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Healthcare Newsbrief

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Welcome

Welcome to this autumn edition of Hempsons' healthcare newsbrief. We hope we will be meeting some of you in person if you have picked up this copy at the NHS Providers conference in October – sponsored by Hempsons.

It has been a busy few months for the NHS in the legal system with some ground-breaking decisions on key areas such as withdrawing clinically-assisted nutrition and hydration, fitness to practice and procurement. Sadly, many trusts will have had experience of cases where patients have little prospect of recovery and have what is termed a prolonged disorder of consciousness. Withdrawing clinically-assisted nutrition and hydration in these cases – and allowing the patient to die - has involved an application to the courts. A recent Supreme Court decision has clarified that this does not need to happen automatically, as Helen Claridge explains.

Boards will need to be aware of the ongoing review of the fit and proper persons requirement – something which all board members have to meet. We look at the changes which are being considered, especially around what being of "good character" means.

Many NHS executives will have been aware of the case of Dr Hadiza Bawa-Garba who was found guilty of manslaughter by gross negligence and the concerns it has engendered among fellow clinicians. Laura McIntyre reports on the recent Court of Appeal ruling on this case and what it could mean for the health service.

Using massive datasets to plan and improve patient care and develop new treatments offers enormous opportunities for the NHS and its partners – but many organisations have been concerned about how data can be used within the law. Chris Alderson looks at some of the restrictions and how they could be overcome. He concludes that it is possible to use data in this way and still comply with the General Data Protection Regulation and other laws – but trusts will need to tread carefully and potentially take advice on the safeguards they need to build into any projects.

Lucy Miles looks at a recent Employment Tribunal case involving the dismissal of a staff member where there was a lack of consensus among clinicians over whether a mental illness could have contributed to her behaviour. The importance of considering all relevant evidence, testing it and giving it proper weight came through in this case, which the trust lost.

Procurement is an area full of pitfalls. In our last article, we look at a case where a local authority awarded a contract to a private provider but was then challenged in the courts by two NHS trusts who had also bid. The judge looked in great depth at how the tender was awarded and found the council's process wanting. Procurement expert Andrew Daly looks at the ramifications of this decision for NHS organisations – whether they are bidding for a contract or awarding one.

We hope these articles give you food for thought as you prepare for the challenges of the months to come.

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Landmark Supreme Court judgment **on withdrawing clinically assisted nutrition and hydration**

A landmark Supreme Court ruling has provided much needed clarity in relation to the role of the Court in withdrawing clinically-assisted nutrition and hydration (CANH) from patients who are not in a position to make the decision themselves.

Trusts have usually sought the support of the courts in cases where it was proposed to withdraw clinically assisted hydration and nutrition from patients in long-term states of low consciousness. This has happened even when the patient's family are agreed that it would be in their best interests.

Applying to the courts in such cases is expensive, can be distressing for all involved (especially the family), and means there is a delay before hydration and nutrition can be withdrawn. This judgment should make the process easier for all involved in these cases.

Hempsons represented the Trust and CCG in this case.

Factual background

Mr Y was an active man in his 50s when, in June 2017, he suffered a cardiac arrest which resulted in brain damage. After extensive assessment, his treating team concluded that he was suffering from a Prolonged Disorder of Consciousness (PDOC) and would likely require a significant level of care for the rest of his life. His family believed that he would not wish to be kept alive in such circumstances. They agreed with his treating team that it was not in Mr Y's best interests to continue to receive CANH and that this should be withdrawn, allowing him to pass away with dignity. An expert clinician independent of the NHS bodies involved, agreed that this was in Mr Y's best interests.

Legal proceedings

The legal position at the time was that court endorsement should be sought prior to withdrawal of CANH from a patient in a PDOC, regardless of the level of agreement as to best interests between those involved in the patient's case. The treating Trust (with the support of the CCG) decided to challenge this and, in November 2017, applied to the Queen's Bench Division of the High Court for a declaration that it was not mandatory to apply to the Court of Protection prior to withdrawal of CANH from a patient in PDOC when the family and the clinical team are in agreement that it was not in the patient's best interests to receive that treatment.

Trusts will no longer have to seek court approval before withdrawing nutrition and hydration in cases where clinicians and family agree

In the first instance, the Trust's position was supported in the judgment handed down by Mrs Justice O'Farrell but the Official Solicitor appealed to the Supreme Court.

Mr Y passed away before the case could be heard in the Supreme Court in February 2018 but, because of the importance of the issues raised by the case, the Supreme Court decided that it would still hear argument and give a ruling.

Supreme Court judgment

Lady Black, giving the leading judgment, concluded that neither the common law nor the European Convention on Human Rights impose a mandatory requirement to involve the Court to decide upon the best interests of every patient in a PDOC before CANH can be withdrawn.

As long as the provisions of the Mental Capacity Act 2005 (MCA) are followed, the relevant professional guidance is adhered to and there is agreement between family and clinicians as to best interests, there need not be an application to the Court prior to withdrawal.

Courts should still be involved in cases where there is disagreement about the best course of action

What does this mean?

This is a significant judgment which provides much needed clarity as to the role of the Court in end of life care.

For clinicians working with patients in PDOC, there will be no need to involve the Court or the Official Solicitor prior to withdrawal of CANH of patients in a PDOC when all are agreed as to best interests. However, it is vitally important that clinicians demonstrate consideration and application of both the MCA and the relevant professional guidance (most importantly the RCP guidelines). There will need to be clear evidence of discussion and agreement with family members as to the proposed withdrawal.

In cases where there is no such agreement, i.e. when there is a dispute as to diagnosis or best interests, an application must still be made to the Court prior to withdrawal.

Please contact Helen Claridge, the solicitor who acted in this case, if you have any questions in relation to this case or any related queries.

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Helen is a partner in Hempsons' healthcare advisory team.

Much of Helen's caseload involves mental health and mental capacity issues. She advised in relation to the Mental Health (Approval Functions) Bill and regularly acts on behalf of healthcare providers in complex applications to the Court of Protection concerning deprivation of liberty and best interests.

Helen works across a wide range of health and social care issues in different jurisdictions including the Coroner's Court, the Family Division and the First Tier Tribunal (health and social care). Helen regularly advises organisations in relation to CQC registration and challenge, clinical governance and funding disputes.

The fit and proper persons requirement – working in practice

The fit and proper persons requirement was introduced on 27 November 2014 (for NHS providers) to much fanfare with the stated aim of making NHS providers and their directors more accountable and to encourage a more open and transparent culture. Now, four years on, we look at how the requirement works in practice and how it might be extended in the future.

Recap – what is the requirement?

Providers cannot appoint, or have in place, an individual unless they:

- are of "good character"
- have the necessary qualifications, competence, skills and experience
- are healthy enough (with reasonable adjustments in place if necessary) to perform their role.

In addition, the individual must not have been responsible for or involved in any serious misconduct or mismanagement while carrying out a regulated activity.

They can't be bankrupt, on a barred list or have a legal impediment that would stop them from taking the role.

The employer must consider any criminal convictions and removals from any professional register, but these factors are not absolute barriers to appointment.

Under the regulations the obligation applies to directors and "equivalents" but the Care Quality Commission (CQC) guidance says that this is limited to executive, non-executive, interim and associate directors only.

The CQC is responsible for ensuring that organisations comply with the duty. It also has the power to impose conditions on a provider's licence to ensure that the organisation acts to remove a director who is not fit and proper.

The CQC's guidance states that it requires chairs to confirm that all newly appointed directors have been assessed and to declare that they are satisfied that the individuals are fit and proper persons.

If an organisation becomes aware that a director is no longer able to satisfy the fit and proper person requirement, it must take such action as is necessary and proportionate to ensure that a fit and proper person takes up the role and that, if the director is registered, that their regulator is informed.

How it has worked in practice

Most NHS providers have introduced a fit and proper person requirement policy or procedure setting out how they will apply the requirement in recruitment, how they will keep it under review and how they will investigate concerns when they arise.

We have given advice most frequently about concerns and how to investigate them properly.

"The fit and proper persons" requirement could be extended beyond NHS provider organisations

The first decision for a provider to take is whether a concern is sufficiently serious to merit an investigation. That is not always an easy question. Most of the advice we have given has been in cases where there is a concern about the director's "good character" rather than allegations of "serious mismanagement " or "serious misconduct".

"Good character" is a subjective concept and the guidance from the CQC on how to assess whether someone remains of good character is broad.

There is no statutory guidance on how to interpret “good character”, however the CQC set out the features normally associated with “good character” as being:

- honesty
- trustworthiness
- integrity
- openness/transparency
- ability to comply with the law.

The CQC guidance also says that a director should be someone in whom the NHS provider, the CQC, people using the services and the wider public “...can have confidence and who will comply with the law”.

We have advised several of our clients on the best way to conduct an investigation into concerns and have suggested a step-by-step process in each case. It is important that any investigation is carried out with regard to general principles of fairness and natural justice.

Government review is considering more specific examples of misconduct

In some cases, it may be appropriate to commission an external investigation of the concern to establish the facts. In determining whether an asserted fact is proven the test is the balance of probabilities (i.e. the asserted fact is more likely to be true than not).

As a general principle, directors should be given the opportunity of responding to the concern as part of the investigation process.

Ultimately the NHS provider must come to a decision on whether the director remains a fit and proper person. If they conclude that they do not, an employment/HR process will be necessary to effect a fair dismissal.

The future

As part of his report into Liverpool Community Health NHS Trust, Dr Bill Kirkup recommended that the government undertake a review of the fit and proper persons requirement. This recommendation was accepted by the government on 8 February 2018 and it announced in May this year that the review would be led by Tom Kark QC.

The review, which is due to be published shortly, has considered the scope, operation and purpose of the fit and proper person test as a means of specifically preventing the re-deployment or re-employment of senior NHS managers where their conduct has fallen short of the values of the NHS.

The terms of reference for the review include:

- whether to extend the requirement to other NHS organisations, not just providers and whether to extend beyond directors
- to consider whether to specify the following as "misconduct" within the test:
  - a failure to cooperate with a properly constituted review or investigation
  - a loss or falsification of records
  - bullying and harassment
  - conduct which might inhibit or discourage appropriate whistleblowing
  - a failure to secure relevant approvals for, or notify relevant bodies of, any "settlement agreements" and associated payments
- to review the application of the test compared with models of professional regulation in other areas of employment, for example those applying to clinicians.

Boards need to be aware of likely changes and react accordingly

The extension of the fit and proper requirement to other NHS bodies may be inevitable but it does not sit easily with CQC enforcement given that only providers fall within their remit.

The terms of reference also indicate a willingness on the part of the government to be stricter in the application of the requirement. The examples of potential "misconduct" appear to have come from some of the more widely reported cases.

Although it is difficult to disagree with the proposition that these elements could amount to "misconduct" it will cause some alarm to directors if these specific elements are added into the requirement without further detail. For example, what does "inhibiting" whistleblowing mean? What does it mean to "discourage" whistleblowing? Would a requirement that an employee comply with the employer's raising concerns policy fall within these categories? We would hope that the Kark report will provide us with some answers.

Conclusion

It is very likely that the current fit and proper persons requirement will be extended by the government to include NHS bodies (other than providers) and that it will become more restrictive. NHS bodies would be well advised to watch out for the next developments to ensure that existing policies and procedures are updated to reflect the changes.

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A summary of the Dr Bawa-Garba case

and what this may mean for trusts

Background

On 18 February 2011, six-year-old Jack Adcock, who had Down's syndrome and a heart condition, was admitted to Leicester Royal Infirmary with sickness and diarrhoea. Dr Bawa-Garba, a trainee paediatrician, was responsible for the care of Jack and has been found to have been responsible for a series of errors, which led to Jack's death later the same day. These errors were also contributed to by agency nurse, Isabel Amaro, who was responsible for Jack's hands-on care.

Importantly, the Trust's internal investigation concluded that no single root cause could be identified, and multiple actions were recommended in order to minimise risk to future patients. Concerns have been raised that the wider system in which Dr Bawa-Garba and Ms Amaro were working also contributed to Jack's death and that they have been 'scape-goated' for systemic failures.

The systemic failures included difficulties with the IT system used to review test results and staffing issues; the on-call consultant was not on-site until the afternoon and the other registrar due on duty was attending a training day, with no cover provided. Dr Bawa-Garba also worked her 13-hour shift without a break and had just returned from maternity leave to a hospital which was new to her, having received no induction.

Criminal convictions and professional sanctions

In November 2015, Dr Bawa-Garba and Ms Amaro were found guilty of gross negligence manslaughter and were both handed two year suspended prison sentences.

In August 2016, it was found that Ms Amaro's fitness to practise was impaired and she was stuck off the register by the Nursing and Midwifery Council (NMC). In June 2017, Dr Bawa-Garba's fitness to practise was also found to be impaired by the Medical Practitioners Tribunal (MPT) and she was suspended from practice for 12 months. The MPT considered Dr Bawa-Garba's actions to be neither 'deliberate or reckless' and decided that she did not 'pose a continuing risk to patients'; erasure would therefore be disproportionate.

GMC's appeal

The General Medical Council (GMC) was of the view that the MPT had re-examined the criminal case and arrived at its own, less severe, conclusion regarding Dr Bawa-Garba's personal culpability. It therefore appealed the decision of the MPT to avoid setting 'a wider precedent in allowing tribunals to unpick the findings and outcomes of the criminal court process'.

In January 2018, the High Court held that Dr Bawa-Garba's sanction should be substituted for erasure from the GMC register, saying that "the tribunal did not give the weight required to the verdict of the jury, and it was simply wrong to conclude that, in all the circumstances, public confidence in the profession and its professional standards could be maintained by any sanction short of erasure".

In March 2018, Dr Bawa-Garba was granted leave to appeal this decision and the High Court rejected the GMC's argument that a manslaughter conviction should result in automatic erasure from the register.

Dr Bawa-Garba's appeal

Dr Bawa-Garba appealed the decision of the High Court and was successful. Accordingly, the sanction of erasure has been set aside and the original order of 12 months suspension from practice, subject to review by the MPT, has been restored, with a review hearing to be held as soon as possible.

In handing down its unanimous judgment, the Court of Appeal held that the Divisional Court was wrong to interfere with the decision of the tribunal and commented that an appeal court should only interfere with the "evaluative decision" of a tribunal if:

- there was an error of principle in carrying out the evaluation, or
- for any other reason, the evaluation was wrong, in the sense that it was a decision which fell outside the bounds of what the adjudicative body could properly and reasonably decide.

Timeline

Date	Event
Feb 2011	Jack Adcock dies from sepsis at Leicester Royal Infirmary
Dec 2014	Dr Bawa-Garba and Ms Amaro are charged with gross negligence manslaughter
Nov 2015	Dr Bawa-Garba and Ms Amaro are convicted of gross negligence manslaughter and given two year suspended prison sentences
Aug 2016	Ms Amaro is struck off the NMC Register
Dec 2016	Dr Bawa-Garba is denied permission to appeal against her manslaughter conviction
Jun 2017	Dr Bawa-Garba is suspended for 12 months by the MPTS
Jan 2018	The High Court substitutes the sanction of erasure from the medical register
Mar 2018	Dr Bawa-Garba is granted leave to appeal her erasure and the GMC's argument that a manslaughter conviction should result in automatic erasure from the register is rejected
Jul 2018	Dr Bawa-Garba's appeal is heard in the Court of Appeal
Aug 2018	Judgment is handed down; Dr Bawa-Garba's appeal was successful and her erasure is set aside and the Order for 12 months suspension restored.

The Court of Appeal held that neither of the above grounds applied in this case and highlighted that the criminal court and the MPT are different bodies with different functions. They also said that the tribunal were just as entitled to take the systemic failings of the hospital and others into account when deciding sanction, as the criminal court had been when passing sentence.

The GMC has confirmed that it will not appeal to the Supreme Court.

Concerns with the GMC's decision to appeal

The GMC's appeal of the MPT's decision has led to widespread unrest within the medical profession, largely because it is recognised that the systemic failures which contributed to Jack's death are becoming the 'norm'. Some of the concerns raised are:

- a fear that written reflections may be used against doctors in future cases (though this was not the case here). As a result, there is concern that doctors will be less frank in reflecting upon mistakes and that this will, in turn, threaten the learning culture within the profession, thus impacting on patient safety
- the GMC's own regulator, the Professional Standards Authority, considered the GMC's appeal to be without merit, given the established case law
- the perception that the GMC is lenient in cases where personal conduct is more worrying, for example doctors placed on the Sex Offender's Register, or found guilty of fraud. It is argued that the GMC should concentrate on dealing with doctors who are deliberately and repeatedly dishonest, rather than those who are conscientious and make a single clinical error
- the GMC's sanctions guidance clearly outlines that the purpose of fitness to practise proceedings is not to punish the doctor a second time. Therefore, if the doctor presents no danger to the public, their career should not be sacrificed in order to satisfy a demand for blame and punishment.

Future

Independent reviews have been commissioned by both the GMC (the Marx Review) and the government (the Williams Review) in relation to gross negligence manslaughter charges for doctors. The Williams Review, published on 11 June 2018, included a recommendation to strip the GMC of its right to appeal MPT decisions. Then health and social care secretary, Jeremy Hunt, said that he planned to implement this change amongst others, which includes a review, by medical examiners, of all deaths not currently considered by coroners.

The legislative process to repeal the GMC's right of appeal will be lengthy and, in the meantime, the GMC has confirmed that it intends to continue exercising this right.

Comment

The systemic failings identified in this case resulted in the Crown Prosecution Service (CPS) re-examining whether University Hospitals of Leicester NHS Trust should be charged with corporate manslaughter. The Marx Review will also look at the tendency to pursue gross negligence manslaughter charges against individuals, as opposed to corporate manslaughter against trusts. Although the CPS decided not to pursue the Trust in this case, it remains to be seen whether the Marx Review will make any recommendations on this area. It is clear that there is currently a call from the profession for corporate manslaughter, rather than gross negligence manslaughter, to be the "go to" offence in cases such as this. It is therefore important that trusts adopt policies and procedures to avoid systemic failings becoming the "norm." Attitudes, policies and accepted practices which encourage or tolerate any failure to comply with health and safety legislation should also be identified and challenged.

A report by NHS Improvement on the pilot of the Department of Health's Medical Examiners found that possible adverse harm was detected in 10.5% of all deaths reviewed; half of which would not otherwise have been detected at this early stage. This therefore, allowed the coroner to be involved at an early stage. Whether this will have an impact on the number of claims and prosecutions in the future remains to be seen but it does offer the opportunity to gather evidence for such at a time close to events, which is essential should a claim arise. It also offers an invaluable opportunity for trusts to engage with the families of the deceased, which may reduce future litigation risk.

Written reflections should continue to be used as a tool for reflective practice by clinicians, so that patient safety is not compromised. Guidance has been published by the GMC on the content of written reflections and is a useful guide, should clinicians raise concerns.

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Laura has a variety of previous experience working within the healthcare sector and is currently in the final year of her training contract with Hempsons. Laura has worked with NHS Resolution, NHS trusts, defence organisations, CCGs and individual clinicians on a wide range of matters, including clinical negligence claims, fitness to practise proceedings and deprivation of liberty applications. At present, Laura is sitting in the Corporate & Commercial Department assisting on matters involving novation agreements and procurement issues.

Big Data, Health Data

How to unlock the potential of health data within a compliant information governance framework.

The NHS holds what are arguably the largest and most detailed digital, linkable (and thus potentially interrogatable) databases of healthcare data in the world. The potential for using this NHS data for medical research and the development of better and more efficient treatments has only just started to be tapped. The development of AI and machine learning techniques to analyse massive datasets means technology is becoming equal to the task of exploring the opportunities provided by such rich data sources. Multiple sources of funding are being made available to promote such innovation.

However, as recent headlines demonstrate, it is vital to ensure that the technical possibilities arising from such data do not dazzle researchers and developers so that they ignore the legal and ethical rules that govern the use of such data, including those set out in the Caldicott Principles, the Confidentiality: NHS Code of Practice and the GMC guidance "Confidentiality: good practice in handling patient information".

Fundamental principle

Patient-identifiable data (also known as patient confidential data or personal confidential data) should only be used for purposes connected with the direct delivery of care to the patient, and only shared with those who need to know within the direct care team. Use of patient-identifiable data outside this normally requires either patient consent or one of the recognised gateways where patient confidentiality can be set aside. This current safeguard for patient data anticipated a number of the requirements under the General Data Protection Regulation, including the principle of data minimisation and the requirement for data protection by design and default.

The problem

"Big Data" projects will generally require individual-level data in order to be useful. While the identity of the patient can be stripped out from individual-level datasets, they are usually so data rich it is impossible to truly anonymise them (under the GDPR, anonymisation means that reidentification must be "reasonably impossible" by anyone). In addition, "Big Data" projects will involve medical research or similar activities, and so will fall outside the direct delivery of care to patients (even if the project might ultimately result in a product that will influence patient care). Obtaining express consent from patients will not be feasible for any "Big Data" project, due to the scale of the dataset.

It might therefore be thought that the rules protecting health data are incompatible with any ambitions to use these datasets outside direct care.

There is enormous potential for "Big Data" held by the NHS to be used for research and development but trusts and their partners need to ensure this is done within the law

The solution

With appropriate safeguards, it is perfectly possible to undertake these projects using health data. The GDPR criteria for anonymisation are so stringent it is likely that most individual-level data must still be regarded as personal data even when the direct identifiers are removed. However, the GDPR is reasonably permissive regarding the use of health information for medical research and the management and improvement of health care systems or services provided appropriate safeguards are in place. Similarly, the common law rules relating to the use of health care data do not require that the data is anonymised to GDPR standards; instead what is required is

that the patient-derived information is anonymised in the hands of those carrying out the non-direct care activities.

There are a number of data extraction tools that enable the automated extraction of patient-level data without the patient identifiers, enabling the creation of a de-identified patient-level database while still enabling linkage of individual cases through the use of pseudonyms. These "de-identified" databases can then be interrogated for "Big Data" projects, including AI-driven machine learning tasks, which have the potential to spot associations and interactions that would simply be impossible using human researchers.

A de-identified but still patient-level database is vulnerable to accidental or intentional re-identification if combined with other data sources. Accordingly, it is essential that an appropriate controlled environment is created to house this de-identified dataset and protect it against the potential risk of re-identification. This controlled environment will involve a combination of organisational, physical and digital barriers to ensure that those using the de-identified dataset cannot access any other dataset and cannot use that de-identified dataset for purposes beyond those authorised by the data controller supplying the source data.

The importance of these controls is reflected in the UK Government's acceptance of the Caldicott 3 recommendation that re-identification of de-identified data without the permission of the data controller be a criminal offence, now enacted in section 171 of the Data Protection Act 2018.

This is a complex area and trusts and their partners need to ensure they get good advice before embarking on projects where data is shared

As de-identified data is still personal data within the meaning of the GDPR, data controllers must still comply with their controller obligations in relation to the "Big Data" project. In particular, this means there should be transparency about the project, including its purpose, who the data is shared with, what activities will be undertaken and what protection for the data is in place. The fact of de-identification and the safeguards against re-identification will assist the data controller in showing that such uses of the information are fair and do not conflict with patients' interests, rights and freedoms.

Provided appropriate thought and planning is given to information governance concerns at the stage of project design, and the task to be undertaken is one that would objectively be regarded as a "fair" use of data, it should be possible to establish a framework that will enable a "Big Data" project to proceed lawfully. In some cases, Research Ethics Committee approval will be required, dependent on the anticipated outcomes.

The opportunities

The scope of "Big Data" projects in healthcare is only just beginning to be explored. The potential for establishing a better understanding of conditions, treatments and medication means there is a real opportunity to achieve the holy grail of delivering better, more effective care at a lower cost than existing treatments. There is a strong moral case for pursuing these projects, which is reflected in the increasing funding streams being made available to support innovation in this field.

Hempsons have advised on a number of "Big Data" projects, including a major Phase 1 Test Bed project.

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Chris is an expert in the field of information governance, and regularly advises NHS and other healthcare providers, third sector entities and tech start-ups in the field. He also provides advice on transactional work involving a change in usage of personal data. Recent work in this area has included advising an NHS body in relation to the IG issues in a major NHS Test Bed project, and preparing clients for GDPR implementation.

Can a disability account **for bad behaviour?**

A recent Employment Tribunal decision serves as a timely reminder that where conduct issues are said to arise from an underlying mental health condition, employers should be cautious of departing from medical opinion.

Facts

Ms Wheeley was a long-standing employee of University Hospitals Birmingham NHS Foundation Trust and held a senior management role. She had suffered from recurring periods of depression, managed by medication, since she was a teenager but this had not led to any absences from work. The Trust was unaware of any mental health concerns until the disciplinary process at the heart of this case was underway.

Ms Wheeley had a clean disciplinary record but she had been a challenging employee. Her behaviour was difficult and inappropriate at times, such as banging her fists on the table or walking out of meetings. However, this behaviour was not formally addressed by the Trust and there was no suggestion that it was related to her health.

In May 2015 Ms Wheeley learned that her department was to be restructured and she made clear her hopes for a promotion. Following the restructure, she was unhappy about a number of matters, including that she was not promoted, and she sent an email to the medical director in which she refused to report to a new line manager. She also threatened to write to her team "informing them that the announced change would not be happening and why". She was given an express management instruction not to do so.

Despite this instruction, Ms Wheeley later responded to a group email which included members of her team and the Trust's executive directors stating that she had not been aware that communication about the restructure would be sent and that she was "considering her position".

Ms Wheeley was suspended for responding angrily, failing to follow a management instruction and communicating and acting inappropriately. An investigation commenced, following which an additional allegation was added because Ms Wheeley went to the medical director's house outside working hours in an attempt to discuss the issues. Ms Wheeley accepted she should not have done so and apologised, but largely sought to justify her other actions throughout the course of the investigation. She also reported symptoms of stress and depression and the disciplinary hearing was postponed because she was deemed unfit to attend.

Trusts need to ensure that a dismissal is "fair" if it is to stand up to the scrutiny of an Employment Tribunal

Ms Wheeley remained unrepentant and issued a lengthy grievance. She also changed her trade union representative, at which point concerns about her mental health were raised. Ms Wheeley was referred to Occupational Health, who subsequently referred her to a psychiatrist. The psychiatrist was unable to reach a definitive conclusion about whether or not Ms Wheeley had bipolar disorder but he felt it was "certainly possible".

Shortly after the grievance was heard (her complaints were rejected), Ms Wheeley made a private appointment with another consultant psychiatrist, who felt that a bipolar diagnosis was not supported. Occupational Health later arranged a referral to an independent psychiatrist, Professor Oyebode.

Rejecting a medical opinion without further clarification of it can make it harder to defend unfair dismissal and disability discrimination cases

Professor Oyebode reported that Ms Wheeley presented with the cardinal features of bipolar disorder and took the view that there was clear evidence of periods of depression and mania. He reported that it is well recognised, in manic phases, that people can exhibit behaviours that are out of character and which demonstrate irritability, hostility, recklessness and poor judgement. He referenced Ms Wheeley's threatening and insubordinate emails and said she regretted these

behaviours and considered them to be out of character. Professor Oyebode's opinion was that Ms Wheeley was in a manic phase during the period in question and that her behaviour, which formed the basis of the disciplinary allegations against her, was compromised by severe mental illness.

The Trust's disciplinary panel considered this opinion in the context of mitigation but was not convinced that Ms Wheeley's behaviour had been out of character, due to the history of her challenging behaviour. The allegations were therefore upheld and Ms Wheeley was dismissed for gross misconduct.

Employment Tribunal

She brought a claim for unfair dismissal and discrimination arising from disability in the Employment Tribunal. The ET found that absent any mitigation, Ms Wheeley's behaviours amounted to "gross insubordination on a grand scale". It also found that notwithstanding her long service and clean disciplinary record, dismissal would ordinarily have been well within the band of reasonable responses.

However, the ET went on to find that the disciplinary panel had departed from the medical opinion of Professor Oyebode by essentially finding that Ms Wheeley's mental health did not substantially cause or exacerbate her misconduct, since the behaviours were not seen to be out of character. The Trust had reached this conclusion without raising further questions with Professor Oyebode and it could not produce cogent evidence before the ET that Ms Wheeley's mental health had played no more than a trivial part in the events under consideration. The ET therefore determined that her condition did in fact have a significant impact on her actions, which arose in consequence of her disability.

The ET went on to consider the Trust's justification for its actions and agreed that its aims had been legitimate. However, it found that summary dismissal had not been a proportionate response in circumstances where the Trust had simply rejected a key medical finding that Ms Wheeley's actions were compromised by severe mental illness. This had been unreasonable and the ET concluded that no reasonable employer would have done so.

Ms Wheeley therefore succeeded in her claim, but her compensation was reduced by 25 per cent to reflect her contributory conduct.

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Lucy advises clients on all aspects of employment law which arise during the course of an employment relationship and thereafter including recruitment, drafting contracts and handbooks/policies, holiday and holiday pay issues, maternity and other family related leave, sickness absence management, redundancy and restructuring, grievances and disciplinary matters, protected conversations, managing exits and settlement packages.

Lucy has experience of successfully bringing and defending a range of Employment Tribunal proceedings including claims for discrimination, whistleblowing and unfair dismissal. She also frequently resolves disputes successfully without recourse to the Employment Tribunal.

Inadequate record keeping invalidates contract award

Hempsons recently acted on behalf of Lancashire Care NHS Foundation Trust and Blackpool Teaching Hospitals NHS Foundation Trust (the "Trusts") in successfully challenging Lancashire County Council (the "Council") in relation to a procurement challenge for the provision of 0 – 19 services.

The Trusts challenged the Council's decision to award a contract for public health and nursing services for children and young people (0 – 19) to Virgin Care Services Limited. The process was run under the Light Touch Regime.

The judge, in a ruling handed down on 22 June 2018, upheld the challenge and concluded that the procurement decision should be set aside. The Trusts demonstrated that the reasons given by the council for the scores awarded to the trusts and the winning bidder for the quality evaluation questions were insufficient in law and as a result, the decision of the council to award the contract to Virgin must be set aside.

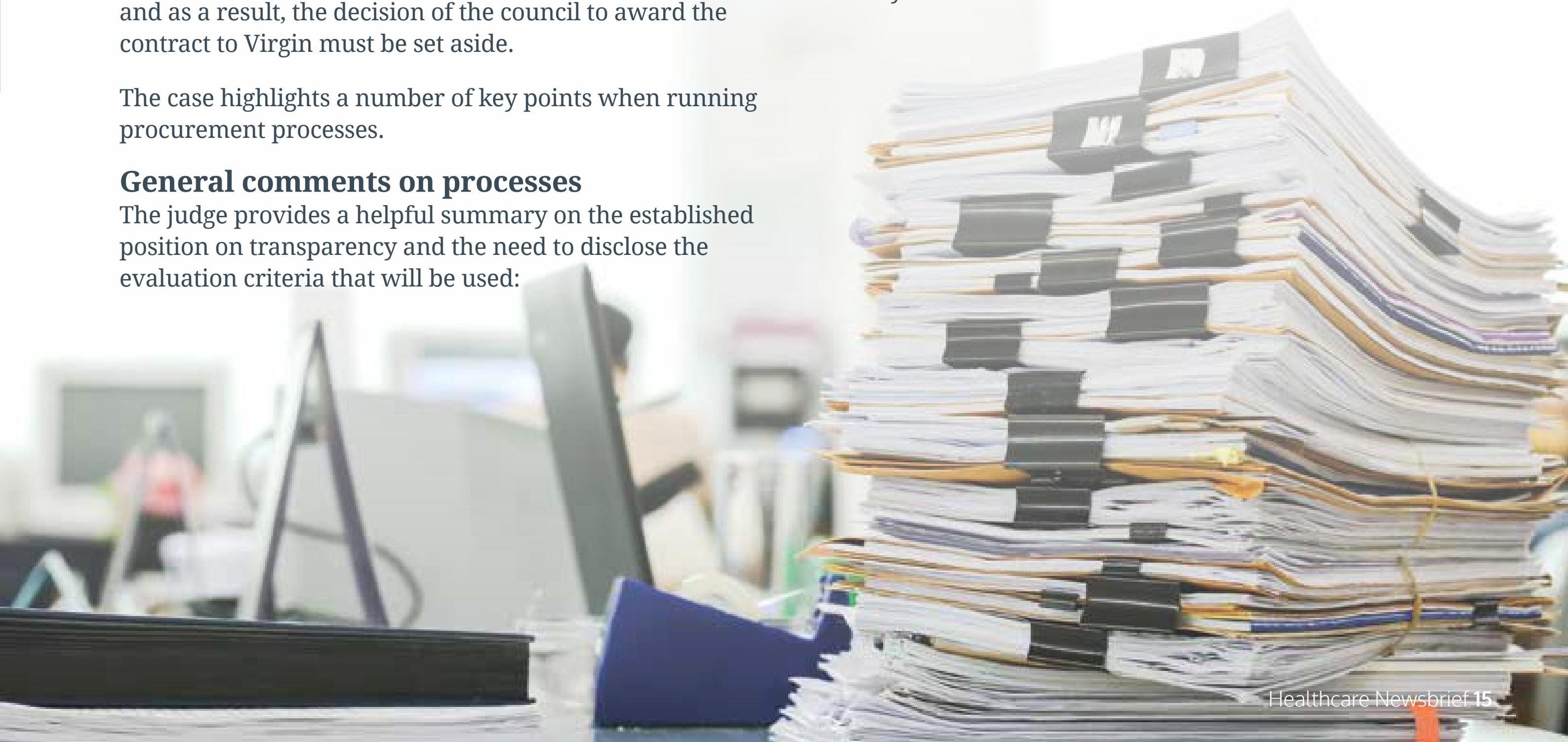
The case highlights a number of key points when running procurement processes.

General comments on processes

The judge provides a helpful summary on the established position on transparency and the need to disclose the evaluation criteria that will be used:

"[Crown Commercial Services (CCS) guidance on the Light Touch Regime states] the key things are to be clear about what your process will involve, making sure the process ensures transparency and equal treatment of suppliers, and sticking to the process that you decide to run. It would also be necessary to be transparent about any award criteria to be used, and the weightings for the criteria and sub-criteria, to comply with the general transparency obligations".

Case law has held that: "tender documents are to be construed on the basis of an objective standard, that is the standard of the Reasonably Well Informed and Normally Diligent (RWIND) tenderer. It follows that the tender documents must state the process to be followed, including how marking of bids will be carried out, in terms that can be objectively assessed and understood by a RWIND tenderer; and, having done so, the contracting authority must stick to it".



Key learning points

1 Reasons for the decision

In any process, it is imperative that the bids are scored and that there is a final rationale for the score(s) awarded. If there is a staged evaluation process, this exercise should be carried out at each stage. In this case the judge was critical of the lack of reasons for the decision at moderation. He stated: "the reasons given by the defendant for the scores awarded to the claimants and Virgin for the quality evaluation questions are insufficient in law". The consequence of this breach was that "the decision of the council to award the contract to Virgin must be set aside".

The judge stated: "although the panel reached consensus on scores, there was not necessarily or even probably congruity of reasoning that led each evaluator to subscribe to the consensus score for the question". It is imperative that a contracting authority is able to justify the decision that it has made. The judge accepted that "a procurement in which the contracting authority cannot explain why it awarded the scores which it did fails the most basic standard of transparency".

While it may not be mandatory (depending on the process followed) that all the moderators agree on all of the reasons for awarding a particular score, it should be possible from the evaluation notes to understand the basis on which the moderators arrived at a particular score. In this case, the judge was satisfied that the "notes do not provide a full, transparent, or fair summary of the discussions that led to the consensus scores sufficient to enable the Trusts to defend their rights or the court to discharge its supervisory jurisdiction".

The judge is clear that he is not suggesting "that it was necessary to keep a complete record of what was said or a comprehensive note of every point that was made [at the moderation]", but there must be reasons for the decision to enable "the trusts to defend their rights or the Court to exercise its supervisory jurisdiction".

It is therefore imperative that there is a clear audit trail for the scores provided.

What is clear is that the moderation stage of any evaluation is critical

2 The moderation process

As we have consistently advised, having a fair and transparent moderation process is fundamental to any procurement. In this case, the Council had identified specific bullet points in the Invitation to Tender (ITT) which bidders were expected to cover as part of a satisfactory answer to each question. However, the record of the moderation meeting did not clearly identify which of those bullet points had been considered and the moderators' views on each issue, or clearly set out those points that justified the scores awarded.

The judge held: "In the absence of a comprehensive record of the discussions at moderation, the absence of any recorded point that is attributable to a particular bullet point does not enable me to infer that the bullet point in question was not mentioned or discussed." Further, the records of the moderation "are not a complete record of the points that were made or even the points that were considered…" He notes that "there was no consistency in the manner in which any discussion or decision-making process were recorded…"

The judge also stated that "there was no consistency either in identifying what were said to be key points or in highlighting points to show that they had been influential".

At the end of the moderation meeting, after the scores for each bid were agreed, the Council procurement officer began to prepare notes on the 'strengths and comparative advantages' of the VCSL bid. Unfortunately, those notes were added to the moderation notes without clearly identifying which comments were subsequently added in. The judge commented:

"The lack of clarity in the manner of recording the discussion and reasoning of the panel is compounded by the interpolation of comments which, on their face, appear to indicate that the scoring was done by comparing the trusts' answers with Virgin's, which was not the permitted approach" and agreed with one of the council's witnesses that "it would have been better to have started fresh notes or at least identify within the note what he was doing".

The judge was satisfied that the reasons provided: "do not provide a full or accurate account of the reasons or reasoning that led either individual panel members or the panel as a whole to reach the consensus scores that were reached".

What is clear is that the moderation stage of any evaluation is critical. It is when a commissioner determines

who will be awarded the contract as it is when the moderated score is agreed. There needs to be a rationale for this score, that is recorded.

3 Following the stated process

The judge was of the view that the council's own guidance on how the process was to be run was "ignored". The council had stated that the chairperson at the moderation would "ensure all evaluation documents, including all evaluation comments, justifications, marks and amendments are fully documented and agreed by both the panel members and the chairperson". This did not take place. "No one purported to agree the notes of the moderation. They were never agreed by the panel as an accurate record of the moderation". Commissioners should ensure that they follow their stated process.

4 Use of terminology to describe the criteria

One of the issues in this case was what were the criteria/sub-criteria? The judge stated: "what matters, in my judgment, is that the authority should identify (a) what the tenderer is required to address and (b) how marks are going to be awarded. Once it does that, it must... stick to what it has said it requires of tenderers and how it has said it will mark the tenders. Provided it does, it does not matter whether the language of criteria and sub-criteria are used at all". Put another way "potential tenderers should be aware of all of the elements to be taken into account by the contracting authority in identifying the economically most advantageous offer, and their relative importance, when they prepare their tenders".

The language therefore is not critical, but rather the critical issue for commissioners is to be clear what a bidder is required to do, and how this this will be assessed.

5 Openness with challengers

As is common in procurement cases, the Trusts sought further information and documentation from the Council. Certain of the documents disclosed by the Council were redacted and backdated, which created the impression that documents had been signed earlier in the process than was in fact the case. The judge held that "the Council misled" the Trusts as a result and further commented "To describe this (as the council did) as merely "a regrettable episode of poor administration" is, to my mind, an unacceptable understatement".

It should not be surprising that the council was criticised for this. Contracting authorities should bear in mind from the outset that procurement documentation is prepared as part of a formal, legally reviewable process and that considerable care should be taken to ensure that documents accurately reflect the reality of the process as actually conducted. Any inadvertent (or deliberate) action that could mislead bidders or the Court is likely to be the subject of adverse comment, as here, and could have a significant adverse impact for the contracting authority.

6 The evaluator/moderator

The role of the evaluator/moderator is clearly crucial to the success of any process. We therefore recommend that consideration is given to training evaluators on the importance of their role and an explanation of why the rationale/reasons are critical.

Hempsons' specialist, integrated procurement and litigation teams will utilise their significant experience to guide you through these issues if you need to challenge a procurement process, or to defend a challenge.

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Andrew specialises in procurement law, acting for both contracting authorities and bidders. He utilises the knowledge gained from acting for clients on both sides of the fence, to provide pragmatic advice on running both defensible procurement processes, and also to challenge defective processes for bidders. Andrew regularly provides training on procurement law duties and writes articles for publications dealing with procurement.

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