov.uk/sector-regulation/pricing/consult_view

52. Improving services for children - Consultation

Opening Date: 29 October 2012
Closing Date: 31 January 2013
The Care Inspectorate has launched 'How well are we improving the lives of children and young people? A guide to evaluating services using quality indicators'.

The framework of quality indicators is designed to support Community Planning Partnerships in their self-evaluation of performance across the full range of services for children, young people and families. Ministers have requested that the Care Inspectorate lead the development of a coordinated approach to the scrutiny and improvement of services for children and young people and the indicators will also be used by inspectors when they carry out independent scrutiny.

The Care Inspectorate want to find out your views about how useful this guide is, how it might be improved and how we can support and build capacity for joint-self-evaluation across partnerships.

Click here to read the document.
Click here to complete the consultation.
http://www.scswis.com/index.php?option=com_content&task=view&id=8135&Itemid=363

53. Proposals to revise the regulation of NHS charities - A consultation

Opening Date: 01 November 2012
Closing Date: 31 January 2013
Consultation looking for views on proposals to revise the governance of charities which were established to receive and manage charitable funds to support healthcare in the NHS.
http://www.dh.gov.uk/health/2012/11/nhs-charities/

54. Social workers asked for views on fitness to practise

Consultation opens 02 October 2012
Consultation closes 02 January 2013
The Care Council for Wales is consulting on the development of fitness to practise rules for dealing with allegations against registered social workers, social care workers and students. The aim is to move from delivering public protection through assessing whether someone has committed misconduct to assessing whether, as a result of their actions, they are fit to practise - in line with the approach taken by the Health and Care Professions Council.
Take part in the consultation

55. HCPC launches new consultation on standards for prescribing

Consultation opens 02 October 2012
Consultation closes 04 January 2013
The Health and Care Professions Council (HCPC)

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has launched a consultation today to seek the view of stakeholders on new standards for prescribing.

Currently, chiropodists / podiatrists, physiotherapists and radiographers may become supplementary prescribers following the appropriate training and annotation of the HCPC Register. In July 2012, the Department of Health announced that the medicines legislation will be amended to allow appropriately trained chiropodists / podiatrists and physiotherapists to act as independent prescribers. Chiropodists / podiatrists and physiotherapists will only be able to act as independent prescribers if they are annotated on the HCPC Register as independent prescribers. Radiographers will continue to be eligible for supplementary prescribing only.

The HCPC has developed new standards for prescribing in line with this announcement. These standards, which will apply to both supplementary and independent prescribing, will be published in one document divided into two sections:

- The first section contains standards which education programmes
- delivering training in prescribing will need to meet.

- The second section contains standards which individual prescribers
- will need to meet to demonstrate safe and effective prescribing
- practice.

Michael Guthrie, Director of Policy and Standards at the HCPC, said:

"Currently, the standard of proficiency related to supplementary prescribing sits within the standards of proficiency for the particular profession. We think that publishing the standards in one document allows us to clearly set out our expectations for prescribing practice and makes it easier for stakeholders to find the standards.

"As with all our standards, the primary purpose of the standards for prescribing is to protect the public. To ensure that the new standards are robust and reflect the latest in safe and effective prescribing practice, we looked at a variety of sources on prescribing during the drafting process, including standards and frameworks set by other regulators."

Once the consultation closes, the HCPC will analyse the responses and publish a document detailing the comments received and explaining the decisions made as a result. These will be published on the HCPC website.

The HCPC then hopes to publish the new standards on April 2013. Subject to the change in legislation, it is expected that training in independent prescribing will start to be available in autumn 2013.

56. New safeguards to protect patients - Ensuring continuity of NHS services - A consultation

Opening Date: 01 November 2012
Closing Date: 04 January 2013
A consultation on new measures that will protect the services that patients need has been launched.

The Health Special Administration consultation sets out how safeguards to protect the services that patients need will be extended to NHS services provided by social enterprises and other companies.

For the first time, the services these organisations provide will be secured if they become insolvent. This will ensure that, regardless of the type of provider, patients will receive an uninterrupted service they can rely on.

Under the Health and Social Care Act, Monitor, the financial regulator of the NHS, will be able to put independent providers of NHS services through rigorous checks to ensure they are able to remain financially stable. As a last resort, Monitor will be able to seek the appointment of a health special administrator, who will take control of the company, working with local health professionals so that service can continue.

Currently if a company that provides NHS healthcare becomes insolvent and can no longer provide services, there are few safeguards in place to ensure that patients can still access those services.

Health Minister Lord Howe said:

"*Charities, social enterprises and independent providers play an important part in providing NHS care. They can help give patients more choice of where and how they are treated by the health service. It is vital that however patients are treated in the health service they receive a high quality service that they can rely on.*

"The Health Special Administration procedure will only be used as a last resort when all other options have been explored. But it is an important step to ensure that regardless of how services are provided, we always meet the needs of our patients. It is vital that everyone in the health service looks at the consultation and feeds in their opinions so we can get this

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right."

The consultation published yesterday will run until 4 January. The Department will publish the response to the consultation early in the new year.
http://www.dh.gov.uk/health/2012/11/hsa-consultation/

57. Views sought on strengthening NHS Constitution

Consultation opens 05 November 2012
Consultation closes 28 January 2013
The main changes proposed cover:

- a new responsibility for staff to treat patients not only with the highest standards of care, but also with compassion, dignity and respect
- a new pledge making it explicit that patients can expect to sleep in single-sex wards
- a new pledge to patients that NHS staff must be open and honest with them if things go wrong or mistakes happen – this 'duty of candour' will become a condition in the NHS Standard Contract from April 2013.

The changes also make it clearer that:

- patients, their families and carers should be fully involved in all discussions and decisions about their care and treatment, including their end of life care
- patients who are abusive or violent to NHS staff could be refused treatment
- the NHS is equally concerned about physical and mental health.

Health Minister Norman Lamb said:
"With this Government, the founding principles of the NHS – free at the point of delivery to all, regardless of their ability to pay – will not only be supported, but reinforced.

"The NHS is one of this country's greatest achievements. This government will always make sure it is free to all, no matter your age or the size of your bank balance. That's why at the same time as we are protecting its budget, we are strengthening this Constitution, which enshrines the right of everyone to have first class care, now and in the future."

Download A consultation on strengthening the NHS Constitution

The consultation follows work carried out by the NHS Future Forum on how the Constitution could be strengthened. The Government accepts the Forum's recommendations in full and the new proposals reflect this.

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58. Comments wanted on proposals to revise the regulation of NHS charities

Opening Date: 01 November 2012
Closing Date: 31 January 2013
The DH wants feedback from the NHS and other interested parties on final proposals to revise the governance of NHS charities.

NHS Charities were established to receive and manage charitable funds to support healthcare in the NHS and are usually linked to individual NHS providers (mainly hospital trusts) and range from Great Ormond Street to residual historical funds.

The proposals will:

- remove regulation by ministers
- enable NHS charities to establish and operate more flexibly and independently, in the interests of donors and patients
- preserve the close relationship with the providers of NHS services that the charities support.

http://www.dh.gov.uk/health/2012/11/nhs-charities/

59. NICE: Current consultations

To browse through consultations go to
http://www.nice.org.uk/page.aspx?=consultations.current

Care Quality Commission, CSSIW, Social Care and Social Work Improvement Scotland & Healthcare Improvement Scotland

59. New recruits

31 October 2012 - CQC News
CQC recently appointed two new National Professional Advisors - Fay Baillie (Midwifery and Nursing) and Dr Julie Hankin (Mental Health). They have both come to CQC with a wide range of experience and expertise in their fields.
Read their profiles here...

60. Speaking Up charter

31 October 2012 - CQC News
CQC has joined with other regulators, professional bodies and trade unions to launch the "Speaking Up" charter. This is a commitment to work together to support people who raise concerns in the public interest.
Read more about the charter…

61. Inspector blog

31 October 2012 - CQC News
Read the fifth instalment of the CQC inspector blog. In this issue, a CQC compliance inspector talks about an inspector's knowledge, surgical procedure, and

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why ticking boxes can have quite significant benefits.
Read more here...

62. What do you think of our website?

31 October 2012 - CQC News

CQC is carrying out a short survey to find out people's opinions of its website. Do you visit it's site to search for care services and read inspection reports? Or do you use it to find out the latest news about CQC and it's activities? CQC also wants to hear about any features you like or dislike, and new features you'd like to see in the future. The survey is running for one more week and will be used to improve the website and make it work better for you.
Read more...

63. CQC staff survey shows morale still low

02 November 2012—Health Service Journal

Just 16% of staff at the Care Quality Commission think morale is good while less than a fifth think changes are effectively implemented, the organisation's latest staff survey reveals.

Ed. I wonder when the survey was undertaken; if recently, it rather suggest that Mr Behan has much more to do to turn the organisation around than I had previously thought...

Dementia

64. Few people making plans for social care should they lose capacity

29 October 2012 – Community Care

Alzheimer's Society has warned that people with dementia are missing out on benefits of making a Lasting Power of Attorney for planning their future care needs, after low take-up rates were revealed.

Research found 106,299 registered a health and welfare Lasting Power of Attorney (LPA), enabling someone else to take decisions on their behalf should they lose capacity to do so, in England and Wales from 01.10.2007 to 30.06.2012.
http://www.communitycare.co.uk/Articles/29/10/2012/118636/Few-people-making-plans-for-social-care-should-they-lose.htm

65. Alan Rosenbach Blog

31 October 2012 - CQC News

CQC's Special Policy Lead, Alan Rosenbach, has written a guest blog for the 'In whose shoes'... series, about care and support for people living with dementia.
Read more here...

66. Consultation over closure of Sheffield dementia sites

31 October 2012 – BBC News

A public consultation will to be held over the future of two of Sheffield's three dementia support centres.

Sheffield City Council said closing Norbury Centre in Fir Vale and Bole Hill View in Crookes would save about £835,000 and the money saved would be used to provide more services to people at home and in Hurlfield View at Arbour.
http://www.bbc.co.uk/news/uk-england-south-yorkshire-20143256

67. Clinical trial launched for Alzheimer's treatment

01 November 2012 – Barchester.com

TauRX Therapies will be undertaking clinical trials to determine the efficacy of a new treatment for Alzheimer's disease.

The company has revealed that it will conduct two phase three clinical trials testing drug treatments to halt the progression of mild to moderate Alzheimer's disease.
http://www.barchester.com/Media/News/2012/10/clinical-trial-launched-for-alzheimers-treatment.htm

68. Consultation over closure of Sheffield dementia sites

31 October 2012 – BBC News

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http://www.bbc.co.uk/news/uk-england-south-yorkshire-20143256

69. Nursing Times Award Success

02 November 2012 - Dementia Centre, University of Stirling

Professor June Andrews received The Chief Nursing Officer's Award for Lifetime Achievement at the Nursing Times Awards on 31.10.2012. This award recognises Professor Andrews as a world-leader in the field of evidence-based improvements to dementia care practice.
Find out more

Ed. We are pleased to add our congratulations to Prof. Andrews on her most recent award.

Ireland, Scotland & Wales

Ireland

70. Watchdog report: 'unexplained injuries' at care home

02 November 2012 – BBC News

The PSNI has revealed that a number of staff at Ralph's Close in the Gransha complex have been suspended while the health watchdog investigates allegations of mistreatment.

The review was carried out by the Regulation and Quality Improvement Authority which inspects the quality of health and social care in Northern Ireland.

In September a number of staff members were suspended during the police investigations.
http://www.bbc.co.uk/news/uk-northern-ireland-foyle-west-20177719

Scotland

71. Some NHS Lothian patients 'could be sent to Europe'

29 October 2012 – BBC News

NHS Lothian's health board says that patients might have travel to Europe for operations in a bid to stay within new guidelines of being treated within 12 weeks.

NHS Lothian declared that it could have up to 500 untreated patients by the New Year if it did not make contingency plans.

Legislation since 01.10.2012 means operations must be conducted within 12 weeks.
http://www.bbc.co.uk/news/uk-scotland-edinburgh-east-fife-20128784

72. Scottish winter death rate at record low

31 October 2012 – BBC News

New figures released by the National Records of Scotland show that the number of winter deaths in Scotland has fallen to the lowest level since records began.

19,119 deaths had been registered in the four months to March 2012, that figure was down by 507 on the previous year and was the lowest total since records began in 1951/52.
http://www.bbc.co.uk/news/uk-scotland-20136907

73. Dementia: Every Scottish health board now has dedicated expert

04 November 2012 – BBC News

Every Scottish health board now has a dedicated dementia expert, according to the Scottish Government.

A total of 14 Alzheimer Scotland dementia nurses are now available to help raise care standards and improve the quality of life for people with the condition and are also helping carers and families within hospitals.
http://www.bbc.co.uk/news/uk-scotland-20193166

Wales

74. Welsh government-backed mental health scheme expanded

29 October 2012 – BBC News

The Welsh Government is looking to expand the number of people in Wales trained to help with mental health in the workplace to reach over 10,000.
http://www.bbc.co.uk/news/uk-wales-20131117

75. Welsh Ambulance Service fears at lack of budget

31 October 2012 – BBC News

Apparently patients could be put at risk because the Welsh Ambulance Service does not know exactly how much money it has to spend this year.

Board members of the ambulance trust are "*extremely concerned*" that its budget for this year has not been finally agreed.
http://www.bbc.co.uk/news/uk-wales-20143304

76. Children's Commissioner for Wales calls for abuse probe

04 November 2012 – BBC News

Children's Commissioner for Wales calls for abuse probe

04 November 2012 – BBC News

North Wales abuse: Children's commissioner wants inquiry

04 November 2012 – BBC News

North Wales abuse: Steve Messham's investigation call

04 November 2012 – BBC News

Children's Commissioner for Wales backs abuse inquiry

04 November 2012 – BBC News

The children's commissioner told the Sunday Politics Wales that he will be writing to the first minister to call for a new inquiry

The Children's Commissioner for Wales, Keith Towler is to write to the nation's first minister to request a new inquiry into the abuse of children at care homes in north Wales in the 1970s and 80s.

He said that he suspects a group were protected by each other's power, enabling the abuse to continue.
http://www.bbc.co.uk/news/uk-wales-20196086

http://www.bbc.co.uk/news/uk-20199987
http://www.bbc.co.uk/news/uk-wales-20198087
http://www.bbc.co.uk/news/uk-wales-20197432
http://www.bbc.co.uk/news/uk-20197499

77. Systemic problems forcing older people into care, says Wales commissioner

04 November 2012 – BBC News

Sarah, Rochira, the older people's commissioner for Wales says that bad planning with hospital discharges and lack of planning causes some older people to move unnecessarily into care homes.

About 23,000 older people are in residential care homes in Wales.
http://www.bbc.co.uk/news/uk-wales-20191348

Learning Disabilities

78. Ministerial statement on Winterbourne View

29 October 2012 - DH

Norman Lamb, Minister of State for Care services, made a statement in response to the sentencing of those convicted of abuse at Winterbourne View.

"The abuse of patients at Winterbourne View hospital was horrifying. I hope that these sentences will send a clear message that such criminal behaviour will not be tolerated and that there will be real consequences for the perpetrators.

"We are continuing to work closely with key stakeholders, including service users and carers, to ensure real improvements in the quality of care, and that people with learning disabilities and behaviour that challenges receive the care they need, and should be supported to live in the community wherever possible.

"We will publish the final report of the Winterbourne View review shortly. Alongside that, we will publish an agreement setting out the responsibilities of government, commissioners, providers, professional bodies and regulators and the timetabled actions that each body commits to deliver.

"We will continue to work with voluntary organisations, people with learning disabilities and their families so that they can hold health and social care bodies to account in making sure we deliver real change."
Read full ministerial statement laid in Parliament
See Department of Health interim report on Winterbourne View

Brunswicks LLP (@BrunswicksLLP)
29/10/2012 16:30

BBC Panorama - further exposé about the ill-treatment of people with learning disabilities; BBC 1 this evening

More in BHCR later this week

79. 29 October 2012 - Mencap

Dear Keith,
Thank you for taking action to stop abuse at institutions like Winterbourne View.

Panorama on tonight

There is a follow up Panorama about Winterbourne View on tonight, Monday 29th October. It is on from 8.30–9pm. This will tell some of the untold stories of patients and reveal details about how the NHS was charged up to £3,500 per week for each person there. The programme will question whether the patients who left Winterbourne View when it was shut down are now safe, and really being protected.

You can take part in the discussion on Twitter by following @mencap_charity and the #winterbourne hashtag.

Take action

The sentencing of the abusers at Winterbourne View took place on Friday. Six of the 11 staff members were given jail sentences, the other 5 suspended sentences. But the sentencing is only the start of stopping this abuse and neglect of people with a learning disability.

Things will only change if the Government leads a closure programme of services like Winterbourne View and ensures that local support is developed. We are concerned that they won't commit to this.
Please take action and email Norman Lamb MP, the minister responsible, and tell him to use his powers to stop another Winterbourne View happening. Use our template email and it will only take one minute of your time.

Until the Government takes strong action, people are going to continue being at risk of abuse in places like Winterbourne View.

Thank you for your continued support.

80. Proforma letter to the Minister for Care Services

29 October 2012

Dear Mr Lamb MP,

I am deeply concerned that the government's final report and action plan on Winterbourne View will not stop abuse like that happening again.

Urgent action needs to be taken to stop people with a learning disability being sent away to institutions like

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Winterbourne View, often hundreds of miles from home and their families, where they face increased risk of abuse and neglect.

Assessment and treatment units like Winterbourne View are extremely costly, and are being treated as 'dumping grounds' by local commissioners. Local services, which are often cheaper, need to be developed, so people with a learning disability can be supported near their families in their communities.

As Mencap and the Challenging Behaviour Foundation's Out of Sight campaign report says, the government must drive through the closure of places like Winterbourne View and ensure that people with a learning disability get the right support and services locally. As part of this, the CQC needs to be given the power to deregister and shut down these places.

This is a critical opportunity for the government to ensure people with a learning disability and behaviour that challenges stop being put in high risk services, which the Serious Case Review into Winterbourne says 'should not exist.'

I am calling on you to ensure that the government's final report and action plan commit to real change and stop another Winterbourne View happening again.
Please read the Out of Sight report at http://www.mencap.org.uk/outofsight-report

81. Provider sparks probe into placement claim

31 October 2012 - Health Service Journal
A PCT is reportedly refusing to fund placements at a privately run facility for patients with learning disabilities because of its proximity to the site of a scandal-hit NHS hospital.

82. Our latest case study

31 October 2012 - CQC Newsletter
CQC's latest case study is from Hayling Island (Hampshire), a small care home for people with physical and learning disabilities. Read how CQC's actions and work with the provider, after finding poor care, resulted in a much improved service.
Read the case study here...

Legislation Update

83. SI 2012/2672 - The Health and Social Care Act 2012 (Consequential Amendments – the Professional Standards Authority for Health and Social Care) Order 2012

29 October 2012 – OPSI
http://www.legislation.gov.uk/uksi/2012/2672/contents/made

84. Impact of deprivation on death rates limited

30 October 2012 - Health Service Journal
Ten trusts had a higher than expected mortality rate during 2011-12, in comparison to 14 during the previous year, latest data reveals.

Ed. I don't have access to the underlying materials which underpin the headline.

85. Commissioner for Older People Act 2011 (Commencement) Order (Northern Ireland) 2012

30 October 2012 – OPSI
http://www.legislation.gov.uk/nisr/2012/388/contents/made

86. SR 2012/389 - The Health (2009 Act) (Commencement No. 2) Order (Northern Ireland) 2012

31 October 2012 – OPSI
http://www.legislation.gov.uk/nisr/2012/389/contents/made

87. 2012 c. 18 - Mental Health (Approval Functions) Act 2012

31 October 2012 – OPSI
http://www.legislation.gov.uk/ukpga/2012/18/contents/enacted

Mental Capacity

88. Where social workers are going wrong on the Mental Capacity Act

31 October 2012 – Community Care
Five years on from implementing the Act, the risk-averse practice is preventing its principles of empowerment and support from being realised.

It seems that social workers and other professionals are still failing to apply it in the spirit that it was created and local authorities are misusing the Act to support risk-averse practice, with some failing to provide practitioners with the training they need to apply the legislation properly.
http://www.communitycare.co.uk/Articles/31/10/2012/118652/Where-social-workers-are-going-wrong-on-the-Mental-Capacity.htm

Mental Health

89. Action to clarify processes under the Mental Health Act

29 October 2012 - DH
The Department of Health is taking action to correct an irregularity in the application of the Mental Health Act 1983.

A technical issue has been identified in the way some Strategic Health Authorities (SHAs) have been administering the process for approving doctors to work under the Act. This involves the process of approving doctors to assess and detain patients. This issue applies in four SHAs (North East,Yorkshire and Hum-

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ber,West Midlands and East Midlands).

There is no suggestion that the hospitalisation or detention of patients has been clinically inappropriate; nor that the doctors involved are anything other than properly qualified to make the recommendations; nor that these doctors might have made incorrect diagnoses or decisions about the treatment that patients need.

The issue is a technical irregularity involving the approval process of doctors who make the assessments – not the validity of the assessments themselves. Doctors who assess patients, and make recommendations under the Mental Health Act, are required under section 12 of the Act to be 'approved' to do so. The Act requires the approval to be by the Secretary of State. The Secretary of State has properly and lawfully delegated that approval function to SHAs since 2002. However, four out of the ten SHAs asked mental health trusts to carry out the validation and approval process for them, but did not ask for it to be referred back to those Strategic Health Authorities for final confirmation.

All doctors involved have now been approved under the correct processes. There is therefore no issue with new assessments taking place under sections of the Act as of today.

Although there is clear legal advice that there are good arguments that previous detentions under the Mental Health Act were and are lawful, it is important that there should be no doubt about this. That is why, in relation to past and existing sections under the Act, the irregularity will be corrected by emergency retrospective legislation. The effect of the legislation will be retrospectively to validate the approval decisions that were made.

Because of the need for absolute clarity in this area, the legislation will be a simple and rapid process, and will apply in principle to the approval of all doctors under the Mental Health Act since its introduction in 1983.

Health Secretary Jeremy Hunt said:

"*We believe that all the proper clinical processes were gone through when these patients were detained. They were detained by medically qualified doctors. We believe that no one is in hospital who shouldn't be and no patients have suffered because of this.*

"But for the avoidance of any remaining doubt, and in the interests of the safety of patients themselves, as well as the potential concerns of their families and the staff who care for them, we are introducing emergency legislation to clarify the position."

The processes involved in this issue will be subject to an investigation so that any and all lessons for the future are learned. Not least, the Department wants to learn any lessons to help inform how these processes work from April 2013, when the structure of the NHS changes.

The Department of Health has asked Dr Geoffrey Harris, Chair of NHS South and former Chair of Buckinghamshire Mental Health Trust to undertake an independent review to look at how this responsibility was delegated by these four SHAs; and, more broadly, the governance and assurance processes that all SHAs use for delegating any responsibilities

Dr Harris will report to the Secretary of State by the end of the year with recommendations to ensure every part of the new system employs the highest standards of assurance and oversight in the delegation of any functions.

90. Mental health sectioning error

29 October 2012 – BBC News

Health Secretary, Jeremy Hunt, has said that urgent retrospective legislation is needed to correct a "*technical error*" affecting up to 5,000 patients sectioned under the Mental Health Act since 2002.

The error means doctors who sectioned patients in England did not have the right jurisdiction to do so.

He has ordered an independent review.
http://www.bbc.co.uk/news/health-20126569

91. Mental illness 'biggest UK health challenge' - Miliband

29 October 2012 – BBC News

Labour leader, Ed Miliband declared that the problem of mental illness in the UK is the "*biggest unaddressed health challenge of our age*",

He wants to give patients the same legal right to mental health therapies as physical healthcare and called for a culture change.
http://www.bbc.co.uk/news/uk-politics-20117661

92. Technical change to the process for approving doctors working under the Mental Health Act

29 October 2012 – DH

Letter outlining the technical issue that was been identified in the way some strategic health authorities have been administering the process for approving doctors to work under the Mental Health Act.
http://www.dh.gov.uk/health/2012/10/technical-change-act/

93. Joint Ombudsmen investigation into section 117 aftercare complaint

30 October 2012 - Parliamentary and Health Service Ombudsman and the Local Government Ombudsman

A report of a joint investigation by the Health Service Ombudsman and the Local Government Ombudsman about a complaint into the provision of section 117 aftercare has been published.

The complaint by an individual, referred to as Miss M, related to the standard of mental health care provided by Avon and Wiltshire Mental Health Partnership NHS Trust and Wiltshire Council to her late mother, Mrs M. In particular, Miss M complained that her mother had to fund her own care in a residential care home.

Citing section 117 of the Mental Health Act 1983, which makes provision for patients who have been compulsorily detained under the Act to receive free aftercare, Miss M complained it was wrong for Mrs M to have funded her own care during the five years she spent as a resident of the care home.

The Ombudsmen did not uphold any of Miss M's complaints. Although they found there was no doubt Mrs M had had a severe and enduring mental illness over many years, they could not conclude that her period of residence in a care home, in the last years of her life, was linked to aftercare arising from compulsory detention in hospital some 15 years earlier. Because Mrs M's general deterioration could not be definitely attributed to her mental health problems, the Ombudsmen could not therefore conclude that the care home's fees should have been met from public funds. They also found that, despite some procedural failings, Mrs M did not fail to receive the medical or social care services that she needed from the trust or the council.

Download the PDF version.

94. Mental health loophole 'closed'

30 October 2012 – BBC News

Emergency legislation designed to close a loophole in the law on mental health has now been approved by the Commons, correcting a technical error affecting up to 5,000 patients sectioned under the Mental Health Act since 2002.

The error meant doctors who sectioned patients in England did not have the right authority to do so.

Health Secretary, Jeremy Hunt, insisted that they were all qualified to make the clinical decisions and that no patient was wrongly detained. He has ordered an independent review.

http://www.bbc.co.uk/news/health-20145578

95. Response on funding allocations for independent mental health services and the treatment of armed forces' compensation in charging for social care

31 October 2012 - DH

DH published its consultation response and a summary of views received on options for distributing funding to local authorities for Independent Mental Health Advocate (IMHA) services and the treatment of armed forces' compensation in charging for social care.

The IMHA service will be funded by Department of Health grant from April 2013 onwards. Further details about the allocation of the grant will be made available in late 2012, alongside the provisional 2013/14 local government finance settlement.

The Care and Support White Paper announced that the Government will amend social care regulations and charging guidance so that members of the armed forces injured as a result of service will no longer need to use monthly Guaranteed Income Payments (GIPS) for their injuries from the Armed Forces Compensation Scheme to fund publicly arranged social care. The Department also sought views on how to allocate additional funding for this new disregard.

Further details about the allocation of the grant for GIPS disregard funding were issued on 24.10.2012.

There were 36 responses to the questions on allocation of funding for IMHA services, and 14 responses to the GIPS questions in the consultation.

Read:
Consultation response and summary of views
Original consultation

96. Una Butler seeks changes in mental health care provision

31 October 2012 – Irish Times

Una Butler, the wife of a man who took his own life after he'd killed their two daughters, is campaigning for a change in the way mental health patients are treated.

In an interview, she called for the Mental Health Act to be changed so that medical professionals were required to involve the partners and families of mental health patients in their treatment.

http://www.irishtimes.com/newspaper/breaking/2012/1031/breaking17.html

97. Amendments to the high security psychiatric services directions 2012

02 November 2012 - DH

These directions apply to the 3 trusts which provide high secure mental health services at Ashworth, Broadmoor and Rampton Hospitals. They should be

read alongside the High Security Psychiatric Services (Arrangements for Safety and Security at Ashworth, Broadmoor and Rampton Hospitals) Directions 2011 and associated guidance.

- 2012 directions make amendments to clarify the time limit for such appeals
- 2011 directions make provisions regarding appeals to the Care Quality Commission against decisions to withhold post or monitor telephone calls

98. Statistical press notice: Mental Health Community Teams Activity Data

02 November 2012 - DH

Quarterly Mental Health Community Teams Activity data for 2012-13 Quarter 2 and revisions for 2011-12 and 2012-13 Quarter 1.

The main findings for 2012-13 Quarter 2 were:

- Early Intervention (EI) teams served 5,137 new cases of psychosis in Quarter 1 and 2 of 2012-13.
- 97.2% of patients under adult mental illness specialties on Care Programme Approach (CPA) were followed up within 7 days of discharge from psychiatric inpatient care.
- 98.1% of admissions to psychiatric inpatient wards were gate kept by Crisis Resolution Home Treatment (CRHT) teams.
- Detailed reports with information by provider and commissioner can be found via the Department of Health website.
- Revisions to historical data caused a small reduction in the number of new cases of psychosis served by Early Intervention (EI) teams. Revisions had very little impact elsewhere.

Table 1 summarises the impact of revisions at national level on the number of new cases of psychosis served by early intervention (EI) teams.

Table 1 – Impact of revisions at national level

99. Mental health community teams activity - Updated

November 2012 – DH

Quarterly data on new cases taken on by Early Intervention in psychosis services, the number of patients on Care Programme Approach, followed up within seven days of discharge from psychiatric inpatient care, and gate-keeping inpatient admissions by Crisis Resolution Home Treatment teams.

http://transparency.dh.gov.uk/2012/06/21/mental-health-community-teams-activity-data-downloads/

Miscellaneous

100. Statement on medicines and pharmacy regulation from the UK Chief Pharmaceutical Officers published

29 October 2012 – DH

UK Chief Pharmaceutical Officers have published a statement on exploratory work with professional and regulatory bodies in pharmacy on the balance of medicines legislation and statutory independent professional regulation. This work is linked to Medicines & Healthcare products Regulatory Agency (MHRA) work to scope a review of sanctions and penalties, for which MHRA has issued a statement.

The Chief Pharmaceutical Officers' statement is as follows:

"Rebalancing" Medicines Legislation and Pharmacy Regulation[1]

Recent discussions about the supervision of the sale and supply of medicines in registered pharmacies have taken place against a background of a wider, but associated, agenda. This includes the Medicines & Healthcare products Regulatory Agency's (MHRA) work on the consolidation of medicines legislation and the planned review of penalties and sanctions, the recommendations from the Royal Pharmaceutical Society (RPS) & the Professional Forum of the Pharmaceutical Society of Northern Ireland (PFPSNI) review of the implementation of the Responsible Pharmacist (RP) Regulations and the General Pharmaceutical Council's (GPhC) consultation on standards for registered pharmacies.

Developments in the broader context of legislation and regulation generally, including the Government's initiatives to reduce regulatory burden, greater reliance on professional regulatory standards and, linked to that, the aim of avoiding use of detailed legislation to regulate professional activity except where this is unavoidable, suggest that now is the time to consider the interplay of the medicine supply components of medicines legislation and GPhC& PSNI regulation, and how they impact on patient and public safety and professional practice.

Professional practice in pharmacy has changed in recent years to become considerably more clinical in nature. This is set to expand further.

Although at a very early stage, the UK Health Departments' Chief Pharmaceutical Officers, together with the MHRA, are considering exploring with professional and regulatory bodies in pharmacy the balance of medicines legislation and statutory independent professional regulation and consistency with other health professionals. The aim would be to examine the respective scope of legislation and regulation, and the interface between them, with a view to ensuring these are optimally designed to provide safety for us-

ers of pharmacy services, while facilitating and reducing the barriers to responsible development of practice, innovation and a systematic approach to quality in pharmacy.

Elements for discussion are likely to include the role of quality systems within the diversity of pharmacy practice in different service settings in providing robust, systematic assurance and protection of public and patients' interests; roles and responsibilities; enhanced professionalism; governance and accountability; and links with wider work, such as the review of sanctions and penalties, being led by MHRA.

Ideas are at an early stage and any further work will depend on the outcome of these initial discussions. Updates will be shared as discussions move forward. Stakeholders will be involved when proposals are further developed.
http://www.dh.gov.uk/health/2012/10/cpo-statement/

Ed. [1] "Medicines legislation" here refers particularly to the medicine supply components of medicines legislation. "Pharmacy regulation" refers to the regulation of pharmacies, pharmacists and pharmacy technicians.

101. District nurse put my father on death pathway – in his own home

30 October 2012 - Daily Mail

The family of Thomas James, 90, who had terminal cancer was looked after at home because the family was concerned that he had been put on the Liverpool Care Pathway in hospital two years earlier when he had a leg amputated.

A community nurse is alleged to have put him on the pathway at home without mentioning it to anyone or gaining consent.

102. A lethal arrogance

30 October 2012 - Daily Mail

Melanie Phillips writes follow-up to last week's article about the Liverpool Care Pathway.

103. Care UK's recently acquired Rhodes Farm gains national recognition

30 October 2012 - Beating Eating Disorders

Care UK's Rhodes Farm has been awarded the Beat Assured Quality Mark, an endorsement by leading national campaigning eating disorders charity Beat of the quality of the service as experienced by patients and their parents and family members. The North West London based service was acquired by Care UK in early 2011, retaining the effective treatment model in place since the service opened in 1991. Accessible from anywhere in the UK and also from abroad, Rhodes Farm provides treatment for males and females aged 6 to 19 with a range of diagnoses including anorexia nervosa and bulimia nervosa.

104. Keep having scans despite the downsides, women told

'I'd be dead without that scan'

Overdiagnosis should be understood: it is still cancer

30 October 2012 - The Times

Needless cancer therapy for 4,000 women

30 October 2012 - Daily Mail

To screen or not to screen?

31 October 2012 - Daily Mail

Two pages in each publication about the breast screening of women; they are advised to continue to undergo screening despite evidence that it has "*significant downsides*".

105. New Chair for the Care Provider Alliance

31 October 2012 - Care Provider Alliance

The Care Provider Alliance has announced that Alex Fox, the Chief Executive of Shared Lives Plus, will be taking over From Martin Green, of The English Community Care Association, as Chair of the Care Provider Alliance on 01.11.2012.

Outgoing Chair, Martin Green said:

"The Care Provider Alliance has established itself as an important part of the social care architecture and I am delighted to be handing over the chairmanship to Alex Fox, who has tremendous experience and a real commitment to ensuring that care services deliver high quality support to service users and their families".

106. Continuing international partnerships amid the transition to PHE

31 October 2012 - DH

Duncan Selbie shares positive developments for Public Health England in both international partnerships and across local government

Last week's announcement of a proposed common basis for food labelling, with support from the main supermarkets, was the culmination of years of patient negotiation on the part of government, industry, consumers, and the public health community. It is an important and most welcome achievement and is exactly the sort of practical public health measure the public are very much behind. Everybody understands the need for lower sugar, salt and fats in foods and this clear new system should be hugely helpful in enabling individuals and families to make more informed choices.

Our international programme will be a very significant part of our work and we will get off to a flying start. For example, the Health Protection Agency (HPA) supports a wide global health portfolio. Work-

ing with the World Health Organization, the HPA has recently sent six members of staff on two missions: to Qatar in support of the coronavirus incident and to Sierra Leone in response to their cholera outbreak. They are also about to appoint staff on secondments to Thailand, Taiwan and Vietnam where they will focus on strengthening relationships, improving collaboration, and public health capacity building. This is a contribution to meeting the UK's obligations under the International Health Regulations and we are planning to extend this programme within PHE.

There are already clear signs that the transition to PHE is thankfully not disrupting international partnerships, far from it, as is evidenced by some really good news coming through on the research front. For example, the US Government, through their National Institute of Allergy and Infectious Diseases, has just awarded us, in partnership with NanoBio Corporation, a contract worth £4 million to develop a next generation anthrax vaccine, while other contracts are in the pipeline. These are encouraging signs and critical to our mission to translate research into practical benefits that make a real difference to the public's health.

Improving the public's health is everybody's business and this is really taking hold across local government. Two weeks ago in Greater Manchester, Alan Higgins, the Director of Public Health for Oldham, described a Public Health Charter for their residents and this was approved by the full council last week. Its straightforward aim is to ensure that all their decisions – which influence economic opportunity, early childhood development, schools, housing, workplaces and environment – contribute positively to the health and wellbeing of their residents. This is exactly the approach PHE will be advocating and we will all need to pool our resources and our expertise if we are to address the health inequalities across the country.

And finally, we are close to settling the locations for all our staff. Although for most this will mean no change, some people will be on the move. If anyone is unsure of their own position they should check with their line manager; we are determined to get this right.

107. Breast screening

31 October 2012 - The Times, Letters to the Editor

Prof. Michael Baum writes in support of Sir Michael Marmot's review of the benefits and harm of breast screening, but, calls for results of all-cause mortality in the trials be known.

108. Clinical trials

31 October 2012 - The Times, Letters to the Editor

David W Melville, former big pharma executive, acknowledges that there are occasional mistakes and sharp practice in clinical trials of drugs but that getting journals to publish all results would be a devil of a job and that there are insufficient resources in the Amazonian rainforest to do so.

Ed. I have an idea – all the pharma companies could establish a central repository, controlled by academics, on which all materials can be made available globally via electronic media. It would be a heck of a challenge – but, if botanists can do it for the global seed bank then these big, profitable businesses could do it too. If the UK takes the lead, we could secure this jurisdiction's influence into the future. Worth seed capital from the Government? Not needed; the companies could establish a charity to do all this stuff and contribute to running costs, all tax deductable.

109. BMJ to reject papers unless trial findings open for all

31 October 2012 - The Times

It has been announced that the BMJ will refuse to publish papers unless all clinical trial data is available for independent scrutiny.

110. GP contract talks breakdown over 1.5% funding offer

31 October 2012 – BBC News

The British Medical Association (BMA) has rejected a proposed 1.5% funding increase for GPs in exchange for changes to the services they deliver.

The BMA says the proposals would involve more "*box ticking*" and that many family doctors were already "*work-load saturated*".

http://www.bbc.co.uk/news/uk-wales-politics-20156050

111. IBM's Watson supercomputer goes to medical school

31 October 2012 – BBC News

IBM's Watson supercomputer will be helping to train doctors at a medical school in Cleveland, Ohio.

The machine gained fame when it beat two human contestants on the US quiz show Jeopardy last year and now its technology will be put to a more practical use helping students to consider challenging cases and offering potential diagnoses.

http://www.bbc.co.uk/news/technology-20159531

112. NICE needs to get nasty with Winterbourne-like units

31 October 2012 – NCF

Bill Mumford, VODG chairman says that NICE needs to get nasty with Winterbourne-like assessment and treatment units and that they should end such long-stay centres.

http://www.nationalcareforum.org.uk/forums/forum_posts.asp?TID=5311&PN=1

113. Faulty implants: Europe 'too slow'

01 November 2012 – BBC News

A Parliamentary committee has warned the European Commission that it is not acting quickly enough to protect patients from potential harm from medical implants.

Current Europe-wide regulation on medical implants, such as hip replacement joints, is too slow to change.

The EC is currently revising the regulation, but changes are not expected to take effect until at least 2015.

http://www.bbc.co.uk/news/health-20156202

114. Skin cancer drugs approved 'for first time in over a decade'

02 November 2012 – Nursing in Practice

NICE recommends NHS use of new melanoma drugs

2 November 2012 – Nursing Times

Draft guidance by the National Institute for Health and Social Care Excellence (NICE) now recommends the use of Ipilimumab and Vemurafenib for the treatment of advanced skin cancer – the first new drugs to be approved for routine use on the NHS for the disease in more than ten years.

NICE's stamp of approval comes after the manufacturers of both drugs agreed to offer a discount, overturning a previous rejection of the treatments by the watchdog.

http://www.nursinginpractice.com/article/skin-cancer-drugs-approved-first-time-over-decade

http://www.nursingtimes.net/nursing-practice/clinical-zones/dermatology/nice-recommends-nhs-use-of-new-melanoma-drugs/5051368.article

115. Multiple sclerosis: New drug 'most effective'

01 November 2012 – BBC News

Researchers at the University of Cambridge say a cancer drug, which wipes out and resets the immune system, has better results than other options for treating relapsing-remitting multiple sclerosis.

However, there is concern that a drugs company is about to increase the cost of the drug as a result.

http://www.bbc.co.uk/news/health-20151891

116. Dementia Lead Associate

02 November 2012 - Dementia Centre, University of Stirling

This post offers an exciting opportunity to become an integral part of the DSDC team, delivering training and consultancy services to support the improvement of dementia services. The post will be based in the Iris Murdoch Building at the University of Stirling and will require some travel including overnight stays, both within the UK and overseas. The working hours will be flexible and a secondment arrangement to this post is welcome.

Applications close on 19.11.2012

View further details and apply online

117. Cancer drugs approved

02 November 2012 - The Times

NICE has ruled that patients with advanced skin cancer can have access to two so-called 'breakthrough' drugs – ipilimumab and vemurafenib.

118. Hunt announces plans to prepare NHS for winter

03 November 2012 - DH

Plans to help keep people safe from the cold this winter have been set out by Health Secretary Jeremy Hunt. The plans will help the NHS prepare for winter and meet the increase in winter related health problems always seen at this time of year.

England sees thousands of extra deaths in the winter as a result of cold weather and associated health problems. Heart attacks, stroke and respiratory problems rise in the cold weather and the NHS comes under increased pressure from people getting flu, people injuring themselves through falls or slips and other health problems associated with colder weather, such as the norovirus vomiting bug.

As is the case every year, the NHS puts preparations in place before the winter and those are now in place in every area of England.

The Department of Health has put in place the following measures to help people keep well this winter.

1. **A flu vaccination advertising campaign** to encourage people in at risk groups to get vaccinated if they haven't already done so. This has been done because:

Vaccination rates for some at risk groups are behind where they were at the same point last year and we want to improve on last year's rates (figures in notes to editors below);

- To guard against any possible false sense of security following a mild winter last year; and
- To build on local campaigns which have been running.

2. **The Cold Weather Plan,** which will be jointly run with the Met Office and Health Protection Agency. This will;

- Advise people on how to stay healthy and thus relieve pressures on the NHS.
- support local communities and professionals to

better prepare for and respond to severe cold weather events in the coming winter.

3. **The Winterwatch website.** This will;
- provide a one-stop shop for winter related health stats (this will launch on 15 November)

4. **A £20 million fund, distributed among local authorities.**
- Local authorities bid for this money to help vulnerable people in their areas stay warm and well this winter.
- Around 4,700 people die every year after getting flu. People in at risk groups are eleven times more likely to die than someone who is not in an at-risk group.
- The flu advertising campaign will launch on Monday (5 November) and will encourage people in at risk groups who haven't yet been vaccinated to make sure they protect themselves from flu.

Health Secretary Jeremy Hunt said:

"Cold weather can be hazardous for our health — particularly for older people and those with respiratory illnesses. Each year, the cold weather is responsible for an increase in deaths and thousands of cases of flu, falls, heart attacks and strokes. In past years, these extra pressures have cost the NHS £42 million in emergency admissions alone.

"As winter approaches, we should all be on our guard against health problems – by taking simple steps and looking after our older friends and family we can keep warm and well."
Public Health Minister Anna Soubry said:
"We have taken the decision this year to run a flu campaign because too many people in at risk groups have not come forward for the jab yet, although local campaigns have been running for the past month. People may be lulled into a false sense of security about the seriousness of flu following a mild winter last year. The national campaign will build on the local 'flu safe' campaigns that have been running.

"Our campaign aims to encourage people who are most at risk from flu, who have put it off or who don't think it is important, to get the vaccine. If pregnant women are vaccinated, they not only protect themselves but also protect their newborn babies from catching flu. If you are in a risk group, don't miss the chance to be vaccinated; contact your GP surgery and make an appointment."

David Salisbury, Director of Immunisation, said:

"You are eleven times more likely to die from flu if you are pregnant or have a serious health condition and each year thousands of people die after catching flu. That's why we are reminding people who are particularly vulnerable to the consequences of flu to get the vaccine.

"Severe weather can be dangerous for vulnerable groups such as older people and those with serious illnesses. It's important for people to look after their health."

Brunswicks LLP (@BrunswicksLLP)
03/11/2012 13:04
Ministers have today intervened in the use of the Liverpool Care Pathway which has been heavily criticised in recent months.

More in BHCR

119. Drug to fix faulty DNA gets go-ahead in landmark move that may alter medicine forever

03 November 2012 – Daily Mail
Regulators have now approved the first therapy in the western world that can correct errors in a person's genetic code.

Europe has approved Glybera to be used against a rare inherited disorder which disrupts fat production in the body, LPLD, lipoprotein lipase deficiency, which can led to acute inflammation of the pancreas.
http://www.dailymail.co.uk/news/article-2226863/First-gene-therapy-drug-given-European-license.html#ixzz2B9WlUiZJ

120. End of life rights for the families

03 November 2012 - The Times

Victory for Care Pathway Families

03 November 2012 - Daily Mail
Health Secretary Jeremy Hunt has said that it will be made a legal requirement for doctors to fully explain end-of-life treatment and the Liverpool Care Pathway in order to obtain consent.

121. Death target nets one hospital £1m

04 November 2012 - The Sunday Times
Liverpool Women's NHS Foundation Trust made more than £1m by meeting targets linked to the controversial Liverpool Care Pathway.

NHS

122. More transparency to drive up NHS safety

29 October 2012 - DH
Health Secretary Jeremy Hunt has published new data showing the number of NHS "*never events*" reported over the last two years and highlighted fresh action to improve care.

Back Next

Never events are serious patient safety incidents that, by definition, should never happen. Never events include events such as surgery on the wrong part of the body, or surgical instruments being left in the body after an operation.

Following an engagement process with health professionals, royal colleges and the public in 2011, the Government tripled the number of categories that are defined as a never event from eight to 25. To increase transparency and the focus on safety, the NHS has reported on all of these categories in 2011/12. Today's data shows that over 300 never events were reported to Strategic Health Authorities over the past year. It is not possible to compare this figure with previous data as it is the first time that 17 of the categories have been reported on.

The vast majority of never events are surgical. The NHS Commissioning Board is setting up a taskforce to look at surgical never events, in order to make sure that these events are eradicated from NHS surgery. Sir Bruce Keogh, NHS Medical Director and Jane Cummings, Chief Nursing Officer, have also written to the NHS today highlighting these figures and setting out what the NHS needs to do to drive the numbers down across all areas.

Health Secretary Jeremy Hunt said:

"*We know that transparency saves lives and improves care. The NHS treats a million people every 36 hours, and we know that the vast majority of these patients have excellent care. But the NHS needs to do more to really tackle these events. The NHS Commissioning Board is now setting up a taskforce to eradicate these never events from NHS surgery.*"

The 2011/12 data shows that 326 never events were reported to Strategic Health Authorities, with the most common types of incident being;

Retained foreign objects post-operation (161 incidents reported)
Surgery on the wrong part of the body (70 incidents)
Wrong implant or prosthesis (41 incidents)
Misplaced nasogastric tubes (23 incidents)

NHS Medical Director Sir Bruce Keogh said;

"*NHS Leaders should examine these figures and the guidance that sits alongside them and really focus on driving them out of the NHS.*

"There are simple ways to prevent them occurring, like the Surgical Safety Checklist, and everyone working in the NHS should ensure that the checklist is being followed."

Some never events were also reported to the National Reporting and Learning System (NRLS), and these amounted to 163 in 2011/12. This is a separate reporting system and the majority of these reports correspond to incidents also reported to the SHAs, so the totals cannot be added together. Historically the NHS has reported these incidents in different ways. This can lead to confusion and this is why the NHS Commissioning Board is also developing a single incident reporting and management system as part of its work.

123. NHS lost track of 1.8m patient records in a year

29 October 2012 - Daily Mail

Article about the NHS staffs' worrying lapses of security of patient confidential information.

124. Hundreds of patients subjected to NHS blunders that 'should never happen'

29 October 2012 – Telegraph

According to the DH, hundreds of patients subjected to NHS blunders that "should never happen".

A list of never events show that hundreds of patients have had instruments left inside them or surgery on the wrong part of the body.

The list of never events has been increased from eight to 25 to include misidentification of a patient, putting a feeding tube down the nose into the lungs instead of the stomach, incorrect use of insulin for diabetes and transfusing a patient with the wrong blood type.

Most never events happen during or after surgery.
http://www.telegraph.co.uk/health/healthnews/9640413/Hundreds-of-patients-subjected-to-NHS-blunders-that-should-never-happen.html

125. NHS lost 1.8 million patient records in a year

29 October 2012 – Telegraph

New figures show that over 5,000 confidential patient records are being lost by the NHS every day.

Official statistics showed that at least 1.8 million sensitive papers went missing throughout the health service in just 12 months and included in the breaches is data security records dumped in public bins and electronic records found for sale on an internet auction site.
http://www.telegraph.co.uk/health/healthnews/9640168/NHS-lost-1.8-million-patient-records-in-a-year.html

126. Families left grieving and angry by the Liverpool Care Pathway

29 October 2012 – Telegraph

Distraught families have alleged that the NHS protocol designed to allow the terminally ill 'a good death' is being abused.

http://www.telegraph.co.uk/health/9635842/Families-left-grieving-and-angry-by-the-Liverpool-Care-Pathway.html

127. Hospital to cut around 20% of workforce by 2015

29 October 2012 – Healthcare Today

Rotherham NHS Foundation Trust has declared that it wants to cut around a fifth of its workforce by 2015.

The South Yorkshire trust said if it cut 750 jobs and created *"a smaller hospital with substantially fewer beds"* it would be able to save £50 million in four years.

http://www.healthcare-today.co.uk/news/hospital-to-cut-around-20-of-workforce-by-2015/23049/

128. Study reveals NHS patient satisfaction up

29 October 2012 – Barchester

DH data shows that the vast majority of patients are satisfied with the level of care they receive from the NHS.

Research into the initial NHS 111 pilot sites found that 92% of callers are satisfied or very satisfied with the service.

http://www.barchester.com/Media/News/2012/10/study-reveals-nhs-patient-satisfaction-up.htm

129. Doctors harassed over Facebook, patient records lost by the NHS and Ed Milliband's mental health agenda

29 October 2012 – Pulse Today

The Telegraph says that doctors are being 'bombarded' with Facebook messages from infatuated patients. The Medical Defence Union said the number of doctors seeking help to deal with unwanted advances has risen by a third as the rise of email, texting and social networking sites has made it easier for patients to get in contact with them.

In some of the worst cases doctors were forced to call the police and take out injunctions against patients making unwanted contact, along with some doctors being falsely accused of having a relationship with patients, and facing a GMC investigation.

http://www.pulsetoday.co.uk/news/daily-digest/-doctors-harassed-over-facebook-patient-records-lost-by-the-nhs-and-ed-millibands-mental-health-agenda/20000687.article

130. South London Healthcare 'should be dissolved'

29 October 2012 – BBC News

An administrator has called for a financially-troubled NHS trust to be broken up, which would lead to a radical overhaul in services across south east London.

The trust - South London Healthcare - was put into administration in July after being declared bust and is the first time such measures have been taken in the NHS.

http://www.bbc.co.uk/news/health-20086789

131. Work on Bromsgrove emergency hub gets under way

29 October 2012 – BBC News

Building work has started on the new police and fire station in Bromsgrove which will also incorporate an ambulance response post.

The development will replace the police and fire stations currently in the town.

The new building on Slideslow Drive, near the Artrix theatre, would hopefully be ready by January 2014.

http://www.bbc.co.uk/news/uk-england-hereford-worcester-20130280

132. PFI deals crippling the NHS with £1.5bn of handouts needed: PAC report

29 October 2012 – The Telegraph

Patients in every part of the UK face having their NHS services merged, closed or moved to address the financial crisis as crippling PFI debts mean the Government will have to hand over £1.5bn of bailouts.

MPs admitted that patient care could be affected and that it may be more difficult to access healthcare.

http://www.telegraph.co.uk/health/healthnews/9640431/PFI-deals-crippling-the-NHS-with-1.5bn-of-handouts-needed-PAC-report.html

132. Hospital rules 'being made on the hoof'

30 October 2012 - The Times

Hospitals 'may go bust because of Labour PFI deals'

30 October 2012 - Daily Mail

MPs slam DH over NHS trust bankruptcies

30 October 2012 - Pharma Times

The Public Accounts Committee reports that the Department of Health (DH) has been unable to explain to them how it would deal with an NHS Trust that goes bankrupt. Nor could it explain what would trigger a Trust being placed into the failure regime, or exactly how that process would work.

Commenting on the evidence provided to the panel by the DH, committee chair Margaret Hodge said: "*we do not know whether a bankrupt trust would be allowed to fail or how and when Ministers would intervene. And it is not clear how the Department would ensure that essential services are protected if a trust fails.*"

"*It very much looks like the Department is inventing rules and processes on the hoof rather than anticipating problems and establishing risk protocols,"* she added.

The overall surplus of £2.1 billion across all NHS bodies in 2011-12 masks the fact that a significant minority are in financial difficulty, says the MPs' report. In London, two trusts have a combined deficit of £115 million, one of which, South London Healthcare NHS Trust, has been placed in special administration.

"*We are particularly concerned that the financial viability of a number of trusts is being undermined by the fact that they are locked into unaffordable private finance initiative [PFI] contracts. It is unclear how the Department will continue to underwrite payments once most of the money moves to the NHS Commissioning Board*," added Ms Hodge, Labour MP for Barking.

133. Trust Special Administrator at South London Healthcare NHS Trust publishes draft report

30 October 2012 - DH

The Trust Special Administrator at South London Healthcare NHS Trust has published a draft report making recommendations to the Secretary for State in relation to securing a sustainable future for services provided by that trust.

The Trust Special Administrator was appointed in July 2012 by the Secretary of State under the Regime for Unsustainable NHS Providers, provisions for which are set out in primary legislation. The regime seeks to ensure the delivery of high quality and affordable NHS services, protecting patients and staff from failing services. It is a time-limited process which can be triggered when the widest range of other solutions to improve and maintain sustainability have been implemented and not delivered the results required.

The Trust Special Administrator will consult locally on his draft recommendations from 02.11.2012 to 13.12.2012, and make final recommendations to the Secretary of State as to the action that should be taken in relation to the trust in a final report by 07.01.2013. The Secretary of State will make a final decision about whether or not to accept the recommendations by 01.02.2013.

The report, entitled "Draft Report – Securing sustainable NHS services", is available at the Trust Special Administrator's website.

134. Monitor appoints Dr David Bennett as permanent Chief Executive

30 October 2012 - Monitor

The Board of Monitor has appointed Dr David Bennett to the permanent post of Chief Executive with effect from 01.11.2012. This date is when the first of the regulator's main new powers under the Health and Social Care Act 2012 come into effect.

Read the full press release here.

135. Hunt announces crackdown on unsafe surgery

30 October 2012 - Health Service Journal

Health secretary Jeremy Hunt has announced plans for a taskforce to improve safety of surgery after it emerged more than 80% of never events during 2011-12 occurred in operating theatres.

136. MPs slam DH over NHS trust bankruptcies

30 October 2012 – Pharma Times

NHS financial failure regime 'made up on the hoof'

30 October 2012 – BBC News

One NHS trust in five is in bad financial trouble – and Department of Health is failing to plan for bankruptcies

30 October 2012 – The Independent

A committee of MPs has reported that the DH has been unable to explain to them how it would deal with an NHS trust that goes bankrupt nor could it explain what would trigger a trust being placed into the failure regime, or exactly how that process would work.

The Committee on Public Accounts expressed their concerns when publishing its latest report on the financial sustainability of the NHS.

http://www.pharmatimes.com/Article/12-10-30/MPs_slam_DH_over_NHS_trust_bankruptcies.aspx
http://www.bbc.co.uk/news/health-20125448
http://www.independent.co.uk/life-style/health-and-families/health-news/one-nhs-trust-in-five-is-in-bad-financial-trouble--and-department-of-health-is-failing-to-plan-for-bankruptcies-8231603.html

137. Hospital trust refused £21m government loan to ease debts

30 October 2012 – BBC News

Worcestershire Acute Hospitals NHS Trust has been told by the Government it will not receive a £21m loan from the DH to help pay off its debts.

The Trust said it needed the money to help deal with its £18m debt and current running costs, but the Government said the loan could put the trust over its borrowing limit.

It said it would make a decision on a revised applica-

tion by the trust to borrow £9m in December.
http://www.bbc.co.uk/news/uk-england-hereford-worcester-20135326

138. Trust Special Administrator at South London Healthcare NHS Trust publishes draft report

30 October 2012 – DH

The Trust Special Administrator at South London Healthcare NHS Trust has published a draft report which recommends securing a sustainable future for services provided for that trust to the Secretary for State.

The Trust Special Administrator will consult locally on his draft recommendations from 2.11.2012 to 13.12.2012, and make final recommendations to the Secretary of State as to the action that should be taken in relation to the trust in a final report by 07.01.2013. The Secretary of State will make a final decision about whether or not to accept the recommendations by 1 February 2013.
http://www.dh.gov.uk/health/2012/10/tsa-draftreport/

139. Dan Poulter: NHS and social care integration is 'the holy grail'

30 October 2012 – The Guardian

Tory junior health minister, Dan Poulter, has explained his vision for the NHS – and why he's going back to work as a hospital doctor.

This is one of the first of the new patient-led inspections that David Cameron announced in January as a way of driving out poor nursing and, together with the "*friends and family test*" starting in April, of improving the quality of NHS care.
http://www.guardian.co.uk/society/2012/oct/30/dan-poulter-nhs-social-care

140. NHS satisfaction falls amid reforms, cuts

30 October 2012 – Pharma Times

The reform of the NHS coupled with large cuts is driving down people's satisfaction with the National Health Service according to the NHS Spring Public Perceptions of the NHS Tracker Survey.

The survey was conducted by the Ipsos MORI Social Research Institute on behalf of the DH and showed 69% of people are satisfied with the current running of the NHS. This is a 4% fall compared to the survey completed between December 2009 and December 2008, when 73% of the public were satisfied.

Ipsos MORI conducted just over one thousand interviews among a representative sample of adults aged 16 and over, with all interviews taking place between 04-31.05.2012.
http://www.pharmatimes.com/Article/12-10-30/NHS_satisfaction_falls_amid_reforms_cuts.aspx

141. MPs warn of 'hidden' crisis in hospital funding

30 October 2012 – Pulse Today

A report from the House of Commons Public Accounts Committee, warns that despite the NHS being in surplus in 2011/12 it conceals the '*significant minority*' which are in financial difficulty.

The influential group of MPs said this situation was likely to get worse as historically badly performing trusts were secretly bailed out by PCT or SHA managers and CCG leaders were going to expect them to radically change the way they provide services to save cash.
http://www.pulsetoday.co.uk/commissioning/commissioning-topics/secondary-care/mps-warn-of-hidden-crisis-in-hospital-funding/20000704.article

142. Surgeons in safety row blame managers

31 October 2012 - Health Service Journal

Two Mid Staffordshire Foundation Trust surgeons at the centre of a row about safety concerns have blamed the trust's management for problems and called for an investigation.

143. Exclusive: Nearly £3bn returned to Treasury

31 October 2012 - Health Service Journal

DH has returned nearly £3bn of its funding to the Treasury over the past two years, despite facing its tightest financial settlement for five decades.

144. Board could force CCGs to work with its teams on reconfiguration

31 October 2012 - Health Service Journal

The NHS Commissioning Board will have the ability to force clinical commissioning groups to work with centrally appointed groups of doctors on reconfiguration programmes.

145. Still time to register for Health and Wellbeing Boards Event – 8 November

31 October 2012 - DH

Are you ready to rise to the challenge for health and wellbeing boards in their role as system leaders? What are the key challenges and how are you – as leaders – going to respond to these?

This event is a unique opportunity to explore with other leaders, experts and colleagues how you can make a difference through your health and wellbeing board. Discussion and challenge sessions, facilitated by a range of experts, will develop your thinking and give you the opportunity to reflect on what you want to do differently with your board. The sessions will focus on the shared leadership action in three significant areas and explore further what this means to

achieve the ambition of:

achieving service integration
improving health outcomes
reducing health inequalities

Health and wellbeing board members and clinical commissioning group members will be allocated places at registration; all other delegates will receive communication regarding their place within 48hrs of registration.

During this registration process you will have the opportunity to submit your preferred theme area, your issues relating to these themes and any general questions, so the day can be designed around your needs.To register your place, please click visit the event website.

146. CQC warns Bristol Royal Children's Hospital that it must improve staffing levels on cardiac ward to protect patients

31 October 2012 – CQC

The CQC has formally warned University Hospitals Bristol NHS Foundation Trust in relation to staffing levels on a cardiac ward at Bristol Royal Children's Hospital.

Inspectors found that the trust had been failing to meet three essential standards of quality and safety covering staffing levels, staff training and support, and the overall care and welfare of patients. Providers have a legal responsibility to make sure they are meeting all the essential standards.
http://www.cqc.org.uk/media/cqc-warns-bristol-royal-children%E2%80%99s-hospital-it-must-improve-staffing-levels-cardiac-ward-pro-0

147. Epsom Hospital merger: 'Concern and fury' as deal halted

31 October 2012 – BBC News

Last week, an NHS London board meeting agreed that the proposed acquisition of Epsom Hospital by Ashford and St Peter's Hospital NHS should be stopped.

The project was stopped because both parties had been unable to develop *"a financially viable plan".*

Surrey County Council said it was concerned, while Epsom Council said members were "*furious*".
http://www.bbc.co.uk/news/uk-england-20156453

148. Withholding food and drink from terminally ill patients has 'transformed' end of life care

31 October 2012 – The Independent

An article in a leading medical journal praises the Liverpool care pathway, which currently follows the controversial method of withholding food and drink from terminally ill patients so they die quicker has "*transformed*" end of life care.

The Liverpool care pathway recommends that in some circumstances doctors withdraw treatment, food and water from sedated patients in their final days, means that they can have a "*peaceful, pain-free, dignified death*" at home.

However, the method has come under close scrutiny recently as recent reports suggest that doctors are establishing "*death lists*" of patients to put on the pathway.
http://www.independent.co.uk/life-style/health-and-families/health-news/withholding-food-and-drink-from-terminally-ill-patients-has-transformed-end-of-life-care-8268641.html

149. Why some NHS trusts are near financial breaking point

31 October 2012 – The Guardian

An article looking at how the financial problems of South London NHS trust show how quickly trusts can find themselves in trouble.

Financial pressures are mounting on the NHS with a growing number of hospital trusts finding themselves pushed towards a cliff edge.
http://www.guardian.co.uk/healthcare-network/2012/oct/31/financial-problems-hospital-trusts

150. Bristol Children's Hospital heart operations reduced

31 October 2012 – BBC News

Bristol Children's Hospital will be reducing the number of heart operations carried out after a formal warning over staffing levels on its cardiac unit.

A CQC report found the trust failed to meet safety standards for staffing levels, training and support and patient welfare after there were a series of concerns over the care of children at the unit.

Two cardiac high dependency beds have been created and the number of beds at the unit has been cut from 16 to 12.
http://www.bbc.co.uk/news/uk-england-bristol-20136395

151. Jimmy Savile: Leeds hospital claim disputed

31 October 2012 – BBC News

Leeds Teaching Hospitals NHS Trust has disputed claims that Jimmy Savile was regularly handed a key to a Leeds hospital building when he arrived with teenage girls.

Ex-hospital porter Terry Pratt said Savile would arrive at Leeds General Infirmary in the early hours and

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take the girls to the nurses' accommodation, but the Trust said it believed Mr Pratt was "*mistaken in his comments*".
http://www.bbc.co.uk/news/uk-20156576

152. Consultation on new safeguards to protect patients

01 November 2012 - DH

A consultation on new measures to protect the services that patients need has been launched. The health special administration consultation sets out how safeguards to protect the services that patients need will be extended to NHS services provided by social … Read more → - Consultation on new safeguards to protect patients

Ed. Full details set out above at item xxx under 'Consultations'.

153. Staff shortages halt children's heart operations

01 November 2012 - The Times

Staff shortages at Bristol Royal Children's Hospital have led to reduced operations – CQC has demanded improvements within a week. Staff shortages halt children's heart operations

154. Care Provider Associations unite to condemn NHS London

01 November 2012 – NCF

The English Community Care Association, The National Care Association, The National Care Forum and The Registered Nursing Home Association have together condemned NHS London's unilateral imposition of a fee of £700 for continuing healthcare.

The care provider associations were assuranced by NHS London that there would be proper negotiation and both the contract and the price, would be mutually agreed and would reflect the assessed needs of the patient.

Martin Green Chief Executive of ECCA said:

"Despite these assurances, NHS London have behaved in a totally unacceptable and despotic manner and they have reneged on agreements and wasted a lot of the provider sector's time and stolen our expertise to cover their ignorance".

"What was also clear from the process was the duplicity and dishonesty of NHS London and their lack of any understanding about how the market works. They did not justify their decision on costs, they just unilaterally imposed it".

"We are strongly urging all providers to ignore the AQP process and to give NHS London a taste of its own unilateralism. It is important that nursing home providers in London act in unison in order to force NHS London to respect the actual cost of care of an acceptable quality. If a person were to stay in hospital his/her care would be costing approximately £400 per night or £2,800 per week. To ask nursing homes to provide quality care at one quarter of this cost is unacceptable."
http://www.nationalcareforum.org.uk/forums/forum_posts.asp?TID=5315&PN=1

155. Hospital bosses demand full payment for extra work

01 November 2012 – Redditch Standard

Worcestershire Acute Hospitals NHS Trust's hospital bosses are at loggerheads with their NHS paymasters after demanding they are paid the full cost of treating the thousands of extra patients seen through A&E so far during 2012.

The Trust has had its payments reduced to just 30% of what it would normally receive after treating more patients than agreed and since April it has had to pay back more than £2million to commissioners NHS Worcestershire, taking it nearly £4million into the red.
http://www.redditchstandard.co.uk/2012/11/01/news-Hospital-bosses-demand-full-payment-for-extra-work-54425.html#.UJJ1SMK2Xqk.facebook

156. Liverpool Care Pathway: Minister will listen to concerns

01 November 2012 – BBC News

Liverpool Care pathway concerns must be challenged, says minister

01 November 2012 – The Telegraph

Norman Lamb wants a meeting of doctors and patients after saying that it is "*completely wrong*" for terminally ill patients to be put on a "*pathway*" to death without relatives being consulted.

He wants them to discuss worries about the Liverpool Care Pathway - which can see water and food withdrawn.
http://www.bbc.co.uk/news/uk-politics-20170811
http://www.telegraph.co.uk/health/healthnews/9649378/Liverpool-Care-pathway-concerns-must-be-challenged-says-minister.html

157. Staff-led services 'will be good for patients'

01 November 2012 – This is Somerset

Health services for residents in Somerset will improve by GPs playing a bigger role in how they are run, according to Ian Phillips, the chairman of a new GP-led federation in South Somerset. The group will advise an overarching group which has taken over the role of commissioning, designing and buying health services in the county.
http://www.thisissomerset.co.uk/Staff-led-services-good-patients/story-17212578-detail/story.html

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158. Hospital trust may be next for failure regime after merger talks fail

01 November 2012 – HSJ

Epsom and St Helier University Hospitals Trust could be the next to enter the failure regime after the collapse of formal talks aimed at merging the trust's Epsom site with Ashford and St Peter's Hospitals Foundation Trust.

The failure of those plans means the trust is now being seriously considered for the DH's failure regime which is the same high-profile and controversial process which was triggered for South London Healthcare Trust in July.

http://www.hsj.co.uk/acute-care/hospital-trust-may-be-next-for-failure-regime-after-merger-talks-fail/5051352.article

159. Solent NHS Trust patient data left at market stall

01 November 2012 – BBC News

A Freedom of Information request has revealed a series of breaches by Solent NHS Trust, including patients' confidential information being left at a market stall and on top of a parking meter.

The trust had breached data protection a total of 93 times in the past two years.

http://www.bbc.co.uk/news/uk-england-hampshire-20156164

160. Mid Yorkshire Hospitals NHS staff strike over redundancies

01 November 2012 – BBC News

Medical secretaries and receptionists at three hospitals in West Yorkshire are among those who went on strike in a row over potential job cuts.

Unison members were balloted after 74 employees were sent redundancy letters.

The Mid Yorkshire Hospitals NHS Trust, which runs hospitals in Wakefield, Dewsbury and Pontefract, has to save £24m by April 2013.

http://www.bbc.co.uk/news/uk-england-leeds-20157170

161. Ipswich Hospital U-turn over cuts to dialysis patient transport

31 October 2012 – BBC News

Kidney dialysis patients in Suffolk will now continue to get free transport as Ipswich Hospital has cancelled plans to cut the service.

Hospital officials had planned to end free transport for about 30 of the 100 renal dialysis patients but said the U-turn was made as patients and relatives had expressed "*a great deal of concern*".

http://www.bbc.co.uk/news/uk-england-suffolk-20153842

162. Facebook hospital insult and photo: Aneurin Bevan health chiefs act

01 November 2012 – BBC News

Health chiefs at Nevill Hall Hospital in Abergavenny acted quickly after complaints that insulting messages and photos of an elderly woman in hospital were posted on Facebook.

Aneurin Bevan Health Board has reminded staff of its policy that photos of staff, visitors and patients are only allowed with proper consent.

http://www.bbc.co.uk/news/uk-wales-south-east-wales-20167964

163. NHS use of private sector rising

01 November 2012 – BBC News

The latest figures show that the number of routine NHS operations and treatments carried out by the private sector has risen by more than 10% in a year.

The data from the Health and Social Care Information Centre revealed that private providers treated 345,200 non-emergency NHS patients in 2011-12, a 32,900 rise on the previous year and were for planned care, such as knee and cataract operations.

The figure represents 4.3% of all the routine NHS treatments.

http://www.bbc.co.uk/news/health-20167469

164. Monitor vows to improve 'not fit for purpose' pricing system

02 November 2012 - Health Service Journal

Monitor has vowed to improve the NHS treatment pricing system after a King's Fund report said the payment by results system was *"not fit for purpose*".

165. Public health approach to violence prevention outlined

02 November 2012 - DH

A public health approach to preventing violence is set out in a new report.

Ed. See item 8 above under the heading 'Abuse'

166. Statistical press notice: NHS 111 Minimum Data Set – August Release

02 November 2012 - DH

NHS 111 Minimum Data Set – September Release

Call statistics to the NHS 111 service up to and including September 2012 from the ten sites providing this service and able to provide data at this time. The sites are: County Durhamand Darlington, Lincolnshire, Luton, NottinghamCity, Isle of Wight, Derbyshire, the North West, Croydon, Hillingdon and Inner North West London.

The main findings for September 2012 were:

In September, there were 92,578 calls to the 111 service, with 84% of these calls from people directly dialling 111. Scaled up, this would represent 10.5 million

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calls per year acrossEnglandto the NHS 111 service.

In September, 98% of answered calls made to NHS111 were answered within 60 seconds. Of all calls offered 1% were abandoned after waiting longer than 30 seconds.

Average length of a call episode for data up to and including September was 9 minutes 12 seconds, with 78% of callers receiving a triage and 3% of answered calls called back.

On average 30% of call time was handled by clinical staff for all calls up to and including September.
For the period between April 2011 to March 2012, 92% of callers were very or fairly satisfied with their NHS111 experience.

Data can be viewed on the Department of Health website.

167. Statistical press notice: Ambulance Quality Indicators – monthly update for England

02 November, 2012 DH
(Ambulance Systems Indicators for period September 2012 and Ambulance Clinical Outcomes for period June 2012)
The following statistics were released today by the Department of Health:

Ambulance System Indicators; Category A (Red 1) 8 minute response time, category A (Red 2) 8 minute response time , 95th percentile of time from Call Connect to an emergency response arriving, category A 19 minute response time, call abandonment rate, re-contact rate following discharge of care, time to answer call, time to treatment, ambulance calls closed with telephone advice or managed without transport to A&E, ambulance emergency journeys; for period September 2012.
Ambulance Clinical Outcomes; Outcome from cardiac arrest – return of spontaneous circulation, outcome from acute ST-elevation myocardial infarction (STEMI), outcome from stroke for ambulance patients, outcome from cardiac arrest – survival to discharge; for period June 2012.

Main Findings – System Indicators for September 2012
• The proportion of Category A (Red 1) calls resulting in an emergency response arriving within 8 minutes was 74.9% nationally, ranging from 82.1% to 70.7% across different ambulance trusts in mainland England. Performance cannot be assessed for this new indicator until six to seven months of data has been collected.
- Four Trusts – East Midlands, London, South Western and Yorkshire & Humber – failed to achieve the standard for 75% of Category A (Red 1) calls to receive an emergency response within 8 minutes.
• The proportion of Category A (Red 2) calls resulting in an emergency response arriving within 8 minutes was 75.7% nationally, ranging from 78.5% to 72.5% across different ambulance trusts. Performance cannot be assessed for this new indicator until six to seven months of data has been collected.
- Two Trust, East of England and London failed to achieve the standard for 75% of Category A (Red 2) calls to receive an emergency response within 8 minutes.
• The 95th percentile of time from Call Connect of a Red 1 call to an emergency response arriving at the scene of the incident cannot be calculated nationally. The percentiles across the different ambulance trusts range from 11.0 minutes to 15.8 minutes.
• The proportion of Category A calls resulting in an ambulance arriving at the scene within 19 minutes was 96.0%, ranging from 92.8% to 98.0%. Three Trusts – East Midlands, East of England and North West – failed to achieve the standard for 95% of Category A calls to receive an ambulance vehicle capable of transporting the patient within 19 minutes of the request for transport being made. Performance is comparable to the full year figure (April-March), where performance was 96.8%.
• The proportion of calls abandoned by the caller before the call was answered by the ambulance service was 1.6%, which is a deterioration compared to the full year figure (April-March), where the proportion of calls abandoned was 1.2%. Part of this deterioration in August was due to large increase in the calls abandoned for the South East Coast. They have identified this as an anomaly and are investigating the cause. North West did not return any data for this indicator and will be listed as Did Not Return.
• The re-contact rate following discharge of care has two components:
- Re-contact following discharge of care by telephone, where 12.7 % of such calls resulted in the patient re-contacting the Ambulance Service within 24 hours. This is comparable to the full year figure (April-March), where 13.1% of calls resulted in the patient re-contacting the Ambulance Service.
- Where the discharge of care was from face-to-face treatment by the ambulance service at the scene, 6.0% of such patients re-contacted the Ambulance Service within 24 hours, which is comparable to the revised full year figure (April-March) which was 5.2%. The range this month was from 3.1% to 8.7%.
• There is a separate element on those re-contacting the Ambulance Service and that deals with those for whom there is a locally agreed frequent caller procedure in place. Nationally, 1.0% of patients for whom a frequent caller handling procedure is in place re-contacted the ambulance service within the month; however, frequent caller procedures are locally deter-

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mined and protocols will vary across ambulance services. Six Trusts were not able to identify frequent callers. For those Trusts that were able to supply both a numerator and denominator, the corresponding figure was 1.6 %.
• Data on the median, 95th and 99th percentiles was collected, at Ambulance Trust level, for both Time to Answer Calls and Time to Treatment. However, it is not possible to produce a national median/95th/99th percentile.
• For the time to answer a call, the median ranged from less than a second to 3 seconds. The 95th percentile ranged from 1 to 63 seconds and the 99th percentile had a range of 9 seconds to 2 minutes and 14 seconds.
• The median time to treatment ranged from 5.1 minutes to 6.2 minutes, the 95th percentile ranged from 14.4 to 19.9 minutes and the 99th percentile had a range of 21.2 to 40.8 minutes.
• Where ambulance calls were closed with telephone advice or managed without transport to A&E, then 5.9% of emergency calls that received a telephone or face-to-face response were resolved by telephone advice, which is an improvement to the full year figure (April-March), where 5.3% of emergency calls were resolved by telephone advice. The range across all trusts was 3.4% to 10.0%.
• Of those emergency calls that received a face-to-face response, 35.4% were either discharged at the scene, transferred to a destination other than a Type 1 or Type 2 A&E, or were referred to an alternative care pathway. This month's performance is an improvement on the full year figure (April-March), which was 33.9%. This month's performance ranged from 22.9% to 50.9%.
• In September 2012 there were 391,875 emergency journeys, up from 389,737 during September 2011.

Main Findings – Clinical Outcomes for June 2012

This return runs with a 3-month lag on the Systems Indicators, as this time is required in order for those patients transported by ambulance to have their outcomes resolved.
• The Return of Spontaneous Circulation (ROSC) is calculated for two patient groups. The overall rate measures the overall effectiveness of the urgent and emergency care system in managing care for all out-of-hospital cardiac arrests. The rate for the Utstein comparator group provides a more comparable and specific measure of the management of cardiac arrests for the subset of patients; where timely and effective emergency care can particularly improve survival; (e.g. 999 calls where the arrest was not witnessed and the patient may have gone into arrest several hours before the 999 call are included in the figures for all patients but are excluded from the Utstein comparator group figure).
- Of those patients who had an out-of-hospital cardiac arrest, 24.9% had ROSC on arrival at hospital where resuscitation was commenced or continued by ambulance personnel. This is an improvement in performance when compared to the revised full year (April-March) figure of 22.9%. Performance ranged from 18.6% to 34.3% across all ambulance trusts in mainland England.
- For those patients who had an out-of-hospital cardiac arrest that was witnessed, and where the patient had a heart rhythm that was suitable for defibrillation (i.e. the Utstein comparator group),43.0% had ROSC on arrival at hospital where resuscitation was commenced or continued by ambulance personnel. This is stable performance compared to the revised full year (April-March) figure, where performance was 43.2%. Performance on mainland England ranged from 24.0% to 80.0%.
• As with the Return of Spontaneous Circulation, survival to discharge following cardiac arrest is reported separately for all patients, and for the subset of patients in the Utstein comparator group.
- Of those who suffered an out-of-hospital cardiac arrest, where ambulance staff commenced/continued resuscitation, 7.9% were discharged from hospital alive. This is stable compared to the revised full year (April-March) figure of 7.0%. Performance on mainland England ranged from 5.4% to 14.5%.
- For those patients who had an out-of-hospital cardiac arrest that was witnessed, and where the patient had a heart rhythm that was suitable for defibrillation and resuscitation was commenced or continued by ambulance personnel, 18.5% were discharged from hospital alive, compared to 22.1% from April-March, a stable performance. This indicator is characterised by small numbers. Performance percentage figures derived from these figures are likely to be subject to large variation, within and across months. This month performance ranged from 7.5% to 33.3% across mainland England.
• Of those patients with an initial diagnosis of 'definite myocardial infarction' receiving thrombolysis where the first diagnostic ECG was performed by ambulance personnel, 41.2% received the thrombolysis within 60 minutes of the call being connected to the ambulance service. The revised full year figure from April-March is 55.3% so performance is stable. As with the previous indicator, very small numbers were returned across those Trusts that are reporting data for this line. Six Trusts returned zero returns for this element. Of those six, three Trusts do not return this data and have confirmed that this indicator is not applicable to them, as their clinical pathway does not include thrombolysis, only PPCI. These trusts are Great Western, South Central and North East.
• Those patients for whom a primary angioplasty occurred within 150 minutes of the call being connected to the ambulance service following the first diagnostic ECG being carried out by ambulance personnel, represented 87.8% of all such patients that fulfilled this

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criteria, stable compared to the figure of 89.7% from April-March. Performance ranged from 76.2% to 100.0%.
• 74.6% of patients with a pre-hospital diagnosis of suspected ST-elevation myocardial infarction received the appropriate care bundle. This is stable performance compared to the revised full year figure from April-March, where 74.1% received the appropriate bundle. Performance ranged from 60.8% to 100.0%.
• 64.9% of FAST positive patients, who were assessed face to face, arrived at a hyperacute stroke centre within 60 minutes of the call being connected to the ambulance service. Performance ranged from 46.6% to 84.1%. This is a stable performance compared to the full year figure from April-March 2012, where performance for this indicator was 64.9%.
• Of the suspected stroke patients assessed face to face, 95.1 % received an appropriate care bundle, showing a stable performance with the revised figure of 94.2% between April and March 2012. Performance ranged from 100.0% to 88.9% across Trusts in England.

168. Navigating the NHS

Liverpool Care Pathway FAQs
02 November 2012 – WebMD Boots
FAQs to explain the Liverpool Care Pathway, or LCP. It is an NHS scheme giving end of life care to people with terminal illnesses
http://www.webmd.boots.com/nhs/news/20121102/liverpool-care-pathway-faqs

169. Hospitals to use ZOO equipment to scan fat Brits, top docs say

02 November 2012 – The Sun
Top doctors are predicting that the NHS will soon have to scan people with ZOO equipment because normal machines are unable to deal with severely overweight Brits.

Many hospitals have not invested in special "*supersize*" equipment suited to morbidly obese patients and research by surgeons at the North Bristol NHS Trust have found only on in six hospitals had access to MRI or CAT scanners that can take patients weighing 35st.

As an emergency measure they will need to rely on scanners usually operated by vets as the number of obese Brits booms.
http://www.thesun.co.uk/sol/homepage/news/4623379/Hospitals-to-use-zoo-equipment-to-scan-fat-Brits.html#ixzz2B4l51LzA

170. Revolutionary new system to tackle superbug

02 November 2012 – Redditch Standard
A new revolutionary system which uses an antibacterial vapour to kill germs has been brought in as the latest weapon in the fight against a hospital superbug.

Hydrogen Peroxide Vapour (HPV) was introduced by Worcestershire Acute Hospitals NHS Trust as it is in danger of breaching its target for the number of cases of C. Diff this year.

The system produces a vapour which rapidly kills all microorganisms, including spore forming bacteria which regular cleaning, no matter how vigorous, can leave behind. It can be used proactively to prevent infection or to stop outbreaks.
http://www.redditchstandard.co.uk/2012/11/02/news-Revolutionary-new-system-to-tackle-superbug-54556.html#.UJOQ1K7-Hrg.facebook

171. Trust looking for someone with a head for figures

02 November 2012 – Redditch Standard
The cash-strapped Worcestershire Acute Hospitals NHS Trust is looking for a new non-executive director with a recognised financial qualification and senior board level experience.

Board members must commit a minimum of 2.5 days per month to NHS duties, as well as attending public meetings and preparing by reading papers and packs.

Visit www.worcsacute.nhs.uk for an application pack or call 01905 733 960 for an informal discussion about the role.
http://www.redditchstandard.co.uk/2012/11/02/news-Trust-looking-for-someone-with-a-head-for-figures-54563.html

172. End-Of-Life Care: Plan For New Legal Rights

03 November 2012 – Yahoo.com

Liverpool Care Pathway: Relatives 'must be informed'

03 November 2012 – BBC News
Families will now have to be consulted before patients are put on a so-called "pathway to death", under reforms being put out for consultation on 05.11.2012.

Hospitals could also be sued and doctors struck off if they do not involve relatives in the decision to start end-of-life treatment.

Health Secretary Jeremy Hunt is set to make the announcement as part of a raft of changes to the NHS constitution.
http://uk.news.yahoo.com/end-life-care-plan-legal-rights-051502577.html
http://www.bbc.co.uk/news/health-20191568

173. County hospitals 'are not in danger of going bankrupt'

03 November 2012 – Bromsgrove Advertiser

Health chiefs suggest that county hospitals are not at risk of bankruptcy, despite a Parliamentary report warning of the dangers posed by the Government's NHS overhaul.

The House of Commons Public Accounts Committee said in its report last week that the Department of Health was "*inventing rules and processes on the hoof*" to deal with hospital trusts in financial trouble.

10 NHS trusts, 21 foundation trusts and three primary care trusts reported a combined deficit of £356 million.

http://www.bromsgroveadvertiser.co.uk/news/10020011.County_hospitals__are_not_in_danger_of_going_bankrupt_/

174. Medical records found by urban explorer at derelict former Mansfield General Hospital to be removed by health trust

03 November 2012 – Chad.co.uk

Private medical records belonging to Mansfield residents were unearthed by an 'urban explorer' at the town's former General Hospital are being removed by health officials on 03.11.2012.

The 'urban explorer' - who wishes only to be known as 'Mango' - found boxes of medical notes, prescriptions and mortuary certificates dating back to the 1960s in a cellar at the derelict West Hill Drive site along with doctor's diaries, financial records and the medical history of children living on streets nearby the hospital.

http://www.chad.co.uk/news/health/medical-records-found-by-urban-explorer-at-derelict-former-mansfield-general-hospital-to-be-removed-by-health-trust-1-5090122

175. 'Unless it's urgent, stay away,' warn stretched Greater Manchester doctors facing winter waiting rooms

03 November 2012 – Mancunian Matters

Overstretched Greater Manchester doctors have told patients who do not require urgent care to stay away as winter sets in.

http://mancunianmatters.co.uk/content/03116496-unless-its-urgent-stay-away-warn-stretched-greater-manchester-doctors-facing-winter

176. Oxford University Hospitals NHS Trust status switch wins support in consultation

03 November 2012 – Banbury Cake

Residents have given their agreement to long-awaited plans to give hospital managers more independence.

A public consultation in Oxfordshire has supported Oxford University Hospitals NHS Trust's bid to become a foundation trust.

http://www.banburycake.co.uk/news/10024835.NHS_trust_status_switch_wins_support_in_consultation/

177. Choose well this winter

03 November 2012 – Driffield Today

The Choose Well campaign aims to educate and inform people about the different NHS services available to them, promoting self-care and the use of local high-street pharmacy for common complaints such as coughs and colds, flu, stomach upsets and general aches and pains. Advice and information about a range of common winter health complaints, including how long symptoms will last and how to relieve symptoms is available from NHS Choices at www.nhs.uk You'll find an easy to use symptom checker, can search for your local services and use the interactive First Aid toolkit.

http://www.driffieldtoday.co.uk/lifestyle/choose-well-this-winter-1-5083456

178. Dial 111 for A&E shambles

04 November 2012 - The Mail on Sunday

Item which opines that the new NHS phoneline intended to take pressure off 999 blue light responses actually increases ambulance call-outs.

179. NHS 111 minimum data set - Updated

November 2012 – DH

The 111 number should be a new easy to remember route into the NHS for all those who are unclear about which service is best placed to meet their needs. The service has been rolled out to four pilot sites in 2010 with more likely to come on stream in summer 2011. This publication has published data to help assess the efficiency and effectiveness of the different 111 models.

http://transparency.dh.gov.uk/category/statistics/nhs-111-statistics/

180. Ambulance quality indicators - Updated

November 2012 – DH

Statistics on the quality of ambulance services in England including system and clinical indicators.

http://transparency.dh.gov.uk/category/statistics/amb-quality-indicators/

Nursing

181. NMC accepts £20m from government and raises registration fee to £100

31 October 2012 - NMC News

The NMC Council decided to accept the government's offer of a £20m grant to help support the costs of regulation, and took the difficult decision to raise the registration fee to £100.

The increased fee will allow us to eliminate our historic caseload, have the capacity to handle the growing length of hearings, deliver more efficient registration services and achieve long term financial stability.

Council were presented with an analysis of the consultation into the fee rise, which closed on 24 August 2012. Council made the decision following a discussion and after hearing from observers, including representatives of trade unions.

Key facts

- The annual registration fee is to be raised from £76 to £100.
- The fee will remain at £100 each year for the next two years.
- The increase is due to take effect from 1 February 2013.
- You can still claim tax relief on your registration fees if you are a UK taxpayer.

Mark Addison CB, Chair of the NMC, said:

"Patients and the public deserve to be able to have confidence that the nurses and midwives who care for them are well regulated. The NMC's costs have increased dramatically over recent years in spite of extensive efficiency and cost-saving activity.

"The Council discussed the concerns expressed by observers at the meeting, as well as the valuable consultation evidence. We had to strike a very difficult balance between the need to protect the public and the financial burden of regulation on hard working nurses and midwives."

We have produced an FAQs to answer your queries about the fee rise.

We have published the results of the fee rise consultation (PDF) and the equality impact assessment (PDF), which was undertaken as part of the analysis on whether to raise fees.

Full statement on raising registration fee

Older People

182. Elderly people 'staying at home for fear of falling'

31 October 2012 – BBC News

A survey by the WRVS suggests that a fear of falling is making many elderly people prisoners in their own homes.

More than one in five of the 500 people aged 75 and older, lived in fear of falling with 5% being so fearful that they will not leave their homes unaccompanied.

A third of them had suffered falls in recent years and a fifth of these said they had lost confidence as a result.

http://www.bbc.co.uk/news/health-20138731

183. 'Independent living' fund announced

30 October 2012 – Age UK

The Government has announced new plans to help older people live in their own homes for longer by making funding worth £300 million available to town halls and housing providers to help them build specially adapted homes.

As many as 9,000 supported properties could be built under the scheme, with features such as fewer stairs, lower cupboards and adapted bathrooms.

http://www.ageuk.org.uk/latest-news/independent-living-fund-announced/

184. Drop in number of vulnerable people having free flu jab

03 November 2012 – BBC News

New figures show that many potential flu victims have not been vaccinated despite winter approaching.

The DH stated that the number of pensioners who have been given the jab has fallen compared with the same period last year and also seen a drop for those under 65 who suffer from medical complications like asthma and diabetes.

http://www.bbc.co.uk/news/health-20190343

Parliament

06.11.2012 – HoC - Home Affairs Select Committee - Localised child grooming
Witness(es): Witness tbc; Jim Taylor, Chief Executive, Rochdale Council and Roger Ellis, former Chief Executive, Rochdale Council
06.11.2012 – HoL – Oral Question - Retention of women doctors in the NHS - Baroness Deech

07.11.2012 – HoC – Westminster Hall - Disability access and the aviation industry - Graham Evans

07.11.2012 – HoL – Oral Question - Cancer networks - Lord Hunt of Kings Heath
08.11.2012 – HoL - Short Debate - NHS patients dying at home - Lord Warner

09.11.2012 – HoC – Legislation - Disabled Persons' Parking Badges Bill - Report stage - Simon Kirby.
Adjournment - Future of Kettering General Hospital - Mr Philip Hollobone

185. Parliamentary Questions and Debate from the Past Week

The following section is produced in conjunction with specialists in health and social care, PLMR – Political Lobbying & Media Relations – www.plmr.co.uk

29 October 2012 – House of Commons – Written Ministerial Statement from Care Services Minister

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Norman Lamb about ongoing activity in relation to Winterbourne View private hospital.

To view online, click on the following link:
http://www.parliament.uk/documents/commons-vote-office/October_2012/29-10-12/4.Health-WinterbourneView.pdf

30 October 2012 – House of Commons – Commons debate following a request from Liz Kendall (Lab, Leicester West) asking Care Services Minister Norman Lamb to make a statement on government actions to ensure the safeguarding of former Winterbourne View residents.

To view online, click on the following link:
http://www.publications.parliament.uk/pa/cm201213/cmhansrd/cm121030/debtext/121030-0001.htm#12103035000007

31 October 2012 – House of Commons – Written Answer from Care Services Minister Norman Lamb in response to a question from Tracey Crouch (Con, Catham and Aylesford) about the criteria and assessment process for awarding the dementia friendly community status outlined in the Prime Minister's Challenge on Dementia. In response Mr Lamb said the Alzheimer's Society recently carried out a consultation on the recognition process for dementia friendly communities, on behalf of the Champion Group, and the responses to that consultation are currently being analysed.

To view online, click on the following link:
http://www.publications.parliament.uk/pa/cm201213/cmhansrd/cm121030/text/121030w0002.htm#121030w0002.htm_sbhd5

2 November 2012 – House of Commons – Committee Evidence from the House of Commons Backbench Business Committee in which Robert Buckland (Con, South Swindon) made a case for a debate on autism that would give members of the House who are not on the Education Select Committee to ask questions and look at evidence relating to the drafting of the Children and Families Bill.

To view online, click on the following link:
http://www.publications.parliament.uk/pa/cm201213/cmselect/cmbackben/uc3010/ucbbc3010.htm

Social Care

186. Social workers should be able to finish at 5pm, not be attacked for it

31 October 31, 2012 – Community Care
An article looking at the reactions to a joke social worker cartoon posted up on the Community Care website. It drew plenty of 'likes' from social workers but also drew an angry response from one commenter.
http://www.communitycare.co.uk/blogs/social-work-blog/2012/10/social-workers-should-be-able.html

187. A very practical guide for social workers working with older people

01 November 2012 – Community Care
A book on social work with older people has been published and it offers an in-depth and practical guide for the profession on this complex area of care.

Ann McDonald, the author of Social work with older people, aims to provide an authoritative and practical guide to working with older people in a range of settings.
http://www.communitycare.co.uk/blogs/adult-care-blog/2012/11/a-very-practical-guide-for-social-workers-working-with-older-people.html

188. Social care professional body forced to close

01 November 2012 – Community Care
Social Care Association chief, Nick Johnson has signed off with an attack on lack of support for non-social work care staff.

The Social Care Association went gone into liquidation and closed with the loss of six jobs.
http://www.communitycare.co.uk/Articles/01/11/2012/118658/Social-care-professional-body-forced-to-close.htm

189. Councils 'must be more transparent about adult care performance'

01 November 2012 – Community Care
Peter Hay, chair of the Towards Excellence in Adult Social Care Performance (TEASC) programme board has urged councils to be more open with each other and local people, following concerns that some are not opening themselves up to scrutiny.

The comments were made after criticism that some authorities are failing to participate in the peer support improvement regime that TEASC oversees.
http://www.communitycare.co.uk/Articles/01/11/2012/118657/Councils-39must-be-more-transparent-about-adult-care.htm

190. Social workers put off by high-profile whistleblowing cases

01 November 2012 – Community Care
Many social workers and care professionals are currently reluctant to come forward when they witness unsafe practices, in case of repercussions

Social workers are duty bound to blow the whistle on harmful practices that could put service users, an organisation or its employees at risk
Read Community Care's guide to whistleblowing in social work
http://www.communitycare.co.uk/Articles/01/11/2012/118632/

social-workers-put-off-by-high-profile-whistleblowing-cases.htm

191. Government to appoint two chief social workers, not one

02 November 2012 – Community Care

The Government is going to appoint two chief social workers for England – one for adults' services, and one for children and families – rather than the one it initially envisaged.

It started its hunt for a single chief social worker in April, advertising the post with a salary of £110,000 , and in August sources said three candidates were in the running.

But on 01.11.2012, the Government confirmed its change of direction, with a DH spokesperson saying the two successful candidates would *"work together side-by-side to provide unified leadership to the sector".*

http://www.communitycare.co.uk/Articles/02/11/2012/118659/Government-to-appoint-two-chief-social-workers-not.htm

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Nothing to report

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