action against medical accidents

RESPONSE TO

DEPARTMENT OF HEALTH CONSULTATION:

“A Rapid Resolution and Redress Scheme for Severe Avoidable Birth Injury”

MAY 2017

About AvMA

Action against Medical Accidents (AvMA) is the UK charity for patient safety and justice. Established in 1982, AvMA provides specialist support and advice to around 3,000 people each year who have been affected by lapses in patient safety. We have staff and trustees with extensive knowledge of and experience in patient safety and medico-legal matters including clinical negligence. AvMA works with government departments, health professionals, the NHS, regulatory bodies, lawyers and other patients' organisations to improve patient safety and the way injured patients and their families are treated following lapses in patient safety. This has involved working with government departments and other stakeholders in England, Wales and Scotland on alternatives to litigation for providing redress. AvMA also accredits specialist clinical negligence solicitors so that injured patients or their families have access to the best quality legal advice if they need it. All this means AvMA is uniquely well positioned to respond to this consultation from the perspective of the people who would be affected by the proposals.

Executive Summary of our response

We agree with the policy objectives and welcome appropriate measures to improve learning; safety; provision of proper redress without the need for litigation; and the introduction of an "avoidability test" rather than the test of negligence to establish eligibility for compensation. As well as making compensation available for more children, the avoidability test approach would be more conducive to a learning culture. However, we believe that the proposals as a whole as they stand in the consultation document are not yet fit for purpose. They do not provide sufficient incentive or certainty for families to choose the scheme over litigation. Our main concerns are listed below and expanded upon in the detailed answers to the consultation questions which follow.

- We do not think it is fair or reasonable that the injured baby/their family should have to forgo any of the compensation that would be applicable if it were a court case in order to help pay for the scheme. (The consultation estimates around 10% less compensation would be available under the scheme)). Many readers of the consultation will not have realised this was the intention. There is not even a consultation question on this – arguably one of if not the most contentious parts of the proposals. The compensation awarded in litigated cases are based on need. The NHS should already investigate incidents thoroughly, recognise where there has been avoidable harm and offer to settle cases with appropriate compensation. There can be no justification for a brain damaged child losing any of the compensation they need and deserve to pay for this scheme. We are astonished the document assumes, without any evidence, that at present families are being overly compensated. If the scheme went ahead and worked there would be savings on legal costs and of course from avoidance of future incidents through patient safety improvement.

- We do not think the NHSLA (even with the name change to NHS Resolution) would provide enough independence to be able to run the scheme and enjoy public confidence. Its role should be limited to administering the payments – not any involvement in making decisions on eligibility or in choosing or instructing investigators or panel members. The robustness and independence of the scheme (and public confidence in it) would also be helped if specialist independent advice and support was built in (see below).

- Families will need appropriate independent advice and support at each stage of the process. We note that the proposals currently include some provision for 'legal advice' and 'counselling' for families going through the scheme. Whilst both are welcome we think that the authors have misunderstood the overall needs of families. The document rightly talks about involving families from the start in the investigation. In our experience the ordinary person needs help and advice to be able to play an empowered role in such a process. They will need specialist advice on the various options open to them and to be able to make an informed decision on whether to take part in the scheme and how to participate if they do decide to. Such support should be able to empathise with their situation, signpost to other sources of independent help (including counselling if appropriate), and put them in touch with other people who have had a similar experience. We would suggest that an independent charity / charities would be the best source of such advice and support. It is a very different role from the information and services of the scheme's staff itself or case managers.

- We believe that the scheme should include other serious harm from maternity care such as stillbirths, child and maternal deaths. Although they may be of lower monetary value, they are just as serious and it is just as important that there is learning from them. Concentrating solely on high monetary value cases adds to the potential impression that the scheme is mainly about saving money

- The role of 'investigator' and medical / midwifery 'expert' needs to be separate. Investigators are specialists in investigations and establishing facts. Experts contribute by providing reliable clinical opinions based on the facts. Both need to be chosen / drawn from and paid for independently from an NHS body. The investigations must be undertaken by expert investigators who need not necessarily be clinicians. All of the investigators, clinicians alike need to be specially trained for this purpose; this training should be compulsory.

- The early payments envisaged as being available through the scheme are far too low. Interim payments made in litigated cases are usually much higher. Many clients require specialist accommodation at an early stage, the cost of which, especially in London and the South East can be far in excess of £100,000. If this is not going to be achievable under the scheme it will be a major disincentive to participate in it.

- The consultation makes reference to compensation or care being provided 'in kind' without defining what that means. It is unclear as to whether eligible families will have to accept public sector care as opposed to be able to commission private care for their child. More clarity would be needed in order to make a fully informed judgment about the scheme. We believe families should have a choice. If public sector care is part of the compensation and care package then that care needs to be of the same standard as would have been commissioned from the private sector. This rate is reflected by the court when damages for care are awarded, the court is informed of the appropriate rate from expert evidence. This head of damage is often agreed between the parties, the court need only approve the rate identified. This reflects the fact that both claimant and defendant organisations recognise that providing adequate, good quality care costs money. We also wish to emphasise the importance of ensuring that the care needs identified refer to the child's needs only. External factors such as the family's income or the amount of care available through a particular local authority must not be a consideration.

- Certainty about the future care needs of their child being met is paramount for families. The service provision needs to be guaranteed for the lifetime of the recipient if still needed, and not subject to local or national government budgetary or policy changes.

- It is critical that the scheme is guaranteed to be fully open and involving with the families participating in it. The Duty of Candour must be complied with by individual trusts but any independent investigation must also follow the same principles, if families are to have trust in it. This means sharing any relevant evidence as a result of an investigation with the family. Without this not only would families not be able to be fully involved in the investigation and check the veracity of evidence provided against their own experience, but if there is any possibility of relevant information being withheld from them, they will not be able to have confidence in the scheme. For the avoidance of any doubt, the application of so-called "safe space" arrangements as currently framed in arrangements for the Healthcare Safety Investigations Branch would be entirely inappropriate for this scheme.

- The scheme needs to be entirely voluntary and remain so. Legal Aid therefore needs to remain available in cases where the family withdraws from the scheme or choses to litigate instead. The expert investigation and patient safety learning part of the scheme needs to apply to all cases that meet the initial criteria whether or not a family decides to 'enter' the scheme as such. It would make no sense to ignore opportunities for learning or withhold evidence because a family intends to litigate.

An alternative way forward

We remain committed to working with the Department of Health to achieve the policy intentions and develop a suitable scheme if possible. However, given the problems with the proposals as they stand and the fact that the NHS Litigation Authority has changed its name to NHS Resolution and will be taking a more pro-active role in identifying avoidable harm, it may make sense to concentrate on making this a success rather than setting up a completely new scheme. It is a fact that if NHS bodies were already doing what they are supposed to in terms of recognising incidents; investigating them properly; complying with the Serious Incident Framework and the Duty of Candour with patients/families; and admitting liability earlier, there would not be a need for such a scheme. The new approach by NHS Resolution coupled with intensive work to improve the quality of local NHS incident investigations with the help of the new Healthcare Safety Investigation Branch may be able to realise the policy objectives at much lower cost and without taking money from injured children to pay for a new scheme. In any event, we recommend that the policy objectives of this proposed scheme are looked at afresh in a collaborative way with all stakeholders, including families and specialist organisations who work with them.

Whether or not a scheme goes ahead there needs to be a concerted drive to improve the safety of maternity care, and the scheme must not distract from or delay that. The improvements seen in Sweden are not solely the result of the scheme they introduced. Their staffing levels are much higher and patient safety has been prioritised. There is sufficient existing knowledge of what goes wrong and ways of reducing harm, such as the PROMPT initiative developed in Bristol (and described in our response below), which should be rolled out across the NHS as a matter of priority.

Our answers to the Consultation Questions and Other Comments

Question One: Investigation Design	Yes	No
Do you agree that the scheme should include early investigations, conducted by professionals independent from the trust involved, potentially including at least one obstetrician and one midwife? We believe that early investigations should be happening already. In order to preserve the cogency of the evidence investigations should occur as soon as possible after the event has been identified or suspected. However, we think that the professionals conducting these investigations need to be expert and experienced and trained in how to conduct these investigations. They need not necessarily be health professionals, although access to independent expert clinical advice is necessary.	✗	
If yes, how independent would the investigating team need to be in order for families to have confidence in the findings? Would investigations need to be conducted by clinicians in the trust, that were not involved in the incident being investigated nor have had direct management of those involved. We believe that as regards the scheme, it is vital that the investigation and decision making process is independent and seen to be fully independent for the public to have confidence in it. However there are different types of investigations where involvement of staff from the trust itself could and should be involved including Serious Incident Reviews (SIRs).		✗
Outside the trust involved, for example through the proposed regional Maternity Clinical Networks (proposed by Better Births)? This may well be a useful source of obtaining independent clinical advice. However, we think that an understanding of medico-legal issues is also important. Medical experts for the scheme could be from a list jointly agreed by NHS Resolution and AvMA, both of whom have their own databases of medical experts experienced in this work.		✗
- with oversight from the Royal Colleges or other independent bodies? This is another possible option but we would want to have more detail about how the Royal Colleges were going to operate. We question whether Royal Colleges would be seen as sufficiently independent or necessarily have the experience and expertise for this role.		✗
Any further comment If there is to be a scheme then the independence and perceived independence of it is vital if families are to choose it as an alternative to litigation. We also firmly believe that it should not become a requirement for families to use the scheme – it must remain entirely voluntary. Agreement will need to be reached with the Legal Aid Agency to ensure they do not make people use the scheme first, before being eligible for legal aid. A condition along these lines would in practice make the RRR scheme compulsory. If families are forced down the RRR route they will resent it, any compulsory aspect to the scheme risks thwarting all of the avenues open to them to access justice. The scheme must be about real choice.		

Question Two: Investigation Design	Yes	No
We are aiming to launch an investigation into the incident with 90 days. Do you agree with his approach, or have comment on the feasibility? We think it is vital that investigations are commenced earlier than this.		✗

Any further comment:

For the avoidance of any doubt, there should be no room for the SIR process to be delayed. Serious incidents should be reported as soon as possible and in any event within 2 days. It is mandatory for a serious incident to be declared where acts or omissions have occurred in NHS Funded care that have resulted in unexpected or avoidable death; unexpected or avoidable injury that has resulted in serious harm or unexpected or avoidable injury to one or more people that requires further treatment by healthcare professionals. It must be remembered that not all families will opt for the RRR scheme.

For those who don't, the SIR will be an important tool to help families understand what the trust say went wrong with the care provided to them and for trusts to learn from their mistakes. It would not be acceptable if investigations into the incident and learning from it were to be lost because a family chooses not to participate in this scheme. Therefore, either all SIRs need to be conducted promptly by the scheme's investigators or there needs to be both a SIR investigation and an investigation by the scheme. It is noted that the existing SIR guidance recognise that there are circumstances when SIRs should be conducted by an independent body.

Whichever approach is adopted the family needs to be fully involved and supported throughout the investigation(s). They will need to have access to evidence in order to do this, and we suggest, would need to have independent advice and support made available to them.

Leaving aside the question of the investigators' turnaround time and availability, there can be no excuse for failing to take full statements from the staff on duty at the time of the incident. Families need to be fully involved in the process from the outset, this must mean at the SIR stage. Families need access to the relevant, available documentation at that time and they need access to high quality legal advice. It is highly likely that the family can identify key members of staff relevant to the care provided; the names of those staff may not be known to the family but should be discernable from the medical notes. Statements should be obtained from those staff during the SIR stage, whilst the events are fresh in their minds. If, agency staff are involved it is crucial that those staff provide statements as soon as possible, before they move on at which point it may become difficult to trace them. These statements should be taken for the purpose of compiling the SIR and should be taken at the first possible opportunity, 90 days after the event is too late.

It can be difficult for ordinary members of the public to know who might be a relevant witness, access to specialist information and advice of the type AvMA can provide is vital at this early stage for the purposes of enabling and empowering families within the process in a way that makes them feel supported and listened to. Families are not likely to know the name or names of the relevant parties, these may only be identifiable from the medical records. It is imperative the family has access to this documentation at the outset. It is equally important that they are properly signposted to organisations that can help them.

It must be remembered, that many families take time to adjust to a new baby. The adjustment time is likely to be even longer where a family is aware that there is a risk that their new baby may have suffered severe brain injury. Some women will have been rushed to surgery so their baby can be delivered by way of caesarian section, this procedure on its own can render a woman fairly immobile for some 6 weeks afterward, and others may have had a difficult birth. Those women may not be well placed to deal with a potential investigation into the circumstances of their child's birth – 6 weeks is already half way through the 90 day target time. These factors may be further complicated by mothers and or parents experiencing feelings of guilt for the poor outcome their infant will have to endure for the rest of its life. These are complex factors, many of which may never be resolved or may only be resolved with time. This is another reason why families need access to independent advice and support at this early stage and should be introduced to it as soon as possible after the birth.

Question Three: Investigation Design

How can we ensure alignment with, and avoid duplication of, other investigative processes, such as the Serious Incident framework and the role of Regulators?

You cannot avoid duplication and should in fact welcome some level of duplication.

Currently, there are three levels of serious incident investigation which may be carried out: Concise investigations which are generally conducted at local level by a small group of individuals; Comprehensive investigations which are complex issues that should be managed by a multidisciplinary team involving experts or specialist investigators; and Independent Investigations which are normally reserved for situations where the integrity of the internal investigation is likely to be challenged or where it will be difficult for organisations to be objective. Inevitably there is already overlap between these processes, this is necessary in order to identify the central issues and to determine from the initial evidence which category is most appropriate for the incident.

There are many situations where SIR do not answer the families questions (often because they have not been involved in the initial stages or been involved in identifying the terms of reference). Families frequently resort to using the complaints process in order to obtain the answers to their questions; inevitably this requires an element of overlap between the SIR process and the complaint process. Equally, the complaints process may in fact act as the catalyst for a SIR being compiled in circumstances where the trust has not done this.

There is considerable evidence to demonstrate that many NHS trusts have not achieved a satisfactory standard of objective reporting when compiling SIRs. There are some trusts that do this well or better than others but the approach is not consistent nationally. It would useful for the investigation panel to have an additional role in critiquing the SIR and or complaints process; this provides an opportunity for the panel to view the findings in an impartial and independent way, and feed back to the trust on the quality or their SIR investigation. This could play a significant part in helping to improve the quality of this type of reporting. Hopefully, the lessons learned from this potentially very valuable feedback will resonate with all SIR investigations, not just those prepared as a result of birth injuries.

When an incident occurs it is vital that the available evidence can be captured as soon as possible so it can be preserved, so far as is possible for future use. Complaints and the SIR process are the first real opportunities for the trust to do this. It is accepted that litigation can take a long time to come to fruition, however the RRR proposals recognise that even with a two stage avoidability test it may take several years before the extent of the child's condition becomes clear. Whilst a family may be quickly identified as being eligible to enter into the RRR scheme based on meeting the Stage 1 Administrative Eligibility requirements, that is, the infant displaying the clinical markers set out in the RCOG Guidelines. The paper makes it clear that eligibility for Stage 2 will vary: ***"When a panel would be able to decide on an infant's eligibility for compensation under Stage Two would vary, as in some cases of severe neurological injury it can take several years for the extent of the condition to become clear"*** (p34 IA).

The paper also makes it clear that ***"Instead of all cases from Stage One being automatically eligible for Stage Two, an additional eligibility test may also be applied to assess whether the case is eligible for compensation"*** the paper continues: ***"Further testing of these options and additional evidence will be sought during the consultation before developing more detailed guidance on the exact criteria for eligibility"*** (p14 Consultation). These facts are very relevant when considering whether duplication of the investigative processes might be avoided. What is clear is that the investigative processes are likely to be instigated at different times and potentially occur quite some time apart. The stage 2 investigations could feasibly occur many years after the SIR was prepared and with the benefit of additional information on condition and prognosis.

Given that the family remains free to choose the litigation route at any stage it becomes critical that the early investigative stages are carried out; these will represent contemporaneous evidence in the event that litigation is opted for. That contemporaneous evidence will be of equal importance for any consideration of stage 2; given that the stage 2 test has not yet been identified it seems that the early investigation will be equally important evidence for any expert panel that may be appointed and asked to consider eligibility for the next stage of RRR.

It may be that a family is not happy with the conclusions arrived at by the investigative panel, those conclusions only being reached many years after they have been introduced to the RRR scheme. Families may decide to seek legal advice at this point and this will result in further investigations which may be similar to early investigation but with the emphasis may be on a different aspect of the treatment provided.

Families want the truth, reviewing the evidence should be seen as an opportunity to ensure that the families have answers to their questions as far as is possible, rather than a duplication of processes. The duty of candour is still new and whilst it is beginning to make a difference, has some way to go before it is fully integrated into the culture of the NHS, the duplication is an opportunity to ensure it has been complied with. As currently framed, the duty of candour only applies to the organisation which provided the treatment. It is vital the duty of candour is not side stepped by investigations being conducted independently.

Given the potential time lag between investigations it is important that the evidence is as contemporaneous and relevant as possible and that it is preserved for the benefit of RRR reviews which are likely to take place years later.

Question Four: Investigation Design	Yes	No
Do you agree that the scheme should include an early apology to families, in the form of an early expression of regret? It is not for the scheme to provide an apology but for the organisation and individuals who provided the treatment. Of course the scheme needs to treat families sympathetically and with honesty and respect This is an extremely sensitive area, it can take families many years to come to terms with the fact their child has difficulties as a result of a trauma at birth. The situation can be particularly charged where families believe that the harm was due to negligence and or was avoidable. What families want is to understand what happened, to receive open and honest answers to their questions and to be kept informed of developments and what is being done to prevent it happening again. They want recognition of the fact that something has gone wrong. It is true that many want an apology too but a poorly worded, defensive apology will do more harm than good, it is imperative that the apology is appropriately worded. At p32 of the paper it states that "…***stage one also includes an early apology to families. This may take the form of an expression of regret for any harm which has occurred…"*** An expression of regret risks being interpreted as a self-serving piece of correspondence that demonstrates that the NHS has done what was expected, rather than being a heartfelt apology setting out an open and honest account of the circumstances resulting in the injury. An expression of regret is not the same as expressing regret for causing harm. The Scottish Public services Ombudsman (SPSO) guidance on apologies is excellent and should be taken into account.		✗
Do you agree that the investigations should offer families the opportunity to be involved in the investigation process, with the option for a face-to-face meeting to discuss the findings? Most definitely. Families should be involved in the investigation process as soon as possible, they should have access to support to enable them to understand the medical notes, the medical language and to feel that they have someone on their side who will	✗	

support them. AvMA feels that one of the weaknesses in the SIR process is that not enough families are interviewed before the investigation and that the families are not invited to discuss the terms of reference at the outset. Families bring a lot of information and a key perspective on the treatment provided to them if they are involved at the outset. Although the bonds of trust are very difficult to regain once broken, early involvement helps families and individuals feel as though their concerns are being taken seriously, and that they are being listened to.

However, it is equally important that the family feels supported during the investigative process Most families will not understand their rights; the various investigative and regulatory procedures that may be relevant to their case; or medical or legal jargon. Inevitably there will be a tendency for families to believe that the trust will cover up, because it is in their interests to do so. It is also imperative that families feel supported by an outside agency who has no motive of their own. This is particularly true in face to face meetings.

AvMA has considerable experience in supporting families in these circumstances. For example we provided advocacy services and advice to families who were eligible for a review of their medical records during the Mid Staffs inquiry. We also provide support to families in face to face meetings in medical injury cases. Our experience tells us that many families feel overwhelmed at the thought of these meetings, even though it is what they want. There is invariably a sense of inequality of bargaining power – the ordinary person, who has been let down by the medical profession coming face to face with the CEO of the trust or some other high profile manager. Some people worry about not being able to express themselves properly. These meetings usually take place on the trust premises and this too can make individuals feel like they have lost ground before they even start, it can also bring back difficult memories for them which is a further disadvantage.

AvMA considers that face to face meetings can help to progress the issues and like mediations can be an opportunity to vent emotions – a very important part of helping individuals move forward. However, the face to face meetings are only of real benefit when families are properly supported.

Any further comment:

Independent advice and support for families who are potential participants in this scheme should be commissioned from a suitably experienced voluntary organisation or organisations.

In order for families to be properly involved in investigations and for them to have confidence in the scheme, they need to be confident that all relevant information including evidence such as witness statements elicited through investigations will be made available to them. Experience has shown us that families being able to counter or add to evidence provided by other witnesses can be vital to investigations being successful. <u>For the avoidance of any doubt, the so called ‘safe space’ approach built into the Healthcare Safety Investigation Branch can have no place in this scheme if it is to enjoy the confidence of families</u>. Any evidence relevant to their childbirth and what happened before during and after must be shared with them. We note that Sweden (whose scheme these proposals are based and whose success is quoted to justify these proposals) provides complete openness and disclosure to families.

Question Five: Dissemination of Learning	Yes	No
Do you agree that the scheme design should ensure learning is disseminated locally, regionally and nationally, building upon existing systems where possible?	✗	

There needs to be clearer guidance on what the existing systems are and how mandatory they are. Clearly there are potential roles for NHS Resolution; NHS Improvement; and the Royal College’s ‘Each Baby Counts’ programme. However, it is vital that there is clarity about

who will do what and that duplication or confusion of roles.		
Do you agree to the use of a central learning database to collate findings from investigations, which will then feedback nationally to trusts? This would appear to be a feasible approach in the first instance although it should be monitored to ensure that the central learning system is properly organised and similar issues are grouped so their eventual reduction in incidence can be tracked. The findings contained in the central learning database should be suitably anonymised where the requisite consents have not been given. The findings should be accessible to the public upon request.	✗	
Any further comment / ideas for how this could best work? We would like to understand how it is proposed this database would differ from the National reporting and Learning System (NRLS) already in use. We would be happy to take part in further work on this.		

Question Six: Accountability/Review of Learning

How could we best ensure that learning is implemented?

It is very important that as well as disseminating learning that the learning is translated into clear required actions and that trusts are supported in understanding and implementing them. Simply sending out information without supporting implementation will not lead to the desired transformation.

To be satisfied that the learning has been implemented, the process will need to be monitored and regulated by an independent external agency. We consider independent oversight to be very important. Obviously the Care Quality Commission (CQC) is the man system regulator and it is important that compliance with standards is mandated by statutory regulations as well as supported as discussed above. However the CQC has too wide a remit to be able to monitor implementation in a regular and detailed way, so there is a need for another independent agency to take on that role. This may be appropriate for Royal Colleges but there would need to be independent stakeholder involvement.

As well as monitoring implementation, it is important that the success of the learning and implementation is measured. Success should be tracked by reference to the number of similar incidents occurring at the trust. It stands to reason that the only way learning can be satisfied is by the trust demonstrating that the number of injuries arising out of a set of facts has been noticeable reduced with the opportunity for them to be eradicated in the future. This can be proved by the trust being able to point to the fact that injuries arising from the same causes have in fact been severely reduced or eliminated.

Question Seven: Dissemination of learning

Do you think there are additional potential barriers to learning that are not addressed by the current design of the policy? If so, do you have suggestions about how these can be addressed?

AvMA has asked its experts what the factors are that prevent clinicians from coming forward when a mistake has been made. In our 2016/17 questionnaire we asked clinicians to indicate whether they strongly agreed, agreed, disagreed or wished to add another comment to a series of possible reasons aimed at exploring why clinicians don't come forward. The answers are in the process of being collated, we are happy to share these in a redacted form once we have completed our analysis of the answers. However, we do understand that fear of litigation is not the only reason why clinicians are reluctant to come forward; this is a complex issue. The RRR consultation does not address how clinicians who do come forward under the RRR scheme will be protected, supported and limit the impact such mistakes may have on their future careers.

The RRR scheme does not explain how whistle-blowers will be protected. In order for bullying to be minimised the inherent culture within the NHS needs to change first. All of the concerns raised by clinicians need to be properly addressed in order to prevent them acting as a barrier to learning. RRR is silent on how this might be achieved; its focus is on avoiding litigation.

Question Eight: Support for clinicians

What improved support could be provided to practitioners following these tragic events?

This is an issue that needs proper consultation with clinicians. We suggested that there is work done with the relevant Royal Colleges in order to identify what support they wish to see.

Question Nine: Early Upfront Payments	Yes	No
Do you agree that families should be provided with an early upfront payment, likely to be in the average range £50-100k, when avoidability can be established?		✗

We agree with the concept of an early upfront payment. However, we have grave reservations about the amount of the award particularly as the consultation states that the early payment represents “***upfront costs required to care for the child such as adaptations to accommodation”.*** In our experience, the sum of £100,000 is unlikely to represent the cost of the adaptations required in a typical cerebral palsy case. We have serious concerns about this suggestion and cannot see how will work in practice, particularly how it will cover accommodation needs.

We are in favour of extending the test to one of avoidability thereby maximizing the number of children and their families who are eligible to apply. However, the compensation awarded by a court, including the care costs are based on need. It is a well-established legal principle that claimants should not be in a better position than they would otherwise be simply because they have recovered damages through litigation. It occurs to us that the question of need is one of fact, either the family requires the additional help and care, or they don’t. The level and standard of need is an absolute one, it must be met by any RRR scheme in the same way as it is met in litigation, and this cannot be compromised.

We are also concerned that this sum will only be made available once the child reaches 4 years of age. In our experience, it is imperative that children with neurological difficulties are able to access relevant therapies at the earliest age when their brains are still developing so that building blocks for learning can be put in place. This means they need paediatric physiotherapy, speech and language therapy (SALT), specialist information technology, occupational therapy, play therapy and so forth at the earliest possible time and certainly by the age of 2 years when children often start at nursery. The fact is, there is insufficient funding available to local authorities to allow children access to these key therapies in the quantity and of a quality which they require.

We have concerns about the wording of this question in that it talks in terms of when avoidability can be established. Administrative eligibility can be established by reference to meeting the clinical markers identified in the RCOG guidelines, this determines entry into the scheme at stage 1. However it would appear that stage two clinical eligibility will only be considered once the applicant passes from stage 1 to stage 2. Currently, the exact criteria for stage 2 eligibility is not determined (testing is being sought during the consultation). In any event, an applicant will only pass from stage 1 to stage 2 once the extent of the injury becomes clear, it is acknowledged that this may take some time.

Early stage payments may encourage families to use the RRR scheme if they are at a level that would be made if litigated. Lengthy delays between Stage One and Stage Two of the RRR process or inadequate early payments may encourage them to litigate instead.		
If yes, do you agree that the first significant payment should be made when avoidability can be established, which is on average when the child is around 4 years old? (As described in paragraph 4.18, earlier support such as a case worker will be available at an earlier stage) See comments on age of first significant payment above. Therapies need to be introduced without delay and that means well before 4 years of age. This gives a child the chance of developing its maximum potential later in life. If it is the case that RRR applicants will have to wait until the extent of the injury becomes clear and in the event that the applicant is likely to succeed in a case for clinical negligence then it is difficult to see the incentive to use this scheme. Once the injury is clear in terms of avoidability i.e. the extent of the injury then it will also be clear whether the claim meets the legal liability test. To be successful the RRR scheme needs to provide families with the incentive to use it rather than litigate. If NHS Resolution is committed to resolving concerns fairly and to ***"resolving concerns fairly and to minimise legal costs and deliver resolution in its broadest sense, which is more than just money"*** then there should be early admissions of liability on these cases. An early admission of legal liability will enable families to apply to the courts for an interim payment. If the interim payment is for accommodation and or adaptation costs and or therapies the courts are likely to be persuaded to make significant interim awards far in excess of £50-£100,000 offered under RRR. Where NHS Resolution makes appropriate early admissions before the child is 4 years of age, it is open to the family to seek an interim payment early on.		✗

Question Ten: Approach to accessing and paying for care	Yes	No
Do you think that periodical payments should be made "in-kind" through a personal budgets type approach, administered by a case manager? (see para 4.2.1) We have concerns about this proposal. It is not spelt out what is meant by 'in kind'. The bottom line is that children/families should have access to the services they need and that a court would provide for, at the same level/quality that they would receive had the case been settled by the court. Furthermore there needs to be a lifetime guarantee that the child will continue to receive such services unless their needs change. Any package must be guaranteed – protected from changes in future national or local government policies or budget constraints – as they would be in a litigated case. We strongly disagree with the assumption that children will only receive approximately 90% of the compensation they would receive had their case been settled through litigation. This amounts to taking away some of the compensation a child needs in order to fund a scheme which would not be necessary if the NHS were already doing what it should be doing. Families caring for a child with cerebral palsy or other brain injury need access to services such as carers. There are practical difficulties with carers, the main one being there are not enough care services available through the local authority. Families who go through the		

litigation process are often driven to do so because of need; it is not unusual to find families who have spent several years going through litigation who have been without any sort of care assistance, whether private or state funded, throughout that time.

It is not clear that the families will have any earlier access to services through the RRR scheme particularly given that the emphasis on accessing services will be considered at Stage 2 – the paper is clear that the exact criteria for eligibility from stage 1 to stage 2 is not yet known. At page 34 the paper states: ***"when a panel would be able to decide on an infant's eligibility for compensation under Stage Two would vary, as in some cases of neurological injury it can take several years for the extent of the condition to become clear"***

Once care is introduced, it can often be very difficult for families to get used to having carers in their home; they are often people that they don't know well or who are strangers to them, yet they are there to provide care, often intimate tasks to their child. It is a difficult relationship and one that needs to be carefully nurtured; consistency and trust are important factors. If the personal budget can provide the care needed to families and if this can be introduced at an early stage then this is to be encouraged.

It is understood from the paper that the scheme is offering a personal budget type approach although it is different and more generous than the personal budgets administered by the local authority which is the route to state funded care. The paper is short on the detail of how this will work in practice, however if the personal budget approach can deliver the care required to put the family back in the position they would have been but for the avoidable injury (or negligence) then we would support this.

The care required by the family should be based on what the family genuinely needs, that need should not be assessed in the context of what the state can provide. We are concerned that in practice the family's needs will take second place to the cost of the services, at page 11 the paper makes clear that: ***"The intention is to strike a reasonable balance between the cost to the taxpayer and the needs of the family"*** - who is going to determine where that balance lies? It is difficult to see how the local authority could do this without allowing its own objectives to keep costs to a minimum taking priority.

We are also concerned that the balance is said to be between the taxpayer and the family; the need must relate to the individual child, regardless of their family background. We could not support an assessment of care that took into account how wealthy the family themselves were, this is irrelevant. It is the individual child that has been injured and harmed, it is their care needs that are relevant, and the fact that they are the child of a high income family does not mean that they need less care because the family is in position to pay for it. Conversely, it should not mean that a family from a lower income background gets more care because they cannot pay for it. It is about the child's needs, regardless of their circumstances. In our experience families do benefit from and need a case manager to co-ordinate carers' attendance, sort out the family's holiday needs as well as cover for the carers' holiday and or sickness cover, tax and NIC payments and so forth.

According to IA p32, the RRR process aims to "***continue the improved service to families, compared to the current experience they face under the tort route. This would include …a dedicated case manager to facilitate provision of service".*** This is expanded on slightly at IA p76 "…***being able to provide an RRR compensation package that effectively meets people's needs, each family having access to a case manager who can quantify payments necessary or arrange for services to be provided is essential".*** The fact still remains that unless funding is available to pay the market rate to care providers then it will not be possible to recruit good quality carers, the appointment of a dedicated case manager doesn't change that fact. It is not clear who is going to pay the case manager – the local authority? If that is correct then the case manager is going to be compromised and will have to determine what the child/family receives by way of care in accordance with what the local authority can provide – this is not the same as meeting a family's needs.

If not, do you think that they should be made as cash payments?

Families must have access to the services they need. The courts will award funding for care at a rate that reflects the market rate of pay. If a family can pay a carer properly this inevitably increases their chances of successfully recruiting suitably qualified staff to help them. By contrast the RRR model even with topping up the local authority rate will still be less than the court would award and therefore represents less than the market rate. This will make it difficult to recruit qualified staff.

Making a cash payment, presumably to the value of the local authority rate plus top up will not improve this situation; market forces of supply and demand remain the same. If the payments do not reflect the market rate then making a cash payment to the family will simply throw the burden of trying to locate those services on to them, this will be additionally stressful and time consuming for them. It may result in the family having to undertake additional tasks such as ensuring taxes are deducted and other necessary state contributions are paid. There also appears to be a very real risk that there will be delays in the family receiving payments and for that matter, carers being paid. p54IA says under the heading "***Compensation in practice – There may be risks in translating the timing of payments as reflected in the model into practice - - for example practicalities of providing payment when it is needed to secure essential support such as accommodation…There are risks around ensuring families receive the right level of care…"***

However, if the family were able to receive a cash payment that reflected the market rate for payment of carers, they may prefer this as the family might consider that this gives them more control. We completely support families having this option, it is imperative that payments for care are made on time and to the full value. The scheme should be responsible for delivering the services although this aspect could be piloted.

Any further comments:

Certainty is very important for families. They need to know that the services will remain available to their child and not be subject to changes of policy or public sector budgets**.**

Adult social care is already considered to be inadequate and at tipping point, it seems highly unlikely that this situation will improve in the immediate future. It is clear that there is already a fundamental problem with recruiting people with the right skills to do this work. Even those who receive compensation for damages for care from the court can struggle to find the right care staff. The awards made by the court are done so with the benefit of specialist reports which identify what the actual market costs of finding suitably qualified care workers is. The RRR scheme needs to match those care costs so that people eligible under the scheme can also meet the problems of recruiting care staff.

The courts do not award costs for care without scrutinizing the available expert reports, these reports are usually available from both claimant and defendant legal teams. Those costs do not aim to put the child or individual in a better position than they would otherwise have been, they aim to ensure that sufficient money is available to provide what is required, the RRR scheme appears to overlook this point particularly as it considers the payments made by the Court to represent over provision, see IAP 54 "striking the balance between under provision (leading to litigation) and over provision (paying as much as is currently provided through litigation) is required

Question Eleven: Balance between PPOs and Lump Sum Payments	Yes	No
Do you agree with the shift towards more staged (periodical) payments PPO?		✗

Any further comments:

We cannot see how moving 50% of the lump sum entitlement to periodical payments will help the child/family. It must be remembered that litigation awards a sum to put the claimant back in the position they would have been if the injury had not occurred. In practice the lump sum and any past losses allowed are put towards accommodation and adaptation costs. With the change in the discount rate announced in February 2017, the lump sum payment is much higher than it previously was, the figures set out in the paper do not allow for this and the various models have not allowed for a negative variation in the discount rate.

The paper is again short on detail about how accommodation and or adaptation costs are going to be dealt with. This needs to be addressed.

Question Twelve: Needs Assessment	Yes	No
Do you agree that there should be an ongoing needs assessment of provisions for the injured child?	✗	

There definitely needs to ongoing needs assessment for an injured child. A child of 4 years of age will have very different needs to a child of 18 years of age. However, we are again concerned by the fact that the paper refers to the fact that ***"if an individual's care needs increase, the PP would undergo a "sensitive reassessment" and the reassessment would likely increase the size of the PP"***

The use of the words "would likely increase" are not very reassuring in this context. Either the changing care needs will be met, or they won't be.

If yes, at which ages should these reviews be:

- ages 5, 12, 18?

Any other comments on age intervals?

In practice litigation will typically arrange a review of care needs in accordance with advice from care experts. That advice is likely to vary according to the child's needs. The care expert will look at the particular circumstances of each child, the wishes of the family and make recommendations based on the likely changes of circumstances in the future. It is therefore difficult to be prescriptive about what age the review should take place much will depend on the extent of the physical disability, the psychological profile and the cognitive abilities as well as what he family's wishes are.

Reviews should occur at least at ages 5, 12, 18 and 21 – We would urge that the review takes into account the extent of the child's disability and other experts' opinions such as doctors who are involved in the child's care as well as the family's wishes.

Should families be able to trigger a needs assessment for their child, when services can be reviewed and care potentially adjusted (if found necessary)? Yes the family is best placed to identify whether the child's needs have changed and need reviewing. However, this should be in addition to a standard yearly reassessment by an expert.	✗	

Question Thirteen: Scheme Administration	Yes	No
Do you agree that NHSLA (or new division within NHSLA) should administer the scheme?		✗

Any further comment:

There is insufficient trust in the NHS LA or the rebranded NHS Resolution, to allow for them to administer such a scheme. It is very important that the scheme is administered by someone neutral and who is not seen as either the perpetrator of the injury or with a motive of their own for refusing to increase funding. If the scheme is administered by the NHS LA (NHS Resolution) there is unlikely to be confidence in it and the uptake will be poor.

We suggest that an independent body is created to oversee the scheme and to give impartial feedback to the participants. An independent body is more likely to gain the trust of the public.

Question Fourteen: Clinical Eligibility	Yes	No
Do you agree that the clinical eligibility into the scheme should be defined using the RCOG definition of avoidable brain injury?	✗	

If not, what are your objections and any proposed alternative?

We have no objection to the use of the RCOG guidelines as a means of determining eligibility for stage one of the RRR scheme. However, we are surprised that the scheme does not seek to include still births and neonatal deaths. These outcomes are often a consequence of medical mismanagement during labour. They are often the result of the same failings that give rise to severe and complex brain injury in infants. Given that a key tenet is learning we consider it important that these categories of cases are included in the scheme.

The proposed cohort of babies eligible under the scheme only represents a limited proportion of the total number of babies injured as a result of failures in care during pregnancy, childbirth and in the neonatal period and a excludes many other injuries that may be arise. In terms of learning and prevention, all cases of significant avoidable harm in maternity care need to undergo the same level of scrutiny and for the evidence to be collated alongside the cohort represented by the proposed scheme

We would also suggest that the symptoms identified under the RCOG guidelines should be used as a trigger for investigation by NHS Resolution; these markers recognise that the child has experienced harm, the investigation should determine what the likely cause of the harm was.

Question Fifteen: Administrative Eligibility	**Yes**	**No**
Do you agree with the principle of administering the scheme using an avoidable harm test?	✗	

Further comment

We agree with the proposal to use an avoidable harm test for the scheme. This would make compensation available to more children who need and deserve it; encourage use of the scheme as an alternative to litigation (provide the problems we have identified are addressed); and create an approach which is much more aligned with patient safety and organizational learning and accountability**.**

We agree with the principle of widening the scope of people eligible to benefit from services and on the face of it, the avoidability test appears to be a workable idea. However, we are concerned that this scheme offers too much, too quickly. It should start by demonstrating that the NHS LA or NHS Resolution is able to consistently prepare independent, objective SIR reports. That it has the skills and will to deal with complaints in an effective and satisfactory way, that it can and will admit liability early on and resolve cases fairly without the need for them to resort to litigation.

Further, this is an opportunity for the NHS to demonstrate how it is using the early investigation phase to learn from mistakes and to address change. It is also an opportunity to roll out a regional although ideally a nationwide commitment to a PROMPT type scheme.

If the NHS can do this, it will be a start in showing that it is genuinely willing to change the culture and this in turn will enable it to gain public confidence. It will also reap the benefits of less litigation costs.

One of the initial attractions of the RRR scheme is that it is likely to lead to early resolution of cases. The scheme asserts that a "***Further lump sum and any periodical payments calculated in line with need would be received on average a year earlier than they would through the courts"*** **(4.19)** However it is difficult to understand how the paper has arrived at this conclusion particularly given that at page 34 of the impact assessment it recognises that ***"when a panel would be able to decide on an infant's eligibility for compensation under Stage Two would vary…it can take several years for the extent of the condition to become clear"*** That situation is no different to litigation – if it takes time to resolve causation, condition and prognosis in litigation it also clearly takes the same time under this scheme.

This approach could be piloted quite easily. Arguably, if the PROMPT method is also implemented nationwide there is every reason to believe that the learning may be more along the lines of that seen by Southmead Hospital, namely a 50% reduction. See our response to question 17 below.

Question Sixteen: Avoidable Harm	ECT	RCT
Do you prefer the proposed 'Experienced Specialist' test (EST) or the 'Reasonable Care' test (RCT)?	✗	

Why/why not?

We fully support the principle of widening the test to one of avoidability based on the Experienced Specialist test. This will widen the pool of children eligible to claim. It will allow families to have a choice and the option of avoiding the stress of litigation; resolving these cases early and saving legal costs. Use of the "Reasonable care test" would not represent a significant change than the existing test of negligence. We note that Sweden (whose scheme these proposals are based and whose success is quoted to justify these proposals) uses the Experienced Specialist test.

Question Seventeen: Piloting the scheme	Yes	No
Should the scheme be piloted?	✗	

Please provide rationale:

We can see the benefits of some form of pilot before any scheme goes fully 'live'. However, we can also see an argument that the same objectives could (and should already) be met by a shift in culture properly resourced drive to improve the quality and timeliness of investigations, be completely open and honest with families, and realign existing bodies to ensure that lessons are learnt and implemented and their success measured.

Given the declared intentions of NHS Resolution and existing guidance / requirements such as the duty of candour and the Serious Incident Framework an obvious question arises as to whether a scheme should be necessary at all. If the NHS were already doing what it should be then it wouldn't be. An option would be for NHS Resolution to pilot improving early investigations and seeking early resolution of cases using the avoidability test without families having to resort to litigation. A new culture and approach such as this may be possible without the additional cost and obvious challenges of a whole new scheme. Other elements envisaged for the scheme such as independent advice and support could still be built into such an approach.

If it were to operate in this way then it would provide NHS Resolution with an opportunity to prove that it can fulfil the purpose for which it was set up. In particular it would allow NHS Resolution to demonstrate its commitment to being more involved in incidents at an early stage. The pilot should monitor how effective the "***strategic shift***" and the "***new approach to the way in which it responds to incidents involving brain damage at birth"*** is***.***

Other Comments

1. As we have said we strongly disagree with the assumption that children/families in effect forgo 10% of the compensation they would receive if the case had been litigated. We find it astonishing that there was not even a consultation question about the acceptability or otherwise of this.
2. Consideration of and development of a scheme should not delay urgent action being taken to act on what we already know to improve patient safety in childbirth. We suggest that there are already effective and proven ways of introducing safer care at minimal cost. Mr Tim Draycott, Consultant] Obstetrician at North Bristol NHS Trust founded the Practical Obstetric Multiprofessional Training (PROMPT) method. He also led the research into Safety and Quality (RiSQ) group which developed an automated maternity dashboard and a simple tool to measure maternal satisfaction after delivery. Prior to developing PROMPT his initial findings were that less than 50% of working midwives and obstetricians could employ anything more than basic care in an emergency situation. To address this Mr. Draycott implemented better training, which resulted in a reduction in harm. The PROMPT training programme was introduced into Southmead Hospital in 2000, the outcomes are impressive, it resulted in a 50% reduction in hypoxic babies, low APGAR scores (at 5 minutes) and an almost 100% reduction in brachial plexus injury following shoulder dystocia. His key message is for units to learn to call for help early on and to work with each other as a team; training is embedded in the systems in place in his department.
3. Mr. Draycott's department at Southmead Hospital is a crucible of practical improvements; it has made it easy for everyone to do the right thing with everyone following simple steps to make taking the right steps easy. These improvements were made in an NHS trust, without additional funding but with commitment and determination. The lessons learned at Southmead could and should be followed elsewhere. The costs of doing so are minimal, and are not paid for by the injured child and achieve a far higher reduction in injuries than the 25% target set in the consultation paper. According to Mr. Draycott "***if training were as effective nationally as it is at Southmead Hospital, over 100 severe birth injuries would be prevented each year, which would significantly benefit children and their families, and could potentially reduce £64 million per year in NHS litigation claims alone"***

Given these outcomes it seems to us inexcusable that other trusts are not compelled to follow this lead which has a focus on teamwork especially when the IA p68 identifies that "***over 70% of sentinel events in obstetrics are associated with failures in teamwork and communication"***