HEMPSONS

Healthcare Newsbrief

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Welcome

Welcome to the summer 2022 issue of the Hempsons Healthcare Newsbrief.

As the impact of the COVID-19 pandemic continues, the public inquiry is expected to start in 2023. We have included an article on the upcoming COVID-19 public inquiry with advice on issues to consider and how you can start to prepare now.

Since the implementation of the NHS People Plan in July 2020 and its accompanying action plan, there has been confusion around how to implement the changes. Andrew Davidson examines the main elements of the plan from a legal perspective and examines some of its main challenges.

We feature two articles looking at the changes afoot with regard to procurement. Andrew Daly and Maria Gomez look at the implications of PPN 06/20 and Tim Dennis and Sam Stone review developments regarding the Procurement Bill 2022.

We are all keenly aware of the importance of policies and procedures in order to improve services and reduce risk. In her "Diagnostics legal review" article, Liz Hackett talks about the importance of minimising mistakes and gives an overview of how we can work with trusts to improve patient safety through diagnostic reviews of legal services.

We recently launched the second series of our inquest podcasts, which guides listeners through coronial inquests. The first series examined the journey of an inquest, with series two delving into inquests in different settings. In this Newsbrief you will find a list of the topics covered and a link through to listen. We also include details of our GP podcast series, looking at key issues impacting primary care.

We hope you will find something of interest to you in this Newsbrief and please feel free to get in touch with any of the authors to discuss any of the issues raised.

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Preparing for the COVID-19 Inquiry

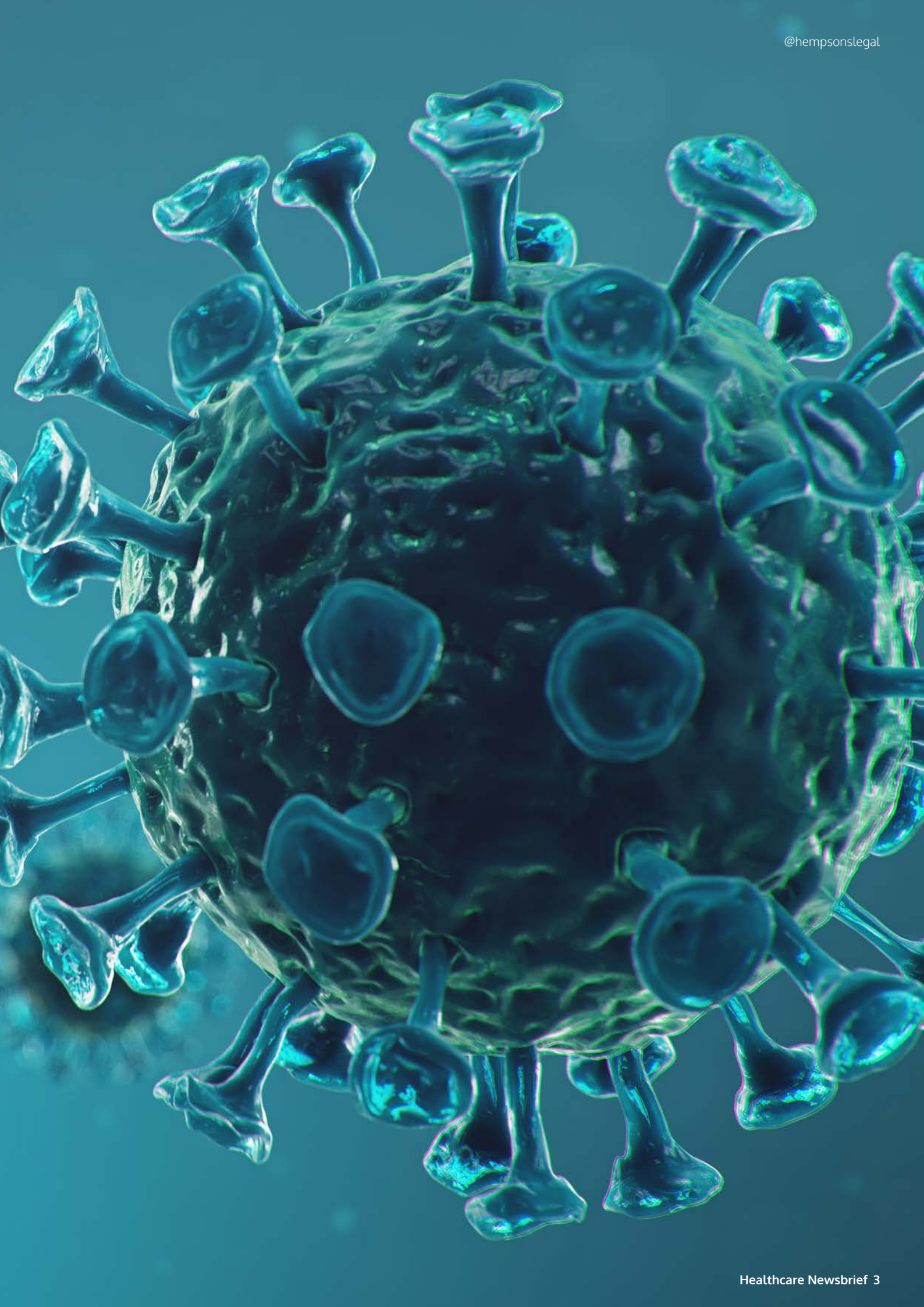
The COVID-19 Public Inquiry into the handling of the pandemic in the UK has started to gather traction.

In May 2021, the Prime Minister announced the Public Inquiry, and stated that it will be a *"proper, full, and above all, independent inquiry"*.

Momentum has started to gather, with the appointment of the Rt Hon Baroness Heather Hallett DBE as Chair of the Public Inquiry, and steps are being taken to finalise the Terms of Reference. With the key lines of enquiry for health and social providers and representative organisations starting to crystalise, it is time to ensure that you are ready to comply with your obligations in the event that the Inquiry team seeks disclosure of information from your organisation.

What does it mean for you and your organisation?
The fact that it was announced that the Inquiry would be a statutory inquiry is significant, meaning that the full formal powers of the Inquiries Act 2005 will apply.

What does this mean?
The main and fundamental difference between statutory and non-statutory inquires is that statutory inquiries are generally deeper and more effective. That is because a non-statutory inquiry relies on the voluntary compliance of witnesses, with no set procedures and few legal requirements. Witnesses cannot be compelled to give evidence in a non-statutory inquiry and evidence from witnesses cannot be taken on oath. In contrast, inquiries held under the Inquiries Act operate under a presumption that the hearings will take place in public, and there are limitations on what the inquiry can withhold from publication. Statutory inquiries are supported by powers to require disclosure of documentation, and to compel witnesses to give evidence on oath. This distinction is perhaps of less significance for registered medical professionals, and why perhaps there is evidence of effective non-statutory inquiries in the health sector, the Morecambe Bay Inquiry being an example. This is because there are professional duties on all registered healthcare professionals, notwithstanding the legal basis of any inquiry, to co-operate with formal inquiries and to be honest and trustworthy with writing statements and giving evidence, checking accuracy and not deliberately leaving out relevant information: GMC Good Medical Practice para 71-73 (replicated in the NMC Code and elsewhere).



A public inquiry is inquisitorial, rather than adversarial. An inquiry cannot find individuals or organisations liable for their acts or omissions by means of determining civil or criminal liability. The emphasis is on fact finding and not on individual or collective fault or blame. However, all inquiries make factual determinations which may, by their very nature, identify acts or omissions on the part of an individual or organisation and in doing so, determine a level of accountability. Those findings may also underpin subsequent action, whether it be a civil claim, or in the most serious of cases, criminal investigations. As public inquiries are convened to deal with issues of public concern, they play a pivotal role in public accountability.

Whether a public inquiry is convened to examine the foot and mouth outbreak, the war in Iraq, a terrorist incident, the provision of healthcare in a particular hospital setting, or the actions of an individual doctor, the purpose remains the same: to find out what happened, why it happened and hopefully to learn lessons to avoid a recurrence of event. The Shipman Inquiry demonstrates the role public inquiries have in identifying procedural and systemic weaknesses and bringing about changes with the aim of protecting the public from further harm. In July 2003, Dame Janet Smith published her third report, concluding that the death and cremation system in place at the time, which had failed to detect that Harold Shipman had killed any of his victims, was almost completely dependent upon the integrity and competence of the medical profession and failed to protect the public from risk. Recommendations from that inquiry led to an overhaul of the death certification process, a system which is still in place today.

Since announcing a public inquiry, the Government has stated that it is *"fully committed to learning the lessons at every stage"* of the pandemic by placing the *"state's action under the microscope"*.

The Terms of Reference

In March 2022, the draft Terms of Reference were published followed by a public consultation. This has been a significant time as the Terms of Reference inform what the Inquiry can, and therefore by exclusion cannot look at.

The March 2022 draft Terms of Reference confirmed that the Inquiry will examine, consider and report on preparations and the response to the pandemic in England, Wales, Scotland and Northern Ireland, up to and including the Inquiry's formal setting-up date. In doing so, it will consider reserved and devolved matters across the United Kingdom, as necessary, but will seek to minimise duplication of investigation, evidence gathering and reporting with any other public inquiry established by the devolved administrations.

It was stated that the aims of the Inquiry are to:

1. Examine the COVID-19 response and the impact of the pandemic in England, Wales, Scotland and Northern Ireland, and produce a factual narrative account.

   In terms of **the response in health and social care**, the Inquiry intends to consider specifically:

   - preparedness, initial capacity and the ability to increase capacity, and resilience
   - the management of the pandemic in hospitals, including infection prevention and control; triage; critical care capacity; the discharge of patients; the use of 'do not attempt cardiopulmonary resuscitation' (DNACPR) decisions; the approach to palliative care; workforce testing; changes to inspections; and the impact on staff and staffing levels
   - the management of the pandemic in care homes and other care settings, including infection prevention and control; the transfer of residents to or from homes; treatment and care of residents; restrictions on visiting; and changes to inspections
   - the procurement and distribution of key equipment and supplies, including PPE and ventilators
   - the development and delivery of therapeutics and vaccines
   - the consequences of the pandemic on provision for non-COVID related conditions and needs
   - provision for those experiencing long-COVID
2. Identify the lessons to be learned from the above, thereby to inform the UK's preparations for future pandemics.

Following a four-week consultation period with bereaved families, representatives from different sectors and the public, and having received over 20,000 responses on what the Inquiry should look at, Baroness Hallett has recommended to the Prime Minister that the Terms of Reference be further expanded to include:

- children and young people, including the impact on health, wellbeing and social care, education and early years provision
- impacts on mental health and wellbeing of the UK population
- collaboration between central government, devolved administration, local authorities and the voluntary and community sector

The unequal impact of the pandemic was a theme that strongly came through in responses to the consultation. Baroness Hallett has also recommended that the Terms of Reference be reframed to put inequalities at its forefront, running through the whole Inquiry.

Without question, the draft Terms of Reference are widely drafted. Insofar as they relate to the response to the pandemic in health and social care, in order to be explored in a full, fearless and candid way, will require input from individual health and social care providers.

What next?

At the time of writing this article, the expanded Terms of Reference are awaiting approval by the Prime Minister. This should be a formality and it should follow therefore in the very near future that the Public Inquiry is formally established with the full powers under the 2005 Inquiries Act. It is the intention of Baroness Hallett and her team (which has already seen the appointment of 12 senior barristers – QCs) to make timely progress, with the aim to begin the first public hearings in 2023.

Experience tells us that in the coming weeks and months we will see:

- a timetable being set – our best guestimate is that public hearings for those key lines of enquiry relevant to health and social care taking place in late 2023/early 2024
- guidance on and appointment of core participants – the key individuals and organisations in the Inquiry
- guidance on how the Inquiry team will collate evidence. This should include details of what information the Inquiry team wants from individual health and social care providers, the form in which it should be submitted, and how it should be submitted – this will be the best indication of the nature and extent of the role in the Inquiry for individual health and social care providers

Getting ready
To put your organisation and staff in the best possible place to comply with any disclosure request, there are preparatory steps that you should be taking:

- has your organisation appointed an Inquiry Lead?
- has a "stop notice" been sent to all staff to prevent the destruction of evidence?
- are the processes up to date for ensuring contact details for leavers and key personnel?
- have you started collating and sequencing documentation "relevant" to the Terms of Reference for possible:
  - disclosure to the Inquiry?
  - referencing in statements, reports or evidence?
- are you ensuring that you keep staff fully informed and supported?

Whether or not your organisation has experience of public inquiries, there is no escaping the fact that the task ahead of you may be both daunting and time consuming. By taking a proactive approach, you will be best placed to respond to any disclosure request made by the Inquiry team with the least disruption to your organisation, in what continue to be challenging times. A structured and informed approach to preparation is also essential in the event that your staff are required to produce statements and/or give evidence at the Inquiry.

With extensive experience in supporting NHS trusts and care providers in high profile public inquiries, Hempsons is here to help.

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Trust integration – system thinking and conflicts

ICS system structures will soon be a statutory reality, becoming the accountable bodies for commissioning health in their areas. As all within the NHS will be aware, this will involve: the abolition of CCGs; the transfer of functions to integrated care boards (ICBs); and the creation of integrated care partnerships. How the interests of individual bodies, and the system interests will be managed is a key area of attention for trusts in the lead up to the July "go live" of the new structures.

Individual trusts will not be represented automatically on the ICB by *"ordinary members"*. The Health and Care Act 2022 provides for certain designated positions on the board (chair, chief executive and at least three other members), but leaves flexibility in the number of *"partner members"* to be nominated by relevant bodies. The Act provides for at least one member to be jointly nominated by the eligible NHS trusts and foundation trusts for the ICB area. The guidance (*Guidance to clinical commissioning groups on preparing integrated care board constitutions* (13 May 2022) ("Constitution Guidance")) indicates that the nominated partner member(s) is expected to be the chief executive of one of those NHS trusts/foundation trusts.

The key concept for the partner member(s) appointed, is that they are not appointed as a delegate of their employing organisation, or as advocates for their sector alone. The aim is that the board should have a diverse membership and that the partner members *"will bring knowledge and experience from their sector and will contribute the perspective of their sector to the decisions of the board"*.

NHS England have confirmed that they do not intend to publish separate conflicts of interest guidance for ICBs (as they did for CCGs), although the existing NHS wide guidance (*Managing Conflicts of Interest in the NHS*) will be updated to confirm that it applies to ICBs. In the recently published Constitution Guidance, the requirements of the Act in relation to conflicts of interest are summarised, and NHS England recommends eight principles for managing conflicts.

Save for involvement in competitive procurement decision making, where an individual associated with an organisation with a vested interest in the procurement is expected to recuse themselves, the principles seek to ensure that decision making is transparent. Also, that the spirit of collective decision-making is preserved, with proportionate mitigations being used where conflicts may arise or be perceived to arise.

It is clear from the guidance that simply being a member of an organisation will not, in itself, necessarily mean that a board member is conflicted, but such conflicts should be acknowledged and considered with the precise role in decision making determined. The ideal is to ensure that where individuals have a material interest in a decision that they *"do not, and do not appear to, affect the integrity of the ICB's decision making processes"*. How this will be achieved in practice once boards begin to take decisions, and where challenges may arise, will be a learning process for all involved.

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The Health and Care Act 2022 – what now for primary care?

The Health and Care Bill received Royal Assent on 28 April and is now The Health and Care Act 2022. In this article, Ross Clark explores what has changed since the Bill was first published and what the future holds for primary care in this new landscape.

What has changed?
The Health and Care Bill received royal assent on 28 April and is now The Health and Care Act 2022.

The new structure remains broadly unchanged, with integrated care boards ("ICBs") replacing CCGs and commissioning services across the whole integrated care system ("ICS"), assisted by integrated care partnerships ("ICPs") advising at a strategic level. The focus remains on integration between providers of health and social care services, but the "go live" date for ICBs was pushed back (it was originally 1 April) and will now take effect from 1 July 2022.

One important change has been the introduction of measures to tackle the COVID-19 backlog and rebuild services badly damaged by the pandemic. These are to be funded by the injection of £36bn over the next three years, raised from the health and care levy (a 1.25% increase in national insurance contributions which commenced in April).

However, despite the efforts of the House of Lords to amend the Bill, there has been a lack of progress on workforce planning, one of the most significant factors currently affecting the NHS, where there are currently circa 110,000 staff vacancies. Chris Hopson (former chief executive of NHS Providers), cited this as *"the major, missed opportunity to introduce a statutory duty to ensure proper long term workforce planning in the NHS"*.

It's all about integration
However, whilst the structure will be in place for 1st July, the real underlying challenge is the integration that is required to deliver on the objectives of the new system. This can be considered within the three distinct levels of the ICS:

- **system (whole of ICS):** at this level the focus is likely to be on horizontal integration between NHS trusts to form pan-ICS hospital trusts or at least to integrate service provision
- **place (likely to be co-terminous with local authority boundaries):** this is where vertical integration is likely to occur, with place-based provider collaboratives agreeing how NHS trusts (ie hospital care) can integrate with the delivery of primary care, mental health, community nursing, social care and the services offered by charity and third sector organisations
- **neighbourhoods (co-terminous with PCN areas):** this is likely to be the area that is the *"engine room"* for the delivery of integrated care to patients and will also see a need for horizontal integration between primary care and the other community based providers of health, social and support services

This is not going to be easy. As GPs have found when seeking to merge or where they have come together within PCNs, it takes time to build trust and confidence when working together, and this is the cornerstone of good and productive integrated working. Trying to expand the success of PCNs into a wider collaboration with a much broader and more diverse range of providers is

a real challenge. And the pressures from the pandemic and the workforce crisis only exacerbate the difficulties of successful integration at neighbourhood level.

What now for general practice?
Leaving aside the pressures from the pandemic, the issues surrounding the employment of ARRS staff within a PCN company and the possibility that DES funding will disappear into the general ICS budget at the end of the current five year contract framework in 2024, there are other forces at work on general practice.

The 2022 publication by Policy Exchange *"At Your Service"*, with a forward by the Secretary of State for Health, gives an insight into the possible direction for general practice. In looking at the role of general practice in the future, this publication proposes:

- *"reform is required to ensure it thrives in the future. The current model is neither adequately staffed, nor optimally planned"*
- *"reform to the underlying model of general practice should not be regarded as a distraction (from the workforce crisis).... elements of the partnership model and how it is reimbursed contribute to the current challenges"*
- *"This report calls for a model predicated upon 'layers of scale'. The objective is to ensure that the agglomerated benefits of scale...are realised."*
- *"To achieve this, we envisage the phase-out of the small-scale independent contractor model across much of general practice."*
- *"This...should be regarded as a ten-year transition, with...alternative contracting models introduced and running in parallel to the 2024/25 five-year framework."*
- *"Under this arrangement we expect to see an increasing number of GPs salaried or employed by scaled providers."*

In particular, the suggestion of GPs employed by *"scaled providers"* suggests the vertical integration of general practice within NHS trusts, unless general practice can build its own at scale models.

In his foreword, Sajid Javid cites *"the potential of the NHS working 'as one'"*, claims there is *"an exciting future for primary care"* and concludes *"this report offers some credible ideas and insights...I welcome the report as a pragmatic contribution to this vital debate on the future of the NHS"*.

So, the direction favoured by the centre seems to be clear and, at present, there seems to be little in the way of a unified national voice representing general practice against these proposals. They are only proposals and are not inevitable but the structure of the ICSs under the Health and Care Act 2022 does seem to provide a framework for this to take shape.

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NHS People Plan – from a legal perspective

The NHS People Plan was published in July 2020. Since publication, NHS organisations have been grappling with how to implement the plan and the action plan published alongside it.

This article examines the main elements of the People Plan from a legal perspective and considers some of the main challenges.

The key areas as we see it are:

- systems working
- flexible and remote working
- addressing inequalities and staff health and wellbeing
- recruitment

The focus upon systems working is consistent with the implementation of ICSs across the country and support for a more flexible NHS workforce.

There are several common legal challenges around greater system working and some thought needs to be given to the mechanism by which organisations, both NHS and in other sectors, work together. That can raise questions around potential secondments, the transfer of undertakings and changes to terms and conditions.

Strategic assessment at the beginning of any change programme is important to understand the potential legal implications of the various integrations.

For example, it is not unknown for there to be an unintended transfer of undertakings (TUPE). Inadvertently creating a TUPE transfer could have serious consequences for the organisations involved, not least because a failure to undertake adequate consultation and provision of information can give rise to claims of up to 90 days' pay per affected employee. With organisational changes involving hundreds of employees this can be a very significant potential liability.

It reiterates the need to have a well thought through plan for integration and to take full advantage of flexibility within existing terms and conditions, secondment arrangements etc.

In some cases changes to terms and conditions are necessary. The process by which terms and conditions are changed needs to be fair and well considered.

Another key theme of the People Plan is to move towards flexible and remote working. Since January 2021 the position for all NHS advertised roles should be that they are flexible by default. In addition, there is flexibility for junior doctors in their training, and the existing statutory right to request flexible working has been significantly expanded upon and improved in Agenda for Change (AfC) terms and conditions.

There has been significant work on addressing inequalities within the NHS but there is still some work to be done.

Of particular concern is the 'disciplinary gap' for black, Asian and minority ethnic (BAME) staff. The action plan included the goal of 51% of NHS organisations to have eliminated the ethnicity gap when entering a formal disciplinary process by the end of 2020. This was always an ambitious goal.

There has already been considerable work undertaken by NHS organisations in relation to the review of their disciplinary and grievance procedures following the letter to trusts from Baroness Harding in May 2019. There remains some work to be done to ensure that existing inequalities are reduced and ultimately eliminated from employee relations procedures.

There is also work to be done in ensuring that NHS leadership is representative of the overall BAME workforce. Although positive discrimination is not lawful under the Equality Act 2010, there is room for employers to take positive action where they are able to demonstrate a need. Thinking in terms of aspirational targets rather than quotas is the right way to proceed.

Relating to health and well-being, there is a stated intention to improve the level of occupational health support and to support employees through sickness.

We have seen an increased focus upon mental health issues in the workplace place and employers should be mindful of their obligation to consider making reasonable adjustments for those with a mental impairment.

In relation to recruitment, there should be a renewed focus on policies and procedures for those who retire and return. In particular, fixed terms for those who retire and return should be considered carefully as they may be potentially discriminatory on the grounds of age.

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Conclusion

There is a lot to implement within the People Plan. Some of the actions required have significant legal implications.

NHS England guidance on applying net zero and social value in procurement

PPN 06/20 introduced a new model to deliver social value, which applies to procurements covered by the Public Contracts Regulations 2015 and requires a minimum of a 10% weighting for social value questions.

In March 2022, NHS England published guidance to extend the principles within PPN 06/20 to ensure the consistent approach of all in-scope organisations to apply net zero and social value to the commissioning and purchase of goods and services by NHS organisations.

Visit **https://hpsns.co/ppn0620** to read PPN 06/20 in full

Visit **https://hpsns.co/netzero** to read the Net Zero guidance

The NHS England guidance sets out a clear approach to apply and implement such principles within PPN 06/20. The guidance sets out details on:

- selecting the social value themes
- determining net zero and social value weighting at or above the 10%
- adding net zero and social value questions into a tender
- evaluating tender responses
- effective contract management

All procurements undertaken by in-scope organisations will contribute to the net zero and social value goals and should therefore take such guidance into account when commissioning and purchasing goods and services.

Care is required when implementing the guidance, as in-scope organisations will need to consider and be compliant with the Public Contracts Regulations 2015, as well as the impact implementing such guidance has on framework agreements.

All in-scope organisations should adopt such guidance to all procurements from 1 April 2022.

Hempsons' specialist procurement team can advise you on the issues raised within the guidance or any other procurement issues.

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The Procurement Bill 2022 – new procurements, same old challenges?

On 12 May 2022, the Procurement Bill was published in the House of Lords and is currently being debated. The intention is for the Bill to make its way through the legislative process and obtain royal assent sometime in 2023, with a minimum period of six months' notice before 'going-live'.

The Government has stated that the Bill will: create a simpler and more flexible system for public procurement; open up public procurement to new entrants such as social enterprises, allowing them to compete for and win more public contracts; and embed transparency throughout the commercial lifecycle so that public spending can be properly scrutinised.

As stated in a previous Hempsons article, the Bill is lengthy and there will be much to consider over the coming weeks and months. Changes are likely, to at least some extent, prior to royal assent and we are informed that much of the detail may be included in (yet to be published) secondary legislation. However, one aspect of the Bill which does not, on the face of it, appear to make revolutionary changes to the current regime is around procurement challenges and remedies. The remedies available to bidders remain broadly the same.

Remedies available

Prior to a public contract being entered into, the remedies of an order (a) setting aside a decision of the contracting authority (b) requiring the contracting authority to take certain action(s) and (c) for the award of damages, all remain available.

The Bill maintains the concept of the automatic suspension on contract making in circumstances in which a claim is issued prior to the contract being entered into. However, interestingly, this appears to be limited to circumstances in which a claim is issued during the standstill period, as opposed to any point prior to the contract being entered into, as is the case under the current legislation (it is worth noting that the standstill period outlined in the Bill is a period of eight working days from the publication of a contract award notice rather than the current 10 calendar days running from the issuing of standstill letters).

It was envisaged that the current test applied by the Court in deciding if the automatic suspension should be lifted (ie is there a serious issue to be tried?; are damages an adequate remedy for the parties?; where does the balance of convenience lie? (known as the American Cyanamid test)) would be replaced by a simple, single limb test which provided for suspensions to be lifted where there were overriding consequences for doing so.

The Bill, in fact, requires the Court to take into account:

(a) the public interest, including the public interest in:
  (i) upholding the principle that public contracts should be awarded, and contracts should be modified, in accordance with the law
  (ii) avoiding the delay in the supply of goods, services or works provided for in the contract or modification
(b) the interests of suppliers, including whether damages are an adequate remedy for the claimant
(c) any other matters that the court considers appropriate

It will be interesting to see how such a test (which is, in many ways, arguably not dissimilar to the existing one) is applied by the Court, how different the analysis will be in practice and the extent to which the existing case law will be applied.

Post award, the remedy of ineffectiveness essentially remains, but will now be known as the remedy of *"set aside"*. Damages will also be available in such circumstances, although the need for the Court to impose a civil financial penalty when making an order of set aside is not included.

Also, set aside will be available if the Court is satisfied that the claimant was denied a proper opportunity to seek a pre-contractual remedy because *"the breach became apparent only after the contract was entered into"*. This is new and, if it remains, may well be the focus of much (satellite) litigation.

Limitation periods
The general 30 day limitation period, commencing from the date the claimant knew or ought to have known of the circumstances giving rise to the claim, in which a claim must be issued remains the same (as does the ability of the Court to extend this period to a maximum of three months).

The *"long stop"* date by which a claim for set aside must be started is six months from the date of the contract was entered into, as is the case with a claim for ineffectiveness under the current regime. However, how that long stop date interacts with the 30 day limitation period is seemingly different and may need some clarification.

Proposals not adopted
On publication of the Government's response to the consultation which followed the publication of the green paper, *Transforming Public Procurement*, it was clear that several of the original proposals made, such as imposing a cap on the level of damages available to claimants, were not, in fact, going to be adopted.

One proposal in the green paper which was of particular interest to procurement litigators was the abandoning of the need for contracting authorities to issue standstill letters following evaluation and prior to entering into the contract with the preferred bidder. It had been proposed that the contracting authority would, instead, disclose to each bidder a suite of documentation created during the evaluation, both in relation to its own bid and that of the preferred bidder (redacted as appropriate). It was felt by many litigators that this could lead to a great deal of complaints/litigation/requests and applications for disclosure. Despite the Government's response to the consultation confirming its intention to proceed in this way, the Bill, in fact, requires contracting authorities to issue to each bidder an *"assessment summary"*, setting out information regarding the assessment of that bidders bid and that of the preferred bidder. The type of information and level of detail to be included in such a document is not specified but it may well be that this document will essentially replicate standstill letters as we know them now.

Regarding practicalities of procurement of claims, such as the use of written pleadings to expedite claims and reduce costs; a fast track system; and enhanced (early) disclosure requirements, these previously raised proposals are not addressed in the Bill. It appears that issues such as these may be dealt with via a revision of the current Technology and Construction Court ("TCC") Guidance Note on Procedures for Public Procurement Cases and/or through amendments to the Civil Procedure Rules.

Conclusion (and a note of caution)
Therefore, as stated above, the changes may not be revolutionary. However, if introduced, they will no doubt generate points of dispute whilst those involved in procurement get to grips with the new landscape.

Finally, a warning. Whilst procurement professionals will continue to watch, with interest, how the Bill develops over the coming months, it is, of course, essential to remember that the existing legislation will apply until the new regime goes live. Compliance with the current rules remains essential.

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Diagnostics **legal review**

"It is human to make mistakes so we – the NHS – continuously need to reduce the potential for error by learning and acting when things go wrong."

"Patient safety is about maximising the things that go right and minimising the things that go wrong. It is integral to the NHS' definition of quality in healthcare, alongside effectiveness and patient experience."

(The NHS Patient Safety Strategy (NHSE), July 2019)

There is a considerable amount of information available across the NHS and within your organisation to support learning from incidents and inform patient safety improvements. All NHS trusts will be very familiar with reports and data aimed at learning produced by Getting it Right First Time (GIRFT), NHS Resolution through their scorecards, HSIB maternity investigations, and CQC reports, to name but a few sources. Your organisation will also produce a significant amount of internal learning data, including incident reporting, mortality reviews, complaints investigations, internal investigation reports and action plans, prevention of future deaths reports from coroners, and claims outcomes.

Despite the considerable amount of data and information produced to inform learning and improve patient safety, do you fully maximise the learning from these different streams? And understand the true extent of risk being carried by your organisation?

All too often we hear that the way in which trust legal, patient safety, complaints and learning teams (collectively referred to here as legal services) work in silos, results in missed opportunities for identifying, capturing, evaluating, embedding and evidencing learning opportunities from all available data streams.

To understand whether the internal systems and processes in your organisation support a commitment to learning, and to understand whether your organisations may be carrying an underappreciated level of risk, you need to understand:

- how learning from the investigation of adverse incidents, complaints, inquests, and claims is communicated between teams
- what are the methods for evaluating risk and identifying learning at all stages of legal processes, not just at the time of the incident, or in the event of an inquest
- how you monitor and evaluate ongoing risks, including the identification of themes
- how you support the engagement of staff throughout all legal processes

- candour and how well you engage patients and family or carers, both in terms of sharing outcomes and learning, and learning from their experiences
- how you communicate areas of concern and learning outcomes with coroners and other stakeholders, including the CQC, NHS Resolution and external legal providers

Diagnostic review of legal services
At Hempsons, we are committed to learning from incidents and working with trusts to improve patient safety through diagnostic reviews.

The purpose of a diagnostic review of legal services is to evaluate work processes, methods and culture around capturing and implementing learning from incidents. Hempsons' approach to such a review is holistic. Alongside identifying the risk profile of the organisation in strict legal terms, we consider whether the processes and procedures within the organisation support a culture of learning from incidents. Our reviews inform a diagnostic quality, safety and learning report addressing a range of risk and learning factors such as:

- legal risk being carried by the organisation
- risk being carried by the organisation in terms of public confidence and accountability
- areas of good practice in relation to capturing and embedding learning
- areas where there are missed opportunities to capture and embed learning
- reasons for the missed opportunities to capture and embed learning

Using this analysis, we can make recommendations for changes to policies and procedures to improve the quantity and quality of learning captured (including reducing future incidents) and reducing the level of risk held by the organisation. We also make recommendations for systemic and cultural changes all aimed at making positive and measurable patient safety changes.

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Liberty Protection Safeguards – an update

What?
As contained in the Mental Capacity (Amendment) Act 2019 (yet to come into force), the Liberty Protection Safeguards ("LPS") are due to replace the current Deprivation of Liberty Safeguards.

LPS will provide a new framework for the protection of those aged 16 and over, in any setting who need to be deprived of their liberty, to ensure they receive required treatment or care.

The LPS reform will impact:

- mental health and acute NHS trusts
- CCGs (ICSs)
- local authorities
- independent sector providers – health and social care

Guidance in August 2021 set out intentions for a three assessment approach, greater input from family members and additional scrutiny by approved mental capacity professionals where there are objections to proposals.

The proposed Code of Practice will be a single code, covering both updates to the Mental Capacity Act 2005 ("MCA") and the new LPS.

When?
On 17 December 2021, the Government announced the start date of April 2022 could not be met. On 10 March 2022, the Government set out an overview timeline for next steps, confirming the implementation date will be set at the end of the consultation period.

On 17 March 2022, the LPS public consultation launched with publication of the draft Code of Practice and regulations. The public consultation will run until 7 July 2022.

Visit **https://hpsns.co/MCAcop** to access the open consultation, Code of Practice and draft regulations

Responses are not anticipated until the winter. It will be at least another six months after the consultation closes before the new regime comes into effect.

Once implemented, CQC and Ofsted will monitor and report upon LPS (England only) and there will be parallel running of LPS and the current Deprivation of Liberty Safeguards for one year. Existing authorisations will continue until they expire.

It is essential to prepare now, by reviewing resources required, continuing to make applications under the current regime and focusing on good MCA practice. Everyone affected by the new LPS regime should read the draft Code of Practice and engage with public engagement events, to have your say, assess resources and prepare.

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inquests podcast series

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- Inquests in care homes
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- Inquests and clinical negligence claims
- Inquests in prisons
- Inquests for GPs
- Mental health inquests

We welcome input from our listeners so do let us know if there are any topics you would like us to cover in future podcasts.

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- GP practice mergers – the key considerations
- The future of PCNs
- GP indemnity scheme
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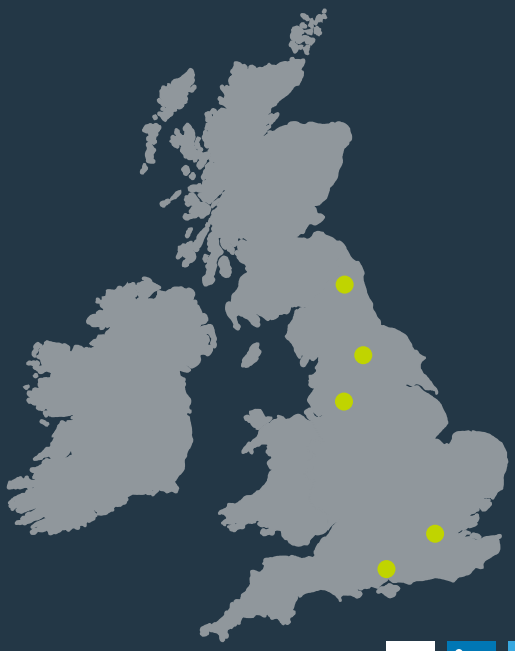

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