

CLINICAL NEGLIGENCE UPDATE

A brighter future for long-term care payments

Cases with large future care elements have, for a number of years, been capable of settlement on the basis of annual payments designed to meet claimants' care costs for the rest of their lives. These payments have been guaranteed by the Government and paid free of tax.

At first blush, most claimants or those looking after their interests had thought that such a resolution represented the ideal answer, removing all uncertainty associated with assessments of life expectancy.

The picture, however, has been far from clear and, in many cases, expert financial advice has warned against the annual payment approach to settling cases. The problem has been that, until the recent appeal decision of *Thompstone*, the rate at which these payments has increased has been linked to the Retail Prices Index. However, the cost of care has, in the vast majority of years, run well ahead of the cost of that basket of items that go to making up the Retail Prices Index. As a result, a case did not have to run on for many years before claimants were finding themselves in a position of a 'guaranteed shortfall' against the cost of their care.

This unfair situation meant that there was a minority of cases settling on the basis of annual payments. The consequences were that claimants were either out-living their life expectancy and finding their compensation running out or families were surviving claimants and receiving an unexpected windfall. Either outcome was patently unattractive and the robust decision of the Court of Appeal in favour of linking future annual payments to the cost of care (specifically by reference to *ASHE 6115*) is a victory for common sense.

Whilst unfortunately for those whose cases have concluded with either RPI-linked annual payments or

with the lottery of a one-off lump sum, this decision has come too late. For injured claimants with long-term future care needs, however, the need to gamble or accept a guaranteed shortfall appears now to have disappeared.

It is understood that the defendants in the *Thompstone* case have sought permission from the House of Lords to appeal the Court of Appeal decision. In the light, however, of the robust and unanimous Court of Appeal decision, it is to be hoped that the House of Lords will reject that application, thereby allowing common sense to prevail and claimants to face their future with this issue, at least, clarified.

LEGAL AND FINANCIAL ADVICE DAY

Foot Anstey will be hosting a Legal and Financial Advice Day in conjunction with the national cerebral palsy charity, Scope, in London on Sat, 12 April 2008.

The event, which will be held at Inner Temple Hall, London, has been designed to provide crucial information to those working with and supporting individuals affected by cerebral palsy. Chaired by Elizabeth Anne Gumbel QC, the day will include presentations on clinical negligence claims, educational tribunal issues, Mental Capacity Act developments and advice on Wills and Trusts.

For further information or to book a place, please contact Scope at:
legalandinformationday12april08@scope.org.uk

Recouping your losses

An investigation by the Ombudsman has resulted in the Department of Health (DoH) issuing fresh guidance in relation to those pursuing claims to recoup continuing care costs.

This new guidance recognises that claimants shouldn't be left out of pocket as a result of pursuing a claim for maladministration.

Foot Anstey's clinical negligence team is representing a number of clients who have won the right to have their continuing care costs funded by the health service and who are now seeking to reclaim the costs they incurred in pursuing this goal.

In our last issue we highlighted that a new national framework for assessing a patient's entitlement to Continuing NHS care had been introduced. It was hoped that this would dispense with the anomalies in the provision of care to the disabled which arose as a result of Primary Care Trusts (PCTs) setting, and then frequently mis-applying their own criteria.

Numerous appeals were anticipated by or on behalf of individuals who had been wrongly assessed as being responsible for meeting the cost of their own care in the period preceding introduction of the framework.

The number of patients entitled to claim appears greater than the PCTs had anticipated and substantial sums have been recovered by clients represented by Foot Anstey at various levels of the appeal process.

These cases may have stretched over a long period of time and the costs of pursuing these have left many out of pocket. Losses range from the legal fees incurred in pursuing the appeal, through to loss suffered by an enforced sale of the patient's home to meet their liabilities. In the latter scenario, those losses may be substantial, the increase in property value over time meaning that an enforced sale, earlier than the patient would have wished, costing them dear in terms of accrued value of their own home.

However, there is no basis in law for a client to recover legal costs incurred under an NHS appeals procedure. The incorrect refusal to fund care may give rise to a statutory right to repayment but does it create a legal cause of action enabling the patient to claim consequential loss as damages? Can a property owner recover a loss arising from the sale of a property at a lower value than might otherwise have been achieved, a claimant not normally being entitled to benefit from the vagaries of the market?

Fortunately, patients appear to be winning the argument. A joint report by the Parliamentary Commissioner for Administration (Parliamentary Ombudsman) and the Health Service Ombudsman for England published under the title, '**Retrospective continuing care funding and redress**' confirmed that there was maladministration in the DoH's decision making and communication of its approach to recompense for wrongly denied continuing care funding.

'Where the complainant has suffered actual financial loss as a result of the maladministration, or faced costs which would not otherwise have been incurred, the general approach should be

to restore the complainant to the position he or she would have enjoyed had the maladministration not occurred.'

The guidance reminds PCTs that they can make compensation payments for financial loss, including interest, which is demonstrably attributable to the wrongful denial of continuing care funding and is aimed at returning the individual to the financial position he, or she, would have been in but for the maladministration.

Examples of additional financial loss identified in the report include:

- loss due to premature sale of a property; and
- loss on an unnecessary insurance plan for future care fees.

The Ombudsman also directed that patients should be compensated for the inconvenience and distress caused by having to make difficult financial decisions at a challenging time which were unnecessary because continuing care should have been funded. Such payments should recognise the degree of inconvenience and distress that was suffered by complainants.

Following the Ombudsman's report the DoH issued fresh guidance: '**NHS Continuing Healthcare: Continuing Care Redress**' accepting the Ombudsman's recommendations. Ex gratia payments may be appropriate in cases where a PCTs decision about continuing care eligibility or recompense has caused either financial loss which significantly exceeded the actual care costs, or distress. PCTs are encouraged to seek legal advice about individual cases where necessary, and make ex gratia payments where appropriate.

If an individual is dissatisfied with the PCTs approach to redress, the local dispute resolution route should be followed, followed by the Healthcare Commission, then the Health Service Ombudsman if the issue remains unresolved.

Although there is no direct reference to legal costs, Foot Anstey clients have been asked to submit details of these costs to PCTs for consideration, giving rise to the expectation of payment.



NICE to see to you to see you NICE?

The National Institute for Health and Clinical Excellence (NICE) has recently been put under the spotlight following decisions to withhold Alzheimer's and cancer drugs and most recently following calls from the Health Committee that the decision making process regarding whether drugs and treatments should be made available to patients is too slow.

In light of this recent publicity one may therefore validly ask who is NICE?

NICE was set up in 1999 by the Health Secretary and according to its website NICE is the 'independent organisation for providing national guidance on the promotion of good health and the prevention and treatment of ill health.'

In essence, NICE is the body which decides which drugs and treatments we should get on the NHS.

New treatments are generally only used if they cost under £30,000 for each year of good health they provide, a measurement known as Quality Adjusted Life Year (QALY) – an accountant's measure of the extra longevity and wellbeing a drug can bring. This means that, for instance, cataract treatment and hip replacements can score highly, as they dramatically improve quality of life, without extending life, whereas an expensive cancer drug that buys a few extra months with bad side effects scores poorly.

NICE are meant to be independent but in November 2005 there was a remarkable intervention by the then Health Secretary Patricia Hewitt when North Stoke Primary Care Trust refused Herceptin to a patient. Questions have also been raised with regard to their independence by virtue of the fact that they do not consider all new treatments but rather those the Department of Health want it to.

So why do we need NICE?

The stark reality of the NHS is that it will never be able to provide every suitable treatment for every patient. Therefore NICE's remit was to consider drugs and treatments to establish whether the benefits outweigh the cost, in terms of side effects, comparison to not providing any treatment and, most controversially, the cost to the NHS.

The directive which led to the creation of NICE applied to the whole of the UK, except Scotland, which has set up its own body, the Scottish Medicines Consortium.

There have been many critics of NICE, both in terms of the actual decisions they make in respect of individual drugs but also in relation to the general process.

NICE hit the headlines in 2006 when it decided to withhold Alzheimer's drugs costing £2.50 per day from sufferers in the early stages of dementia, denying patients the drug because they were not 'ill enough'. This decision outraged doctors and patients alike who all claimed they saw daily benefits in Alzheimer's sufferers. Indeed the Alzheimer's Society, as an interested party, lodged a judicial review, though NICE's decision was upheld by the Courts.

Critics also include the renowned cancer specialist Professor Karol Sikora who has said that NICE should stop making decisions based purely on clinical performance but should also consider the social gains a treatment can bring.

More recent criticism has arisen, flowing from the decision time generally taken to approve new treatments.

The fastest appraisals NICE has carried out take on average a year. Many decisions take significantly longer than this. This compares, unfavourably, to the Scottish system where decisions are often made within a few months.

In light of this discrepancy the Health Committee has recently scrutinised the system and concluded that NICE should adopt a 'rough and ready' approach to the decision making process, to speed it up, and that a more in-depth review of new drugs and technologies could be done later if needed.

Another criticism was that NICE appeared to only focus on the most expensive treatments, rather than considering all treatments. The report said that this meant NHS trusts were overly focused on these expensive treatments often at the expense of the cheaper, often effective, drugs that could be prescribed by GPs.

Despite all this criticism the irony is that NICE are envied abroad, where it is viewed as a cost cutting body. Germany and France have recently joined Australia, Canada and Sweden in setting up NICE-like bodies.

Therefore, whilst there is criticism of NICE there appears little call for it to be scrapped. Rather, as the Health Committee suggested, the general consensus is that NICE should be reformed in to a faster, more streamlined system for assessing new treatments for the NHS.

Should anyone have concerns about decisions made regarding the availability of drugs used in their treatment they can contact Foot Anstey on 0845 111 4008.

Case Update

Foot Anstey was instructed recently to represent a client regarding treatment he received for bladder tumours at Medway NHS Trust.

Our client received a course of Mytomycin C following removal of bladder tumours to reduce the risk of developing bladder cancer and of the tumours spreading. In fact, our investigations revealed that the treatment may not have been essential and therefore our client might have avoided the treatment altogether.

This was a difficult argument to pursue however and highlights why it is essential to investigate all aspects of a claim thoroughly with both the client and the advising expert(s). In the end, this claim did not proceed on that argument but on the basis that the treatment should have been stopped once our client started to suffer from adverse side effects.

In June 2004, our client had his first course of Mytomycin C. The following month he underwent further treatment. He developed pain, a burning sensation and was passing blood in his urine. He was informed this was probably an infection by the nurse practitioner administering the treatment and was given antibiotics. Tests showed no infection.

The symptoms persisted. Our client continued to contact the hospital for advice. Two months after his final appointment, he was tested for a chemical infection. These tests were negative.

Our client underwent a pre-planned flexible cystoscopy. The procedure was aborted as he was in substantial pain. He was advised that the Mytomycin C had caused his bladder to ulcerate, the ulcers to contract and caused the bladder to shrink and become inflamed. Our client's bladder was removed and a stoma bag inserted.

Our client's life has changed completely. The stoma leaks regularly. He finds it difficult to go on holiday. He cannot play with his grandchildren as he is wary of the stoma. He experiences discomfort when lifting, severely affecting his hobby of gardening. His social activities and self-confidence are affected and he is impotent.

Our client requires further surgery to prevent leakage of the stoma and to implant a penile prosthesis.

The claim was settled for £100,000. This included a claim for pain and suffering in relation to the unnecessary operations and impotence and associated financial losses.

If anyone has any queries about the issues involved in this case please contact Claire Stoneman, Associate on 0845 111 4008.



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