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Response to Consultation on Civil Bid Rounds for 2010 Contracts

About AvMA

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.

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.

Introduction

The contribution that AvMA makes in responding to the consultation is confined to those areas within our knowledge. Given AvMA's specific expertise in clinical negligence and healthcare law AvMA cannot really comment about many of the other legal aid areas about which the consultation is also concerned. As areas such as housing, family and immigration falls outside of our remit we have only commented where we feel it appropriate to do so. With this in mind, we do not consider a response by way of the on-line form to be appropriate. Also, AvMA believes that the comparatively low prominence of clinical negligence ("CN") within the proposals means that some significant issues have not been addressed by the questions posed and therefore we aim to highlight specific features peculiar to clinical negligence that need to be factored into any prospective civil bid round.

Summary of key issues

a) **Quality:** AvMA currently has concerns about the Key Performance Indicators (KPIs) as currently applied to clinical negligence claims. In particular, as far as we have been able to discern the KPI relies upon the measurement of "outcomes" achieved in relation to "closed" cases. What appears to be important overall to the

LSC is whether any clinical negligence matter start results in a "successful" outcome-ie damages. AvMA does not agree with this measurement of success. Indeed, for reasons that we explain in more detail later on (see our response to Q.45), reliance on such crude data can and does produce some very perverse results.

b) **Access:** A great deal of emphasis is placed on *geographical* access. We agree this is important. Yet the KPI "formula" adopted (see above) is seemingly only focused on "quality." It takes no account of value for money or access (quality, access and value for money being the mantra consistently espoused by the LSC). Furthermore, in keeping with the strategy set out in *Making Legal Rights a Reality*, access is more than just physical proximity to a solicitor. AvMA, like the LSC, wishes to ensure that those affected by a medical accident get access to the best possible legal advice and services. This means that we have real concerns about application of outcome data (currently "success ") as being equivalent to or determinative of quality of service. AvMA has been increasingly conscious of the high thresholds being applied by some firms in screening those cases that the firm will be willing to take on. This leaves a whole raft of clients unable to access help and/or advice because either the case does not satisfy the cost/benefit criteria or because it is deemed at first flush as being too "risky."

c) **Legal help:** It is accepted that most clinical negligence lawyers do not avail themselves of legal help. For reasons set out at b) above, AvMA would like to see this resource deployed in more creative ways, potentially advising and assisting those affected by a medical accident to consider non-judicial remedies (Eg complaints not just against trusts but also against regulatory bodies for example). Such assistance might incidentally reveal issues that might not have been apparent in a firm's initial risk assessment and screening.

d) **Supervision ratios**: In line with AvMA's pursuit in ensuring quality of provision, AvMA has some initial concerns surrounding caseworker/supervisor ratios suggested in the paper. Whilst AvMA does not wish to be prescriptive about what the correct supervisor to caseworker ratio ought to be, we do have concerns that applied to clinical negligence a supervision ratio of one supervisor to four caseworkers maybe too high. Much depends upon the number of cases, skills mix and the experience of the supervisor. We deal with this further within the body of our response below.

e) **Experts and experts' cancellation fees**: once again this is dealt within the body of our response but AvMA does have concerns regarding recovery of fees in relation to medical experts for clinical negligence cases in certain circumstances.

f) **Integrated and holistic services**: AvMA always vociferously argued that matter starts would not be suitable applied in a clinical negligence context, not least because some clinical negligence practitioners do not operate within a general legal aid practice or environment and may well be the only department conducting publicly funded cases within the firm. We therefore commend the LSC for not applying the principle to clinical negligence claims. We are also glad to see that a

clinical negligence contract is not dependent upon this category being combined with social welfare or family law categories. However, we wish to underline the fact that we do fundamentally endorse the LSC global strategy for holistic services and holistic care and therefore express some disappointment regarding the proposed abolition of tolerance in public law in particular as it may be applied in the context of healthcare law. We argue that tolerance, rather than be abolished, ought to be reformulated in such a way as to permit clinical negligence practitioners to undertake public law challenges in areas allied to a client's claim (eg access to treatments/services-see our response to Q.52 below) and to permit CN specialist lawyers to broaden their work into healthcare law more generally, offering clients a much more integrated, smooth and seamless pathway.

The points outlined above are dealt with in rather more detail in responding to the questions raised in the consultation to which we now turn.

Q1-4: AvMA cannot comment on this as it is not within AvMA's knowledge or experience.

Q.5*:* *Is it reasonable that in order to maintain integrated services, where contracts have been awarded on the basis of multiple categories (eg debt, housing and welfare benefits) work in all categories usually lapses where the minimum new matter start size per contract year has not been met?*

Although not strictly relevant to CN, AvMA observes that enforcing this proviso may be counter-productive, not least because in withdrawing a contract from a specialist housing practice that is otherwise providing an excellent service that falls short on welfare benefits matter starts maybe to deprive a region of a quality housing law service. Also, the reasons for failing to meet a target in a particular area may be multi-factorial and not necessarily related to failure by the provider to meet a need.

Q.6 *Are the minimum new matter start sizes required set at the right level in each category?*

Although, CN is excluded from the requirement to meet a minimum level of new matter starts, AvMA wishes to acknowledge the LSC's willingness to consider the arguments raised by AvMA and other practitioners against minimum case numbers. The LSC also appears to have acknowledged the need for differentiation within certain categories of publicly funded work as reflected in some of these proposals.

Q. 7 Is the minimum supervisor to casework ratio set at the correct level?

AvMA's overall feeling is that the ratio so far as clinical negligence is concerned is probably too high. However, caution must be exercised in setting a specific figure. This is because there may be many factors that might militate against a supervisor supervising several caseworkers. There is a matrix of factors that must be taken into account and such factors might consist of the following:

- Whether the firm is a large or a small firm.
- The seniority of the supervisor and the degree of experience of the caseworkers

- The volume of cases that each caseworker is handling
- The supervisor's own caseload
- The complexity of the cases that either supervisor or caseworker is handling
- Whether the supervisor and/or caseworker(s) within their caseload(s) have risky or novel areas of law which they are developing or undertaking?
- Whether the firm is based at multiple sites or n one location?

AvMA suggests that these are factors that might need to be taken into account when establishing a ratio to be applied as opposed to stipulating from the outset what the right level of caseworker to supervisor ratio ought to be. AvMA operates its own specialist clinical negligence panel. Arising from its Panel work AvMA, has concerns about the fact that many of our panel members, due to legal aid franchise requirements, often take on the role of supervisor upon attaining panel status. In some cases, a supervisor might solely supervise and/or manage the clinical negligence department to the point where the clinical negligence panel member him/or herself is no longer running any cases at all or only a minimum number of cases (which does not satisfy the panel requirements in the event of re-accreditation five years later or ironically if the panel member was applying to become on the panel afresh). The question then arises: ought it to be mandatory for a supervisor to carry on his/her own significant caseload? This is the ideal position. For, if a person no longer conducts cases are they, in fact, competent to supervise?

A ratio of 4:1 in a CN context (taking into account factors as outlined above) might militate against a supervisor undertaking his/her own cases. AvMA has seen cases of supervision being undertaken on a Cerebral Palsy (CP) claim in circumstances where the supervisor has never undertaken such a case himself. All this is not to undermine the LSC's interest in introducing a caseworker: supervisor ratio. AvMA certainly would agree that more control needs to be exercised and this concern is particularly great in a low volume category such as clinical negligence where things can go very wrong in circumstances where a supervisor conducting 30 highly complex catastrophic injury of his/her own is asked to supervise four other caseworkers who may each have similar caseloads albeit of less complexity and less experience. Similarly, AvMA has concerns about 'factory style' litigation that has been witnessed in a personal injury context in some larger firms being applied to CN work. There has been a worrying trend of increasing compartmentalisation in the way in which clinical negligence claims are being run. There are firms who now have lawyers dedicated to assessment of quantum only in cases whilst other teams solely concentrate on liability/causation issues. An alternative model is where firms have lawyers working on cases pre-investigation and cases transferred to litigation teams once a claim is issued. AvMA does not see how a lawyer who only sees part of the picture is ultimately going to achieve the best outcome for the client and this correlates often with problems being identified in panel applications. It also does not fit in well with the LSC's commitment to a holistic approach.

Specialist Panels

Given the role of panels such as the Law Society CN Panel (Currently operated by the SRA) and the AvMA panel itself, AvMA is surprised that no mention of the Panel is made in referring to CN quality standards; this despite the fact that several key players at the LSC generally acknowledge panel membership to be a "badge of honour" and that the development of the panels (being a pre-requisite to obtaining a LSC CN contract) being equally acknowledged as improving quality and standards in CN. Importantly figures

published by the LSC consistently indicate that the number of certificated cases has been decreasing since the advent of mandatory panel membership amongst firms undertaking CN. Even after taking into account factors such as financial eligibility that will also have contributed to the decline in certificates there is evidence of screening being much better applied. We still see cases undertaken by non-panel members under CFAs that are subsequently transferred to panel lawyers to sort out. For these reasons, AvMA is concerned that the LSC demonstrate its commitment to retention of specialist panels in CN. Panel membership in combination with Lexcel and/or the SQM including panel membership as part of its quality assurance needs to be embedded in setting the standards. Not to do so risks turning the clock back 20 years when any practitioner could dabble in the area with often dire results. Furthermore, we are not satisfied that any peer review process can ever be a substitute for the rigours of the panel application process itself. As peer review has not been rolled out in any meaningful way in relation to clinical negligence it may be too early to say how it will operate in practice.

We note that setting the minimum quality standard is the subject of ongoing work with the Quality Working Group and AvMA expresses a keen willingness to contribute to the work of the group.

Q's 8- 16: Not within AvMA's knowledge or experience.

Q17: *Do you foresee any issues with the proposed definition of permanent and part time presence?*

The definition as applied to clinical negligence needs clarification. Whilst it is stated that all providers require a presence of some kind in the procurement areas for which they bid for work, CN is a category where presence can be either permanent or part-time. Surprisingly, no account seems to be taken of the fact that many clinical negligence lawyers will attend clients in their homes as opposed to the office environment particularly in maximum severity claims even if this means travelling a significant distance. On the face of it attendance upon a client in his/her home might not meet the proposed requirements to comply with QA standard or Health and safety legislation. In such circumstances will the LSC sanction the continuation of such a practice, given the needs of some seriously incapacitated people? How does attendance upon a client in their home, square with the requirement of part-time or full time presence or indeed outreach work? Can arrangements to see clients at local advice surgeries such as CABs amount to a "suitable office" (for the purposes of part-time presence) provided interviews take place on a designated day or at least one day per week?"

What is also not clear is whether in a situation where there may be saturation of coverage in any particular area, a hierarchy of preference might subsequently be applied with the LSC according preference to a supplier with a *permanent* as opposed to *part-time* presence. It is already conceded by the LSC that in CN the number of providers is likely to remain higher than in other low volume categories. However, the LSC also indicates in Appendix 1 at figure 17 that based on the application of criteria for 2006/7 work, the overall impact assessment to CN is likely to result in no change with regard to the number of providers. The table as set out in figure 17 is erroneous. The column headed "solicitors" does not make sense; the figures pre and post - contract are not actually the same, although we can assume this to be in error in lay-out as opposed to anything more

substantive. Nonetheless we are surprised that the LSC foresees no change in contracts awarded post-contract given that some providers are not meeting the current KPIs.

Q.18-22: Not within AvMA's knowledge or experience

Q.22a: Is it appropriate to use video conferencing to provide face-to-face advice to clients where there is no local "access" point?

No. AvMA believes there is no substitute for face-to- face interviews so far as clinical negligence is concerned in anything but exceptional circumstances (e.g. a disabled client has moved abroad). However, there may be a role for video-conferencing in circumstances where a conference with counsel and multiple experts is required and it is not practicable to conduct it at the claimant's home.

Q.23-26 Not within AvMA's knowledge or experience

Q.27: *Do you agree that in mental health, immigration and asylum and low volume categories we should move towards distributing new matter starts more closely to where clients are located.*

So far as geographical coverage is concerned it is stated (5.28) that "there are no proposals (In CN) to seek to control where providers take on work through the allocation [of] Legal Help matter starts" but either a permanent or part-time presence is required in every location where services are provided (5.41). Several CN practitioners have expressed concern to us about bidding for a specific geographical location in circumstances where many firms have clients in areas some distance from their main office. The fact that many lawyers travel distances to attend to clients in their homes does not appear to have been taken into account. Nor does the fact that in clinical negligence the amount of face to face contact required with a client is fairly infrequent. The geographical location stipulation will also favour firms with a national presence to the detriment of those in single locations with clients representing a wide geographical spread.

It is not clear how the LSC has worked out what coverage is required in any geographical area. How has the LSC assessed demand within regions? By reference to the number of certificates a particular firm has or by reference to the address of the client? Many firms will have a significant number of clients outside their own region. Has the LSC taken into account that a disproportionate amount of certificates may be issued in less affluent parts of the country where more clients are likely to meet the financial eligibility criteria? Many firms are conducting a higher proportion of cases on a CFA basis or cases where claims are funded by BTE insurance. We suggest these factors need to be taken into account given that more people are likely to find themselves eligible for legal aid in the context of the current financial climate and where more people are likely to lose their homes (potentially reducing the availability of BTE).

A distinction needs to be drawn between *geographic access* and access in the wider sense *of access to justice*. Paradoxically there is a risk of the latter being drummed out in the quest for proximity to where clients live. In restricting access to solicitors in the locality a person with a claim approaching limitation or risky/novel or complex in any way may be denied the prospect of representation. Most people would choose having a reputable solicitor managing their case as opposed to not having one at all however far away.

Finally, although not strictly on the point, a word about Welsh solicitors where it is noted (5.55) that all providers delivering services in Wales will be required to deliver those services in Welsh if that is the client's language of preference. AvMA would be interested to note what scoping work if any has been undertaken as to how many CN lawyers in Wales can comply with this requirement, particularly in low volume categories such as clinical negligence. Is it practicable to expect a specialist CN or other lawyer in Wales to deliver all services in Welsh? Will the services of an interpreter suffice and would such costs be recoverable? What of counsel? Many CN lawyers in Wales instruct London counsel. Medical experts are almost certainly not going to be Welsh speaking.

Q.28-37: Not within AvMA's knowledge or experience

Q.38: *Do you think the proposed selection criteria for each category are the best way to differentiate between bids?*

Much of the requirement to deliver advice across multiple access points has already been dealt with elsewhere (see response to Q. 27)

Q.39-39a: Not within AvMA's knowledge or experience

Q.*40 Do you agree with the proposal to remove expert's cancellation and administration fees from the scope of legal aid funding in all civil cases and to cap rates for experts' travel and waiting time?*

For clinical negligence no or at least not entirely. As to whether cancellation fees ought to be recoverable is dependent upon the circumstances in which they apply. If an expert in good faith, clears his/her workload in order to be able to attend trial to give evidence or a round table meeting only for the case to be discontinued for whatever reason then a cancelation fee is entirely justified. On the other hand, an expert who is informed that a case is likely to settle and who creates a "shadow" diary in the event that it does, will not have sustained any loss of work and therefore ought not to be entitled to a windfall. In all cases the onus needs to be on the expert to declare that such losses have been incurred and that notification of a settlement etc came too late to substitute other remunerative work.

Notwithstanding the above, many experts insist that solicitors instructing them engage their services on certain terms including a provision for cancellation fees. As with all issues concerning experts the matter needs handling sensitively. The LSC cannot afford to drive medical experts away from undertaking publicly funded work if it wishes to ensure continuing access to justice for claimants. Given that the opposition is likely to agree to the terms of engagement required by the expert, several might choose to decline claimant work, particularly troubling in cases where there is short supply. For this reason AvMA does not agree to cap rates for experts travel or waiting time.

AvMA argues that no blanket prohibition applies to CN but that the expert will need to evidence any claimed losses, including steps taken to substitute work.

Q.41-44 Not within AvMA's knowledge or experience

Q.45*: Do you agree that contractual KPIs focusing on delivery of quality of work, value for money and access to clients are appropriate?*

For CN, AvMA's view is that KPIs should remain targets rather than contractual terms at this stage. We believe that panel membership coupled with robust systems for supervision is the best way of ensuring quality work.

If KPIs were indeed measurements of quality, value and access the arguments for making them contractual might be more compelling. As it is, we find the question posed almost impossible to answer because nowhere in the consultation is the formulation for the KPIs set out. CN lawyers are habitually referred to the overall success rate for certificated cases as being the determinant of performance. Is this the sole indicator? If so the LSC can hardly claim the application of a range of KPI(s) that might measure quality, access and value for money. Even if that were so, where are the success rates set out? There is a definite lack of clarity about success rates. On the one hand the LSC has stated that if rates are to be made *contractual* then practitioners will be expected to "succeed" in a minimum of 30% of publicly funded cases. [1] On the other hand, the LSC advises practitioners that the target that they need to achieve is 40%. The question arises: is the figure of 40% a merely aspirational one reduced to 30% if targets become contractual? Another point arises also in that CN differs from other areas of law in that limited certificates to investigate and establish prospects are much more common than say in a housing case. This means overall success rates are likely to be lower for cn as a higher proportion of limited certificates issued to investigate and establish prospects of success are included. That cases might be abandoned following investigation is not necessarily reflective of poor screening or lack of competence.

The achievement of a good success rate can be a target but not a contractual requirement

There is a worrying lack of transparency. Solicitors ought not to be asked to contract on terms which cannot be readily understood by them. This lack of clarity is having serious implications in terms of access to legal advice and representation in CN cases as more and more lawyers are becoming increasingly choosy about which cases to take on with the effect that they worry more about the statistics that might affect their contract with the LSC than the best interests of the client. The result of this is that referrals from AvMA where limitation is being imminently approached are being rejected by panel solicitors. Such difficulties are replicated in relation to the lower value cases, cases where clients have mental health difficulties, claims with difficult clients and difficult cases generally.

More fundamentally AvMA does not agree with the premise that measuring outcomes ie success rates on their own is the correct measurement to apply. Information and data that AvMA has compiled following AvMA' s re-accreditation to the CN Panel reveals that good or bad success rates do necessarily not correlate with a firm being either good or bad. In fact the reliance on success can lead to oddities: Statistics can easily give a false picture. For example, the top performing firm in 2004-06 with a 100% success rate achieved this by completing only 1 case albeit successfully Seven out of the top ten performers are all

[1] David Keegan referred to success rates of 30% being required in a recent meeting to CN Panel lawyers convened by AvMA on 13th November 2008.

based in London (6) or the South East(1). Several only take on cases of high value. Many firms are reluctant to take on low value cases.

Arguably, it is those solicitors who take on a mix of cases, both high and low value that are demonstrating the greatest ability. Perhaps it is easier to take on a specific type of case rather than a general mix but it cannot be argued that "outcomes" measure quality and access when people are being denied access to advice or representation in anything other than straight forward cases. Rather, it can only be argued (and not very credibly) that the KPI assesses quality alone. There are no indicators for assessing either access in its broadest sense or value for money; cornerstones of the LSC core strategy. For this reason no cognisance is taken of the rates of recovery in relation to costs that so many CN practitioners achieve. An outlier in terms of success rates may have a very good record on recovery of costs. A firm with a 43% success rate is recovering 64% of costs incurred whereas another firm with a 33% (ie below current KPI requirements) success rate is recovering 80% of costs We would argue that it would be preferable to have firms prepared to investigate a broad range of cases, bringing investigations to a close as soon as possible while minimizing costs at this stage, with such firms going on to achieve good results post investigation, thereby achieving good overall recovery figures and good value for money. The current KPIs don't measure this.

Any KPIs set for CN must be clear and transparent. KPIs need to be established that measure, quality, access and value. This has not been the case to date. We urge the LSC to consult with CN practitioners as well as AvMA in assessing what standards need to be achieved in order to assess performance in reaching its objectives. In setting standards, the LSC can work with the profession to establish what determinants can be reliably employed in order to achieve its objective: Quality, access and value: Objectives that most of us share.

Q.46-49: Not within AvMA's knowledge or experience.

Q.50*: Do you consider that the impacts on experts are justifiable in ensuring sustainable access to legal services for clients?*

Please see our response to Q.40.

Q.51 *Do you have any comments on any prospective impacts of the proposals on clients or providers*?

We do not feel that the proposals in relation to clinical negligence are sufficiently detailed to be able to comment at this stage and that further clinical negligence specific consultation should be carried out

Q.52: *Do you have any comments on any prospective impacts on clients or providers resulting from the introduction of a tolerance bar in actions against the police, education or public law*?

For many years, AvMA has emphasised to its membership its desire for clinical negligence specialists to become more rather than less involved in allied areas which

are integral to a client's claim. We have supported the LSC with regard to its overall commitment to offer clients an holistic service. Accordingly, AvMA would like to have seen a low volume category entitled "healthcare" or" medical law" that would have covered allied areas such as public law in relation to access to treatment cases or medical law in relation to those cases, whilst currently exceptional, that involve "best interests" either in relation to withholding, refusal or consent to treatment decisions. Whilst many of these latter types of cases may not ultimately require applications to court, we know of several clinical negligence lawyers that have undertaken such cases. Strictly speaking medical law cases do not come within the remit of clinical negligence. Along with medical innovation and technological advances such cases are likely to attain more prominence. Whilst AvMA shares concerns with the LSC that a clinical negligence practitioner is unlikely to conduct a housing or family case very effectively (which it is possible to currently do under tolerance), AvMA would urge the LSC to consider reformulating the tolerance within clinical negligence rather than its blanket abolition.

Many clinical negligence (CN) practitioners, particularly AvMA panel members undertake maximum severity claims. Many of their clients will not be accessing state provision to which they are entitled and which will impact on their quality of life at least while litigation is pending if not long term. The interplay between state and private provision in these high value cases is complex and certainly outside the scope of this paper. Suffice it to say, it is our view that in such cases, most clients would be best served by having most of these issues dealt with in-house. From the LSC point of view, duplication of work could be avoided by having one firm dealing with the matter. This is not to say that all practitioners will feel comfortable undertaking public law cases in such circumstances; nor should they be compelled to. The fact is that some larger firms already have dedicated teams undertaking this work. There is a danger of some firms monopolising it. It is readily acknowledged by the LSC that public law is a low volume category with few practitioners specialising in it. If tolerance is abolished, the likelihood is that any CN client wanting to undertake a public law remedy in relation to placement say in a residential care home or refusal of treatment case will have to be referred to another practice. A public law practice is unlikely to be in the same vicinity. Any CN practice will be left with the option of procuring a contract in public law without any real security that a practice will be able to fulfil the matter start threshold will put many off. In anticipation of the LSC wanting to bring together some of the areas of law potentially allied to CN, following *Making legal rights a Reality* AvMA devised several training courses covering education law and public law amongst others. It was apparent that many lawyers were keen to develop their casework in this way and several had undertaken some cases already. We would have thought that it is in the interests of the LSC to broaden rather than restrict the pool of expertise. Most clients would benefit provided that clients were not being compromised by non-experts representing them..

> ***AVMA would like the LSC to consider that tolerance be reformulated so as to enable practitioners to undertake related or ancillary work relevant to a clinical negligence certificated case in order to be able to provide the client with an integrated and holistic service***.

Q53-57: where applicable some of these aspects have been covered already in the body of our response.

Additional observations

Legal help

Although AvMA is based in the South East of England, AvMA is passionate about ensuring that the reach of its work extends to the four countries of the UK. At least twice a year, AvMA holds Lawyers Support Group meetings for AvMA clinical negligence lawyers in Ireland (both Northern and Southern), Wales and Scotland. Recently, we have been intimately involved with redress work that is going on in Wales. AvMA is a unique organisation in that although we work closely with our lawyer members, our contact and concerns relate to advising clients directly who have experienced a medical accident advising them about all their potential options and potential remedies. These may include but may not be exclusively about recourse to litigation. We regularly advise and assist clients through the complaints procedures whilst advising them about the clinical issues that might either undermine or support any response that we get from clinicians or hospitals.

Because AvMA advises in relation to a gamut of options that may include but may not be exclusively about pursing a legal claim (e.g. we might advise about complaints and/or regulatory matters), we are ideally placed to adopt an overview of what may often be disparate elements that need to be looked at in the round, for example conduct issues that may arise in relation to a clinical practitioner that might mandate referral to a regulatory body. It is accepted that most clinical negligence lawyers do not avail themselves of legal help. AvMA would like to see this resource deployed in more creative ways, potentially advising and assisting those affected by a medical accident, either through the AvMA advice line or through CLS direct. Advisors would be able then to assist and advise on non-judicial remedies as well as litigation (eg complaints not just against trusts but also against regulatory bodies for example). Such assistance might incidentally reveal issues that might not have been apparent in a firm's initial risk assessment and screening.

NGOs and legal work

AvMA would also like the opportunity to comment on paragraph 4.16 of the LSC consultation although no specific questions have been raised on this. AvMA in combination with other NGOs such as Liberty, Shelter, Mind, Friends of the Earth and others has been meeting with the LSC to make the case for NGOs being permitted to undertake specialist categories of work in circumstances where the general proposals and strategy of the LSC has not hitherto accommodated such provision. We are pleased that the LSC notes the special position of organisations such as ours. However, AvMA is very concerned to ensure that the general principle of NGOs being permitted to conduct cases is not restricted to certain categories (public law in particular). We are also keen to ensure that not only those with a record of taking on such cases be permitted access to this work. The principle is important because legal cases arise that may forcefully underpin some of an organisation's core campaigning work that will have a strong public interest component. We have been in discussions with the LSC previously on this point and welcome the

opportunity to discuss the implications and practical means of implementation of 4.16 further.

Conclusion

Much of this consultation is focused on categories of law other than CN. Relatively little prominence is given to clinical negligence at all, yet amongst all the hubbub around priority areas such as immigration, family etc it might be all to easy to lose sight of CN and the issues around it. AvMA therefore welcomes the opportunity to participate in this consultation. As ever, we would also welcome the opportunity to amplify and /or discuss further any of the issues raised within our response. We hope that the LSC will avail itself of our continued willingness to work with them to ensure that the best interests of CN clients are preserved and met at all times.

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23/1/09