Action for Victims of Medical Accidents

FORMAL RESPONSE TO "MAKING AMENDS"

the Chief Medical Officer's Recommendations for Reform of Clinical Negligence in the NHS

October 2003

Introduction

In July 2003 Action for Victims of Medical Accidents (AVMA) produced a briefing and discussion paper on the Chief Medical Officer's consultation document 'Making Amends' to facilitate discussion and debate about the issues raised by the recommendations. This formal response has been prepared following discussion with a range of stakeholders, including patients' organisations; individuals who have sought compensation from the NHS for clinical negligence; both claimant and defence solicitors; and NHS bodies, as well as AVMA staff and trustees. As well as commenting on the recommendations and consultation questions, we have offered alternative suggestions and hope to work with the Department and others on potential pilots to test different approaches to the 'NHS Redress Scheme' idea. The response comprises three sections:

A. AVMA's Overview of the proposals as a whole
B. Detailed Comments on each of the recommendations
C. Answers to the 'Questions for Consultation' posed by the Chief Medical Officer

A. OVERVIEW

AVMA warmly welcomes the aims and vision set out by the Chief Medical Officer's report. However, we also have serious concerns about some of the proposals and their likely consequences (whether intended or not). We are pleased that there has been acceptance of many of the points AVMA has been arguing for years – particularly that together with any financial compensation and remedial care must come full and candid explanations of what has happened and why, with apologies and assurances that things will be put right where appropriate. The recognition that there needs to be speedier investigation and settlement of claims is welcome, as is the acceptance that the NHS Complaints Procedure should be able to trigger compensation without having to go through a further bureaucratic and lengthy process. AVMA has always been in favour of developing alternatives to the legal system for the achievement of redress.

On the other hand, the document seems to struggle between a perceived need to control expenditure on clinical negligence and a desire to be fair to people who have been injured as a result of negligence. Whilst there are some very innovative and useful ideas within the proposals, the effect of some of them would be to deprive people access to specialist advice which they need and put people under pressure to accept less than the actual compensation and care that they need and deserve. Effectively, the proposals as they stand would mean that patients injured as a result of negligence in the NHS would have less rights and access to justice than patients in private healthcare, or those injured through negligence in almost any other setting.

AVMA hopes that the recommendations will be thoroughly re-worked bearing in mind the alternative suggestions that AVMA and others have made. This we feel could lead to a fairer and more effective system. In addition to the comments and suggestions set out below AVMA has two key recommendations about the overall process to be followed:

- **As the document presents early thinking with much more detail needed in order to assess the overall implications of the proposed reforms, we believe that it is vital that there is further formal consultation on actual proposals for reform that may emerge.**

- **We hope to be able to work with the Department of Health and other stakeholders on running one or more pilots to test different ways of running a Redress Scheme, which may address the most serious concerns about the proposals as they stand.**

B. DETAILED COMMENTS ON THE RECOMMENDATIONS

1 "An NHS Redress Scheme should be introduced to provide investigations when things go wrong; remedial treatment, rehabilitation and care where needed; explanations and apologies; and financial compensation in certain circumstances"

1.1 AVMA welcomes the proposal for a Redress Scheme to provide faster investigation and resolution of clinical complaints and claims for compensation. We recommend that the Redress Scheme is integrated with an improved NHS Complaints Procedure to allow thorough local investigation of complaints about clinical treatment, which meet the agreed criteria, to result in an offer of a compensation package as part of the final response at local resolution stage. There should be an opportunity to appeal for an Independent Review to look into a complaint/claim dealt with under the Redress Scheme just as with any other complaint. However, we perceive an urgent need for other modifications to the proposals as they stand, which are set out below:

1.2 We are very concerned that the current proposal does not allow for specialist independent medical and legal advice to be made available to the (potential) claimant from the outset of an adverse event. Without this, how would the patient know whether they had a strong case for compensation or whether the claim should be within the financial threshold for the scheme or not? Our experience is that people need specialist advice from the outset even to know what questions to ask to inform an investigation and that without this, a large amount of time and money can be lost in the investigation going down the wrong track. This need can be remedied by :

a) ensuring that legal aid remains available to people to seek legal advice from the outset (as opposed to just when an offer of compensation has been made), and

b) providing funding for AVMA's advice service to be made more accessible. This service, where qualified nurses or doctors with medico-legal training advise people affected by medical accidents, has never received statutory funding and currently would not have the capacity to deal with a large influx of new clients that would be generated. The service could be developed in tandem with the new Independent Complaints Advocacy Services (ICAS), so that local ICAS staff dealing with more general complaints can consult and refer clients to AVMA's specialist staff.

1.3 We are not opposed in principle to the care/treatment that is required as a result of injuries caused by poor quality treatment in the NHS being provided by the NHS. However, there will need to be flexibility built into this. As the report acknowledges, the NHS may not be in a position to provide the care or treatment that is needed, in which case it will need to be 'purchased' from elsewhere. Also, the patient/carer must have some choice and control over the care package. In some circumstances for example, the patient may object in principle to being treated at a certain NHS provider because they have had a bad experience with them in the past. Or, they may feel that the kind of care being offered is just not appropriate or convenient for their needs. They should not be put in a 'take it or leave it' position.

1.4 We have concerns about the independence and clinical robustness of investigations under the Redress Scheme as proposed. As it stands, all of the investigation seems to rest with the NHS body about which the complaint has been made. Our experience of NHS bodies' own investigations of complaints is that they often fail to identify serious failings in care which are subsequently discovered as a result of a more rigorous, independent investigation and specialist representation of the patient. The 'Resolve' pilot 'fast-track' resolution scheme on which the Redress Scheme is said to build, was itself seen as compromising robustness of investigation in favour of speed and reduction in costs. However, even Resolve was based both on the claimant having independent legal advice and the substance of the claim being decided by an independent medical expert.

1.5 More independence should be introduced to the operation of the NHS Redress Scheme. Many people will be unhappy with the concept of the new national body succeeding the NHSLA, which will have as part of its brief defending the NHS from claims, being in complete control of deciding upon compensation packages of up to £30,000 plus the care involved. There are a number of potential ways of remedying or mollifying this:

- a new body or 'tribunal' could be set up specifically to run the Redress Scheme

- independent panels could be established to decide on the merits of individual cases

- independent help and advice could be offered to all complainants through the funding of AVMA's advice service as a key element of the new ICAS service.

- independent clinical assessments / reports could be commissioned as part of the initial investigation

- complainants/claimants should have the right to appeal to CHAI to conduct an Independent Review of the Redress Scheme conclusions, as part of an integrated approach to complaints and redress

1.6 Funding should be available to claimants to seek legal advice not just at the point they are offered compensation, but at the outset and in the event they are not satisfied with the outcome of the NHS Redress scheme. Not to allow this would be incompatible with fundamental commitments to allow citizens access to justice and would put patients injured during NHS treatment at a disadvantage compared with private patients or those injured in almost any other setting.

1.7 AVMA recommends that the criteria for qualifying for compensation under the Redress Scheme should be: "*where there were serious shortcomings in the standard of care; the harm could have been avoided*." We disagree with the proposed third criteria ("*and the adverse outcome was not the result of the natural progression of illness"* which would call into question whether "*serious shortcomings in the standard of care"* would include delayed or misdiagnosis. Not to include delayed diagnosis would unfairly exclude a large cohort of deserving beneficiaries. Where it is apparent that there have been serious shortcomings in the standard of care and harm has been experienced, the patient/family should qualify for compensation unless the NHS body can show that the harm could not have been avoided or was avoidable. The application of the 'Bolam test' and the need to prove causation have meant that many deserving cases have gone without compensation in the past.

1.8 We believe the financial maximum of £30,000 for claims to be dealt with under this kind of 'fast-track' scheme, with an investigation conducted by the NHS itself, is too high. This would mean that some very complex cases would have to be dealt with in a superficial way, which could lead to claimants losing out unfairly or the NHS paying out more than it should. Although it is the complexity of the case which is really the key factor here, if a financial definition is used we propose that claims of up to £15,000 would be more likely to be suitable for this kind of approach. This view is informed by our experience of the 'Resolve' fast-track resolution pilot scheme. It follows that we think that whatever upper financial limit is set, it should include both the cost of care and the cash element. The cash element should include loss of earnings. The application of the maximum figure should not be rigid. For example if an investigation is conducted which indicates compensation above the intended maximum should be made, it would still make sense to 'settle' the case at that stage (with the patient/claimant having full access to independent legal advice) rather than leaving them with no alternative to take legal action. We do not think that there should be a minimum qualifying level.

1.9 Guidelines/protocols are needed to ensure that cases where there has been a death are dealt with thoroughly and sensitively.

2 <u>"The NHS Redress Scheme should encompass care and compensation for severely neurologically impaired babies, including those with severe cerebral palsy"</u>

AVMA has some serious concerns about the proposals as they stand:

2.1 AVMA would greatly welcome improved services for all children with these kinds of disability, but is disappointed that the proposals confuse the issues of 'compensation' for negligent treatment with appropriate care of children who have brain damage as a result of unavoidable accidents or acceptable risks or complications. We believe that people affected as a result of negligent treatment deserve 'compensation', and that the NHS already has a duty to offer good quality treatment to any brain damaged child. This is not 'compensation'.

2.2 Placing an arbitrary limit on the amount of compensation that can be paid in respect of children brain damaged at birth would inevitably mean that some of the most severely damaged claimants might be put under pressure to accept less compensation than they need and deserve. It would mean that compensation packages would no longer be needs led. The maximum payments envisaged appear to be too low to realistically meet the needs of children with the kinds of disability envisaged. The compensation package described does not mention loss of earnings on the part of the parents / carers. This should be an essential component in any such package.

2.3 The report suggests that participation in the scheme will be voluntary and the option of taking legal action in the normal way would remain open to people. We strongly believe that people should be able to go straight to legal action if they have a strong case for proving clinical negligence. However, this will only be a reality if public funding ('legal aid') for the investigation and pursuit of such a claim is still available. It would be unacceptable if the State were effectively to prevent people having access to justice, and would mean that these families would have less rights than those who suffer brain injury through negligence in private care or almost any other setting (e.g. a road traffic accident).

2.4 We also think that it is imperative that families have access to expert legal and medical advice throughout even if they are taking advantage of the NHS Redress scheme. Without this the investigation will rely solely on the NHS Trust and Redress scheme itself and the claimant will not be empowered to participate in a meaningful way. Our experience of these sorts of claims, which are almost by definition very complex, is that a very different conclusion would be drawn if the investigation and brief to expert medical witnesses (or the expert panel) were to be left to the NHS Trusts and NHSLA. Claimants would lose out unfairly.

2.5 It is proposed that families accepting an offer of compensation through the scheme would not be able to litigate subsequently. Clearly, detailed legal advice will be necessary when considering any offer, including independent expert medical opinion in order to be able to make an informed choice. It could be more economical to allow for this as part of the initial process rather than afterwards. It would be unjust if families were put in a 'take it or leave it' situation, and so it is important that offers made remain open for a considerable time whilst families explore other options. Families who first of all attempt resolution through the Courts should still be able to apply to the scheme.

2.6 We have concerns about the eligibility criteria suggested. *"Birth under NHS Care" and "impairment… related to or resulting from the birth"* would appear to exclude children who have suffered harm as a result of substandard ante-natal or post-natal care, which seems illogical and unjust.

2.7 A fairer approach would be to apply the same criteria as we have suggested (in 1.7) for the rest of the Redress Scheme: *"where there were serious shortcomings in the standard of care; the harm could have been avoided"*. In this context the 'harm' could be taken to be neurological impairment. (There would be difficulties in defining 'severe'). Where it is apparent that there have been serious shortcomings in the standard of care and harm has been experienced, the patient/family should qualify for compensation unless the NHS body can show that the harm could not have been avoided. The compensation package should then be calculated based on the actual needs of the child.

2.8 The scheme, if it is implemented, should certainly cover home births. Although independent midwives working outside the NHS would not be part of the scheme, we feel it is important that they, together with all health practitioners, should be required to have appropriate insurance cover.

3 "A national body building on the work of the NHS Litigation Authority should oversee the NHS Redress Scheme and manage the financial compensation element at national level"

3.1 We think that the roles of investigating and awarding claims and of defending the NHS against claims carry with them obvious conflicts of interest which would be damaging to public confidence in the Redress Scheme and the NHS as a whole.

4 "Subject to evaluation after a reasonable period consideration should be given to extending the scheme to a higher monetary threshold and to primary care"

4.1 As explained in "1" above, we believe that the scheme as proposed already has too high a monetary threshold, because in our experience it is likely this would mean that complex cases would be dealt with superficially, with unfair results. We recommend either lowering rather than raising the monetary threshold., or finding a more appropriate method of determining which cases would be appropriate for such an approach.

4.2 We think that the scheme should apply to primary care. It would be hard to justify patients having different rights of redress in different parts of the NHS. However, the pilot phase could be restricted to NHS Trusts at first. Perhaps a smaller scale pilot could be run for primary care to help prepare for its full roll out?

4.3 We would also recommend an initiative to extend the indemnity which the NHS provides to staff within the NHS to GPs, Dentists, Pharmacists and Optometrists working on behalf of the NHS. We feel that the current necessity to litigate against individual doctors or practices creates the adversarial, personalised atmosphere or "retribution" which the indemnity, which was introduced in the NHS in 1990, has done a lot to mollify.

4.4 It should also be a requirement of registration for any health professional to have appropriate indemnity insurance in place.

5 "The right to pursue litigation would not be removed for patients or families who choose not to apply for packages of care and payment under the NHS Redress Scheme. However, patients accepting a package under the Scheme would not subsequently be able to litigate for the same injury through the courts"

5.1 It is essential that people retain the right to litigate rather than accept a compensation package offered through the Redress Scheme. However, whilst the report suggests this would be the case it will only be so if potential claimants have access to public funding (legal aid). We would like assurances about this.

5.2 The recommendation of the Chief Medical Officer concerning access to independent advice is just that "a small amount of money" would be made available to pay for advice "on the fairness of the offer". We strongly advise that funding should be made available to ensure that potential claimants can access specialised advice and make informed decisions about whether to pursue a claim through the Redress Scheme or not; to assist them in the pursuit of such a claim; advise them on the fairness of any offer made, and assist them in and to pursue a legal action if they are not satisfied with the conclusions or the compensation package offered by the Redress Scheme. Even advice on the fairness of an offer could be fairly costly, as it is likely that a solicitor will need to look more deeply into a case than the fast-track nature of the Redress Scheme is likely to. This may involve obtaining independent expert opinion.

5.3 AVMA have concerns that without money being available for independent legal advice there is a risk of advisors and, in particular, claims managers ('claims farmers') exploiting individuals considering compensation under the Redress Scheme. Legal advice might be offered in return for a fee payable on

'successful' claims. The experience of the operation of such schemes in the personal injury context is worrying. It would be wrong to encourage proliferation of such schemes, particularly where modest compensation claims are concerned and where there is a risk of costs exceeding 'damages'.

5.4 It is not clear from the proposals whether people who exercise their right to pursue legal action but who are unsuccessful (before having been offered any 'package' by the NHS Redress scheme), would then be able to apply to the scheme. There may be cases that are pursued in this way because, for example, the potential damages are estimated to far exceed the 'package' that would be available through the scheme, but the case fails over a technical difficulty in proving causation. It would be unfair if these people were then excluded from any form of compensation.

6 "A new standard of care should be set for after-event/after-complaint management by local NHS providers"

6.1 AVMA fully supports this recommendation. It should be linked to the recommendation for a Duty of Candour to be introduced. Compliance with both the duty and the standard should be monitored and action taken when they are seen not to have been complied with, for them to have real value. The Commission for Health Audit & Inspection should monitor NHS trusts' compliance with these standards. Any Independent Review which is held should examine how far these standards have been met.

6.2 With standards should come adequate resources for trusts to conduct better quality investigations into adverse events, complaints and administering the Redress Scheme. Quality at present is very patchy and the status of those involved in investigations and complaints management is too low.

6.3 The standards should seek to ensure that clinical audit and clinical governance systems in trusts use information from complaints, the Redress Scheme, and litigation to improve patient safety.

7 "Within each NHS Trust, an individual at Board level should be identified to take overall responsibility for the investigation of and learning from adverse events, complaints and claims"

7.1 The person designated must have adequate training and experience. We do not think it would be appropriate to give this responsibility to a non-executive member of the Board, as it will require operational involvement at the highest level. Ultimate responsibility rests with the Board corporately. It is vital that adequate reporting to the Board takes place in order for it to oversee this process.

8 "The rule in the current complaints procedures requiring a complaint to be halted pending resolution of a claim should be removed as part of the reform of the complaints procedure"

8.1 AVMA fully supports this recommendation. We recommend that it be implemented at the earliest opportunity rather than waiting for the final package of reforms to be agreed. However, the report does not make it clear whether a full bringing together of the complaints procedure with the Redress Scheme is envisaged. AVMA recommends that they should be. Investigation of complaints where harm is alleged to have been caused through sub-standard care should have as part of its brief to establish whether a package of compensation should be offered. Where appropriate, the Chief Executive's final response should make the offer. Complainants unhappy with the response, including the nature or lack of offer for redress, should be able to ask for an Independent Review by CHAI to include that in its terms of reference.

9 "Training should be provided for NHS staff in communication in the context of complaints, from the initial response to the complaint through to conciliation and providing explanations to patients and families"

9.1 AVMA fully supports this recommendation, but has other important recommendations concerning training as set out below.

9.2 Training in dealing with medical accidents / adverse events should be incorporated into the education and training of all health professionals. This should help clinical staff be prepared for the emotional, practical and ethical issues they are likely to face, and could go a long way to addressing cultural attitudes to patient safety and patients' rights.

9.3 It is essential that there is a role in this training for patients who have been through the system themselves and their advocates. AVMA has years of experience in this area and hopes to develop modules of training from the patient perspective involving both staff and past complainants / claimants.

10 "Effective rehabilitation services for personal injury, including that caused by medical accidents should be developed".

10.1 AVMA supports the recommendation to develop rehabilitation services, and is not opposed to these services forming part of the package of compensation offered through the Redress Scheme provided they are the most appropriate service for the individual and the patient or family have some choice and control.

10.2 However, we would recommend that the driving force for the development of these services should be the clinical need of all the patients that could benefit – not just accommodating people injured as a result of sub-standard NHS treatment.

10.3 We do not think it realistic that local health economies, with the competing demands for resources to meet the health needs of their populations, would prioritise or ring fence rehabilitation services for people affected by medical accidents. There would need to be additional resources allocated from the centre specifically for redress packages, and these packages should come with a guarantee that they will not be reduced or taken away.

11 "The Department of Health together with other relevant agencies should consider the scope for providing more accessible high quality but lower cost facilities for severely neurologically impaired and physically disabled children, regardless of cause"

11.1 AVMA strongly agrees that high quality, good value services should be developed by the NHS for these children "regardless of cause" and is concerned that this issue has been confused with issues around clinical negligence.

12 "A duty of candour should be introduced together with exemption from disciplinary action when reporting incidents with a view to improving patient safety"

12.1 AVMA agrees with the proposal to establish a legal duty of candour to ensure that both health professionals and managers are fully open and honest with patients/families following an adverse event. Health professionals already have a similar professional duty. However, we strongly disagree that it is necessary or right to provide exemption from disciplinary action if they are reporting adverse events. It should also be for the regulatory bodies to decide independently what should warrant disciplinary action, and not for the Department of Health to dictate. We agree that health professionals and others should be able to report adverse events without fear of *unreasonable* consequences, but this can be achieved without sacrificing accountability. This seems to be borne out by early successes of the National Clinical Assessment Authority in reducing the number of unnecessary suspensions, and the support for the 'Charter of Understanding' launched by AVMA earlier this year, from both health professionals' and patients' organisations. There is a range of options open to management following a medical accident, and disciplinary action should only be necessary in extreme and rare cases. The

primary consideration in any such decision should be patient safety. We certainly think that it should be taken into account in any decision about possible disciplinary action that the health professional has willingly volunteered the information, and such a case should be looked at far more sympathetically than if that were not the case. However to provide a blanket exemption for those reporting incidents is, we believe, both impractical and would seriously damage public confidence in the professions and the NHS.

13 "Documents and information collected for identifying adverse events should be protected from disclosure in court."

13.1 AVMA disagrees with this recommendation and believes that it would be perceived as inconsistent with the stated objectives of achieving a fair and open culture and the recommendation for a 'duty of candour'. This recommendation, if implemented, would seriously undermine public confidence in the whole process.

13.2 The suggestion that "protection would only apply to reports of adverse events where full information on the event is already included in the medical record" begs the questions as to why the report should be withheld if full information is already in the medical record, and how the patient could be assured that all such information is already in the medical record without the ability to check.

13.3 If it is decided that there should be some protection from disclosure of information in court, the test should be whether the documents/information are pertinent to the issues being examined by the Court and would therefore help achieve a just outcome. Information that is not directly relevant could be protected from disclosure following an application by the holder of the report. Perhaps a judge could be asked to decide if there is a dispute between claimants and defendants? There is a strong argument for such information not only to be admissible in court, but that it should be brought to patients' / families' attention without them having to 'dig' for it. There should be no ambiguity about the requirement to be fully open and honest with patients and families about adverse events.

14 "Where a claimant was seeking legal aid to pursue a claim for clinical negligence, the Legal Services Commission should take into account whether or not the case had already been pursued through the NHS Redress Scheme"

14.1 We believe that each application should be judged on its own merits. There should not be a rigid condition for people to have gone through the Redress Scheme first if they can put forward a reasonable argument why this is inappropriate. The findings of the NHS Redress Scheme, which as currently proposed would clearly lack independence, should not be given any more credence than findings of an internal investigation or statement by 'the defendant' is currently.

14.2 Some public funding also needs to be made available to potential claimants in order to help patients / families decide whether to participate in the scheme; to be empowered during the investigation to have their case thoroughly presented and investigated; and to advise on the best course of action when compensation is offered or turned down.

14.3 The cost of Conditional Fee Agreements should still be recoverable for cases taken forward outside of the scheme.

15 "Mediation should be seriously considered before litigation for the majority of claims which do not fall within the proposed NHS Redress Scheme"

15.1 AVMA is a strong supporter of the use of mediation to help resolve clinical disputes, where appropriate. However, mediation should not be seen as necessarily appropriate or the only means of

alternative dispute resolution. Consideration should also be given to the use of conciliation and mediation during the complaints / redress scheme process itself.

15.2 Work carried out by AVMA, CEDR, the NHSLA and the LSC has underlined the need for specialist mediators to be trained and accredited for clinical negligence work, together with training for the different stakeholders. This would greatly help informed consideration of mediation and confidence in its likely effectiveness. Also, the development of Pre Process Reviews would provide a suitable means of parties being helped to agree on the most appropriate course to take, helped by a trained, independent specialist.

15.3 AVMA welcomes the intention to build on work already done by AVMA, CEDR the NHSLA and the LSC to pilot the training and accreditation of specialist mediators for clinical negligence cases but is frustrated that proposals to take this work forward have not yet been approved by the Department. We strongly urge the Department to fund the next stage of this work, including training in the use of mediators by the stakeholders involved.

16 "The expectation in paying damages for future care costs and losses in clinical negligence cases not covered by the new NHS Redress Scheme should be that periodical payments will be used"

16.1 AVMA agrees with this recommendation for suitable cases, provided that there is flexibility built in to adjust payments to meet greater than expected care needs.

16.2 There also needs to be a transitional or wind-down period for payments to continue when a dependant dies, rather than an abrupt end. Families will need time to adjust and, where they have had to alter work arrangements to meet care needs, to find suitable employment etc

17 "The costs of future care included in any award for clinical negligence made by the courts should no longer reflect the cost of private treatment"

17.1 AVMA strongly disagrees with this recommendation. Its effect would mean that even when claimants choose to litigate rather than use the redress scheme, or are turned down compensation by the redress scheme and subsequently litigate, and they are successful, they still have to go back to the administrators of the NHS Redress Scheme to access their care package. Also, if the package which claimants agree to as part of the Redress Scheme diminishes in quality, or the NHS is no longer in a position to maintain it, they would not have the legal option of accessing private care

17.2 We are not aware of evidence to suggest that the current arrangements are abused. It is already possible for the NHSLA's solicitors to challenge any unreasonable elements in a compensation schedule and for the Court to insist on the use of State services where available and appropriate.

17.3 We do not believe that care provided by the NHS will inevitably be cheaper than independent healthcare, especially where there are very individual packages of care needed.

17.4 It is proposed that this change in the law will only apply to NHS patients who have suffered clinical negligence. This would mean that NHS patients would be left with less rights than private patients or people harmed by negligence in almost any other setting.

17.5 The most important thing is that the quality of care packages available to people does not suffer as a consequence of any change that is made, regardless of who actually provides the care.

18 "Special training should be provided for judges hearing clinical negligence cases"

18.1 AVMA fully supports this recommendation.

19 <u>"The Department for Constitutional Affairs (DCA) and the Legal Services Commission should consider further ways to control claimants' costs in clinical negligence cases which are publicly funded and the DCA and Civil Justice Council should consider what further initiative could be taken to control legal costs generally"</u>

19.1 AVMA welcomes any initiatives to reduce legal costs without compromising the level of service and access to justice available to victims of medical accidents. However, reforms to public funding are still working their way through the system. They are already meaning that potential claimants are finding it harder to get access to justice, and we would strongly object to any further erosion of people's access to justice.

19.2 The emphasis should not just be on reducing claimants' costs, but the defendants' as well. The successor to the NHSLA should review all cases which ultimately settle for lessons as to whether they could and should have been settled earlier, and why they were not. Single joint experts should only be instructed where both sides agree this is appropriate.

C. <u>RESPONSES TO THE "QUESTIONS FOR CONSULTATION":</u>

The NHS Redress Scheme:

C.1 *"What should be the qualifying criteria: the 'Bolam' test currently used in assessing clinical negligence or a broader definition of sub-standard care?*

AVMA recommends that the criteria for qualifying for compensation under the Redress Scheme should be: "*where there were serious shortcomings in the standard of care; the harm could have been avoided.*" We disagree with the proposed third criteria ("*and the adverse outcome was not the result of the natural progression of illness"* which would call into question whether *"serious shortcomings in the standard of care"* would include delayed or misdiagnosis. Not to include delayed diagnosis would unfairly exclude a large cohort of deserving beneficiaries. Where it is apparent that there have been serious shortcomings in the standard of care and harm has been experienced, the patient/family should qualify for compensation unless the NHS body can show that the harm could not have been avoided or was avoidable. The application of the 'Bolam test' and the need to prove causation have meant that many deserving cases have gone without compensation in the past.

C.2 *"If the latter, what would be the preferred formulation?"*

See answer C.1, above.

C.3 *"Should there be a minimum qualifying level in terms of the extent of the disability, e.g. in terms of days off work or in hospital or in terms of the levels of disability?"*

We do not think that there should be a minimum qualifying level or that it would be practicable to define a satisfactory one. An award of under £10,000 is not seen by an individual on low income or unemployed as 'low value', and yet the current system already discriminates against people with claims of this size.

C.4 *"Should there be an upper financial limit to the cases to be dealt with under the scheme? If so, is £30,000 the right starting point?"*

The most important issue is the complexity of the case rather than financial value. If financial value is used to define qualification for the scheme, £30,000 appears to us to be bound to bring in some very complex cases which it would be inappropriate to deal with in a less robust and independent 'fast track'

way. This is especially so if £30,000 represents the financial ('damages') element only. For a scheme run by the NHS itself, where only limited access to independent advice is available, a limit of £15,000 would be more appropriate. However, some 'low value' claims can also be very serious and complex and thus not lend themselves to this kind of approach either. For example the financial value of a claim from someone who is unemployed will be reduced as there is no 'loss of earnings'. Awards of damages for deaths where there is no dependency claim are often very small, but obviously very serious and sometimes very complex and therefore needing robust and independent investigation. Arguably, there need be no upper limit if all the issues around independent advice and independence in the investigation were addressed, and the scheme was evaluated as having operated fairly over a reasonable period of time.

C.5 *"Should the financial limit for the scheme apply to the whole package of care and cash or the cash element only?"*

For the scheme as described in the report, we would recommend that the limit is inclusive of the whole package, for the reasons given in C.4, above.

C.6 *"Should consideration be given to including primary care from the outset?"*

We would like to see primary care included from the outset. It is inappropriate and confusing for the public to have one part of the NHS operating in a completely different way to the rest of it.

C.7 *"Should patients/claimants be entitled to funding for legal advice to assess the fairness of the Redress Package? If so, what limit should be set on the amount of funding available?"*

We believe that it is very important for patients/claimants to have access to legal advice from the outset. Even if it were only to advise on the fairness of a package offered under the redress scheme, solicitors may need to gather independent expert opinions. The funding available should reflect the complexity of the investigation.

C.8 *"Will making it easier to obtain a package of care and support plus modest financial compensation reduce or increase the number of people making applications to the scheme? Why? Could this be mitigated?*

We would expect the number of people making a claim under a Redress scheme to be more than would have made a legal claim. There may be some compensating savings from a reduction in legal costs.

The NHS Redress Scheme for babies who are severely neurologically impaired:

C.9 *"What should be the qualifying criteria: is "birth-related severe neurological impairment" a reasonable test?'*

As discussed in the response to recommendation 2, there are problems with these criteria and they would appear to exclude babies damaged due to negligent ante natal or post natal care. A fairer approach would be to apply the same criteria as we have suggested (in 1.7) for the rest of the Redress Scheme: *"where there were serious shortcomings in the standard of care; the harm could have been avoided"*. In this context the 'harm' could be taken to be neurological impairment. (There would be difficulties in defining 'severe'). Where it is apparent that there have been serious shortcomings in the standard of care and harm has been experienced, the patient/family should qualify for compensation unless the NHS body can show that the harm could not have been avoided. The compensation package should then be calculated based on the actual needs of the child.

C.10 *"Should a qualifying birth be restricted to one in an NHS Trust?"*

No. Perhaps 'children born with neurological damage due to sub standard NHS care' would be a better definition.

C.11 ***"Should patients/claimants be entitled to funding for legal advice to assess the fairness of the Redress Package? If so, what limit should be set on the amount of funding available?"***

We believe that it is very important for patients/claimants to have access to legal advice from the outset. Even if it were only to advise on the fairness of a package offered under the redress scheme, solicitors would need to gather independent expert opinions. The funding available should reflect the complexity of the investigation.

C.12 ***"Should patients be able to go straight to court and not use the scheme if they believe they can prove negligence?"***

Yes, patients/families should be able to go straight to court if they chose not to take part in the scheme.

C.13 ***"Should courts have access to the deliberations of the expert panel if a compensation package is rejected and the case subsequently goes to court. What might be the impact on numbers claiming compensation?"***

We can not see why deliberations of the panel should be protected from disclosure in court. We do however have concerns about the cost implications for the claimant in circumstances where the claimant achieves a lesser amount of compensation at trial than that offered by the Redress Scheme. There is a possibility that the defence would use the fact of an earlier offer in the manner of a Part 36.

C.14 ***"Should the right to go to court be removed in favour of a new, speedier, more responsive Tribunal system for all cases of severe neurological impairment?"***

No. The right to go to court is a fundamental civil right. All babies with severe neurological impairment should receive the appropriate State funded care and services, in which case a tribunal would have no purpose.

NHS Litigation Authority:

C.15 ***"It is proposed that the new body established to oversee the NHS Redress Scheme should be modelled on or developed from the existing NHS Litigation Authority. What mechanisms would be needed to ensure that a body with this structure would not have a conflict of interest in administering the NHS Redress Scheme and retaining responsibility for assessing claims or recommendations for NHS compensation payments? Should this body be a Special Health Authority? A non-Departmental Public Body?"***

If it were intended that the body administering the NHS Redress Scheme were to have a role in investigating or deciding on the merits of a claim and whether or not to make an offer, it should be independent of the NHS. To place this role with a body which retains the NHSLA's current responsibilities would be a clear conflict of interest and would undermine public confidence in the scheme. If a new body were to be created a non-departmental public body would be preferable to the other options.

Repeal of Section 2(4) of the Law Reform (Personal Injury) Act 1948

C.16 ***"If an NHS cost basis is used to calculate damages for future care costs, should the NHS be required to provide guarantees for this treatment? How might it do this? Would a system of independent case managers be required?"***

AVMA disagrees with the proposal to repeal Section 2(4), as discussed in the response to recommendation 17. It is vital that there is a guarantee that any package awarded is maintained and that there is an appeal mechanism if it becomes inappropriate.

Mediation:

C.17 ***"Are there additional ways of encouraging greater use of mediation and other alternative dispute resolution procedures?"***

As discussed with regard to recommendation 15, the Mediation project proposed by AVMA, the NHSLA and CEDR should be funded. This would provide a specialist pool of mediators for clinical negligence cases; training for the different stakeholders in making use of mediation; and the development of Pre Process Reviews to help parties agree on the most appropriate courses of action.

Legal costs:

C.18 ***"Are there any further steps that could be taken to control legal costs in clinical cases?"***

As well as the reforms which are already having an effect on reducing unnecessary costs, there could be earlier admissions and settlement of cases. We would also urge the government to assess the impact on costs of the growing use of Conditional Fee Agreements (CFAs), because of restricted availability of Legal Aid. More effective use of Legal Aid could be more economical than forcing claimants into the CFA route.