RESPONSE TO

‘QUALITY RELATIONSHIPS DELIVERING QUALITY OUTCOMES: THE PREFERRED SUPPLIER SCHEME”

June 2006

Introduction

Action against Medical Accidents (AvMA) welcomes the opportunity to respond to the Legal Services Commission's Preferred Supplier Scheme.

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. AvMA has played a key role 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.

Accordingly, AvMA's insight and experience is centered on the arena of medical law and clinical negligence, and therefore the observations that we make will focus on those areas within our specialist knowledge. Given these parameters our comments comprise an overview of the consultation paper with some specific comments and recommendations. We will not attempt to respond to the full range of questions, many of which fall outside our direct experience as AvMA does not currently itself undertake publicy funded work. Our concerns therefore derive from the impact the proposed preferred supplier scheme is likely to have on clients i.e. those seeking redress following a medical accident.

OVERVIEW & KEY CONCERNS

AvMA broadly considers that the move towards working with preferred suppliers has the potential to be a positive one. However, we do have some concerns. Our chief concerns are:

- **There are significant benefits for clients in having a large and diverse range of suppliers of legal advice in the field of clinical negligence. We are concerned about the potential impact of *preferred supplier* in reducing dramatically the number of firms providing a clinical negligence service. This could impact on access to local suppliers and on choice, but also on the ability of firms to develop specialist and innovative practice. Although administratively more convenient for the LSC to deal with a smaller number of large providers, biggest is not always best and clients could lose out. The emphasis should be on quality not size or administrative convenience, and effort should be put into helping firms at 'level 3' achieve levels 2 and 1 rather than necessarily reducing the number of suppliers greatly.**

- **We are concerned that the approach taken to assessing and monitoring suppliers is sufficiently sensitive to the role of individual solicitors in clinical negligence – not just the firm as a whole. In particular, supervisors of legally aided work should be members of one of the**

specialist panels (AvMA or the Law Society). The number of non-specialists they supervise should be a realistic number to allow sufficiently close supervision, and the supervisor themselves should have a continuing role in practicing clinical negligence law.

- **The role out of *preferred supplier* in clinical negligence should take account of the existence of the specialist panels which already exist, avoid any unnecessary duplication of effort or unnecessary bureaucracy, and maximize opportunities for synergy with the specialist panel approach. It should remain a priority to have individual solicitors accredited for this specialist role. AvMA would be interested in exploring ways in which it could complement and add value to the *preferred supplier* approach. For example in training /accrediting peer reviewers and ensuring that there is a genuine client focus in the *preferred supplier* process.**

Clinical negligence clients need to be directed to a specialist clinical negligence practitioner. This is why AvMA was at the forefront of developing a specialist panel for clinical negligence solicitors as early as the 1980s. In order to guarantee access there has to be reasonable coverage of specialist solicitors across the country. The proposals undoubtedly will lead to contraction in the number of practices undertaking this work. This is likely to lead to a greater number of practitioners in a smaller concentration of firms. We have witnessed change already in the number of firms that have decided to bow out of publicly funded work if not clinical negligence work altogether. There are mergers of firms and/or departments.

We have already witnessed from our members a great deal of uncertainty over the future of public funding in clinical negligence cases, particularly in relation to the, so called, "lower value" cases that have been the staple of many firms' work. Clinical negligence solicitors have had to deal with uncertainty over the future of clinical negligence claims for many years now. There has been the threat of public funding being withdrawn following investigation of cases. Lawyers have had to do battle in order to obtain funding to represent their clients at inquests. As for the high value cases these do not fare much better: lawyers are exasperated and frustrated by the investment of time that has to be dedicated to paperwork in relation to the higher value cases. They are frustrated by the number of edicts that emanate from the Special Cases Unit and problems, in particular, with recovery of costs and disbursements. The consultation exercise relating to capping expert fees did nothing to improve lawyers' spirits either. Despite assurances that clinical negligence was to be ring-fenced from expert fee capping, we learn from the LSC that this is not the case and that experts' fees are indeed subject to a maximum threshold of £200. All of this despite the legitimate concerns that claimant lawyers posed in responding to this exercise.

The above concerns also need to be seen in the context of "Making Amends." The latter took years to come to fruition only to be much modified by the Redress Bill. It was an albatross sitting on practitioners' collective heads. There still remains uncertainty over the future of lower quantum cases and the very serious issue of claimant representation. No one is any wiser as to how the redress scheme is likely to work. We have noted how some significant players in the field of negligence now decline "small claims" altogether - even those cases that led to death of a family member and where something clearly went wrong.

RESPONSE TO SPECIFIC CONSULTATION QUESTIONS

Question 1

Do you consider the quality of advice tools in appendix A are proportionate? If not, please explain why and indicate the changes you would propose.

On first blush it appears to us that there is a risk of duplication between work undertaken by peer reviewers commissioned by the LSC and the work of appraisers that relate to the panels - although we can speak only of the AvMA panel. Clearly, so far as clinical negligence is concerned, many anxieties relating to quality have been much ameliorated already by panel membership requirements. If the LSC is to deliver a workable scheme with the resources available we question the need to heavily resource an area like clinical negligence whose suppliers, the LSC readily acknowledge, produce relatively high quality work and are leaders in the field of publicly funded work.

In order to qualify for AvMA panel membership, AvMA undertakes an independent assessment of the quality of both advice, management of the caseload and client care. All applicants are required to submit case reports as well as responding to a detailed questionnaire concerning the practice of the firm and the individual prospective panel member. All applicants are interviewed and are often subjected to a test of medical knowledge.

AvMA is also in the process of re-accrediting all its panel members. Re-accreditation might have important ramifications for the LSC peer review. In particular we note the stipulation that all peer reviewers must be peer reviewed themselves and have obtained the SQM (and be a panel member him/herself). The LSC will need to liaise with AvMA to confirm that any peer reviewers recently trained still remain on our panel following re-accreditation. This process is being rolled out from June 2006. However, it is being staged over 3 years so the situation will remain fluid for some time. There is a risk, therefore, that the LSC will be heavily investing in peer reviewers who subsequently lose panel membership.

We also note the intention to peer review firms as opposed to different offices of any one firm. Any peer review system will need to be particularly sensitive to the degree and effectiveness of supervision arrangements in any firm, as a firm's poor performance may be down to an individual outlier rather than practitioners as a whole.

Any system of quality profiling will need to be as simple as possible. A major concern is the nature of the data being collected that is going to be of significance to the LSC, particularly relating to the type of case and results on completion. As the LSC well knows, a negative outcome in a clinical negligence case does not correspond to the quality of the lawyer. There are many unquantifiables that determine the end result, most significantly, the robustness

of the expert evidence; evidence over which the claimant lawyer has little or no control. The worry is that lawyers will become over-concerned with peer reviews and quality profiles to the detriment of those clients whose claims are considered undesirable to take on, being too difficult, complex or unpredictable to warrant taking on at the outset. This has real implications in relation to access.

As to file assessment, if LSC officers are to undertake this exercise of random assessment we do not know how LSC officers are qualified to review "the quality of advice" criteria in relation to clinical negligence cases that are, by their nature, inherently difficult claims.

Q.2 Do our proposals for extending devolved powers strike the right balance between maintaining fund control and reducing the administrative burden for providers? If not please explain why and provide any alternative suggestions.

It appears to us that even though a firm meets the stringent preferred supplier status, delegated powers do not follow automatically. There needs to be some incentive for firms to undergo the rigour of peer review etc. The LSC needs to be clear about what it plans to devolve to practices and how practices can achieve this. Many clinical negligence practices only undertake high value complex claims that result in administratively burdensome requirements, particularly the high cost case plans. It appears the LSC will still retain a range of decision-making in these sorts of cases. No detail is provided as to how the LSC will make decision-making in these cases more "speedy, accurate, consistent, well explained or structured".

Q3 ***Which of the proposed key features and benefits offer most benefit? What other key features and benefits do you see as a priority for future development?***

Reports indicate the relationship manager (RM) appeared to operate well in the pilot phase. However, we wonder how well it will continue to operate on a larger scale, particularly given that the RM will be responsible for the firm, regardless of the number of offices it may have. Other aspects such as delegated powers have been covered above. Speedy and accurate decision-making is to be welcomed as stated but the mechanisms for this are, disappointingly, not described.

Q.4: Is the proposed performance management framework for preferred suppliers set at the right level? If not please explain why and provide any alternative suggestions?

Please see our response to Q.1 relating to outcome measures that we feel need to be regarded with utmost caution in a clinical negligence context.

Q.5 Are there any other ways in which the commission could reduce bureaucracy for providers without compromising our duty to secure quality and value for money services?

AvMA cannot comment on this.

Q6: What improvements if any might you suggest to the proposed process for the award of preferred supplier status (appendices B and C)?

Q.7: What additions or deletions would you make to the proposed selection criteria to identify Preferred suppliers and do you have any comments or concerns about specific criteria?

AvMA is in favour of setting the quality threshold high and therefore the LSC awarding preferred supplier contracts to category 1 and 2 suppliers. We also support the LSC's objective in assisting category 3 providers to improve. We frequently come across a situation when considering a lawyer's application for panel membership that the individual has great potential to achieve the status but is being hampered by the practices and culture of the firm. This tends to be particularly prevalent in areas where clinical negligence lawyers are thin on the ground. AvMA has been exercised over this issue for some time as we acknowledge the tension between ensuring access (by way of sufficient coverage) whilst providing the best. We would therefore be most willing to work with the LSC in developing courses/training for those aspiring both to achieve panel and/or preferred supplier status and with the potential so to achieve. Many are not aware of how their practice is deficient because they have been doing things that way for so long and are working in relative isolation. Mentoring would be a positive step. However, again disappointingly this paper is short on detail as to how raising the threshold is actually to be achieved.

Q.8 Are there any specific considerations that you feel we have not fully addressed that relate to the impact that proposals would have on your business, on the area(s) of law you deliver, or on the clients you serve?

Not applicable as we do not undertake any publicly funded work for the clients that we help.

Q.9 Do you agree with the draft impact assessment (appendix E)? If not, please explain why?

We have no specific comments to make on this.

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AvMA
2/6/02