



Action against Medical Accidents

BRIEFING ON THE NHS REDRESS BILL

31 October 2005

Introduction

The NHS Redress Bill had its first reading in the House of Lords on 12th October 2005. It takes forward elements of an 'NHS Redress Scheme' first mooted in 'Making Amends' by the chief medical officer in 2003. It has huge implications for access to justice for people affected by medical errors and for the NHS. Action against Medical Accidents (AvMA) is a registered charity which has been promoting patient safety and justice for people who have been affected by medical errors for over twenty years. AvMA's casework department deals with approximately 5,000 enquiries a year, and the charity has been at the fore of promoting good practice and reform in handling clinical complaints and clinical negligence investigations. This analysis of the NHS Redress Bill draws on extensive experience of dealing with clinical disputes, the experience of people affected by medical errors, and the considerable wealth of clinical, legal and policy expertise within the organisation. Whilst AvMA welcomes the intention to create an NHS Redress Scheme, which if done well could provide speedier, less painful and less costly access to full explanations, remedial treatment, compensation and actions to reduce the risk of errors being repeated, we have serious concerns about the proposals set out in the Bill.

Overview / Concerns

- **AvMA's main concern is that the Bill provides for a scheme which is totally lacking in independence and therefore lacks the ability to deliver fair outcomes for injured patients / their families, or enjoy public confidence.** NHS trusts responsible for clinical negligence would investigate themselves. The NHS would be asked to be judge and jury over itself.
- There are not sufficient safeguards built into the Bill with respect to specialist advice for patients/families. It will be difficult/impossible for adequate legal advice to be provided just at the end, in respect of offers made. Without specialist medico-legal advice during the course of an investigation, people will not be empowered to play a meaningful role in the determination of their own case.
- The Bill does not do enough to ensure that there will be a 'joined up' approach to making sure that patient safety lessons are learnt as well as determining eligibility for Redress.
- The proposals set out in the Bill are far less radical than the vision shown by the chief medical officer in 'Making Amends'. He had sought a fairer test than the 'Bolam' test which is used by the courts. AvMA have suggested an alternative in the form of an 'avoidability test' (which is described below). However the NHS Redress Bill would see a scheme which uses the 'Bolam' test but without the independence, rigour or representation afforded by the court system. There is also no indication that the recommendation for a legal 'Duty of Candour' will be taken forward.
- The Bill allows for artificial limits to be put on the compensation which can be awarded for elements such as loss of earnings. This would be a move away from the principle of restorative justice. Compensation/redress should be about trying to put people back as nearly as possible where they would have been if it were not for the negligence. Offering less than a court would do would put patients/families under pressure to accept less than they deserve. In practice, short changing people in this way might also make it impossible for them to fund litigation at the end of the process (as they would be seeking to litigate only for the difference between what they are offered and what they would expect to get through the courts). This is particularly the case if the claimant requires legal aid. As both the NHS and the Legal Services Commission are agents of the State, we are exploring whether this would be in breach of the Human Rights Act.
- AvMA believes that unless these weaknesses are addressed, the scheme would be unlikely to be fair to patients/families and would lack credibility and public confidence. If that is the case then many people will choose to litigate instead, using 'no-win no-fee' agreements. The

initiative could create a lucrative market for claims farmers to operate in. This would have the result of costing the State much more, as success fees attached to successful no-win no-fee cases make them much more expensive. There may also be resources wasted in running investigations through the scheme and claimants ultimately still having to turn to the courts to attempt to access genuine justice.

DETAILED COMMENTARY & SUGGESTIONS

Below we set out some of our key concerns in more detail and how they can be addressed.

Why is Independence needed? How can it be built in ?

In the vast majority of clinical negligence cases that are determined in favour of the claimant, the NHS body concerned has defended the claim after having conducted its own internal or NHS complaints procedure investigations. Only when independent medical expert opinion has been obtained, and the claim been subjected to robust legal investigation, is a claim usually settled. Without independence in determining eligibility for redress, many deserving cases will lose out. There would also have to be enormous investment in specialist staff for the NHS to be able to conduct the investigations which would be necessary itself. It might be more economical as well as realistic to provide for more independence as suggested below.

The Bill could be amended to allow for an independent investigation and decision about the merits of the case. Instead of vesting these functions with the NHS Litigation Authority, they could be made functions of an independent body such as the Healthcare Commission.

Alternatively, the Bill could be amended to build on the experience of the 'Resolve' pilot scheme in England and the 'Speedy Resolution' pilot in Wales. In these schemes, independent medical experts determine the eligibility for compensation based on the evidence put before them by lawyers/the trust.

The Bill could also be amended to provide a suitable appeal procedure. There is no appeal mechanism built into the proposals set out in the Bill. We believe that the Healthcare Commission and Ombudsman should have a role in considering the appropriateness of findings in respect of the NHS Redress Scheme investigation, just as they do with respect to the NHS complaints procedure.

Why is specialist independent advice important? How can it be built in?

It is intended that in order for people to qualify for redress, negligence will need to be identified using the same test as is currently used by the courts (commonly known as the 'Bolam' test). However, the Bolam test was developed by and for a court system where legal arguments are developed and tested by lawyers. It is widely accepted that clinical negligence cases are by necessity complex and require the input of accredited specialist solicitors. It would be inappropriate and lead to injustice for injured patients and their families if their cases were to be decided using the Bolam test without any specialist advice/representation for them.

The vast majority of clinical negligence claims which ultimately are successful are initially robustly defended by the NHS. It is only when the often complex and subtle clinical and legal arguments are tested through specialist representation of the claimant that most claims are settled.

The Bill could be amended to guarantee participants in the NHS Redress Scheme access to specialist medico-legal advice or representation. For example, the scheme could build upon the

experience of the 'Resolve' scheme in England and the 'Speedy Resolution' pilot in Wales. In these schemes, speedy resolution of claims is achieved and legal costs kept to a minimum, with specialist lawyers representing claimants on a fixed fee, 'no-win no-fee' basis.

Alternatively, funding could be provided for a scheme to provide independent medico-legal advice to NHS patients/families considering using or involved in the NHS Redress Scheme. It is already well established and enshrined in legislation that people making complaints to the NHS have access to independent advocacy (the Independent Complaints Advocacy Service – 'ICAS'). Advice required for the NHS Redress Scheme will be considerably more specialist than ICAS, which is only designed for generic help with the NHS Complaints Procedure. Specialist independent agencies with appropriate medico-legal expertise (such as, but not necessarily or exclusively, AvMA) could be funded to provide such a service, working in close liaison with ICAS.

Does the proposed scheme do enough to ensure patient safety lessons are learnt?

All the Bill introduces is a provision for a 'specified person' to have responsibility for, amongst other things, advising about lessons to be learnt from cases in the scheme. We believe a far more robust approach should be taken. Putting the investigation in the hands of the Healthcare commission as suggested above would ensure that it could make recommendations for improving safety and monitor that they are carried out. The scheme could draw on the 'Speedy Resolution Scheme' in Wales, where independent medical experts report on patient safety / risk management issues and the trust concerned is required to respond as to what it will do.

Are the proposals inconsistent with the Human Rights Act, article 6; Right to a fair Trial? Will patients/families be put under unfair pressure to accept less than they deserve?

According to clause 3 (4) the NHS Redress Scheme may not offer compensation ('damages') in line with what the Courts would award. Short-changing patients in this way and putting them in a 'take it or leave it' position is contrary to the principle of restorative justice. In effect, patients/families may then find it impossible to fund litigation through the courts for the difference between what the scheme offers and what they might receive through the court, particularly if the claimant is eligible for legal aid (which by definition means the most poor, potentially vulnerable and socially excluded members of society). The Legal Services Commission apply a tight cost-benefit ratio in assessing whether legal aid is awarded. There is also a danger that the Legal Services Commission may turn down applications because the Redress Scheme has turned down a redress package. This would be unfair as the Redress Scheme as set out lacks any independence. As both the NHS and the Legal Services Commission are agents of the State, we are exploring whether this would be in breach of the Human Rights Act.

Would the proposals as they stand encourage claims farmers and other non specialist solicitors to tout 'no-win no-fee' agreements (Conditional Fee Agreements)?

If the scheme lacks credibility and public confidence and if suitable specialist advice / representation within the scheme is not guaranteed, there might be an explosion of claims farming activity and cases being taken through the courts on a 'no-win no-fee' basis. Because of the success fees and insurance premiums involved with these 'Conditional Fee Agreements', this could end up costing the State much more than cases brought under legal aid let alone the Redress Scheme would. Also, it is widely accepted that non specialist solicitors lack the knowledge and expertise to pursue clinical negligence claims efficiently and effectively.

Is the 'Bolam' test a suitable test of eligibility for a non-court scheme? What about an 'avoidability test' as an alternative?

We are disappointed that the chief medical officer's wish expressed in 'Making Amends' to develop a fairer test than the 'Bolam' test to be used to establish eligibility for redress through the scheme,

is not being pursued. AvMA has suggested an alternative in the form of an 'avoidability test' which could be characterised as *"An adverse event is compensatable except where it is the result of an unavoidable complication regardless of treatment or non-treatment."* The onus would be on the NHS to demonstrate that it was an unavoidable complication, or offer redress. Focussing the investigation in this way would also mean that the root causes of adverse events would be identified at the same time, leading to improvements in safety. Such an approach would be able to deal with systemic problems rather than focus on individual blame, which the Bolam test inevitably tends to do. This would be more conducive to the kind of 'safety culture' which it is widely agreed is needed in order to improve safety and the reporting of incidents.

Why is the scheme limited to hospital treatment?

The Bill restricts the remit of the NHS Redress Scheme to hospital services. The vast majority of NHS care is provided in primary care and this is also where a lot of negligent treatment occurs. We believe that all care provided on behalf of the NHS should be included in the remit of the scheme.

Why has the recommendation to create a legal 'Duty of Candour' not been accepted?

We are concerned that the recommendation to create a legal, 'Duty of Candour' for health professionals and managers contained in 'Making Amends' does not appear to be being taken forward. This would have placed a legal obligation on being open and honest in reporting incidents to patients/families. Without this it remains the case that information about negligent harm can legally be withheld from patients/families. The guidance for health professionals (e.g. 'Good Medical Practice' by the GMC) remains only guidance and only applies to health professionals. Without a more formal, binding commitment to openness and honesty it is difficult to see how the necessary culture change to make an NHS-run scheme viable and for it to carry public confidence can be achieved.

Action against Medical Accidents 31st October 2005.