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Healthcare newsbrief

Manchester Trusts complete landmark merger

Digital transformation – are you prepared?

Holiday pay update

GDPR – are you ready?

Accountable care – the art of the possible

Schrödinger's consent: ARB v IVF Hammersmith Limited & R

Farewell to ET fees, but what next?

Welcome

Welcome to the winter edition of Hempsons' Healthcare Newsbrief. Many of you will be reading this at the NHS Providers conference where many of the issues we are writing about – from moving towards digital records to the issues around moving to an accountable care organisation – will be either discussed or on the minds of delegate.

We kick off this issue with a look at an important merger of two Manchester trusts to form the largest foundation trust in the country. As many of you will know, guiding such mergers through the Competition and Markets Authority is no easy task. The two trusts involved were able to demonstrate clear benefits for patients – a crucial point in getting clearance.

We move on to look at digital transformation. Many trusts will be aware of the benefits of having digital records but may not have thought about the implications for intellectual property rights and data protection.

Even if you are not involved in the Global Digital Exemplar programme you need to be aware of the General Data Protection Regulation which comes into effect in May next year. This will apply to all NHS organisations and is more onerous than the current Data Protection Act. We are running hour long sessions for boards to help you understand the changes and what you need to do.

We also take a look at accountable care organisations and systems where we have updated our guide, produced with NHS Providers, on the steps you should consider as you move towards an ACS or ACO.

Consent is always a difficult area but consent around the use of embryos is particularly emotive. We take a look at a case where an IVF clinic was taken to court by a man whose former partner had an embryo transferred without his consent or knowledge. The claim failed but there are lessons for trusts around the importance of informed and enduring consent to treatment.

Employment law is also a fast-moving area trusts need to be on top of. We look at the potential impact of the dropping of fees for employment tribunals and also the latest ruling on holiday pay. There's bad news here for trusts which employ a lot of staff who regularly do overtime or get on-call payments, as these now need to be reflected in holiday pay.

We hope you enjoy reading these articles: we have given contact details with each of them should you need further advice.

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Contents

3 Manchester Trusts complete landmark merger
4 Digital transformation – are you prepared?
8 Holiday pay update
10 GDPR – are you ready?
11 Accountable care – the art of the possible
12 Schrödinger's consent: ARB v IVF Hammersmith Limited & R
14 Farewell to ET fees, but what next?

Manchester Trusts complete landmark merger

On 1 October 2017 Central Manchester University Hospitals NHS Foundation Trust (CMFT) and University Hospital of South Manchester NHS Foundation Trust (UHSM) merged to form the largest NHS foundation trust in the country: Manchester University NHS Foundation Trust (MFT).

The merger, which has widespread support from local and national stakeholders, will allow MFT to deliver improvements to patient care for Manchester and was unanimously approved by the Boards and Council of Governors of CMFT and UHSM.

Hempsons and Aldwych Partners provided CMFT and UHSM with legal and competition advice throughout the process, helping them to secure a landmark clearance decision from the Competition and Markets Authority (CMA) following a phase 2 review. The merger is the first in any sector to be cleared unconditionally by the CMA on the basis of relevant customer benefits following a finding of a substantial lessening of competition. Early indications suggest that the Manchester Trusts' success in obtaining this clearance may shape the CMA's future decisions, allowing NHS mergers to proceed where there is a strong patient benefits case.

The merger is also the first acute hospital merger to be completed under section 56 of the National Health Service Act 2006, following the successful merger of two mental health trusts in Essex in April this year, on which Hempsons also advised. MFT is an entirely new foundation trust with both CMFT and UHSM being dissolved. Hempsons advised on NHS Improvement's transactions process, legal due diligence, employment and governance arrangements and prepared the documentation required to effect the transaction.

Peter Blythin, Programme Director for the Trusts, comments, "*Hempsons and Aldwych Partners have provided first class support to the Single Hospital Service programme. We have been impressed by the quality of advice and effort shown which facilitated CMA clearance and completion of the transaction by 1 October. The degree of professionalism has been outstanding and we would have no hesitation in recommending the team for similar projects*".

Hempsons is the leading law firm for NHS mergers and acquisitions. We have advised on 15 of the 20 completed NHS mergers and acquisitions since 2011. Hempsons is the only law firm to have advised on the two mergers completed under section 56 of the NHS Act 2006.

Hempsons and Aldwych Partners are advising a number of trusts seeking merger clearance from the CMA.

Digital transformation – are you prepared?

Digital transformation is crucial for the NHS as it seeks a sustainable future and to meet expectations of high quality care. A number of different programmes are now in place to support this, including the NHS and industry 'test bed' partnerships, local STP and new care model projects and, most significantly, the Global Digital Examplar (GDE) programme.

Under the GDE programme NHS England is providing funding and partnership support to selected digitally advanced trusts – 16 acute trusts and seven mental health trusts (from the date of this publication), who will use the funding to create blueprints which can be rolled out across the NHS.

All acute trust exemplars are now partnered with 'fast followers' – trusts who will support the spread of best practice and innovation. Mental health GDEs will also partner with fast followers over the next year. And in a separate but parallel funding stream, 12 trusts using DXC Technologies' Lorenzo EPR system are participating in a new "Lorenzo digital exemplar programme".

The GDE programme is seen as essential to achieving digital maturity and moving to a digitised environment, the benefits of which are clearly evident and include:

- better collation of patient data and an easier means of keeping that data accurate and up to date in 'real time'
- improved access to data for both clinician and patient
- greater efficiencies, enabling clinicians to work more effectively, generating a better patient experience and improved outcomes.

Whether your trust is a GDE or fast follower or participating in its own local transformation programme, you will recognise that the road to digital maturity can be a bumpy one. Doing something differently and for the first time often brings unexpected or new challenges.

We have produced a full briefing on these issues available on request and this article outlines the key points that you will want to consider in the following areas:

- managing the innovation process
- procuring suppliers
- information governance requirements
- getting your workforce up to speed.

Managing the innovation process

Innovation is an integral part of any quest for digital maturity and technology underpins most innovative projects. Moving data and services from an offline, paper based environment to online necessitates a new way of thinking, new processes and procedures and often new methodologies and technologies to facilitate the transformation.

There are a number of routes to achieving digital transformation, but it is unlikely that the technical solutions that a trust requires will be available "off the shelf" and ready to go. It may instead need to either work with external suppliers to create bespoke solutions or use its own internal resources to develop a tailored solution.

Both approaches have benefits and disadvantages from a practical and commercial point of view, but both also raise an interesting legal consideration. What happens to any intellectual property (IP) that is generated as part of the innovation process?

With an external supplier, it is very likely they will want to claim ownership over any IP which may potentially be useful to future customers. How trusts respond to this may depend on a number of factors:

- how much of the cost of the development has been borne by the trust and how much by the supplier
- whether there are other trusts who also want to use the technology
- if there is a commercial value to the bespoke systems generated and whether the supplier – or someone else – is best placed to realise that potential and maximise income.

A well written contract at the start of a relationship is the way to ensure that ownership of IP is clear to everyone. Discussions need to cover:

- who owns any IP at the start of the relationship and who owns that created during it
- what right each party has to use IP owned by the other party
- what happens with third party software or systems and do they restrict any future use or roll out of the system
- what is the effect of using any open source software on systems in the future.

If an organisation is developing solutions internally, the situation with IP is generally clear: IP generated by employers is owned by the employer. However, this is not automatically the case if a trust employs a self-employed contractor or uses students or freelancers. To gain the IP from their work, the trust will need to have a contract in place which transfers the IP to the employer.

The start of a transformation project is the best time to ensure these issues are addressed and trusts are in the best position to exploit any resulting IP from projects. Often trusts will have an IP policy which will provide an appropriate framework for dealing with these issues by providing a means for collating and assessing IP information. If not then the start of a transformation project, which will undoubtedly result in the generation of IP, is a good time to formulate such a policy. It is also a good time for trusts to review their existing policies and ensure that they are adequate and appropriate for what is likely to be a period of intense innovation.

IP law is complex and they may wish to seek advice on their particular circumstances.

Procuring technology

There have been predictions that the GDE and fast follower models could lead to a position where no NHS organisations will need to run IT system procurements again. However, this does not sit easily with the current procurement legislation and the wider value for money requirements in the public sector. Trusts will need to find ways to lawfully procure their IT suppliers.

For any IT requirements over the relevant threshold (currently £106,047 for NHS trusts and £164,176 for FTs) a trust must procure its requirements under a set competitive procedure involving advertisement in the Official Journal of the EU (OJEU). Alternatively a trust can make its purchase quickly and more efficiently through a compliant framework such as one of the many various frameworks set up by the Crown Commercial Service.

Trusts will be familiar with standard open or restricted procedures which may be for off-the-shelf purchases. But what about more complex requirements and/or where framework providers do not provide the system/software that are wanted by the trust? If you are a GDE and are in the process of trying to produce a blueprint for deployment to fast followers are you going to be able to do this without negotiating a solution? It seems unlikely and so the standard procedures in the 2015 Regulations are unlikely to assist. Trusts will need to consider alternatives.

Two options are competitive dialogue and competitive dialogue with negotiations. Both can be effective ways to procure with the choice of procedure depending on whether trusts see benefits in dialogue opportunities with a preferred bidder.

Another option may be what is termed an innovation partnership. Innovation is tightly defined under the 2015 regulations as:

"*the implementation of a new or significantly improved product, service or process, including but not limited to production, building or construction processes, a new marketing method, or a new organisational method in business practices, workplace organisation or external relations, including with the purpose of helping to solve societal challenges or to support the Europe 2020 strategy for smart, sustainable and inclusive growth*".

Under this procedure the trust would advertise its need for an innovative solution and select suppliers to set up a partnership – negotiations can take place. A partnership can be set up with one or more providers and the partnership essentially goes through R&D stages. This process has the advantage of allowing, once a successful solution is found, the trust to purchase that solution without any further competition. Hempsons advised on one of the first innovation partnerships in Europe and so are uniquely placed to assist clients where this procedure may be an attractive option.

A competitive procurement is not necessary in every circumstance; the 2015 regulations allow waivers if certain conditions are met. This could include cases where the solutions have to integrate with existing systems. However, the exemptions around this are extremely complex and trusts need to be careful to avoid the prospect of a challenge.

It has been reported that the GDE organisations will form a new procurement framework where they will work with suppliers to sell digital transformation services to less advanced organisations. In theory this presents a neat solution to the procurement problem faced by fast followers and others – once the GDE organisation has a system which works a trust can simply "call off" that solution from a framework. BUT – the framework will need to be set up in accordance with the 2015 Regulations in order for the call off made by the Trust to be compliant with the legislation. There is no clear indication of how NHS England plans to do this yet.

Finally, we note that GDEs and fast followers will be receiving some funding from NHS England; it will be vital to read the terms of this carefully to see if there is any restriction or requirement related to procurement.

Data protection
As a GDE or fast follower you will undoubtedly be looking to digitise data which has previously been not held in electronic form. You may also be migrating electronic records to new systems or joining up or sharing data sets for the first time. All of these activities ring alarm bells for the information governance specialists whose immediate concern will be – can this be done within the law?

If you have anything to do with data or systems, it probably won't have escaped you that there is a new data protection law coming into force in May 2018 – the General Data Protection Regulation or 'GDPR' as it is commonly referred to. This is heralded by many who work outside the NHS as a game changer, bringing much more stringent regulation to our everyday use of personal data.

However, those who work in the field of information governance will be aware that all too often data protection law will be cited as the reason why something can't be done. In reality the problem is not usually the data protection laws, but because the proposed use of data is contrary to the NHS's internal information governance rules. Those rules go beyond current data protection legislation and even with the arrival of the GDPR, those who are used to complying with NHS information governance rules, will find its implementation far less radical than those operating in a non NHS environment.

But what are the key things to remember as you embark on your digital transformation project? It is important to bear in mind that the laws governing data protection are much less concerned with the medium by which personal data is held (for example in paper or electronic form) and are much more focussed on how that data is used and protected, and how data subjects' rights are respected. The GDPR does not dictate the form in which personal data should be held, but sets the standards and rights that apply to that information.

The advent of the GDPR provides a key opportunity for healthcare providers to review how they store and protect records. Fears of hacking of digital records can and must be addressed by ensuring the right security measures are in place and maintained. But this does not mean that paper records are in any way 'safer' than digital records – one of the aspects of maintaining data security under the GDPR includes ensuring the integrity and availability of data services, and being able to show that these standards are being met.

Digital records provide an opportunity to streamline the steps needed to ensure GDPR compliance, and with changes such as the abolition of subject access fees, finding the most cost effective way to store and share records will be a priority.

Digital records also provide a much greater opportunity for information sharing than previously possible – with access to information within and across organisations being much easier than before. Balancing the increased opportunities to share and access information against the need to maintain NHS information governance principles will require care and practical advice. Many of the benefits of digital records will be lost if organisations become too fearful of regulatory action to share data where it needs to be shared, while equally a failure to limit sharing in accordance with patient's expectations could be equally damaging.

We regularly advise NHS clients on the interface between data protection and NHS information governance obligations, and provide practical help and solutions to overcome perceived obstacles to valuable projects. Digital records also provide opportunities for research that are simply not practicable in paper records and we can advise on how such projects can work without infringing data protection law or NHS information governance rules.

Getting staff to adopt new ways of working
With the need to change and reconfigure the existing NHS workforce to meet the demands of new service models comes the need to ensure that the workforce are familiar with and are utilising new technology. A digitally fluent workforce is a necessity.

We anticipate that providers will need to recruit in to wholly new areas to provide the service required and it's crucial that recruitment decisions are taken in an informed way. Pre-employment checks, the risks of discrimination and fair procedures are all areas that trusts need to consider. We also anticipate that there may be a need to engage with specialist recruitment agencies.

It's likely also that existing service models need to be reorganised. This is likely to involve changes to terms and conditions, consultation, possible redundancies and general restructuring. It is important to ensure the changes are implemented with the minimum legal risk and in a way such as to be effective. Early consultation with individual employees and their representatives will be essential.

We anticipate that technological change will involve the increased use of temporary and agency staff in some new areas and it's important to ensure that trusts are aware of the regulations around this and don't encounter any pitfalls.

To some employees the advent of new technology will be a significant challenge and it will be important to ensure that valuable employees are managed so as to positively manage their resistance and minimise the risk of any claims arising. Our team of expert lawyers can advise on performance management, misconduct and dealing with resistance (individually and collectively) from employees as well as assisting trusts with the various issues raised above.

Our focus is on providing actionable advice that supports our clients in their decision making from recruitment through to robustly defending employment tribunals if necessary.

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Jamie is an experienced corporate commercial lawyer specialising in advising a wide range of NHS, independent sector, third sector and social enterprise clients operating in the health, social care and life sciences sectors on corporate, commercial and public law matters. Jamie is currently working on the development of new care models and accountable care systems. Recently this has included advising on the creation of Salford Together's Integrated Care Organisation, The Royal Wolverhampton NHS Trust's pioneering vertical integration project and the merger of central Manchester University Hospitals NHSFT and University of South Manchester NSHFT to form Manchester University NHSFT.

Holiday pay update

Summary

Over the last few years the courts have increasingly ruled more types of payments ought to be included in holiday pay calculations. However, the prevailing view has been that only compulsory overtime need be included.

- **a ruling over the summer has challenged this approach, with a new emphasis on 'normal remuneration' which should include regular/recurring elements of pay, and payments for voluntary additional work which is normally undertaken.**
- **this could affect NHS organisations when it comes to calculating holiday pay for staff who do regular voluntary overtime or on-call. They will need to re-examine their practices to ensure they are compliant with the latest ruling.**

Legal background

Under the European Working Time Directive, EU member states must ensure workers have the right to at least four weeks' paid annual leave. The directive does not specify how holiday pay should be calculated, but it has been interpreted as being based on "normal remuneration".

In Williams and others v British Airways plc, the European Court of Justice held that "normal remuneration" includes not only basic salary, but also an employee's remuneration which is "intrinsically linked to the performance of the tasks which he is required to carry out under his contract of employment. It was noted that the purpose of holiday pay is to ensure workers are not disadvantaged by taking holiday compared to periods when they are working.

The directive is implemented in UK law by the Working Time Regulations, which grant workers an additional 1.6 weeks' leave on top of the four weeks granted by the directive. Under the regulations, workers are entitled to a week's pay for each week of leave, calculated in accordance with the Employment Rights Act 1996. The specifics of how to calculate a week's pay has been the subject of evolving case law over the last decade or so.

The Willetts (Dudley Metropolitan Borough Council v Willetts and others UKEAT/0334/1) case is important because it's the first time the question of whether to include voluntary overtime (where there is no obligation on either side) in holiday pay has been properly argued in the appeal courts – which means it creates a binding precedent.

The case

The claimants were council employees in posts such as electricians, plumbers and roofers. Each employee had set contractual hours of 37 per week. In addition to these normal working hours, once every four or five weeks, the employees were offered the following additional shifts, which they could choose to work on an entirely voluntary basis:

1. Out-of-hours standby shifts
2. Attending call-outs
3. Voluntary overtime.

Previous case law (the Williams case mentioned above and Lock v British Gas Trading Ltd) emphasised the need for a link between "normal remuneration" and the performance of tasks under a contract. In Willets, Dudley Council argued that payments for the additional shifts were not normal remuneration because they were not intrinsically linked to tasks performed under the employment contract.

The judgment

The EAT rejected the council's position and found that pay for these voluntary shifts did amount to normal remuneration. The failure to include it in holiday pay calculations for the four weeks' leave under the directive was unlawful. They found that an intrinsic link between the payment and the tasks performed under the contract was not essential and that in any event, in this case, the tasks were the same as those performed under their contracts, thereby showing a clear link.

The ruling also found that including those payments for voluntary shifts was essential to ensure that the employees were not deterred from exercising the core right under EU social law to take leave.

Comment

Unfortunately for employers, Willetts does not signal the end of uncertainty as far as holiday pay is concerned. Determining whether a payment qualifies as "normal remuneration" will be a question of fact, to be determined on a case by case basis. The frequency and regularity of the payment will be relevant factors to take into consideration but Willetts provides little guidance on what is meant by "regular"; the overtime in that case was worked roughly once every four or five weeks, but it remains to be seen whether payments, say, every six months would be found to be "regular".

The Willetts decision relates only to pay for the four weeks of annual leave afforded under the directive. It does not apply to the additional 1.6 weeks under the UK regulations or to any additional contractual holidays. That leaves the door open for employers to operate different systems for calculating holiday pay for the two types of leave, but whether that is a practical option remains to be seen.

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Julia is an employment law specialist, working in the health sector as well as for charities and other third sector clients. She advises on contentious and non-contentious aspects of employment law, and has a special interest in discrimination.

GDPR – are you ready?

NHS Trust Board training

Keeping confidential information about staff and patients secure is a responsibility NHS organisations have taken seriously for a long time.

But the requirements on them are about to increase. From May 2018, organisations will need to comply with the General Data Protection Regulation (GDPR), an EU regulation.

This has similarities with the existing UK Data Protection Act, but does extend requirements in some areas. The obligation to provide information to data subjects has been enhanced. The need for data controllers to undertake due diligence on their data processers, including the mandatory terms to be included in the contracts with processors, is much more prescriptive. There is a need to ensure that data privacy is built into all activities requiring the use of personal data. Mandatory reporting of information breaches is now a requirement for all data controllers, with a maximum 72 hour time limit.

By the very nature of their work, NHS trusts process large quantities of the most sensitive types of personal data ('special category' data under the new terminology) and so are at greatest risk if such data is not protected or is misused. The maximum fines for data breaches will be increased significantly – the current limit is extended from £500,000 to €20,000,000 or 4% of global turnover. It is likely that subject access fees will be abolished so trusts must ensure that their records teams are able to deal with the increased number of requests, while at the same time coping with the shortfall in income from this process.

The new law means boards and senior management will need to make changes in processes and procedures, appoint people to new roles, and weigh up the impact on some of the organisation's activities such as contracting.

Training

Hempsons is running hour long sessions for boards which cover the crucial areas which board members need to be aware if to and ensure that their organisation is making the necessary changes.

In addition, Hempsons are also providing more in depth sessions targeted at those within the trusts with primary responsibility for implementing the GDPR within the organisation.

These include:

- common myths and misunderstandings about the changes
- the new role of Data Protection Officer
- the changes to the subject access regime
- the effect on contracts
- the increased regulatory powers
- the new risks for the organisation

To book a GDPR session, or to have an informal discussion, contact:

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Accountable care – the art of the possible

A seven step guide

The NHS continues to develop plans for population-based integrated health systems. '*A seven step guide to accountable care*' which we co-produced with NHS Providers earlier this year addressed in brief how NHS organisations might respond to proposals for the evolution of Sustainability and Transformation Partnerships (STPs) into Accountable Care Systems (ACSs) and in some areas eventually into Accountable Care Organisations (ACOs).

Since the publication of the guide, most STP areas have started to make progress with this initiative, albeit at different speeds. We have been continuing to work with clients in supporting them to develop accountable care models and we are pleased to announce the publication of an updated guide to coincide with the NHS Providers conference in November 2017.

The updated guide aims to demonstrate the 'art of the possible' by setting out the options and key issues within the existing legislative framework for organisations to think about as they take the first steps towards ACSs and ACOs.

The seven steps it covers are:

- **phasing** – the need for a roadmap to guide organisations towards accountable care models and first steps that organisations should consider taking
- **partners** – which organisations should and could be involved in an accountable care model, and how
- **governance** – the importance of clarity on who is accountable and for robust decision-making mechanisms
- **contracting** – options for contracting models for accountable care, including alliance contracting and the ACO contract
- **funding** – the evolution towards population-based payment systems
- **organisational form** – the pros and cons of different organisational forms to deliver an ACO
- **enablers** – key enablers including technology, workforce and how to develop a shared culture.

For a copy of the guide please contact Jamie Foster at **j.foster@hempsons.co.uk**

What is accountable care and what is the difference between an ACO and ACS?

Accountable care is a model which brings together a variety of provider organisations, including primary care, to plan for and meet the care needs for a defined population within a set budget to an agreed level of quality. The difference between an ACS and an ACO is that in the former organisationally separate partners work together to integrate care and develop collective responsibility for population health whereas it is envisaged that ACOs will be single organisations holding single contracts which are responsible for the planning and delivery of the majority of health and care services in an area.

Lessons from an NHS Providers roundtable

We were delighted to host a roundtable discussion about accountable care with senior representatives from a number of NHS provider members this summer. Key points discussed were:

- integration of primary care with other health and care services may not be easy to achieve in the short term. GPs speaking with a united voice is important to engagement of primary care in an accountable care model
- robust decision-making is essential to make sure organisations stick to the decisions they make
- in reaching agreements some organisational altruism is likely to be necessary. Partners need to recognise that each of them may have to give up something for a new way of working to emerge
- local context is everything – the model will inevitably need to be tailored to local geography, population, relationships and other factors
- commissioning and provision are two sides of the same coin. Strategic commissioning must be looking to the long-term
- a new payment and funding model is essential to make accountable care work
- it must be made easier for staff to move around in the system – technology and information sharing are key
- culture still trumps strategy, so having the development of a common culture in mind from the outset is important and it needs to be planned for and implemented.

Schrödinger's consent:

ARB v IVF Hammersmith Limited & R

The doctor-patient relationship relies on mutual trust: to assume that every patient may be dishonest would cast a shadow over a doctor's interaction with his patient. Unfortunately, however, there are rare occasions when patients intentionally mislead healthcare professionals, sometimes with grave consequences. The case of ARB v IVF Hammersmith is a recent example of such an instance. Whilst it may not change the law in relation to consent, it is a salient reminder of the importance of confirming the identity and on-going consent of patients to a course of treatment, particularly in the context of assisted reproduction, but also more widely.

Factual background

The case arose from a sad and complicated family breakdown: by all accounts, ARB and R had a difficult relationship. They attended IVF Hammersmith for fertility treatment in March 2010, resulting in the birth of a son. A number of embryos were left over from this cycle and were cryopreserved at the clinic for future use with the couple's consent. They returned to the clinic together in 2010 for an appointment with a consultant to discuss having a frozen embryo transfer. Thereafter, R underwent certain tests to assess her suitability for further treatment, and ARB signed a number of forms.

R attended all subsequent appointments at the clinic alone. An IVF cycle routinely requires patients to attend a number of appointments for scans and tests, and it is not uncommon for the female partner to attend such appointments alone. Indeed, the Code of Practice for IVF clinics published by the Human Fertilisation and Embryology Authority (the HFEA, the regulator for IVF) specifically envisages that the male partner or non-birth mother may not attend the clinic during his or her partner's cycle.

Unbeknown to the clinic, the couple's relationship deteriorated significantly and R moved out of the family home in July 2010. Neither ARB nor R notified the clinic of the breakdown in their relationship or R's change of address.

In October 2010, R attended the clinic alone for a frozen embryo transfer. She provided the clinic with a 'Consent to Thaw' form, purportedly signed by ARB. The embryologist compared the signature with other examples in the medical records, found it to be comparable, and proceeded with the thawing. The treatment was successful and R became pregnant. She notified ARB of the pregnancy for the first time on 14 February 2011, and gave birth to a daughter in July 2011. ARB notified the clinic of what he alleged was the forgery of his signature on the 'Consent to Thaw' form in January 2013.

Breach of contract

ARB brought a substantial claim against IVF Hammersmith alleging breach of contract on the basis that the clinic had agreed not to thaw or use embryos created with ARB's sperm without his consent. ARB alleged that his signature had been forged, therefore the clinic acted in breach of the agreement by proceeding with R's treatment. ARB sought over £1 million for the costs of raising the unwanted second child. The clinic in turn brought a claim against R for an indemnity on the basis that any liability they incurred was as a result of R's fraudulent misrepresentation.

This complex case was listed for a nine day trial in July 2017 before Mr Justice Robert Jay. He considered, amongst other things, whether ARB's signature had in fact been forged, the implied and express terms of the contract between ARB and the clinic, whether the clinic was in breach of those terms, whether ARB's failure to notify the clinic of the breakdown of the relationship was a contributory fault, the public and legal policy issues relating to a claim for the costs of raising a healthy child (albeit unwanted), and the value of ARB's claim.

Evidence

During the trial, ARB maintained that he signed forms in 2010 without reading them, and accepted in retrospect that they contained incorrect information (particularly about the status of the couple's relationship) and that he would have known more about the proposed treatment if he had read them. He further indicated that he had signed a form to extend the storage of the embryos in September 2010 'to avoid another shouting match', but accepted that the only purpose of the continued storage was for the embryos to be used in treating R. ARB maintained, however, that he knew the embryos could not be used without his express consent.

R denied that she had forged ARB's consent, though accepted that she misrepresented the status of her relationship with ARB and her address. Overall, the judge found that most of R's evidence in the trial was dishonest, favouring ARB's account.

The clinic obtained expert evidence from a hand-writing expert that concluded that it was very likely that the signature on the 'Consent to Thaw' form was a forgery. By subjecting the form to specialised lighting, it was possible to detect traces of graphite, suggesting a pencil tracing which had then been erased. The judge accepted this evidence and concluded that R had indeed forged ARB's signature.

Unusually for a court hearing, where the judge is deemed to be a legal expert capable of interpreting the relevant legislation, two 'regulatory' experts were instructed by the parties to provide evidence about the somewhat idiosyncratic licensing and inspection regime governed by the HFEA. Both experts accepted it was not unusual for the female partner to attend appointments alone, and also that it was common to assume that couples would share information about treatment.

Judgment

The court found that the clinic had not been negligent in proceeding with R's treatment without ARB being present since ARB was at least apparently still being treated together with R. Likewise, the clinic was found not to have been in breach of any duty to take reasonable care in obtaining ARB's consent. The judge found, however, that the clinic was subject to strict liability: it undertook not to proceed without the consent of both parties and, in the absence of ARB's genuine consent, it breached that obligation.

The claim failed, however, as a result of legal policy. Having considered the seminal cases of Macfarlane and Rees regarding claims for the costs of raising healthy children born following failed vasectomy and sterilisation procedures, the judge found that the same principles applied to thwart ARB's claim. He considered in particular the inherent difficulty of measuring the loss, an unwillingness to regard a child as a financial liability, the refusal to off-set benefits of parenthood from financial liabilities, and the moral unacceptability of attempting the exercise. He also noted his difficulty with accepting that a private patient could succeed with such a claim whereas an NHS patient could not.

Although the case arose in unusual and – hopefully – rare circumstances, it serves as a powerful reminder of the importance of ensuring that patients provide informed, enduring consent to treatment, particularly in the context of assisted reproduction. This is particularly important where there are gaps in the treatment process, and where one partner does not regularly attend. Hospitals and clinics that enter into contractual arrangements with patients should also ensure that the terms of those agreements are drafted so as to limit or exclude liability for certain eventualities, particularly in the event of dishonesty.

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James advises a large number of clinics, hospitals, universities and research centres licensed by the Human Tissue Authority (HTA) and the Human Fertilisation and Embryology Authority (HFEA). He also regularly advises in relation to research and development of advanced therapies, including immunotherapy, gene therapy, and gene editing.

Farewell to ET fees, but what next?

Summary

- the judgment of the Supreme Court that employment tribunal fees were unlawful will have significant implications for employers including NHS organisations
- there will be an increase in claims but no one knows at the moment how large the increase will be
- employees who were unable to bring claims because they could not pay the fees are likely to bring claims now in the hope that the tribunals will extend the statutory time limits.

For the last four years, an employee wanting to take a case to an employment tribunal has had to pay a fee of up to £1,200. For many lower paid employees – or where relatively little money was at stake – this fee may have been a deterrent to starting action.

But in July 2017 the Supreme Court ruled that the fees were contrary to the common law right of access to justice – and the Ministry of Justice has since dropped them.

This may encourage more employees to bring claims – the number had dropped by two thirds after fees were introduced – and could mean employees who had chosen not to go to an employment tribunal over the last four years will now try to bring cases, even if they fall outside the statutory time limits (which are within three months minus a day of dismissal in most cases). It is likely that employment tribunals will have to make decisions about these 'out of time' claims on a case by case basis: applicants may need to offer a convincing account of how the fees deterred them making a claim earlier.

For NHS organisations, this may mean a rush of new cases filed over the next few months and potentially some claims from further back. These old claims – if accepted to be heard by tribunals – may be challenging to defend as staff involved may have moved on and memories may have decayed. Good written records of processes followed may be particularly important.

Abolition of fees

In July 2013 tribunal fees were introduced by a fees order made by the then Lord Chancellor. Essentially the Government wanted to raise money and decided to shift part of the cost of the tribunal system from the taxpayers to tribunal users. Furthermore, it was deemed that the fee regime would encourage more settlements and deter weak or vexatious claims.

The fees were paid in two parts; an issue fee which was paid when a claim was filed at the tribunal, and a hearing fee if the case proceeded to a full hearing. For the purpose of calculating the correct fee claims were placed into two types. Type A for was for simpler claims such as claims for unlawful deductions from wages. Type B was for every other type of claim including unfair dismissal claims and discrimination claims. There was a fee to issue a claim (£160 for type A, £250 for type B) and a fee if matters proceeded to a full hearing (£230 for type A, £950 for type B).

Claimants could obtain a reduction or wavier of the fee under the remission system where they satisfied a disposable capital test and a gross monthly income test.

Following the introduction there was a very significant decline (68 per cent) in the number of cases received. However, this reduction may be in part due to introduction of mandatory ACAS early conciliation. From 5 May 2014 all prospective claimants have been required to go through ACAS early conciliation before being able to initiate proceedings in the employment tribunal.

Soon after the introduction of fees a number of legal challenges were launched most notably by UNISON. They brought two judicial review claims. The second claim was rejected by the lower courts but then succeeded at the Supreme Court in July 2017.

UNISON's argument that the system of tribunal fees was contrary to the common law right of access to justice was accepted by the Supreme Court which held that the government's approach to the fees regime had been fundamentally flawed from the start. The government had failed to understand that the right of access to the courts is not just a service to be provided to "users" but a right which is inherent in the rule of law and which benefits not just the individual claimant but society as a whole.

Lord Reed noted a contrast between the level of fees in the tribunal, and the small claims court. He emphasised the importance of the rule of law, and that specific statutory rights granted by Parliament may not be reduced by statutory instrument from a minister. He concluded that fees "*…have resulted in such a substantial and sustained fall in the number of claims being brought that it points to the conclusion that a significant number of people have found the fees unaffordable*".

Baroness Hale held that it was indirectly discriminatory to charge higher fees for type B claims (which included discrimination claims) than type A claims and found the fee regime to be contrary to the Equality Act 2010 as it disproportionately affected women.

The Ministry of Justice took immediate steps to stop charging fees in employment tribunals as a result of the Supreme Court's judgment, and confirmed that it would put in place arrangements to refund those who had paid fees. The government will have to refund millions of pounds to the thousands of people charged for taking claims to tribunals since the introduction of the fee regime.

At the time of writing we have no information about the refund system. It is not yet clear whether claimants will need to apply for refunds or whether the tribunal itself will proactively repay fees paid.

The Supreme Court left open the possibility of the government reintroducing fees on a fairer basis but we would not expect this to happen in the short to medium term.

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Andrew works with health, social care clients and third sector clients and supports them with employment law advice. He has particular expertise in handling concerns about doctors (under the MHPS framework), dealing with discrimination issues, Employment Tribunal claims and TUPE.

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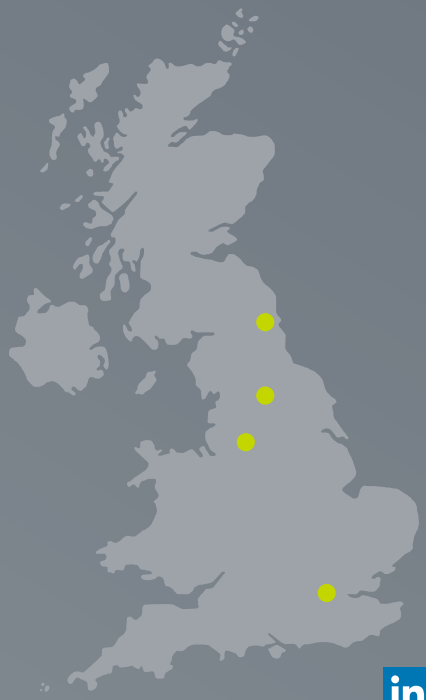

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