
# RESPONSE TO

# Clinical Negligence Scheme for Trusts (CNST)
# NHS Litigation Authority Consultation March 2016

**CONSULTATION DUE: 17th May 2016**

## Introduction

1. Action against Medical Accidents (AvMA) was established in 1982. It is the UK patient safety 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 throughout the United Kingdom.

2. AvMA offers specialist services to the public, free of charge across the United Kingdom. This includes a helpline and an individual casework service staffed by legal and medical professionals.

3. The AvMA Helpline is open to the public five days a week (Monday to Friday) from 10 am to 3.30 pm daily. All of our advisors have a medical or legal background and can be contacted on: 0845 123 2352 – see our website for details.

4. AvMA's pro bono inquest service aims to find representation for people who have been affected by the death of a loved one where the death occurred in a medical setting.

5. Through our inquest work we have developed considerable expertise in providing assistance and representation to members of the public at inquests. We have seen many examples of NHS complaint handling, investigations into serious incidents, as well as care that falls within the definition of a notifiable patient incident.

6. Our inquest experience has enabled us to explore core issues pertinent to the patient's death and to draw attention to them as part of the investigative process of the coroner's court. Our aim is to protect patients by highlighting concerns apparent in a trusts practice and or procedures and to invite the Coroner to use their powers to remedy the failings where appropriate.

7. Our Advice & Information (A&I) service offers a written case work service and can advise on complaints and responses made to hospital trusts and primary care services such as those provided by GPs and Dentists. We can also provide advice on complaints made about private health care. Where appropriate we will advise on how to follow up the complaints procedure by asking further questions or seeking a review by the Health Service Ombudsman.

8. The advice and information service also considers the medical nature of the complaint. Where appropriate we can offer advice on whether the issue complained of is likely to satisfy the legal test for clinical negligence and can advise on the pros and cons of taking legal action which can be emotionally draining and expensive. We only refer clients to solicitors who have achieved the status of AvMA Panel Accreditation.

9. AvMA endeavours to enable patients and or their families by putting them at the centre of the investigation. We try and encourage more effective communication between NHS trust's complaints departments and the patient to enable patients to receive answers to their questions.

10. The A&I service also provides guidance on professional regulatory matters such as referring cases to the GMC, NMC and other regulatory bodies

**AvMA's Response to the Consultation**

11. AvMA has confined its responses to questions where we feel able to comment based on our experience and information available to us through our services and panel accreditations.

# QUESTIONS

**Principles for setting contributions**

**Question 1:**

**Do you agree with the three principles that currently determine CNST contributions? If not, what other principles do you think should apply?**

**Response:**

AvMA does not profess to having any particular expertise in how insurance contributions should be set. Although the principles for setting contributions are not directly within our expertise, it does appear to us that levels set to reflect each member's risk based activity including their previous claims record does, on the face of it, appear to be a fair and equitable way of setting a CNST members' contributions.

AvMA's position on this is influenced by the fact that if a members' CNST contributions reflects their claims record, this in itself should act as an incentive to improve that claims record. There may be little a trust can do about its historic claims record; no doubt a trust's previous claims history including claims yet to be resolved will have a bearing on its contribution. However, going forward the correlation between a trusts claims record and its CNST contributions should prove to be an incentive to reduce their claims and inevitably this will improve a trust's patient safety record.

It has been AvMA's experience that generally trusts play little or insufficient attention to information available to them through their investigation processes, including their complaints process and the coroner's investigations. These are missed opportunities, anything that can be done to encourage trusts to concentrate their efforts on core issues arising out of clinical failings, is to be encouraged and supported.

However, AvMA does have concerns that simply focusing on the correlation between trusts CNST contributions and its claims record may create a false picture. There does need to be a means of policing a trusts approach and response to adverse incidents to ensure that trusts avoid the temptation to deliberately depress and/or suppress information that may give rise to a claim in their focus on keeping CNST contributions to a minimum.

**Question 2:**

**Should the calculation continue to minimise disproportionate impacts of changes to CNST contributions, and if so, how should this best be achieved?**

**Response:**

AvMA does not feel that this question comes within our expertise.

**Pricing Objective**

**Question 3:**

**Are you content that the current approach to setting contributions sufficiently meets this objective? Would you like to see any change to the approach to setting contributions?**

**Response:**

AvMA agrees with a pricing methodology that sets a trusts CNST contributions in a way that encourages patient safety improvements, however as set out in our response to question 1, it is equally important that there is some way of policing the way a trust reports its claims.

AvMA believes that there is a risk that strict consideration of trusts claims record alone may give a distorted view of a trust's true approach to claims handling. Other factors such as commitment to training staff in their obligations under the statutory duty of candour, objective and impartial internal investigation report writing and positively encouraging complaints from the public are equally important and just as indicative of a trusts approach to patient safety and a genuine commitment to reducing claims.

For example, a trust that positively encourages complaints by freely advertising the complaints process and provides user friendly information on how to make a complaint may in fact be doing more to address patient safety issues than another trust which may be effectively discouraging the public from making a complaint. Consequently, the mere fact a trust has a large number of complaints, is not on its own an indication of a failing trust. On the contrary, it may be indicative of a trust which is openly embracing criticism in a bid to fulfil a genuine desire to address the root causes of issues that have given rise to or may give rise to negligence, adverse outcomes or complaints; this approach should be supported and encouraged.

AvMA suggests therefore that the CNST pricing looks further than simply apparent improvements to a trusts claims record and looks to whether a trust can demonstrate a genuine and committed approach to identifying and managing clinical failings. This should be through their complaints procedure and/or their approach to carrying out

internal investigations into adverse incidents and their implementation of the Duty of Candour.

**Extent of risk pooling**

**Question 4:**

**To what extent should the CNST pool risk between its Members? Is the current balance appropriate?**

**Response:**

This question does not fall within AvMA's expertise. However, as a matter of observation, we would be supportive of any approach which means that a trust is incentivised to genuinely reduce its incidence of clinical failings. As referred to above, this may mean going beyond straightforward consideration of a reduction in a member's claims.

**Options for development**
**Voluntary excesses**

**Question 5:**

**Should the CNST reintroduce voluntary excesses, and if so, to what level?**

**Response**

AvMA does not consider itself to have expertise in the insurance industry. However, we are concerned that if the financial burden for the excess on each claim falls to be paid by individual trusts that the commercial viability of some trusts may be put at risk. In some cases the excess could significantly contribute to pushing a trust into insolvency, increasing the number of unsustainable providers.

Clearly, there is a balance to be struck between incentivising trusts to address the issues that give rise to negligence claims and the amount which they are expected to contribute to the CNST.

It is not clear to us from this proposal whether there is a suggestion that a successful claimant in a clinical negligence claim would be expected to enforce part of an award of damages equivalent to the excess from the individual trust concerned. If this is the intention then AvMA does not support this approach. However, if the intention is that the CNST remains liable to a successful claimant for paying the award of damages in full then this is more acceptable subject to our concerns about a trust being pushed into insolvency as stated above.

Many NHS trusts risk insolvency. It is not clear to us what the situation would be if a trust was unable to meet that the amount due on the excess. It is not acceptable for a claimant to have satisfied the legal test for clinical negligence and an award of damages agreed or ordered, for the claimant to discover that the trust is unable to meet its financial liability.

Depending on the level of the excess, the approach could potentially put a great number of low value claims at risk especially as the consultation makes it clear that the excess applies to the first part of the loss or liability.

Much will depend on the detail, in particular how much the excess is going to be and how the excess will be levied. For example, if the intention is for the CNST to satisfy payment of an award of damages in full but can then recover a sum equal to the excess payable from the trust separately, such an arrangement would not jeopardise payment of damages due to a claimant; AvMA would be more likely to support this arrangement.

AvMA does not support any scheme which may result in a successful claimant and injured patient having to enforce part of their judgment or settlement award against an individual trust. If the intention is that the CNST agrees to be primarily liable to any patient who successfully claims against the NHS then there is some support for this suggestion in principle although we consider it imperative that the financial viability of a trust is not challenged or threatened in any way.

AvMA also has concerns that such a scheme would pose difficulties for individual trusts especially in relation to calculating the reserves that need to be put aside by the trust in any one year to cover the excesses on claims that may become due.

**Coinsurance**

**Question 6:**

**Should the CNST introduce co-insurance and if so, at what level?**

**Response:**

The consultation document suggests coinsurance as an alternative approach to paying an excess. Coinsurance appears to be the situation where members pay a share of some or all of each claim. We refer to our response to question 5 above.

To reiterate, where a claimant has been successful in proving a claim for negligence against an NHS Trust, AvMA believes that the CNST should be fully responsible for paying the full award of damages agreed or determined by the court.

If a scheme were to be introduced where a member trust is responsible for paying a share of some or all of each claim then we can see that this would cause potential difficulties for a claimant. Such an arrangement leaves the claimant in a precarious position; if a trust is found to be facing or actually in financial difficulties, there is a risk that the claimant will be unable to enforce the award of damages payable either in full, or in part.

It is important to appreciate that many claimants are very seriously injured as a result of the negligent treatment received, the injuries may have had life changing and devastating consequences for them: they may have lost their ability to work and pay their bills, including their mortgage or rent. Claimants may have been locked in litigation for several years and in debt, they are vulnerable and having succeeded in

proving their case in clinical negligence must be recompensed for their loss. AvMA does not support any suggestion that potentially or actually compromises that position.

If the CNST were to accept that they would be primarily liable to satisfy any judgment debt and/or settlement but would then have the right to be indemnified by its member for some or all of each claim paid out then this is likely to have less of a direct effect on the claimant.

AvMA would need to have more detail about how much a trust would be expected to pay of any claim. We would also want more detail on what legal services a trust would have access to if they were dealing with a situation where the trust is responsible for all of the claim as we believe it is important that trusts are consistent in their approach to how claims are handled.

We are also concerned that it may be difficult for individual trusts to identify what their potential liability to paying all or some of each claim might be in any one year. It is not clear that they have the skills to identify this and whether they could cope with unexpected claims. This fact alone could push a trust into financial difficulties or insolvency, the CNST by contrast is much more experienced in this field and with its buying power is better able to call on experienced professionals to help them gage this exposure.

**Delegated authorities**
**Question 7:**

**Should the NHS LA offer members of the CNST an extended scheme of delegated authority allowing them to manage their own clinical negligence claims? If so, what sort of delegated authority scheme would be of interest?**

**Response:**

AvMA supports the principle of delegated authority and recognises that this can encourage swifter resolution of claims without adding to the costs typically incurred by involving NHS LA claims handlers and/or NHS LA panel solicitors. AvMA has seen examples of situations where clinicians have advised patients to seek independent legal advice because something has gone wrong and compensation is payable. Despite the fact that there has been an apparent admission of liability, when the claim is referred to the NHS LA, it is not unusual to see a retraction of that admission and for the patient to have to seek independent legal advice in order to obtain redress.

Where trusts believe that claims should be settled it could be quicker and more cost effective to enable them to do so. We are aware that currently very few trusts have this power; greater use of delegated authority may facilitate earlier resolution of valid claims. However, delegated authority is only likely to be appropriate for dealing with straight forward, low value claims where there is an admission of liability.

Any trust receiving delegated authority would need to be carefully monitored to ensure that they have sufficient expertise to properly manage claims. The trusts

would need to be checked to ensure they are dealing with cases in a way that is conducive to promoting settlement of valid claims and is compliant with the pledges made in the NHS Constitution. One of the benefits of the current more centralised system is that arguably it offers a more consistent approach to claims handling; the detail accompanying the implications and duties around delegated authority would need to be carefully considered.

AvMA fully supports the suggestion in the consultation paper that any delegated authority carries with it a requirement that individual trusts need to keep the NHS LA informed of all claims resolved by them. This is necessary to ensure that the learning and experiences from those claims is retained and the learning disseminated to other trusts.

**Interaction between different exposure measures**
**Question 8:**

**Should contributions reflect the joint interaction of staffing and activity levels, and in which specialities? Are you aware of any evidence which suggests that a higher headcount for a given activity level reduces the risk?**

**Response:**

AvMA agrees that the number and quality of staffing levels employed by a trust tends to correlate with a reduction in adverse outcomes. One example of this comes from the Swedish model where there are 75 midwives to 100,000 populations as compared to 50 in the UK.

http://ec.europa.eu/eurostat/statisticsexplained/index.php/File:Practising_nurses_and_caring_professionals,_2013_(%C2%B9)_Health2015B.png

Sweden has also seen a 50% reduction in avoidable harm rates over the last 7 or so years. It may be that the ratio of midwives to women in labour is not the only factor but there is strong evidence to suggest that it is a factor.

Further evidence may be gleaned from Robert Francis' report into Stafford Hospital where he identified that the chronic shortage of staff contributed to the appalling outcomes identified there.

AvMA would emphasise that the Francis report highlighted that the problem was not only too few staff but the staff that were employed there were inadequately trained. It is important therefore that contributions calculated on this basis should not only reflect the number of staff employed but should in addition, be weighted to take into account whether those staff who are employed are adequately trained.

A higher head count for any given activity is not the only factor in reducing risk levels. There are several papers that demonstrate how being open with patients when something goes wrong plays a significant part in reducing adverse outcomes. The University of Michigan's Early Disclosure and Offer Programme (D&O) was designed to promote patient safety through the principles of honesty, transparency and accountability.

The D&O programme is based on the principle that honesty is indispensable for safety improvements and that short term focus on financial risk impedes long term

improvement. The system aims to compensate patients quickly and fairly when inappropriate medical care causes injury, communicating openly with patients about errors. The D&O programme also systematically and thoroughly investigates patient complaints, not just claims and sees this as a powerful means of uncovering opportunities to improve patient safety. The D&O model reports that the rate of law suits has declined from 2.13 suits per 100,000 patients per month to roughly 0.75. The median time from claims to resolution has dropped from 1.36 to 0.95 years and costs rates due to total liability, patient compensation and legal fees have decreased as well. Details of the programme were published in March 2013: http://bulletin.facs.org/2013/03/michigans-early-disclosure/

Further evidence on the benefits of being open and honest with patients and the correlative effect of this approach to improving patient safety can be found in a 1999 paper entitled "Risk Management: Extreme honesty may be the best policy" http://annals.org/article.aspx?articleid=713181

AvMA would suggest that in order for the CNST contributions to be reflective of a trusts risk, all of these factors should be taken into account, not just a head count of staff employed.

**Building a forward view**
**Question 9:**

**Do you agree that an element of CNST contributions should be linked to outcome measures linked to harm which is likely to lead to claims in the future?**

**Response**:

AvMA fully supports any scheme that genuinely incentivises trusts to improve patient safety and to learn more effectively. In practice financial incentives are a powerful driver for change and on that basis we agree that an element of CNST contributions, linked to outcome measures, linked to harm which is likely to result in claims in the future appear to be both an equitable way to proceed and an effective incentive for change. However as referred to above, the level of contributions needs to be linked to a number of factors: openness, honesty, full and proper disclosure and communication with injured patients and/or their families; a willingness to learn from mistakes; demonstrable efforts to address the issues that give rise to negligence in the first place; sufficient and adequately trained staff are some of the core issues that should be taken into account when setting the levels of contributions.

**Question 10:**

**Can you suggest any data sources or indicators which may be a helpful predictor of claims risk?**

**Response**:

AvMA believes that some existing processes are potentially helpful predictors of a trusts future claims risk. For example, serious incident reports (SIR) are a good

source of information. In our experience, (particularly through AvMA's pro bono inquest service) all too often the triggers for writing a serious incident report are not followed. Many of the SIRs that are compiled fail to take an impartial and objective view of the circumstances and evidence and result in self-serving, defensive reports being produced, as a result they fail to identify the root causes of the problem. Rarely, are families involved in setting the terms of reference for the SIR and this should be considered more often than it currently is.

The complaints process is also a valuable source of information. Complaints have long been identified as a potentially rich source of information. Sir Robert Francis QC report of the inquiry into Mid Staffordshire Hospital discussed the role of a trust's complaint department at length. Following on from that, the Clwyd/Hart Report entitled **"A Review of the NHS Hospital Complaints System putting Patients Back in the Picture"** also emphasised the need for the complaints procedure to be used more effectively**.**

Non-compliance with patient safety alerts is another potential indicator. Failing to implement an alert suggests that trusts are failing to take their responsibilities towards patient safety seriously.

The coroner's court provides ample opportunity for trusts to identify failings in their clinical standards and practices. Trusts are often able to avoid the necessity of a coroner making a prevention of future death report by providing an action plan. However, once the inquest has concluded there is no formal means of policing whether the action plan has indeed been followed through. Trusts that devise procedures to ensure those actions are carried out ought to be rewarded.

More generally there is a lack of learning coming out of litigation. Following resolution of a claim there needs to be a process by which a trust is obliged to undertake a period of reflection to identify whether there are or were any weaknesses in its serious incident reporting. Equally, it should be seen to be reviewing whether there were any missed opportunities in resolving litigation at an earlier stage, for example at either complaints stage or letter of claim stage. AvMA is currently working on a suggestion that would require a patient safety letter to be prepared setting out weaknesses in the various reporting and investigative stages but this will circulated in due course.

A commitment to training staff in the obligations associated in the statutory duty of candour is a marker for how a trust is changing its approach to risk management, investigation and complaints.

The outcome measures could also be linked to CQC inspections and ratings as a means of gaging standards of treatment and harm that could lead to future claims.

**Early reporting of very high value cases**
**Question 11:**

**Do you agree that the NHS LA should be notified of incidents which are likely to become very high value claims as soon as possible after the event? If so, what do you think should be the trigger/definition for reporting?**

**Response:**

AvMA agrees that the NHS LA should be notified of incidents which are likely to become very high value claims as soon as possible after the event. It is important from an evidential point of view that these incidents are investigated as soon as possible not just to ensure that the cogency of the evidence but to identify if there are any fundamental failings in the trusts procedures which need to be addressed to prevent future risks to the public materialising.

There are already a number of potential triggers for reporting. The statutory obligations around the statutory duty of candour are triggered by a "notifiable safety incident". A notifiable safety incident has a specific definition which is:

> ***"any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a healthcare profession, could result in, or appears to have resulted in:***
>
> ***(i) the death of a service user, where the death relates directly to the incident rather than to the nature course of the service user's illness or underlying condition, or***
>
> ***(ii) severe harm, moderate harm or prolonged psychological harm"***

The threshold at which the duty of candour applies is linked to the current arrangements for reporting safety incidents**.**

For the purposes of notifying the NHS LA of possible, future high value claims as soon as possible after the event, clinicians will be aware at the time that an unintended or unexpected event has occurred and that the event could at some future date result in death, or moderate or severe physical and/or psychological harm. For the purposes of this question the key phrases in this provision are "**any** unintended or unexpected incident", "**could** result in" and/or "**appears** to have resulted in".

AvMA considers that the current triggers/definitions for reporting are effective. However the policing of the systems used by trusts to ensure that the triggers/definitions for reporting are being adhered to and responded to accordingly are ineffective.

**Question 12:**

**Do you agree that notified incidents (as outlined in 11) should be linked to the CNST contributions? In the event that an incident giving rise to a claim is not reported and/or a high quality investigation is not undertaken, should the NHS LA be entitled to withhold part or all of the indemnity for any subsequent claims arising from that incident under the CNST?**

**Response:**

AvMA believes that a financial penalty for failing to advise the CNST of an event or incident giving rise to a claim may be an effective mechanism for better enforcing the existing triggers. Those triggers are the catalysts for reporting potential claims. However, AvMA does not support the suggestion that the NHSLA be entitled to withhold part or all of the indemnity for any subsequent claims arising from the incident as this could potentially have an adverse impact on the patient/claimant.

Claimants already find litigation extremely stressful. Once a claim has been resolved either through agreed settlement or by a court order, the claimant should be entitled to expect swift compensation. AvMA is gravely concerned by the suggestion that the CNST may be able to withhold part or all of any indemnity for a subsequent claim as the person who will suffer the most from this approach is the claimant/patient.

**Larger and/or older claims**
**Question 13:**

**Should the CNST treat older and/or larger claims differently for pricing purposes? If so, what should be the threshold for example 10 years old and/or more than £2 million in value?**

**Response**:

AvMA does not feel able to respond to this question as it does not falls outside of the scope of our experience and expertise.

**Question 14:**

**If older and/or larger claims are treated differently, what alternative approach should be taken? Should there be a greater degree of risk pooling for these liabilities? If so, should that risk pooling be restricted to a particular segment of the membership e.g. trusts delivering maternity services?**

**Response**:

AvMA does not feel able to respond to this question as it does not falls outside of the scope of our experience and expertise.

**Incentives**
**Question 15:**

**Should the NHS LA provide incentives under the CNST in order to fund safety initiatives? If so, can you suggest initiatives or actions which are evidenced to reduce the harm that leads to claims which should benefit from funding?**

**Response**:

AvMA believes that the NHS LA should provide incentives under the CNST in order to fund safety initiatives. Please see our response to Question 8 for further details.

We refer again to the University of Michigan's Early Disclosure & Offer Programme (D&O). The principles of the D&O approach dovetail with the obligations set out under the statutory duty of candour. It is includes: promptly investigating patient complaints; prioritising open communication with patients and representatives; meeting with patients, families and legal counsel to obtain their views; discussing the complaint with the patient/their family and explaining the progress of any investigation; communicating full findings to patients and/or their representatives, as well as a commitment to reducing future injuries and claims through the application of knowledge obtained through the discovery process.

The D&O demonstrates that a careful internal assessment of clinical events increases the chance that safety problems will be fixed going forward. A deny and defend culture is to be discouraged as this only serves to justify substandard care and does not embrace the opportunity to address patient safety issues.

The D&O programme is evidence that by being open and honest the rate of law suits will drop. The D&O approach clearly works but it does require a change of culture and a recognition that litigation costs and awards of damages are not part of doing business but actually a legitimate indication of the quality of care that the trust has provided and continues to provide, unless it goes to the root cause of the issues giving rise to liability in the first place.

**Additional services**
**Question 16:**

**Should the NHS LA offer additional services under the CNST to support the reduction of harm? If so what types of service would be of most benefit?**

**Response**:

AvMA supports initiatives to improve safety and reduce harm to patients. However, we do not have sufficient experience or knowledge of the data analytics programme referred to in paragraph 7.9 of the consultation document or of the bespoke member extranet and interactive score card system referred to. The consultation refers to the ability to use the buying power of the CNST to purchase "international expertise" and "sophisticated data analytics". It is not clear to us how these systems will work or in which particular area this expertise is available. We are therefore unable to comment in any substantive way.

AvMA believes that many of the systems already in place to enable trusts to learn from mistakes could be considerably improved if they were policed and monitored better.

There is a need for collective learning and early learning. In the case of litigation, cases often settle many years after the negligence event occurred – this if often in excess of three years after the index event, this is a long time to wait for any learning to be identified. Improved policing of the systems already in place is likely to incentivise learning from mistakes at a much earlier stage.

**Question 17:**

**If such services are provided, should they be funded by way of purchase of a subscription or the costs of apportioned across all Members? Do you have any alternative suggestions for the funding mechanism?**

**Response:**

AvMA believes that any improvements to patient safety and supporting the reduction of harm should be available to all trusts and on that basis the most suitable option would be for costs to be apportioned across all members. AvMA's concern is that the most financially viable trusts are the ones that are most likely to purchase a subscription. By contrast, those trusts which are struggling or failing financially are the ones where there is a greater risk of increased patient safety issues not being addressed.

Arguably, the financially failing trusts are the ones that will need the additional systems most but they are also the most likely to see the purchase of such a subscription to be unnecessary and a cost saving.

AvMA believes that it is in the interests of the public and all trusts that any additional patient safety services should be made available to all trusts without them having to take out an additional subscription; it should be part of the overall CNST package.

Patient safety issues are a problem which affect all trusts, albeit to varying degrees. Although some trusts are better at managing their patient safety issues than others any additional services designed to support the reduction of harm should be made available to all trusts. A failure to do this will result in the public in some areas having better patient safety and management of issues then others and this will in turn create a post code lottery for treatment..

**Interaction of options**
**Question 18**

**Are there any other options that the NHS LA should consider? If so, please provide details**.

**Response:**

AvMA suggests that there should be a more uniform approach to learning from litigation and where a failing in the standard of care provided has been identified, even if that failing did not give rise to clinical negligence litigation.

Learning should also be gleaned from situations where other clinical failings have been identified. The clinical failings referred to might include care that falls within the definition of a "notifiable safety incident"; care that triggers or ought to trigger investigations being carried out as part of a serious incident report; failings in care that are or ought to be identified from investigations carried out by a trust's complaints procedure.

******END******

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