**Health Committee Inquiry : Independent Sector Treatment Centres:**
**Memorandum by Action against Medical Accidents (AvMA)**

1. Action against Medical Accidents (AvMA) was originally established in 1982. It is the UK charity specialising in advice and support for patients and their families affected by medical accidents. Since its inception AvMA has provided advice and support to over 100,000 people affected by medical accidents, and succeeded in bringing about major changes to the way that the legal system deals with clinical negligence cases and in moving patient safety higher up the agenda. The legal reforms of Lord Woolf in the clinical negligence field and the creation of agencies such as the National Patient Safety Agency and the Healthcare Commission have followed after years of campaigning by AvMA.

2. AvMA is proud of the key role it has played in making clinical negligence a specialism within legal practice. It continues to accredit solicitors for its specialist panel (without membership of AvMA's or the Law Society Panel a law firm is not entitled to a clinical negligence franchise) and promotes good practice through comprehensive services to claimant solicitors. AvMA's interest in the matter of ISTCs is two-fold: first as an organisation campaigning for patient safety; second, it relates to our concern to ensure justice (particularly redress) following the aftermath of an adverse medical incident.

3. AvMA is increasingly concerned about the indemnity arrangements that apply to private sector treatment centres where services have been commissioned by the NHS to treat NHS patients. We have already had examples provided to us by solicitor members, of cases where confusion over where liability lies being a significant problem. The government's controversial plans to increase the role of the private sector gather apace with seemingly little thought given to the protection of patients seeking redress following an adverse event after treatment in such a centre. It is important to emphasise here that although the committee seeks to address the issues surrounding ISTCs in particular, the concerns that we have regarding the NHS indemnity arrangements as they apply to ISTCs also equally apply to private sector involvement in NHS services generally. The range and mix of health services delivered by companies and/or individuals (clinicians as well as ancillary staff) involve complex contractual arrangements, some of which have (for reasons we make apparent below) been insufficiently thought through with potentially dramatic consequences for patients seeking redress (particularly financial compensation) following a medical accident.

**Principles**

4. The Clinical Negligence Scheme for Trusts (CNST) handles all clinical negligence claims against member NHS bodies where the incident in question took place on or after 1.4.95 (or where the body joined the scheme if later). Although membership of the scheme is voluntary, all NHS trusts (including currently foundation trusts) and PCTs in England belong to the scheme. [1] NHS bodies are legally liable for the negligent acts and omission of their employees and should have arrangements for meeting this liability.

5. Where these principles apply, NHS bodies should accept full financial liability where negligent harm has occurred. They should not seek to recover the costs either in part or in full from the

[1] *The above points are covered in more detail in NHS indemnity arrangements for clinical negligence claims in the NHS, issued under cover of HSG 96/48.*

healthcare professional concerned. NHS bodies may carry this risk entirely or spread it through membership of the clinical negligence scheme of the Trusts (CNST).

6. The NHS is unable under the statutory instrument which governs CNST to indemnify the private sector direct.

7. In 2004, Sion Simon MP, a Trustee of AvMA submitted two parliamentary questions for written answer to the Secretary of State for Health. Hansard reports these Questions and Answers on the 9th September 2004 and 20th October 2004 as follows:

> **20th October 2004, Questions for written answer**
>
> Mr Simon: To ask the Secretary of State for Health whether the (a) NHS Litigation Authority and (b) the Primary Care Trust which has made arrangements for out-of-hours general practitioner cover will be liable in cases of clinical negligence where the negligent treatment was provided by an out-of-hours service commissioned by a Primary Care Trust. [1872371]
>
> Mr Hutton: If an out-of hours service is commissioned by a Primary Care Trust (PCT), the provider of the service will be expected to obtain their own insurance cover. The National Health Service Litigation Authority is not liable for claims as it administers the clinical negligence scheme for trusts on behalf of trusts, who retain the legal liability for clinical negligence claims.
>
> If the PCT provides out-of-hours services itself, then any negligent act would be covered by the PCT.
>
> **9th September 2004, Questions for written answer**
>
> Mr Simon: To ask the Secretary of State for Health whether the NHS Litigation Authority will be liable in cases of clinical negligence where the negligent treatment was provided by a private or foreign healthcare provider under contract for the NHS. [187382]
>
> Ms Rosie Winterton: The NHS Litigation Authority administers the clinical negligence scheme for trusts (CNST) in England. The CNST provides indemnity against claims for clinical negligence for member organizations, which include National Health Service Trusts and Primary Care Trusts (PCTs).
>
> Indemnity for cases arising from clinical negligence is as follows:
>
> > Before July 2004, indemnity for clinical negligence for independent sector treatment centres (ISTCs) was covered by commercial insurance arrangements. Subsequently, on a progressive basis, indemnity is now provided through the CNST cover provided to PCTs. The arrangements between ISTCs and PCTs are covered in their contracts.
> >
> > For patients referred to foreign healthcare providers, indemnity for clinical negligence is usually covered by the CNST arrangements of the referring PCT or NHS Trust.

For other private organizations the liability depends upon the terms and conditions of the contract between the PCT, NHS Trust and the private body concerned.

8. Last year we wrote to the NHSLA with our concerns governing legal liability in relation to private commissioning arrangements. We asked them to explicitly advise us as to the position regarding NHS indemnity arrangements relating to the private sector. The response from John Mead dated 29th December 2005 stated:

***"… the position from our perspective is as follows:***

***(1) Independent Sector Treatment Centres***

***We have agreed a special arrangement with the Department of Health whereby cover for clinical negligence suffered by NHS patients is afforded by CNST. We are unable under the Statutory Instruments which govern the CNST to indemnify private companies direct. However, the way in which cover is organised is via the Primary Care Trust which refers the patient to the ISTC. This arrangement will pick up most patients who are referred to the private sector by the NHS.***

***(2) Other commissioning initiatives***

***These are governed by individual contractual arrangements between the NHS and the private sector, which usually states that liability for clinical negligence will rest with the private company. You will appreciate that such arrangements over-ride the common law position. I agree that this can lead to the complications which you describe."***

9. We met with John Mead of the NHSLA, on January 24th 2006 to seek clarification on a number of the points addressed in his letter:

**"SPECIAL ARRANGEMENT"**

10. No regulation or statute governs the indemnity position where the NHS contracts its services to another private sector company. Therefore contrary to the statement that "this arrangement [with ISTCs] will pick up most patients who are referred to the private sector by the NHS – this is not the case. There is no written agreement between the DOH and the NHSLA. The "arrangement" that the NHSLA has reached with the DOH consists of no more than a series of discussions between the NHSLA and the Department of Health. This is clearly unsatisfactory. Most NHS patients would be appalled to learn that responsibility for what they thought was NHS treatment rests with the private clinic to whom they were referred. AvMA has learned from the bitter experience of patients being treated by private doctors (including GPs who are independent contractors) how difficult it can be to establish liability amongst the clinic and doctors. We have experience of many cases where doctors do not have adequate indemnity insurance or in some circumstances none at all.

## INDEPENDENT SECTOR TREATMENT CENTRES

11. Many patients will be surprised to learn that when the NHSLA refers to ISTCs these need to be distinguished from arrangements between the NHS with the private sector generally. An ISTC is distinguished from a hospital, clinic or other treatment centre by virtue of its having been accorded ***designated*** ISTC status. Although 34 treatment centres were open by the end of 2005, we were informed by Mr Mead that only approximately 20 in total have had CNST cover extended to them. These include some mobile clinics, MRI scanner clinics, eye surgery units, amongst others. These centres have been granted retrospective cover and the NHSLA will now be on risk in respect of these designated centres from the date from which they entered into a contractual arrangement with the NHS provider.

## Other Commissioning Initiatives

12. These initiatives will capture "waiting list" initiatives whereby hospitals contract out services to private providers and situations where GPs (independent contractors) or PCTs refer NHS patients to private sector clinics (eg abortion clinics).

13. In circumstances where a treatment centre has not been formally integrated into the CNST, the NHSLA advice is that claims ought to be made in the first instance against the Primary Care Trust with responsibility for commissioning services from these private sector centres. The NHSLA advise us that they will consider such claims in the first instance and review the contractual arrangements between the Primary Care Trust and the private company. If the NHSLA repudiate liability then they will disclose the contractual agreement between the Primary Care Trust and the private clinic/company to the complainant. If a hospital contracts out services to another private hospital/treatment centre, the claim ought to be made against the acute Trust. However, the NHSLA will always consider the contractual position. Unless the ISTC is 'designated,' it is questionable whether CNST will be extended.

## Issues

14. There is now a danger of patients/claimants falling through a "black hole" when it comes to obtaining redress against those who may not be covered by CNST. Having now spoken to John Mead, it is quite clear that despite his assurances in his letter of 29th December, the arrangements that the NHSLA has reached with the Department of Health will not "pick up most patients who are referred to the private sector by the NHS". On the contrary, he was specifically suggesting that only those designated centres would be covered in the first instance and while the NHSLA will look at other cases there is no guarantee that they will take them on. On the contrary, he made it clear that the liability would most likely fall with the private company in most cases. This is a retrograde step taken by the Government. We have long had concerns about difficulties in obtaining redress against private doctors, clinics and GPs. These structural arrangements only intensify these problems further.

15. We have grave concerns that Primary Care Trusts, that are certainly not used to having claims made against them [given that primary care in the main is delivered by General Practitioners] are not geared up for responding to these claims. They do not have the resources, capacity or knowledge to deal with these claims. It appears that the information that has been disseminated to Primary Care Trusts and other Trusts has been minimal if any exists at all. We are not convinced that Trusts are up to speed with regard to the complexity of these contractual arrangements. Most Primary Care Trusts do not even have Claims Managers let alone in-house legal teams.

16. We envisage problems arising with regard to NHS indemnity in the following areas:

- Waiting list initiatives – in situations where Trusts have an overwhelming objective to meet their waiting list targets they are contracting out to the private sector to undertake routine or not so routine operations, e.g. hip replacements. John Mead gave us no assurances that in situations where an acute Trust commissions additional resources in this way from the private sector and where the NHS patient ends up in a private hospital that the patient would be indemnified by the NHS hospital under the CNST. On the contrary, John Mead advised us that contractual arrangements would have to be looked at before the NHSLA agreed to accept liability.

- Overseas treatment – As in the well-publicised case of Yvonne Watts who was forced to have her hip replacement surgery undertaken in France.

- GP referrals to abortion clinics. Again, will the PCT be liable? Much depends upon the contract between the PCT and the clinics to whom the GP refers. The NHSLA will look at these cases on a piecemeal basis.

- What of the situation whereby a GP refers a patient for a smear test to a woman's health clinic (a designated ISTC) but the cytology is undertaken by another diagnostic unit? In a situation where Cytology Limited go bankrupt, there would appear to be no redress for the Claimant who is diagnosed with advanced cervical cancer as a result of mis-reporting of a smear.

- Many GPs, following the new GP contract, contracted out of "out of hours" cover with the effect that PCTs have taken on responsibility for providing 'deputising' services. In practice, PCTs have commissioned these services from other providers. The Secretary of State's answer to the parliamentary question of 20th October 2004 states that the private provider will be responsible unless the PCT supplies the cover itself.

- With regard to "other commissioning initiatives" although John Mead advised contractual arrangements between the NHS and the private sector will override the common law position, he did concede that if a Trust commissioned services from a body whose consultants proved incompetent/insufficiently qualified without adequate checks the Trust would most probably be liable in negligence.

**Patient safety: Overseas doctors**

17. Foreign companies in the main were invited and recruited to run the ISTCs, primarily because such companies could import staff, thus reducing the risk of "hiving off" NHS staff to these centres. The Royal College of Surgeons has articulated its concerns about adequacy of training of overseas surgeons particularly given the fact that surgeons do not need to be on the specialist register even though they must be registered with the GMC. We share concerns that have been expressed by health professionals' regulators about the varying arrangements for education, training, audit and fitness to practice procedures across European Union states. Under European law doctors have a right to work in any member state.

18. At the moment independent healthcare providers are required to comply with the standards of the Healthcare Commission (HC). The HC is currently consulting on bringing inspection of private providers in line with the NHS. Therefore, the drive to increase ISTCs is ahead of the regulation being in place to ensure adequate standards.

19. AvMA has learned through the bitter experience of patients being treated by private overseas doctors who subsequently seek redress when treatment goes wrong of how difficult it is to locate doctors or establish whether they have adequate indemnity arrangements in place. Frequently insurance cover is inadequate if not non-existent.

20. The Department of Health appears to have taken these steps with little or no attention to patient safety. The fragmented and complex nature of these arrangements means that the advantage the NHSLA always had in identifying patient safety issues, disseminating learning and feeding this into clinical governance will be lost.

**Patient and public involvement (PPI)**

21. The private sector does not have a good record on PPI

22. Clarity needs to be forthcoming on how complaints handling is to operate in circumstances where complications arise or issues arise following treatment in an ISTC/private treatment centre.

23. Patients need to be informed about nature of treatment and after- care in private treatment centres. How easy will it be for the patient to be remitted into the NHS following a complication in a private centre rather than expecting the same centre to resolve the issue itself?

**Summary**

24. Many issues and concerns surround the subject of ISTCs. Many problems are now becoming apparent since the inception of ISTCs two years ago. We suspect that even more difficulties will surface as time goes on. Many of our lawyer members are reporting incidents where complications have arisen, particularly with patients demonstrating co-morbidities. The troubling feature has been that when something has gone wrong, no-one seems to accept the blame – each party pointing the finger at another. No patient ought to be caught in the web of the complex commissioning arrangements established between the NHS, clinicians and private sector organizations. We have sought to highlight the problems inherent in these arrangements. Much anxiety regarding indemnity arrangements could be alleviated by extending CNST to all companies contracting with the NHS. In turn, the NHS can seek indemnities from the companies responsible – The NHS will thus be in a position to audit performance and quality and ensure safety and justice for patients always comes first.

**Fiona Freedland**
**Legal Director**
**AvMA**

**13th February 2006**