As this chapter has shown, such a reform would undoubtedly remove a great deal of the potential for confusion that currently exists.

1 House of Commons Health Committee 'Complaints and Raising Concerns' HC350 (13 January 2015) para 31.

Sir Robert Francis QC chaired the Mid-Staffordshire Hospital Inquiries, is a board member of the CQC and President of the Patients Association.

CHAPTER 3

The UK medical defence organisations and the NHS Litigation Authority

Dr John S F Holden

John Mead

This chapter was written in two parts. The section on medical defence organisations was by John Holden, the section on the NHS Litigation Authority was by John Mead (para **3.96** onwards).

SUMMARY

GENERAL INTRODUCTION

3.1 The first part of this chapter begins in 1858 and traces the establishment, evolution and modern function of the medical defence organisations in the UK. The second part of the chapter begins in 1990 with the introduction of NHS indemnity and describes the establishment and modern function of the NHS Litigation Authority in 1995.

THE UK MEDICAL DEFENCE ORGANISATIONS

Introduction

3.2 The first part of this chapter describes the generic nature and role of a medical defence organisation (MDO) within the UK, illustrated by reference to the three organisations: the Medical Defence Union (MDU), the Medical Protection Society (MPS) and the Medical and Dental Defence Union of Scotland (MDDUS) (nowadays an established UK-wide organisation). The three organisations are fundamentally similar, but the following sections include descriptions of key differences.

3.3 The following account has been aided by reference to the websites of the three MDOs[1] and in particular the respective annual reports for 2012. Otherwise, specific documents have been individually referenced.

1 www.mddus.com; www.themdu.com; www.medicalprotection.org/uk.

3.4 The MDOs find themselves at the hub of modern healthcare for the simple reason that they exist for the benefit of their members, who in turn owe their existence to the patients for whom they care. The sections that follow inevitably refer to a large number of bodies including the General Medical Council (GMC), General Dental Council (GDC) and National Clinical Assessment Service and processes (such as coronial inquests and the NHS complaints process) that are described in detail elsewhere in this book. These paragraphs, therefore, do not duplicate those fuller descriptions, but simply describe the relevant aspects as they impact upon the members of MDOs.

3.5 Dr Robert W Forrest, Convener of the MDDUS (1902–1910) stated:

'No member of the profession, however he may have enjoyed immunity from attack and however confident he may be of the care with which he discharges his duties, can claim to be free from charges and claims made against him. Such claims are made when they are least expected and deserved'[1].

Those sentiments remain true a century later. To facilitate understanding of the nature and purpose of the modern MDOs, the circumstances of their creation are reviewed.

1 See, for a full history, Muir and Bell *A Century of Care – A History of the Medical and Dental Defence Union of Scotland* (MDDUS, 2002).

Historical background

3.6 The Medical Act 1858 was enacted 'to regulate the qualifications of practitioners in medicine and surgery', introducing clarity to the concept of

a legally qualified medical practitioner. The Act established 'The General Council of Medical Education and Registration of the United Kingdom', known then simply as 'The Council'. Registrars were appointed to maintain and publish a register of suitably qualified practitioners. The Council was also charged with publishing a British Pharmacopeia. The benefit to patients was that they could identify registered doctors, and to this day the modern GMC exists fundamentally to register doctors to practise medicine in the UK and to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.

3.7 The Dentists Act 1878 introduced a dental register. Only dentists listed in the dentists' register could use the title 'surgeon dentist' or 'dental surgeon'.

3.8 In 1883 the British Medical Journal reported a charge of manslaughter against two Dulwich practitioners, following the death of a child. The magistrate dismissed the case as vexatious. Unsurprisingly, the case generated anxiety, causing the President of the Royal College of Physicians, Sir William Jenner, to establish a committee to collect subscriptions to assist with the legal expenses incurred by the two doctors. In a further case, Dr David Bradley of Chesterfield was wrongly convicted of assaulting a female patient in his surgery. He served 8 months in prison before receiving a pardon. The committee funds enabled all three doctors to return to practice, but the outrage generated in the medical community following Dr Bradley's wrongful conviction led directly to the establishment of the Medical Defence Union in 1885. Following the resignation of some MDU members, the London and Counties Medical Protection Society (now known simply as the Medical Protection Society) was established in 1892.

3.9 A clinical negligence claim against Dr Murray of Leith, in relation to his management of an infected finger, led to the establishment of the Medical and Dental Defence Union of Scotland in 1902. As the British Dental Journal noted in 1903, the fundamental differences between Scottish and English law and judicial procedures merited, at that time, a purely Scottish defence organisation. The modern MDDUS is, of course, well established as a UK-wide organisation.

3.10 The MDU first admitted dental practitioners in 1948. The MPS subsequently established its own wholly-owned subsidiary Dental Protection Limited, followed by the Dental Defence Union, a specialist division of the MDU, in 1994.

Mutual status

3.11 The Department for Business, Innovation and Skills recognises 'mutual' as an umbrella term for several different ownership models. The defining characteristic of a mutual organisation is that 'the organisation is owned by, and run for, the benefit of its members, who are actively and directly involved in the business – whether its employees, suppliers, or the community or consumers it serves, rather than being owned and controlled

by outside investors'[1]. The MDO mutual model is generally as stated by the MPS:

'We are a mutual organisation, meaning that we are owned by our membership. All subscriptions paid by members are retained by the business; we have no shareholders to answer to, so members' money is invested solely for their benefit'[2].

1 Department for Business, Innovation and Skills *A Guide to Mutual Ownership Models* (November 2011) at p 2.
2 Medical Protection Society *The Right Choice* (2012) at p 4.

3.12 The benefits of membership of the three MDOs, as mutual not-for-profit organisations, are discretionary. Ultimately the extent of assistance is determined by the respective Boards of Management under the individual Memorandum and Articles of Association.

Medical defence organisations and insurance

3.13 The public, lay and health professionals often speak or write loosely, inter-changing the terms 'insurance' and 'indemnity'. The MDOs are not insurance companies and the following account is provided to facilitate a fuller understanding of the evolution and current functioning of the MDOs.

3.14 The Insurance Companies Act 1974 contains no definition of 'contract of insurance'. In *MDU v Department of Trade and Industry*[1], the court considered whether an MDU member against whom a claim was made could require the MDU to consider whether to conduct proceedings on his behalf and provide him with indemnity and whether membership constituted a contract of insurance. The court held that the member did not have a right to have proceedings conducted by the MDU on his behalf or to be given an indemnity and although the member acquired a benefit it did not satisfy the requirements for a contract of insurance[2].

1 [1979] 2 WLR 687.
2 Summary of the case by 3 Verulam Buildings; for further detail see http://www.3vb.com/userfiles/pdfs/Newsletter_Autumn_2008.pdf.

3.15 Although the MPS, as described above, is a mutual company, it established MPS Risk Solutions Limited (an insurance company authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority) as a wholly-owned subsidiary to address the corporate malpractice insurance needs of doctors and other health professionals[1]. In June 2012, MPS Risk Solutions Limited withdrew from the insurance market, to enable MPS to focus on its core business of providing discretionary indemnity. All policies have expired and the main purpose of MPS Risk Solutions Limited now is 'to focus on providing the highest standard of service for claims management, in respect of those incidents that have been notified and accepted under policies that were previously in force'[2].

1 Medical Protection Society *The Right Choice* (2012) at p 14.
2 www.mpsrs.co.uk (2015).

3.16 Soon after the millennium, the MDU introduced a professional insurance indemnity policy (although the MDU was not itself an insurance

company). Although the non-claims assistance to MDU members continued solely under a discretionary model, claims assistance now had contractual and discretionary elements. The policy operated on a claims-made basis. Dr Christine Tomkins, the MDU's Chief Executive, described the inter-relation between the insurance policy and discretionary assistance to the House of Lords European Union Committee in 2008, and the minutes provide a helpful summary of the situation at that time[1]. Although Dr Tomkins was reported as stating 'we believe that doctors should have similar cover if they move provider or cease to practise for whatever reason', the MDU announced in 2013 that from 1 April 2013, as members renewed their membership, they would no longer be issued with an insurance policy, as going forward the full range of member services and benefits would be provided exclusively from MDU funds. The explanation given by Dr Tomkins was that in a 'prevailing economic and regulatory environment where low investment returns are the norm, we (the MDU) believe insurance no longer represents the best value for money for members'.

1 http://www.publications.parliament.uk/pa/ld200809/ldselect/ldeucom/30/08110604.htm.

3.17 Whilst the MDU remains a mutual company owned by its members, MDU Services Ltd (a wholly-owned subsidiary of the MDU) is an insurance intermediary, authorised and regulated by the Financial Conduct Authority (FCA) for insurance mediation and consumer credit activities only.

Discretionary indemnity versus insurance

3.18 The three MDOs are mutual organisations that provide assistance to their members on the basis of 'occurrence', meaning members may seek assistance of the respective MDO so long as they are, or were, a member at the time of the incident in question.

3.19 Occurrence-based indemnity is often cited by MDOs as a defining advantage over the insurance 'claims made' model (which requires an insurance policy to be in place at the time the claim is made) as practitioners leaving an insurance company will need to buy run-off cover, or negotiate purchase of a 'nose-payment' (whereby the new indemnifier may agree to provide retrospective indemnity).

3.20 It is generally postulated by MDOs that the very nature of discretion enables the organisation to extend assistance without being fettered by the inflexibility of an insurance product whose rigidity may not be able to accommodate the complex and rapid changes in clinical practice and society itself. The MDOs do not currently charge an excess or cap cover. Further, MDOs have knowledge and expertise built up over more than a century and provide to their members medico-legal advice and assistance over and beyond simple indemnity for claims in clinical negligence, as described below. Such extended benefits are generally considerably more limited, or non-existent, in the insurance market and if provided would normally attract additional payment.

Demographic aspects

3.21 The MPS describes itself as the world's leading mutual defence organisation, based upon an excess of 280,000 members in more than 40 countries. The main jurisdictions covered, outwith the UK, are Ireland, South Africa, New Zealand, Hong Kong, Singapore, Malaysia, the Caribbean and Bermuda, Kenya and others. The MPS does not permit permanent membership in all countries, most notably the USA and Canada (except to students on electives).

3.22 The MDU describes itself as the leading medical defence organisation in the UK, based on a membership which includes more than half the doctors in the UK. The MDU confines its membership to the UK and Ireland, although short-term indemnity is available for teaching or supervised training purposes except in the USA, Australia, Canada, Bermuda, Israel, Hong Kong, Nigeria or Zimbabwe.

3.23 The MDDUS concentrates on the separate legal jurisdictions that exist within Scotland, England, Wales and Northern Ireland and does not offer indemnity outside these countries. MDDUS, as its name suggests, has its historical roots in Scotland and continues to maintain its preeminent share among Scottish doctors and dentists. Prior to the early 1990s membership was confined to Scottish graduates or those working in Scotland, but in recent years growth is predominantly due to an increase in English members. The 2012 annual report states that over 17 per cent of English GPs are MDDUS members (compared to 9 per cent in 2006), with a total membership in excess of 35,000, more than 50 per cent of whom practise outside Scotland.

3.24 All three MDOs provide worldwide indemnity for Good Samaritan acts. A Good Samaritan act is generally understood as the provision of clinical services, without charge, at an incident arising as an emergency when the member is a bystander, rather than participating within their normal contracted duties or clinical practice. Common examples include attendance at a road traffic accident or a public event, where the practitioner is a spectator.

The requirement for indemnity or insurance

3.25 There are no current express statutory requirements or provisions dealing with professional indemnity arrangements for registered medical practitioners or those seeking registration with the GMC. Indeed, there is no compulsory statutory requirement for any doctor to be a member of an MDO or even to have professional indemnity or insurance arrangements[1]. However, since 1997, the GMC in its core guidance *Good Medical Practice* has placed a professional duty on doctors to have such arrangements in place. Paragraph 63 states that registered doctors must make sure that they have adequate insurance or indemnity cover so that their patients will not be disadvantaged if they make a claim about the clinical care a practitioner has provided in the UK[2]. Therefore, practitioners in the UK whose work is indemnified by their employer or covered by NHS need not belong to an MDO to satisfy this requirement. However, as MDOs regularly point out in

their educational and marketing activities, the wise practitioner will seek the wider benefits of an MDO, which are described below.

1 http://www.gmc-uk.org/doctors/information_for_doctors/14195.asp.
2 General Medical Council *Good Medical Practice* (2013), para 63.

3.26 Standard 1.8 of the GDC's publication *Standards for the Dental Team* states that 'You must have appropriate arrangements in place for patients to seek compensation if they suffer harm'. The only types of cover that the GDC recognises are:

- dental defence organisation membership, either personally or via an employer's membership;
- professional indemnity insurance held by the practitioner or the employer;
- NHS/Crown indemnity.

3.27 The GDC does not require dentists to have their own policy and/or defence organisation membership, but stresses the merits of defence organisation membership in terms of the additional support and advice, particularly during GDC fitness to practise investigations[1].

1 http://www.gdc-uk.org/Dentalprofessionals/Standards/Documents/Guidance%20on%20indemnity%20(Sept%202013).pdf.

Membership

3.28 Registered practitioners (and in the case of medical practitioners, holders of a licence to practise) may apply for membership. The applicant will usually be asked to agree to disclosure of a letter of good standing from any previous MDO, which will be considered, in conjunction with the applicant's declaration of any previous claims, complaints, regulatory, disciplinary or relevant criminal matters, as part of an underwriting process.

Subscriptions

3.29 General practitioners contracted to provide NHS services are not generally covered by NHS indemnity. GP subscriptions are normally set according to the number of sessions the GP works. Junior hospital doctors will normally pay a subscription according to their stage of training. Compared to the GP rate, the subscription will normally be relatively modest, as the NHS normally indemnifies such doctors against claims, so the risks borne by the MDO are those that are unrelated to clinical negligence. The subscription normally allows junior doctors a modest private income, such as may be generated from signing certificates and incidental documents.

3.30 Consultants pay subscriptions that are actuarially determined according to their speciality and private non-indemnified earnings, taking into account the historical claims experience of the organisation for the speciality. Consultants whose work is exclusively NHS indemnified will usually pay a basic subscription that provides the non-claims related benefits of membership, (although in practice the basic subscription may permit and indemnify a modest private income).

3.31 Since 1 April 2013, Local Education and Training Boards (LETBs) have taken on the functions of Postgraduate Medical Deaneries in England. Some of the 13 LETBs now arrange block indemnity for GP speciality trainees (GPST) in England directly with an MDO, after considering tenders. The MDO indemnifies the individual GPST against claims arising from the GP placement. NHS indemnity is retained during hospital placements but the individual GPSTs usually continue to receive the additional benefits of membership of the relevant MDO.

Education and marketing

3.32 MDOs increasingly provide educational material to their members. The more traditional means of a journal (delivered by post), lectures, seminars and workshops persist and retain a useful function, but are increasingly supplemented by online resources in the form of advice sheets, articles, e-newsletters and journals, videos and podcasts.

3.33 Education is more than a simple marketing strategy. Practitioners who are aware of the potential jeopardies that they potentially face when working (be it a claim, complaint, coroner's inquest, criminal allegation, GMC investigation or disciplinary investigation) are wiser, especially if they are more mindful of simple methods to minimise the risk of criticism; whether by keeping better records, making appropriate use of a chaperone, or better communication. Consequently, the practitioner is not only more informed but also poses less risk to the patient, who in turn is safer, more reassured and content, and less likely to express dissatisfaction. As a result practitioners will need less formal assistance from their MDOs, whose financial reserves will have less demands put upon them, ultimately constraining the future subscription members will need to pay. Further, the public purse benefits whenever a formal investigation is prevented. Therefore, an MDO's education program is good for the patient and society as well as the member and the MDO.

3.34 Practitioners are more likely to change MDO than they were a generation ago, but brand loyalty is strong. The MDOs are commercial competitors and seek to recruit both neophyte and established practitioners. The medical and dental schools are key sources of recruits. Students may join one or all MDOs but at qualification will harden their choice to a single MDO. Increasingly, as described above, MDOs compete to recruit new members in bulk by tendering for GPST members via the LETBs. The challenge is then to retain the member when they enter general practice as a salaried practitioner or partner – a challenge hardened by the possibility that the partnership may have existing group membership of another MDO.

24-hour advisory helpline

3.35 A member's first contact with their MDO is usually via the telephone advice line. MDOs recognise the value their members attach to this resource. The vast majority of contacts occur during the working day but the availability of 24-hour medico-legal advice reassures members. The initial contact is normally with a medico-legal adviser (MLA), or dento-legal

adviser (DLA), who may be supported by colleagues with a background in nursing or practice management. Whilst many calls are concluded with verbal advice, the advice line is the portal for most new written files. The range of advice and assistance is described below.

Medico-legal advisers and dento-legal advisers

3.36 MLAs are registered medical practitioners who are expected to participate in the GMC's re-validation process and to retain a licence to practise as MLAs. Most have previous clinical experience as a general practitioner or a hospital-based specialist, holding postgraduate qualifications such as Membership of the Royal College of General Practitioners or a specialist college such as the Royal College of Surgeons or Royal College of Physicians and increasingly, higher clinical doctorate degrees. Most MLAs already possess, or acquire early in their medico-legal career, an undergraduate or postgraduate legal degree. Increasingly, MLAs have also completed vocational legal training, and a few have also practised as a solicitor or barrister. Many MLAs have a higher degree in medical law. Increasingly, MLAs are Members (or Fellows) of the Faculty of Forensic and Legal Medicine of the Royal College of Physicians (FFLM), that was inaugurated in 2006.

3.37 DLAs have a similar background to MLAs, albeit with clinical experience in dentistry rather than medicine. DLAs often continue to undertake some clinical work. Currently, DLAs are not eligible to become Members of the FFLM, but may apply to be examined for the Faculty's newly introduced Diploma of Legal Medicine.

The role of the medico-legal adviser and dento-legal adviser

3.38 MLAs and DLAs participate in the telephone advice rota, as above, but the majority of an MLA's time is spent on a range of written files, as described below.

3.39 A small number of members become very distressed during GMC or disciplinary investigations in particular. The MLA is well placed to support the member and ensure that the member is consulting their GP and obtaining occupational health guidance and by flagging up specific agencies such as the BMA's 'Doctors for Doctors' service[1].

1 http://bma.org.uk/practical-support-at-work/doctors-well-being/about-doctors-for-doctors.

3.40 The role of the adviser in relation to claims files varies across the three MDOs. Some advisers work exclusively in non-claims related work, alongside medical or dental colleagues who are committed entirely to claims. Other advisers have a dual role, working in conjunction with claims handlers. All advisers work closely with solicitors (whose role is described below).

3.41 Advisers participate in educational activities across the full spectrum, from medical and dental students to general practitioners and specialists, which include workshops, seminars, formal lectures and specialist

conventions, often with support from marketing colleagues. Advisers also contribute to the individual MDO's own publications, including journals, newsletters and press releases, and externally to the medical press. Occasionally advisers will be interviewed on radio or television in relation to topical medico-legal matters.

With experience and seniority advisers may also participate in additional roles such as underwriting, risk-management and liaison with external agencies.

Legal services

3.42 Legal services are a major expense but play a key role within the wider function of an MDO. In recent years MDOs have developed in-house legal divisions. The major saving for MDOs is VAT. However, the number, flow and complexity of cases cannot be absolutely predicted. Consequently, the MDOs require the assistance of external specialist legal firms, negotiating rates within a service level agreement. In-house and external solicitors will instruct barristers from specialist chambers, where appropriate.

Assistance to members

3.43 The need for medico-legal advice grows year on year. In 2012, the MDDUS advisory team handled 5 per cent more member contacts (telephone, email and letters) than the previous year, continuing a seven-year rise.

3.44 Members may seek assistance with a variety of matters. The fundamental requirements are that the practitioner is a member of the relevant MDO at the time of the incident in question and that the nature of the assistance falls within the remit of the MDO.

3.45 The MDOs publish indicative membership guides to inform members of what is normally included and not included in their membership. The key element is that the incident should arise from the *bona fide* practice of clinical medicine, although ultimately all assistance is at the discretion of the individual board of management.

3.46 Assistance to members is broadly 'non-claims' or 'claims' (although of course many non-claims matters have the potential to evolve into a claim). 'Non-claims' matters are sub-divided as follows. The distinctions are arbitrary as they may overlap, morph or evolve into more than one category.

Non-claims assistance

Advice

3.47 Many telephone requests for advice are straightforward and are closed at the end of the call. Such calls include advice on disclosure of records, consent and confidentiality. Some scenarios are complex and challenging and may generate a written file, allowing time for considered advice to be given

and, where appropriate, a formal legal opinion to be sought. The advice line is the main initial portal for the following specific categories of assistance.

Crime

3.48 Crime is an uncommon reason for members to contact an MDO, but criminal allegations have considerable personal impact upon a medical or dental practitioner and the additional potential to generate disciplinary and regulatory processes.

3.49 The most common criminal scenarios that members face are unrelated to their clinical practice – drink-driving, altercations in night-clubs and domestic scuffles – and would not normally attract direct assistance from an MDO. However, the adviser has the opportunity to ensure members know when they are obliged to inform the GMC[1] (and other bodies such as the NHS England Local Area Team, in relation to the Performers List Regulations). This opportunity is significant in terms of damage limitation, as the police have historically informed the GMC when a practitioner is charged according to an agreement between the GMC and the Association of Chief Police Officers[2]. This meant that a failure to inform the GMC proactively risked an investigation and potential criticism by the GMC both for the incident itself and the failure to disclose. The Home Office is currently reviewing the circumstances in which the police share information with regulatory bodies at the early stages of a criminal investigation in England, Wales and Northern Ireland, as described in the GMC strategy and policy circular, April 2014[3].

1 http://www.gmc-uk.org/guidance/ethical_guidance/21184.asp.
2 http://www.cps.gov.uk/legal/assets/uploads/files/mou.pdf.
3 http://www.gmc-uk.org/16___The_Home_Office_review_of_police_disclosure_of_pre_conviction_information_about_doctors.pdf_56433195.pdf.

3.50 Individual MDOs exercise discretion as to whether a member is assisted with a GMC investigation subsequent to a non-clinically related criminal matter.

3.51 Criminal investigations may arise from allegations of inappropriate sexual contact with a patient in a clinical context; mainly involving a male doctor and a female patient, but not exclusively. Such allegations are serious matters for a medical or dental practitioner, who if found guilty are likely to receive a custodial sentence.

3.52 Some allegations are vexatious and many arise from simple misunderstandings, such as a failure to explain why a particular examination is required. Miscommunication is not confined to chest, breast and pelvic examination; even fundoscopy, in a darkened room, with close proximity between a doctor and patient can alarm a vulnerable patient. Clear explanations, obtaining consent, recording the history and need for the examination and the examination itself are not only good practice but also reduce the risk of unwarranted criticism. In particular the adoption of, and adherence to, a chaperone policy in line with the GMC's guidance on intimate examinations and chaperones is paramount[1].

1 http://www.gmc-uk.org/guidance/ethical_guidance/21168.asp.

CHAPTER 14

Damages awards: lump sums and periodical payments

Jennifer Stone

SUMMARY

INTRODUCTION

14.1 This chapter in the last edition of this book commenced by introducing what was at the time, the *totally new legislative framework*, in relation to future losses created by the statutory periodical payments regime. That regime

14.10 The lump sum and its associated problems were outlined by Lord Scarman over 30 years ago in the case of *Lim Poh Choo v Camden and Islington Area Health Authority*[1], when he stated:

'The course of litigation illustrates, with devastating clarity, the insuperable problems implicit in a system of compensation for personal injuries which (unless the parties agree otherwise) can yield only a lump sum assessed by the court at the time of Judgment. Sooner or later, and too often later rather than sooner, if the parties do not settle, a court (once liability is admitted or proved) has to make an award of damages. The award, which covers past, present and future injury and loss, must, under our law, be a lump sum assessed at the conclusion of the legal process. The award is final: it is not susceptible to review as the future unfolds, substituting fact for estimate. Knowledge of the future being denied to mankind, so much of the award as is to be attributed to future loss and suffering (in many cases the major part of the award) will almost surely be wrong. There is only one certainty: the future will prove the award to be either too high or too low'.

1 [1980] AC 174.

14.11 Structured settlements, the predecessor to periodical payments, arose in the UK in the late-1980s. The early structured settlements were Byzantine in their bureaucracy, and were seen to restrict the wider use of such settlements. Compensation for personal injury has come a long way since then.

14.12 The first structured settlement in the UK was implemented in 1989 in the case of *Kelly v Dawes*[1]. Since then, a number of initiatives and legislative changes have occurred, leading us to the current system whereby periodical payments can be imposed by the court. It is perhaps worth outlining a brief history of the legislative attempts to move away from the lump sum.

1 (1990) Times, 27 September, [1990] CLY 1724.

14.13 The Law Commission published Consultation Paper 125 in October 1992 and, having received wide-ranging responses, recommended many changes to the structured settlement system in Paper No 224 published in September 1994. Having considered the responses to the consultation paper, the Law Commission stopped short of giving the court the power to impose structured settlements on one or other of the involved parties.

14.14 A number of legislative changes followed. First came the introduction of the Finance Act 1995, which gave provision in the Income and Corporation Taxes Act 1988 to secure the tax-free nature of structured settlements. It enabled defendant insurers to purchase structured settlement annuities on behalf of claimants. An annuity is an income stream purchased in exchange for a capital sum. The annuity providers made tax-free payments direct to the claimant. However, the Finance Act 1995 did not cover all possible circumstances in which structured settlements might arise, hence further provision was made in the Finance Act 1996.

14.15 Next came the Damages Act (DA) 1996, which was intended to establish structured settlements firmly in the legislation as the safest form of 'investment' in the UK. It led to the provision of 100 per cent protection of structured settlement payments under what was then the Policyholders Protection Act.

As a result of the Finance Acts 1995 and 1996, and the DA 1996, the process for establishing structured settlements in suitable cases was greatly simplified, and the security of payment was guaranteed in the event that the annuity provider (usually an insurance company) ceased to exist.

14.16 Following this push to establish support for structured settlements in the legislation, take-up remained surprisingly low. The perceived major flaw in the system was that structured settlements could only be implemented by consent between the parties. Despite the ground-swell of support in many quarters, both claimant and defendant practitioners often viewed structured settlements with suspicion.

Arguably, without suitable advice on the benefits of structured settlements, the natural preference of claimants was in favour of a lump sum award. Time and again structured settlements were not considered in cases that were eminently suitable for their inclusion within damages awards.

14.17 *Wells v Wells*[1] was a landmark case in the history of personal injury. Lord Steyn outlined in his judgment a potential resolution to the problems:

'The solution is relatively straightforward. The court ought to be given the power of its own motion to make an award for periodical payments rather than a lump sum in appropriate cases. Such a power is perfectly consistent with the principle of full compensation for pecuniary loss. Except perhaps for the distaste of personal injury lawyers for a change to a familiar system, I can think of no substantial argument to the contrary, but the judges cannot make the change. Only Parliament can solve the problem'.

1 [1999] AC 345.

14.18 In March 2000, the Lord Chancellor published the consultation paper 'Damages: The Discount Rate and Alternatives to Lump Sum Payments'. Other initiatives followed, including Structured Settlements: Report of the Master of the Rolls' Working Party.

14.19 The Master of the Rolls' Working Party's report on structured settlements was published in August 2002. The purpose of the Working Party was to provide comprehensive, balanced and informed views. It was chaired by Brian Langstaff QC (as he then was), and comprised representatives from the relevant sectors. The Working Party's view on lump sums was as follows:

'The one thing that is certain about a once and for all lump sum award in respect of future loss is that it will inevitably either over-compensate or under-compensate. This will happen particularly where the claimant survives beyond the life expectancy estimated at the date of trial, or alternatively dies earlier. It will frequently be the case in practice that there is over-compensation in six figure sums, or, correspondingly, that a combination of increased life expectancy, the cost of care, and (it may be) the cost of new but necessary medical treatments is such that the sum needed exceeds anything that might have been awarded at the date of trial'.

They went on to state:

'Further, the method of compensation on a "once and for all" basis is most frequently made by the multiplication of the annual loss, assessed at the time of the award, by a multiplier which is derived from assumptions as to investment performance (as we have pointed out above), which may be vulnerable to future movements in interest

rates and which assumes that the cost of provision of services and the specialised needs that the seriously injured may require will rise in accordance with the RPI rather than the National Average Earnings Index, or at some other rate'.

They concluded:

'Accordingly, we prefer a system that is better able to meet future needs as and when they arise. Such a system may also have its defects – as we shall go on to point out – but we believe the advantages outweigh them'.

14.20 The outcome from the Working Party was the implementation of CPR Practice Direction 40(c) relating to structured settlements, whereby cases with future losses in excess of £500,000 required consideration as to whether a lump sum or structured settlement was a more appropriate form of award. The Practice Direction related only to minors or patients (now protected parties/beneficiaries), and was subject to the DA 1996, hence the consensual basis remained. That said, it represented a sensible step in the right direction, and required the parties in prescribed cases to obtain proper advice.

14.21 This was quickly overtaken by the result of the Lord Chancellor's further Consultation Paper *Damages for Future Loss: Giving the Courts the Power to Order Periodical Payments for Future Loss and Care Costs in Personal Injury Cases*. This Consultation Paper concluded as follows:

'That in most circumstances periodical payments are, in principle, the more appropriate means for paying compensation for significant future financial loss. Periodical Payments better reflect the purpose of compensation, which is to restore the claimant's prior position. They also place the risks associated with life expectancy and investment on defendants rather than claimants'.

14.22 The outcome of this consultation was the Courts Act 2003, ss 100–101, which provides the courts with the power to impose periodical payments on the parties.

The tax-free nature of periodical payments, whether provided by a self-funding body or by the purchase of an annuity, is enshrined in the Income Tax (Trading and Other Income) Act 2005, ss 731–733.

Courts Act 2003

14.23 Consensual structured settlements were replaced on 1 April 2005 by periodical payments.

On that date the provisions of the Courts Act 2003 relating to payment of damages for future pecuniary loss came into force. The courts now have the power to order those losses to be paid periodically, whether wholly or in part, if that approach is found to be in the best interests of the claimant.

14.24 The new legislation amended the DA 1996 and significant amendments have been made to the Civil Procedure Rules 1998, in particular to Parts 36 and 41. The rule changes are supplemented by new provisions in their respective practice directions.

14.25 Practice Direction 40(c) relating to structured settlements was swept away. There is now no lower limit to the value of a claim where periodical payments may be appropriate. That limit used to be set at £500,000 in terms of future loss under the structured settlements practice direction. Cases of maximum severity will always fall to be considered, but claims of much lesser value now come within scope. What, for example, of the unsophisticated claimant with modest earnings loss? That type of individual may be best compensated by regular income, thus avoiding worries over management or, worse still, early dissipation of a lump sum.

14.26 The DCA's paper 'Guidance on Periodical Payments', issued shortly after the new regime came into effect, was indicative of a *fundamentalist* approach, based on a *bottom up* assessment of the claimant's needs. In theory this means that the order for periodical payments provides for the claimant to be paid the appropriate amounts for his need (usually life), escalating in line with RPI unless the court orders otherwise. It follows that there is no need for speculative estimates or extended disputes about life expectancy, as payments will be based on the claimant's annual needs and will be payable as long as necessary.

14.27 An example of this would be a child with cerebral palsy aged seven with a life expectancy to age 45 according to the defendant's expert, and to age according to the claimant's. The care and case management costs are agreed to increase in cost at the age of 19 from £35,000 per annum to £95,000 per annum. Under the lump sum route, life expectancy would need to be agreed or adjudicated, in order that an appropriate lump sum is paid. With periodical payments, once the multiplicands are agreed or the subject of judicial finding, the idea would simply be to pay those annual amounts for the lifetime of the individual.

14.28 Many years into the regime, it is widely accepted amongst experienced practitioners that it is necessary still to calculate the lump sum in each case. That way, it is possible to evaluate offers inclusive of periodical payments made during negotiation with reasonable accuracy. The multiplier/multiplicand route still holds great weight, and can be used as a yardstick in settlement negotiations.

14.29 On reflection, following decided cases and also a lack of development of an annuity market, some of the DCA guidance has been shown to be misguided. For example, the implementation of the periodical payments regime coincided with the withdrawal from market of the two insurance companies providing appropriate annuities.

Although a new annuity provider entered the market, the cost of its RPI-linked annuities was usually far in excess of the lump sum equivalent award, hence that approach was most unattractive to defendants. Further, the indexation litigation (of which much more below) rendered RPI-linked annuities effectively redundant. The annuity market in relation to periodical payments has not recovered, save for some preliminary interest by a conglomerate of interested insurers.

There are other issues with periodical payments that neither the pre-legislative consultations nor the DCA guidance identified, which have implications for clinical negligence practitioners, and which are explored later in this chapter.

PERIODICAL PAYMENTS – THE LEGISLATION

CPR Part 41 and CPR PD 41B

14.30 CPR Part 41 relates to the court's powers under the DA 1996, s 2(1) to order that *all or part* of a personal injury damages award is to take the form of periodical payments. Early consideration of periodical payments by the parties and the court is prescribed by the broadly drafted CPR 41.5–41.7:

41.5 Statement of Case

(1) In a claim for damages for personal injury, each party in its statement of case may state whether it considers periodical payments or a lump sum is the more appropriate form for all or part of an award of damages and where such statement is given must provide relevant particulars of the circumstances which are relied on.

(2) Where a statement under paragraph (1) is not given, the court may order a party to make such a statement.

(3) Where the court considers that a statement of case contains insufficient particulars under paragraph (1), the court may order a party to provide such further particulars as it considers appropriate.

Court's Indication to the Parties

41.6 The court shall consider and indicate to the parties as soon as practicable whether periodical payments or a lump sum is likely to be the more appropriate form for all or part of an award of damages.

Factors to be taken into account

41.7 When considering:

(a) its indication as to whether periodical payments or a lump sum is likely to be the more appropriate form for all or part of an award of damages under rule 41.6; or
(b) whether to make an order under section 2(1)(a) of the 1996 Act

The court shall have regard to all the circumstances of the case and in particular the form of award which best meets the claimant's needs, having regard to the factors set out in Practice Direction 41B'.

Practice Direction 41B states as follows:

'Factors to be taken into Account (Rule 41.7)

1. The factors which the court shall have regard to under rule 41.7 include:

(1) the scale of the annual payments taking into account any deduction for contributory negligence;

(2) the form of award preferred by the claimant including:

(a) the reasons for the claimant's preference; and
(b) the nature of any financial advice received by the claimant when considering the form of award; and

(3) the form of award preferred by the defendant including the reasons for the defendant's preference'.

14.31 For the parties and the court, such early consideration is not an unsophisticated exercise. Statements of case should be drafted on the basis of the parties' reasoned preferences being to hand. From the claimant's perspective, Practice Direction 41B anticipates the availability of expert financial advice. It may be difficult for the legal team to advise the claimant without such input. Overall, there must be sufficient information to allow the court to indicate the most appropriate form of damages, whether that is a lump sum, periodical payments, or a mixture of both. If the required information is unavailable at that early stage, it would be wise to delay taking expert advice.

In spite of the above, in practice, periodical payments have been firmly in the territory of the cases of highest value. How periodical payments fit within an award of damages can usually only properly be considered once quantum investigations are complete and a schedule of loss is to hand.

14.32 Contributory negligence and its effect on the form of award is specifically dealt with by Practice Direction 41B. Presumably, the similar effect of litigation risk discount falls to be considered accordingly. Some practitioners still take the view that a discounted award is best paid by way of lump sum, so as to be as flexible as possible in meeting the claimant's needs.

This is not always the case, however, as year-on-year tax-free payments can be of great benefit, particularly where the effects of the compromise may be compounded by uncertain life expectancy and an inappropriate discount rate.

14.33 The regime also applies to circumstances where the court considers that part of the award should continue after the claimant's death. CPR 41.8(2) states:

'Where the court orders that any part of the award shall continue after the claimant's death, for the benefit of the claimant's dependants, the order must also specify the relevant amount and duration of the payments and how each payment is to be made during the year and at what intervals'.

14.34 Practice Direction 41B explains that this applies in situations where a dependant would have had a claim under the Fatal Accidents Act 1976 if the claimant had died at the time of the accident. The DCA guidance notes provide the example of a court ordering damages for care costs that last for the claimant's lifetime *and* part of the damages for future loss of earnings that should be paid after the claimant's death, until his child has reached the age of 18. An important factor that the court will have to take into account is that awards pursuant to CPR 41.8(2), and paid periodically after the claimant's death, will not be tax free, as the tax exemption applies only to payments in the hands of the claimant or someone receiving payments on behalf of the claimant. It is likely that very few awards have been made on this basis.

14.35 Overall, however, expert financial advice can help clarify the merits of the options available. The claimant will have had the benefit of being advised on a risk-free alternative to the lump sum settlement. So often in the

recent past, consideration of a structured settlement or periodical payments very late in the claim (and to the surprise of the claimant) led to rejection of what might have been a more appropriate settlement.

CPR Part 36 and CPR PD 36A

14.36 Whether claimant or defendant, formulating, evaluating or clarifying an offer under CPR 36.5, it is likely that some expert financial input will be necessary.

Although the pure lump sum payment is preserved, Part 36 offers can be very sophisticated. It is provided for in the rule that offers may be made on the basis of a smaller lump sum in conjunction with periodical payments. That accompanying lump sum would usually comprise general damages and past losses, but may be supplemented by capitalised heads of future loss.

14.37 The provisions relating to lump sums accompanying an offer of periodical payments are straightforward and provide for flexibility, whether the defendant's offer to pay or the claimant's to accept. The claimant or defendant *may* state how the lump sum is constructed. There may be capitalised heads of future loss in addition to general damages and past losses.

14.38 As regards the periodical payments element of an offer from either side, CPR 36.5(4) requires considerable detail. Duration and amount of payments must be specified. Payments relating to care and other annual lifelong needs must be shown separately to loss of income. Payments for renewable capital items such as vehicles or equipment must also be distinguished from other types of periodical payments. Claimants may only accept the whole of the defendant's offer and cannot accept the lump sum leaving the periodical payments to be decided at a later stage.

14.39 The possible permutations under CPR Part 36 are manifold. Costs therefore will inevitably be more complex. With such a mix and match of periodical payments and lump sums, the parties may call on the help of a financial expert, but what of the judge at trial? The Rules Committee takes the simple view that the trial judge would have the benefit of knowledge of the substantive proceedings so would be best placed to deal with costs issues.

14.40 After almost a decade of the statutory periodical payments regime, practical experience has shown that Part 36 offers have not caused too much by way of difficulty. It is uncommon to find offers made on a lump sum basis, particularly where periodical payments would be the normal approach to settlement. For example, a claim based on full liability, in relation to a claimant with lifelong needs on account of birth injury – in those circumstances, the court would be unlikely to approve a lump sum award. Generally speaking, following the indexation cases, the court would normally expect settlements to be inclusive of periodical payments, where the claimant is a minor or a protected party.

14.41 Lump sum awards can be appropriate in certain cases, for example, where there is a very significant reduction on account of liability, but expert financial advice would usually form an important part of the Approval bundle.

Variation of periodical payments

14.42 The Damages (Variation of Periodical Payments) Order 2005[1], sets out how the periodical payment regime fits with provisional damages. *Variation* applies only to claims issued post-1 April 2005. As with provisional damages, variation is restricted in its use. A low take-up rate was identified in Parliamentary debate during the genesis of the legislation. Nevertheless, the court has the power pursuant to article 2 of the Order to make variable orders:

'If there is proved or admitted to be a chance that at some definite or indefinite time in the future the claimant will:

(a) as a result of the act or omission which gave rise to the cause of action, develop some serious disease or suffer some serious deterioration, or

(b) enjoy some significant improvement, in his physical or mental condition, where that condition had been adversely affected as a result of that act or omission.

The court may, on the application of a party, with the agreement of all the parties, or of its own initiative, provide in an order for periodical payments that it may be varied'.

1 SI 2005/841.

14.43 Variation differs from provisional damages in that the potentially improving claimant comes within scope. Although improvers will be few and far between, some may in fact end up with increased periodical payments: what of the bedridden claimant whose improvement brings some mobility? There may well be increased care and equipment costs to maximise that mobility.

Experience of the periodical payments regime has illustrated that the ongoing costs of a deputy have come under scrutiny in this regard. The overall approach to this head of loss has become more sophisticated over recent years, resulting in much increased claims. Defendants have sought, in cases where there is a chance that the claimant's capacity might return, to cater for that eventuality, by way of medical reviews from time to time. In such cases, there is the possibility that periodical payments might vary by ceasing altogether.

14.44 It is important to distinguish variation from increases or decreases in periodical payments as provided for in CPR 41.8(3). Variation relates to a *chance* of change in *medical condition*, as opposed to changes in condition or circumstances that are agreed between the parties or the subject of a judicial finding.

Reasonable security

14.45 Under the DA 1996, s 2(3) the court will order or approve a periodical payments order only if it is satisfied that continuity of payment under the order is *reasonably secure*.

14.46 The definition of *reasonably secure* is found at the DA 1996, s 2(4)[1].

'2(4) For the purpose of subsection (3) the continuity of payment under an order is reasonably secure if:

(a) it is protected by a guarantee given under section 6 of the Schedule to this Act;
(b) it is protected by a scheme under section 213 of the Financial Services and Markets Act 2000 (compensation) (whether or not as modified by section 4 of this Act); or
(c) the source of payment is a government or health service body'.

1 As substituted by the Courts Act 2003, s 100(1).

14.47 The DA 1996, s 2(4)(c) is clarified in the Damages (Government and Health Service Bodies) Order 2005[1]. Designation under the Order removes the need for a ministerial guarantee to be given under the DA 1996, s 2(4)(a).

1 SI 2005/474.

14.48 The DA 1996, s 2(4)(c) should have been simple to apply, but there were difficulties, which have since been resolved. During late 2005, the two cases of *YM* and *Kanu*[1] ran into troubled waters. The defendant NHS Trust, which had converted to Foundation status, was not covered by the NHS Residual Liabilities Act 1996. Such a trust can become insolvent and, as the provider of periodical payments, the case could not proceed to approval until the security issue had been resolved.

1 [2006] EWHC 820 (QB).

14.49 The position of Foundation Trusts in relation to periodical payments alerted legal teams to wider issues. What would result if an NHS Trust already funding periodical payments, converted to Foundation status? Most trusts were expected to follow that route, and since then, the Health and Social Care Act 2011 stated an intention for all hospitals to be part of a Foundation Trust, or a Foundation Trust in its own right by April 2014. As at May 2014, 147 Foundation Trusts were in existence.

14.50 In *YM* and *Kanu*, the Secretary of State for Health was made a party to the action by the judge. In addition to the ministerial guarantee that can underpin periodical payments, the application of the NHS (Residual Liabilities Act) 1996, in relation to Foundation Trusts required clarification. Section 1 of that Act states:

'1. (1) If a National Health Service trust, a Health Authority or a Special Health Authority ceases to exist, the Secretary of State must exercise his statutory powers to transfer property, rights and liabilities of the body so as to secure that all of its liabilities are dealt with'.

14.51 *YM* was approved by Mr Justice Forbes on 30 January 2006. A model order was produced to deal with the resulting terms of settlement. Various scenarios were considered by the court. First, should a foundation trust become insolvent, it was suggested in argument that the Department of Health would be unlikely to turn its back on a failing Trust and should, therefore, put the National Health Service Litigation Authority (NHSLA) in funds. That authority should consequently meet any remaining liability under a periodical payments order. The NHSLA would be named in the order as source of payment, for the purposes of security, but would not be a party to the action. This is not to be confused with a DA 1996, s 2(4)(a) *ministerial guarantee*. Such a guarantee has not as yet been given, apparently because no guidelines exist as to how one should be made.

14.52 Second, the NHS (Residual Liabilities) Act 1996 covers present NHS Trusts. On conversion to Foundation status, the Trust would enter into an agreement with the NHSLA as regards cover in the event of insolvency. A lump sum would be payable to the NHSLA should the Foundation Trust leave the Clinical Negligence Scheme for Trusts (CNST[1]). The NHSLA would then administer and pay outstanding periodical payment order liabilities. Existing periodical payment or structured settlement liabilities are also covered by one or other of the above procedures.

1 The Clinical Negligence Scheme for Trusts handles all clinical negligence claims against member NHS bodies where the incident in question took place on or after 1 April 1995 (or when the body joined the scheme, if that is later). Although membership of the scheme is voluntary, all NHS Trusts, (including Foundation Trusts) and Primary Care Trusts (PCTs) in England currently belong to the scheme (www.nhsla.co.uk).

14.53 Aside from NHSLA cases, where the security issue has been resolved, problems remain as regards indemnifying bodies such as the Medical Defence Union and the Medical Protection Society. Therefore the areas of general practitioner negligence and that relating to the growth area of private medicine, cannot presently be considered automatically secure for the purposes of s 2(3).

14.54 The Medical Defence Union, although an indemnifying body, operated an insurance-based scheme until 1 April 2013. Claims reported before that date would be dealt with under the terms of the agency agreement made with the insurers involved (SCOR UK Company Ltd and International Insurance Company of Hannover). Both insurers are regulated by the Financial Conduct Authority, hence are secure in terms of the DA 1996, s 2(4)(b).

In other words, should the relevant insurer become insolvent and default on its liability under a periodical payments order, the Financial Services Compensation Scheme would meet that ongoing liability in full in its stead.

The insurance-based scheme will no doubt continue to feature over the next few years in relation to cases initiated before April 2013. After that date claims will be dealt with on the basis of discretionary indemnity from the Medical Defence Union's own resources.

14.55 The insurance scheme requires further scrutiny, due to the applicable level of indemnity, set at £10 million. At first glance that appears more than sufficient to meet most high-value claims in this field. However, periodical payments paid over a long period and proofed against inflation by an earnings-related measure, might reach an accumulative total greater than the indemnity. If that were the case, payments would cease once the indemnity was exhausted. It would be difficult for the court to be satisfied of the continuity of payments being reasonably secure in such circumstances. The test, however, is one of reasonableness, and using reasonable assumptions as to likely earnings inflation and life expectancy, it is possible to provide forecasts to assist the court. If sufficient headroom between the possible accumulative total and the indemnity is the result, the court may be able to approve the periodical payments order. A further point to bear in mind is that the lump sum that would accompany periodical payments and, in addition, both sides' legal costs would need to be deducted from the indemnity as a starting point. The net indemnity for the purposes of periodical payments would therefore be substantially less than £10 million.

14.56 Now that the insurance scheme is no more, the position as regards security in the sense of the DA 1996, s 2(3) is far from clear, as the Medical Defence Union will be meeting all claims notified post-1 April 2013 from its own resources on the basis of discretionary indemnity. In the guidance issued by the Department for Constitutional Affairs (DCA) at the outset of the periodical payments regime, para 36 states as follows:

'Section 2(4) does not cover periodical payments self-funded by the Motor Insurer's Bureau, medical defence organisations, offshore insurers or private defendants as none of these payments attract statutory protection under the FSCS'.

14.57 However, para 39 of the DCA Guidance goes on to state the following:

'This does *not* mean that the courts cannot order periodical payments against these defendants and insurance bodies. They may be able to provide statutorily secure periodical payments by purchasing an appropriate annuity from a life office for the benefit of the claimant, thus attracting the full protection of the FSCS under Section 4 (1) and (2) of the 1996 Act … Alternatively, it is open to these bodies to satisfy the Court that they can offer a method of funding other than one of those deemed secure under section 2(4) that is reasonably secure'.

14.58 Developments since the Guidance was published include the court holding that the Motor Insurers Bureau is secure in the sense that it can self-fund periodical payments from its own resources. The case of *Thacker v Steeples and MIB*[1] considered the issue and the Bureau was held by the court to be reasonably secure because:

- it has longevity and significant resources;
- it is a collective of 80 motor insurers. If one fails, MIB would simply increase the levy on remaining 79;
- the MIB is the body through which the government satisfies its obligation to ensure compensation for victims of uninsured and untraced drivers under Article 4 of European Directive on Motor Insurance. Therefore, morally and politically it is unlikely that the government would allow the MIB to dissolve, without its continuing liabilities being provided for.

1 (16 May 2005, unreported), see Lawtel Quantum AM 0900821 and [2005] 3 Kemp News 5.

14.59 Whether or not the Medical Defence Union, the Medical Protection Society or the other, smaller, indemnifying bodies can satisfy the court in the sense of the required reasonable security, is unclear. By analogy with the *Thacker* decision, and without going in to a detailed history of those bodies and forensically examining their respective assets and funding arrangements, it might be argued that the longevity and resource points might be met.

14.60 Beyond that, a direct comparison between the MIB and the above indemnifying bodies is not possible, due to the differing nature of the respective organisations. However, as the Medical Defence Union and the Medical Protection Society appear to be robust, the court may take the view that self-funded periodical payments are secure. As regards reasonable security, a note of caution was sounded, however, by Mackay J in the case of *Bennett v Stephens*[1]. The case was in the context of a road traffic accident, but the judge's analysis of the resources backing the insurer, which was not automatically reasonably secure, sets a high bar, and gives an indication of the level of judicial scrutiny that will be applied in similar cases:

'However, if I make a periodical payment order and continuity of payment is broken and those payments cease, the claimant's position here would be a disastrous one. He would have no further recourse to the defendants, to whom he will have given a legal discharge as a consequence of making of the order, he will have no recourse to any compensation scheme or guarantee. He will be left with desperate measures seeking to set this Order aside many years hence, or making a claim against his solicitors.

While therefore, I am only required by the statute to consider whether the proposed order is reasonably secure, I am not required to find that it is entirely secure or free of all risk, it seems to me that my satisfaction has to reach a high level, given what is involved and I must finish up satisfied on something higher than a mere balance of probabilities…

So, the primary obligation to fund a periodical payments order lies with Farraday. It is as I said, a major reinsurer in its own right, doing very substantial business in the Lloyds market, regulated by Lloyds and the FSA … it is a wholly owned subsidiary of Berkshire Hathaway Inc, a substantial and well known United States corporation. It is itself fully reinsured in respect of the risks of which now effectively the insurer, the lead reinsurer being Munich Re, itself one of the world's largest reinsurers with a market capitalisation in excess of £21 billion and a 2009 operating profit of more than €2.5 billion. The following reinsurance market behind it is composed of reinsurers of repute.

If matters rested there, however, I would be reluctant to pronounce myself satisfied under Section 2(3). Without in any way denigrating the current status or stability of Farraday as a going concern, taller trees than it have fallen in the financial forest before now and, unless it could claim the backing of Section 2(4) which it cannot as I am presently invited to assume, I would hesitate to say that I could sufficiently discount the risk that it might fail sometime in the next 50 years or so, which is the period I have to consider covered by the proposed order in this case'.

1 [2010] EWHC 2194 (QB).

14.61 The required standard of security is reasonableness, not perfection. If a funding mechanism could be constructed either by trust or similar vehicle providing certain safeguards, then it may well be that the reasonable security test as set by Mackay J is passed. The safeguards in relation to such a scheme might be:

- the scheme's sole purpose is to fund the periodical payments liability;
- the nature of the vehicle is that it is irrevocable and the indemnifying body cannot call upon any of the assets to be repaid unless and until the scheme's liabilities have been met;
- the appointment of an independent trustee/member of the scheme, preferably with expertise in representing claimants' interests;
- prudent and conservative actuarial assumptions used in calculating the sum to be paid into the scheme by the indemnifying body when considering new periodical payment liabilities. For example, the discount rate calculated net of tax (as opposed to the normal gross approach); the assumption of normal life expectancy in circumstances of impairment; and the assumption that liability under a periodical payment order increases in relation to earnings related inflation;
- the requirement of an annual actuarial valuation of the entire scheme to prevent deficits arising;
- amendment of the scheme can only be made in circumstances which will not (in the view of the actuary), adversely affect the ability to meet its obligations;
- any funds invested, should be managed on a cautious basis in terms of investment risk.

As things stand presently, it is worth emphasising that periodical payments and their numerous and very significant advantages may be denied to claimants, where medical practitioners are indemnified as above.

Assignment or charge of right

14.62 The DA 1996, s 2(6) prevents the assignment or charge of the right to receive periodical payments unless the court that made the original order is satisfied that there are special circumstances that make it necessary. This is intended to avoid the possibility of claimants receiving less than the true value of the award as a result of their assigning their right to receive the payments in return for a lump sum. The US experience has been that a large secondary industry has arisen in the market, known as 'factoring'.

14.63 The restrictions on claimants' ability to assign periodical payments do not affect their ability to borrow future income. Unsecured loans are permissible, but not secured loans that put the claimant's right to receive payments at risk.

Fatal accidents

14.64 Fatal accident claims are included within the periodical payments regime, ensuring that, where appropriate, dependants receive tax-free periodic income. The DA 1996, s 7 incorporates fatal accidents within its definition of *personal injury* and in addition, refers to quantification of those claims, pursuant to the Fatal Accidents Act 1976 and the Law Reform (Miscellaneous Provisions) Act 1934.

Judicial Studies Board

14.65 The Judicial Studies Board training paper, *Periodical Payments under the Damages Act 1996*, was authored by His Honour Judge Oliver-Jones QC and Master Ungley and was circulated to the judiciary in July 2005. The following excerpt from the Lord Chancellor's Department Consultation Paper 2002 concluded the JSB training paper:

'So it will be for the courts to develop the principles and guidelines for deciding which form of damages for future loss (and care costs) should take … we hope that the courts will normally order periodical payments in cases of significant future loss. If they do, the majority of cases will do so against that background. Although the parties will be free to agree a lump sum, and no doubt many will, it will be harder for a party to insist on a lump sum where the other party wishes to settle for reasonable periodical payments; so we hope that periodical payments will become the norm for settlements too'.

14.66 Procedural judges have been aware since publication of the JSB paper of the court's duty pursuant to CPR 41.6, to:

'Consider and indicate to the parties as soon as practicable whether periodical payments or a lump sum is likely to be the more appropriate form for all or part of an award of damages'.

14.67 The JSB paper confirms that the court's indication is simply that – an indication. It is not binding on the parties, or the trial judge. It is no more than a case management tool. Its purpose is not to force the parties into concessions that may change as cases progress. The training document offers no practical guidance as to what form the court's indication might take. It does, however, guide judges through the factors set out in CPR PD 41, but without instruction as to how much weight to attach to each of those factors.

It would probably be fair to say that despite the new procedural powers, judges when case managing were reluctant to apply the new rules. However, as hoped, the courts have developed the principles and guidelines which have shaped the periodical payment regime. A review of the key cases follows.

Case law

14.68 Decided cases have shaped the periodical payments regime to a very significant extent. Initial low take-up of settlements inclusive of periodical payments can perhaps be attributable in part to the slow pace at which the procedural judiciary warmed to its new powers. However, the principal cause was the indexation issue. This is illustrated by the cases, but in outline, periodical payments from the outset were seen as being targeted at care costs. Therefore, annual payments would be used to pay carers' earnings. Earnings-related inflation had historically outstripped prices inflation for many years. As periodical payments were linked to the RPI, there was grave concern that periodical payments would lag behind the increasing costs of care, year on year, resulting in a growing shortfall and substantial under compensation.

CHAPTER 22

Psychiatry

Dr Laurence Mynors-Wallis

INTRODUCTION

22.1 In broad terms, psychiatry is no different from other specialities in medicine when considering clinical negligence. Psychiatrists are expected to undertake a thorough examination of their patients, request appropriate investigations, come to a conclusion with regard to diagnosis and treatment, monitor the effectiveness of the treatment and make necessary adjustments as required to the treatment plan. Psychiatry does differ in one important aspect of treatment and that is in the potential use of Mental Health Act legislation in order to compulsorily treat patients. This is an important additional responsibility which alters the balance between clinician and patient responsibility for treatment decisions.

22.2 Psychiatrists, like other doctors, are guided in their work by standards set by regulatory and professional bodies, including the Royal College of Psychiatrists, the General Medical Council and by the policies and procedures of the organisations in which they work. In the UK, the National Institute of Health and Care Excellence has set out guidance for the assessment and treatment of many common psychiatric disorders to inform practitioners with regard to evidence-based practice. It is expected that psychiatrists will be mindful of the relevant advice and guidance available and if they depart from it will set out a reasoned justification for doing so.

PSYCHIATRIC DISORDERS

22.3 Psychiatric disorders are common. It is broadly accepted that one in four individuals will experience a psychiatric disorder at some point in their lives. The majority of patients with the common mental disorders of anxiety and depression are seen and treated in primary care by their general practitioners without referral to psychiatrists. Psychiatrists in the UK focus their work on the more severe mental disorders, including psychotic disorders and the management of patients with the more severe common disorders that have not responded well to treatment.

22.4 In the past, psychiatric diagnoses were broadly categorised into neurotic and psychotic disorders. Neurotic disorders represent part of the spectrum of common emotions such as low mood and anxiety but in a severe and sometimes disabling form with symptoms occurring in situations in which individuals do not normally experience them. In psychotic disorders, eg schizophrenia, patients experience symptoms, for example, hearing voices or holding bizarre beliefs that are rarely experienced by most in the general population. There is, however, a significant overlap between neurotic and psychotic symptoms. For example, patients with depression can become so unwell that they hold delusional beliefs about guilt and poverty and similarly patients with psychotic disorders, such as schizophrenia, can be enormously troubled by symptoms of anxiety. Hence the distinction between psychotic and neurotic disorders is now rarely used in clinical practice, which favours a more precise diagnosis meeting the criteria set in one of the two classificatory systems.

22.5 The classification of psychiatric disorders is set out in two documents: the *International Classification of Diseases* in its 10th edition (ICD-10)[1] the 11th revision due to be published in 2015; and the *Diagnostic and Statistical Manual of Mental Disorders*, now in its 5th edition (DSM-5)[2]. These classification systems have many similarities but also important differences. The DSM-5 has been developed particularly for use in North America. It sets very clear criteria for diagnosis and can be particularly helpful in a medico-legal setting because of the precision and clarity of the diagnostic categories. The ICD-10 has been developed for use in the rest of the world and, reflecting this, the diagnostic categories are broader, which often gives it greater utility in clinical settings where there are many patients whose diagnosis does not fall neatly within the DSM classificatory system.

1 *The ICD-10 Classification of Mental and Behavioural Disorders* (1992).
2 *The Diagnostic and Statistical Manual of Mental Disorders* (5th edn, 2013).

22.6 In the UK, although the ICD-10 system is used within the Department of Health, it is acceptable clinically for practitioners to use either system.

22.7 There is a small group of doctors who question the value of diagnosis. The position of the vast majority of psychiatrists and the Royal College of Psychiatrists is clear: patients benefit from clarity about diagnosis because of the important implications with regard to understanding treatment and prognosis[1].

1 Craddock and Mynors-Wallis 'Psychiatric Diagnosis: impersonal, imperfect and important' (2014) 204 British Journal of Psychiatry 93–95.

22.8 The broad diagnostic categories found in both classifications are as follows:

(1) organic disorders: dementia, delirium, mental disorders due to brain damage, dysfunction and physical disease;
(2) mental and behavioural disorders due to drug and alcohol use;
(3) schizophrenia and delusional disorders;
(4) mood (affective disorders): depressive disorders and bipolar affective disorder (manic depression);
(5) anxiety disorders;
(6) obsessive compulsive and related disorders;
(7) trauma and stress related disorders;
(8) somatic symptom and related disorders;
(9) behavioural disorders: eating disorders, sleep disorders, sexual dysfunction and behavioural disorders;
(10) disorders with onset usually in childhood and adolescent: attention deficit hyperactivity disorder, conduct disorder, separation anxiety;
(11) neurodevelopmental disorders including intellectual disability;
(12) personality disorders.

ASSESSMENT

22.9 At the core of good psychiatric practice is a thorough clinical assessment of the patient. A thorough assessment allows the psychiatrist to make a diagnosis, formulation and treatment plan.

22.10 The standards for psychiatric assessment are set out clearly in the syllabus of the Royal College of Psychiatrists. What is expected is summarised in the first learning outcome for core psychiatric training[1] as follows:

'To be able to perform a specialist assessment of patients and document relevant history and examination on culturally diverse patients to include:

- presenting or main complaint;
- history of present illness;
- past medical and psychiatric history;
- systemic review;
- family history;
- social and cultural history;
- developmental history'.

1 Royal College of Psychiatrists *Competency Based Curriculum for Specialist Core Training in Psychiatry* (February 2010).

22.11 The first standard in *Good Psychiatric Practice*[1] emphasises this point.

'A psychiatrist must undertake competent assessments of patients with mental health problems and must:

(a) be competent in obtaining a full and relevant history that incorporates developmental, psychological, social, cultural and physical factors, and:
   (i) be able to gather this information in difficult or complicated situations
   (ii) in situations of urgency, prioritise what information is needed to achieve a safe and effective outcome for the patient
   (iii) seek and listen to the views and knowledge of the patient, their carers and family members and other professionals involved in the care of the patient

(b) have knowledge of:
   (i) human development and developmental psychopathology and the influence of social factors and life experiences
   (ii) gender and age differences in the presentation and management of psychiatric disorders
   (iii) biological and organic factors present in many psychiatric disorders
   (iv) the impact of alcohol and substance misuse on physical and mental health

(c) be competent in undertaking a comprehensive mental state examination
(d) be competent in evaluating and documenting an assessment of clinical risk, considering harm to self, harm to others, harm from others, self-neglect and vulnerability
(e) be competent in determining the necessary physical examination and investigations required for a thorough assessment
(f) ensure that they are competent and trained, where appropriate, in the use of any assessment or rating tools used as part of the assessment'.

1 Royal College of Psychiatrists College Report CR154 (3rd edn, 2009).

22.12 *Good Psychiatric Practice* sets out standards of practice for psychiatrists and is aligned to the General Medical Council *Good Medical Practice* (2006), the standard for all medical practitioners. These standards of practice apply to members of the Royal College of Psychiatrists or other psychiatrists whatever their grade, whatever their clinical setting and whenever they are practising.

22.13 The Royal College of Psychiatrists has a standard, set out in *Safe Patients and High Quality Services; a Guide to Job Descriptions and Job Plans for Consultant Psychiatrists*[1] that in general adult and old age psychiatry approximately one hour should be set aside for completing such an assessment. On occasions, less time may be required for patients with relative straightforward conditions. At times, for those patients with more complex disorders and a long history, the assessment may be completed over several appointments. Following a careful history and examination further investigations may be required for example, blood tests, scans or more specialist diagnostic tools. In psychiatry, however, investigations are often of less value in determining management than in many branches of medicine. Investigation may require gaining information from other informants, such as family and friends.

1 Safe Patients and High Quality Services: a Guide to Job Descriptions and Job Plans for Consultant Psychiatrists, Royal College of Psychiatrists College Report 174 (November 2012).

22.14 Assessment requires, in modern psychiatric practice, an assessment of risk. Risk is often considered under three headings: risk to self (risk of self-harm or suicide); risk to others; and risk of self-neglect. The assessment of risk is an imprecise technique. Different categorisations are used, but commonly a judgment is made: low, moderate or high. The exact definitions of what is meant by such adjectives is far from clear. What is expected, however, is that the assessment sets out the psychiatrist's understanding of the risks involved and a resulting management plan, where possible, seeking to reduce the risks identified. The standard is clear in *Good Psychiatric Practice*:

'A psychiatrist must appropriately assess situations where the level of disturbance is severe and risk of adverse events, such as injury to self or others, or harm from others, may be high, and take appropriate clinical action'.

22.15 Although a psychiatrist is an expert in mental health, it is expected that part of the assessment will take account of the physical health of the patient. It is known that patients with mental health problems often have poor physical health outcomes and that the treatments provided may have significant adverse physical health side effects. The Royal College of Psychiatrists has set standards with regard to the physical health of patients with schizophrenia and published audit findings[1].

1 Report of the National Audit of Schizophrenia (2012).

22.16 A thorough assessment should lead to a formulation of the patient's problems that includes an appropriate differential diagnosis. The diagnosis should be made using an accepted classification system, either ICD-10 or DSM-5. The formulation allows for broader consideration of the patient to include problems and difficulties and aetiology.

22.17 Following assessment, diagnosis and formulation, a management plan must be drawn up. This should be done in collaboration with the patient and where appropriate carers and relatives. The management plan should incorporate interventions to address the key areas identified in the formulation including diagnoses, risks, physical disorders and relevant problems. Again, *Good Psychiatric Practice* has a clear standard for this:

'A psychiatrist must ensure that treatment is planned and delivered effectively, and must:

(a) formulate a care plan that relates to the patient's goals, symptoms, diagnosis, risk, outcome of investigations and psychosocial context; this should be carried out in conjunction with, and agreed with, the patient, unless this is not feasible;
(b) if the treatment proposed is outside existing clinical guidelines or the product license of medication, discuss and obtain the patient's agreement, and where appropriate, the agreement of carers and family members;
(c) involve detained patients in treatment decisions as much as possible, taking into account their mental health and the need to provide treatment in their best interests;
(d) recognise the importance of family and carers in the care of patients, share information and seek to fully involve them in the planning and implementation of care and treatment, having discussed this with and considered the views of the patient'.

TREATMENTS

22.18 Psychiatric interventions can be broadly classified into three categories:

(1) physical treatments, medication and electroconvulsive therapy (ECT);
(2) psychological treatments;
(3) social interventions, eg support with housing, advice about employment, help with finances.

Management should include arrangements for follow up and if no follow-up is required, the reason for this should be stated.

22.19 All patients should have a care plan. For those on the Care Programme Approach (CPA) (see para **22.37**), clear guidance and formal documentation should be evident. For the many patients treated by an individual practitioner (often a doctor alone), the care plan should be set out in the letters that the psychiatrist writes to the patient's GP, often but not always copied to the patient.

Physical treatments

Electroconvulsive therapy (ECT)

22.20 ECT is largely restricted to patients with severe depressive disorders meeting the following criteria:

(1) psychomotor retardation resulting in significant difficulties with maintaining adequate food and fluid intake;
(2) severe psychotic depressive disorder not otherwise responding to treatment.

Other indications for ECT include a prolonged and severe manic episode which has not responded to drug treatment, and catatonia[1].

1 Guidance on the use of Electroconvulsive Therapy (April 2003), National Institute for Clinical Excellence Technology Appraisal 59.

22.21 The benefits of ECT treatment have been shown in several randomised controlled trials. It is recommended in a NICE Technology Appraisal[1]. It is important that clear standards for ECT delivery are adhered to, including informed consent, an explanation for the patient of side effects, and appropriate monitoring of efficacy. The Royal College of Psychiatrists has in place an accreditation scheme to which many of the organisations which deliver ECT subscribe and adhere to their standards[2].

1 Guidance on the use of electroconvulsive therapy Issued: April 2003 last modified: October 2009 NICE technology appraisal guidance 59.
2 ECTAS Standards (11th edn, 2013).

Medication

22.22 The main psychiatric drugs can be broadly grouped into the following categories:

(1) antidepressants;
(2) antipsychotics;
(3) anxiolytics;
(4) mood stabilisers;
(5) anti-dementia drugs;
(6) stimulants.

Antidepressants

22.23 Antidepressants are among the most widely prescribed drugs in medicine. They act on serotonin and noradrenergic pathways in the brain, though the detailed mechanism of action is poorly understood. The most widely-prescribed class of drugs is the specific serotonin reuptake inhibitors (SSRIs). These include fluoxetine, citalopram, paroxetine, sertraline and fluvoxamine. These drugs are relatively safe in overdosage and side effects are often better tolerated than the older generation of drugs.

22.24 Tricyclic antidepressants were the first class of antidepressants to be made available and have been used in the treatment of depression since the 1950s. This class of drugs is toxic if taken in overdosage and therefore caution and a risk/benefit assessment has to be used in patients who are a significant suicidal risk; side effects include sedation and dry mouth.

Monoamine oxidase inhibitors are a third group of antidepressants not widely used nowadays, largely reflecting the fact that they require patients to limit certain aspects of diet.

Other widely used antidepressants in the UK include venlafaxine, a specific serotonin and noradrenalin reuptake inhibitor, and mirtazapine which has a different mechanism of action from other antidepressants.

Antipsychotics

22.25 The use of antipsychotic drugs in the 1950s, starting with chlorpromazine, contributed to the significant reduction in the number of psychiatric beds needed for patients with severe mental illness. Current

drugs are broadly grouped into two categories: the first generation antipsychotic drugs (including chlorpromazine, haloperidol, trifluoperazine, sulpiride, perphenazine) which are effective but are recognised as having significant side effects including sedation and both short- and long-term movement disorder side effects. The second generation antipsychotic drugs or atypical antipsychotics (risperidone, quetiapine, olanzapine, amisulpiride, aripiprazole) are equally but not more effective than the older drugs. The side effects of the atypical antipsychotics vary, but include weight gain, movement side effects and the risk of developing diabetes.

22.26 Antipsychotic drugs can be given in oral dispersible form to improve compliance and by depot injection.

Clozapine is an antipsychotic drug that is particularly effective for treatment resistant schizophrenia but needs careful monitoring through blood tests because of a potential side effect of lowering white cell counts in the blood.

22.27 Antipsychotic drugs should be used with caution in patients with cardiovascular disease. The British National Formulary recommends that in prescribing for the elderly, a balance of risk and benefit should be considered before prescribing antipsychotic drugs.

'In elderly patients with dementia, antipsychotic drugs are associated with a small increased risk of mortality and an increased risk of stroke or transient ischaemic attack … It is recommended that:

- Antipsychotic drugs should not be used in elderly patients to treat mild to moderate psychotic symptoms.
- Initial dose of antipsychotic drugs in elderly patients should be reduced to half the adult dose or less taking into account factors such as the patient's weight, cormorbidity and concomitant medication.
- Treatment should be reviewed regularly'.

Antipsychotic drugs are sometimes prescribed alongside anticholinergic drugs such as procyclidine to avoid the Parkinsonian side effects of the antipsychotic.

Anxiolytics and hypnotics

22.28 Older anxiolytic and hypnotic drugs such as barbiturates and carbamates are now obsolete because of their lack of safety in overdose. The most widely-used drugs for anxiety are the antidepressant drugs. Benzodiazepine drugs continue to be widely prescribed both as anxiolytics and hypnotics. They are effective in reducing anxiety and aiding sleep but all have significant problems with tolerance and dependence. Tolerance is when over time an increasing dose of the medication is required to achieve the same effect. Dependence is when patients experience physical symptoms when trying to reduce and stop the medication. Benzodiazepines should only be prescribed for brief, time-limited episodes. The advice in the BNF[1] is clear:

'Anxiolytic Benzodiazepine treatment should be limited to the lowest possible dose for the shortest possible time:

(i) Benzodiazepines are indicated for the short term relief (2–4 weeks only) of anxiety that is severe, disabling or causing the patient unacceptable distress, occurring alone or in association with insomnia or short term psychosomatic, organic or psychotic illness;
(ii) the use of Benzodiazepines to treat short term mild anxiety is inappropriate;
(iii) Benzodiazepines should be used to treat insomnia only when it is severe, disabling or causing the patient extreme distress'.

Other drugs used in the management of anxiety are buspirone and pregabalin.

1 BNF 66 (2013). BMJ and Pharmaceutical Press, London.

22.29 For the short-term relief of disturbed sleep, a new class of sedative drugs has been introduced: the 'Z Drugs' (zopiclone, zolpidem, and zaleplon).

Mood stabilisers

22.30 Mood stabilisers are drugs used to prevent or reduce the severity of relapses for patients with bipolar disorder. The first made available was lithium, which requires regular blood test monitoring. Other mood stabilisers include anticonvulsants, eg sodium valproate and carbamazepine. Antipsychotic drugs can also be used as mood stabilisers.

Stimulants

22.31 Stimulants are recognised as effective in treating attention deficit hyperactivity disorder (ADHD) in children and there are increasing requests for them to be prescribed in adults reflecting the fact that the disorder does not stop on an 18th birthday.

Drugs for dementia

22.32 Anticholinesterase inhibitor drugs and the glutamate receptor antagonist, memantine, are used in the treatment of dementia. In some patients, these drugs slow the progression of dementia but they do not reverse it and do not stop the inexorable decline of dementia. There is little evidence for their efficacy for types of dementia other than Alzheimer's disease.

Psychological treatments

22.33 Although there are different types of psychological treatments, there is considerable overlap between therapies described. There is also evidence that the relationship between the therapist and the patient can be more important in predicting recovery than the specific type of therapy offered. The main categories of therapy used in the UK are as follows:

(1) **Cognitive behaviour therapy (CBT)**: CBT is the treatment for which there is the strongest evidence base, with controlled trials demonstrating its particular effectiveness in the treatment of depression and anxiety disorders. The content of the treatment has been set out in manuals. The treatment is time limited and usually offered for between 12 and 16 one-hour long sessions. The treatment is based on the concept that a problem is caused by the patient's perception (their cognitions about

what has happened) rather than by the event itself. Therapy aims to change the cognitions by talking and challenging the thoughts and by specific behavioural tasks. CBT can be delivered on an individual basis, in groups or as self-help via books and computer programmes;

(2) **Counselling**: Counselling is a more non-specific treatment than CBT with less evidence demonstrating its effectiveness. It can provide an opportunity for individuals to talk about their current experiences and difficulties with a professional. Therapists often attempt to link the past to current difficulties;

(3) **Psychodynamic psychotherapy**: This is the therapy espoused by Freud and Jung. There is much less evidence for its effectiveness as a treatment than CBT-based treatments and it is not now widely available in the UK. Treatment occurs over a period of at least 18 months;

(4) **Dialectical Behaviour Therapy (DBT)**: DBT was introduced in 1991 by Linehan and colleagues as a treatment for patients with borderline personality disorder. Patients are taught to both understand their emotional difficulties and, using both group and individual work, taught new skills to better manage emotional distress.

22.34 In England, psychological therapies are widely delivered through the Improving Access to Psychological Treatment (IAPT) Programme. IAPT offers a stepped-care treatment approach with often a telephone assessment, followed by signposting to self-help and support groups, stepping up to more complex treatment delivered by more experienced therapists as necessary.

Social interventions

22.35 Many psychiatric disorders are, if not caused by, certainly worsened by social problems. Also many patients with a severe mental disorder such as schizophrenia experience significant problems in management of their everyday lives. An important part of many psychiatric management plans, therefore, is the practical help and support given to patients with concerns such as housing, employment, benefits, daytime activities and social interactions. An important concept of modern psychiatry is that of recovery. Recovery does not mean simply the improvement and reduction of psychiatric symptoms, but an approach to enable patients with mental illness to lead fulfilled and rewarding lives.

Physical healthcare

22.36 As noted above, patients with a mental disorder have poor physical health outcomes compared with the general population. It is important that psychiatrists, as doctors, are alert to the physical health treatment requirements of their patients. Psychiatrists in inpatient units have a responsibility for ensuring that their patients receive appropriate physical health treatments. If they do not feel confident in the management of conditions diagnosed, they must make the appropriate referral to other specialists.

Care Programme Approach

22.37 In England and Wales, treatment within NHS services is provided within the framework of the Care Programme Approach (CPA). This is

key national guidance[1] which should ensure patients with the most severe disorders get the treatments required. The CPA guidance[2] says that you should get help under CPA if you have:

- severe mental illness (including personality disorder);
- problems with looking after yourself including:
  - self-harm;
  - suicide attempts;
  - harming other people including breaking the law;
  - a history of becoming unwell and needing urgent help;
  - not wanting support or treatment;
  - vulnerability;
- severe distress at the moment or you have felt a lot of severe distress in the past;
- problems working with Mental Health Services or have done in the past;
- another non-physical condition alongside mental illness, for example learning disability, drug or alcohol misuse;
- services from a number of agencies such as housing, physical care, criminal justice or voluntary agencies;
- recently been detained under the Mental Health Act or are detained at the moment;
- recently been put in touch with Crisis/Home Treatment Team or getting their help at the moment;
- a need for a lot of help from carers or you provide a lot of care to someone yourself (children or adult);
- disadvantage or difficulties due to parenting responsibilities, physical health problems or disability, unsettled accommodation or housing issues, employment issues, mental illness significantly affecting your day to day life, ethnicity issues.

Local teams will follow guidance set their by organisations which may differ in detail but not in principle from what is set out above.

1 Care Programme Approach: Positive Practice Guidance (2008).
2 Care Programme Approach Factsheet Version 2 (2013). Rethink Mental Illness, www.rethink.org/resources/c/care-programme-approach-cpafactsheet.

22.38 Patients looked after within the framework of CPA should have a care coordinator (often a nurse) who should:

(1) fully assess the patient's needs;
(2) set out a care plan with the patient which shows how the needs will be met;
(3) regularly review the care plan to check progress.

The care coordinator is the person who links together and coordinates all the people who may be providing an individual's care.

22.39 The care plan should fully involve the patient and, if appropriate, their carers and may include interventions looking at the following:

(1) medication;

(2) therapy;
(3) help with money problems;
(4) advice and support;
(5) help with everyday living tasks including employment and training;
(6) help with housing;
(7) community care services.

The care plan should be reviewed on a regular basis as set out in local policies, usually every 6 or 12 months.

LEGAL ISSUES

22.40 Mental health legislation varies across the different countries of the UK. In England and Wales, the current legislation is the Mental Health Act 1983 which was amended in 2007. The Mental Capacity Act 2005 regulates decision making on behalf of incapable adults and was implemented in 2007.

In Scotland, the Mental Health (Care and Treatment) (Scotland) Act of 2003 replaced the previous Mental Health Act of Scotland 1984 in October 2005. The relevant capacity legislation is the Adults with Incapacity Act 2000, which was implemented between April 2001 and 2003.

In Northern Ireland, the care and treatment of patients with mental disorder is regulated by the Mental Health (Northern Ireland) Order of 1986, amended by the Mental Health (Amendment) (Northern Ireland) Order of 2004. There is currently no specific incapacity legislation.

22.41 All the Mental Health Act legislations allow medical practitioners to admit patients to hospital for assessment and treatment, detain patients who are already in hospital and, with the provision of Community Treatment Orders, authorise compulsory powers for patients in the community. Details of how the Acts are implemented differ in different countries within the UK but all have safeguards allowing for appeals by patients and their relatives. All require the use of least restrictive practices compatible with safe and effective care and all have relatively broad definitions of mental illness or mental disorder.

The Human Rights Act 1998 has been used in legal cases to determine whether satisfactory care was provided.

Consent to treatment

22.42 It is fundamental to the provision of medical care that treatment for patients should be with their consent. For consent to be valid, the patient must have capacity to make the medical treatment decisions and the consent must be informed, ie the patient has fully understood the details and implications of what is proposed, and they must be freely given, ie not under duress. General Medical Council *Good Medical Practice*[1] sets out clearly:

'You must be satisfied you have consent or other valid authority before you undertake any examination or investigation providing treatment or involve patients or volunteers in treatment or research'.

1 *Good Medical Practice* (2013). General Medical Council, London.

22.43 If a patient does not consent to treatment that the psychiatrist believes to be necessary, they must consider firstly whether compulsory treatment under Mental Health Act legislation applies or whether best interest treatment under capacity legislation applies.

Mental Capacity Act 2005 (England and Wales)

22.44 The Mental Capacity Act 2005 (applicable in England and Wales) is underpinned by a set of five key principles:

(1) presumption of capacity: a person is presumed to have capacity unless it is established that he lacks capacity;
(2) all practical steps are taken to allow autonomy: a person is not to be treated as unable to make a decision unless all practical steps to help him to do so have been taken without success;
(3) allow unwise decisions: a person is not incapable merely because he makes an unwise decision;
(4) best interests: an intervention under the Act on behalf of a person who lacks capacity must be in his best interests;
(5) least restrictive option: any intervention under the Act on behalf of a person who lacks capacity should restrict, as little as possible, his basic rights and freedom.

22.45 There is a two-stage process for assessing incapacity:

(1) a person lacks capacity if he is unable to make a decision for himself in relation to any matter because of permanent or temporary impairment of the functioning of the mind;
(2) a person is unable to make a decision for himself if he is unable to:
   — understand the information relevant to the decision;
   — retain that information for a sufficient period to make a decision;
   — use or weigh that information as part of the process of making a decision;
   — communicate the decision.

THE TRAINING AND EXPERIENCE OF PSYCHIATRISTS

22.46 Psychiatrists are doctors who have undergone the same core training as doctors in any other speciality. This is often poorly understood by the general public, who can be confused, particularly about the distinction between a psychologist (who is not a medical practitioner) and a psychiatrist.

22.47 The training of psychiatrists matches in structure that of the training for doctors in other specialities. It is now the case that all doctors on graduating from medical school in the UK undertake two years of foundation training. In these posts the doctors are closely supervised by more senior doctors. The doctors usually rotate through posts every four months, in order to obtain wide experience across many fields of medicine. At present, doctors are registered with the General Medical Council at the completion of their