RESPONSE TO

Department of Health Triennial Review of the NHS Litigation Authority – Call for Evidence

CONSULTATION DUE: 6TH NOVEMBER 2014 (Midnight)

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. In September 2009 AvMA committed resources to providing a specialist pro bono inquest project in England and Wales; the project was officially launched in July 2010. The project 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.

4. The pro bono inquest service has developed so that it now provides advice on approximately 100 inquest cases per annum, some of these cases are referred to solicitors especially if there is a potential civil claim. Through our work, we have developed considerable expertise in providing assistance and representation to members of the public at inquests where the death arose in a healthcare setting.

5. 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 his powers to remedy the failings where appropriate.

6. As an organisation our aims are to champion patient safety and access to justice. Accordingly, where appropriate we invite the coroner to consider the need for a conclusion to reflect that neglect aggravated the cause of death and to record evidence of systemic failings. We also consider any Action Plans put forward by the trust and where relevant address the coroner on the need to make a Prevention of Future Death Report (PFD).

7. AvMA provides specialist support services for legal professionals through our Lawyers Resource Service including the recommendation of expert witnesses. We organise specialist training courses and conferences for health and legal professionals, advice agencies and members of the public.

8. AvMA operates a specialist accreditation scheme and assess solicitors for eligibility to the panel based on their experience and expertise in clinical negligence. The AvMA panel has been running since the late 1980's and is the longest running clinical negligence accreditation scheme as well as being the first accreditation scheme of its kind. We reaccredit our panel solicitors after 5 years to ensure that they are maintaining standards, both the original application for accreditation and reaccreditation process require solicitors to submit case reports. As a result we have access to over 200 case reports annually.

9. The case reports ask for a number of pieces of key information, for example: when the solicitor first had contact with the client; when the letter of claim was sent; when the letter of response was received; when proceedings were issued; when the case settled. The information is collected as a means of identifying how quickly a solicitor progresses claims. Where there is delay, the solicitor has the opportunity to explain reasons why delay occurred. The information not only enables us to assess a candidate but also provides us with a keen sense of the difficulties commonly encountered by Claimant solicitors in progressing cases.

AvMA's Response to the Consultation

10. 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.

Executive Summary of AvMA Recommendations

11. AvMA believes that the NHS LA would improve its operations by placing the patient at the centre of their objectives. Although the NHS LA has developed a Safety and Learning function and refers to having developed key links with patient groups, we are not aware of who those groups are or how they feed in to the strategic aims.

12. Patient/Claimant involvement is important and should be developed further. We would like to see plans to give the patient/claimant a voice to feedback their experiences to the NHS LA. This could be done, for example, through greater involvement with organisations such as AvMA. AvMA is uniquely placed to contribute to such discussions given its medico legal insight derived from its direct access to accredited clinical negligence solicitors. It also brings a perspective from its patient safety and campaigning work. AvMA's direct involvement with the public through its Advice and Information, Helpline and Inquest Service, enable us to give voice to concerns expressed by the public.

13. Feedback of this nature could provide a further source of information on how the NHS LA and or their panel solicitors have progressed and managed claims.

14. It is our view that the NHS LA is best placed to steer its way through the fast changing legal market by consolidating its existing relationships. AvMA and the NHS LA have established a relationship but it is one which could be developed further. For example, the relationship would benefit from a more consistent approach to collaborating and discussing projects, concerns or issues that arise. A Memorandum of Understanding about how we might work together may help to facilitate this. It is likely that the NHS LA could benefit from taking this approach with other external organisations it works with.

15. One example of how further collaboration might work would be in relation to mutual promotion of accredited solicitors bringing clinical negligence claims. This would benefit the public/patient but would also help the NHS LA as claims brought by solicitors with experience and expertise in clinical negligence will be run more efficiently. A

collaboration of this nature might reasonably be expected to result in a reduction in the number of unmeritorious claims being brought thereby reducing the burden on the NHS LA. It may also promote more speedy resolution of claims, a matter of particular importance given the relationship acknowledged to exist between the length of time it takes to settle a case and costs incurred.

16. AvMA would encourage greater transparency around information available from the NHS LA and its panel firms. One example is in relation to the rates payable to experts by the NHS LA, this would promote discussion on the differences, if any, in expert rates paid by claimant solicitors. This would be an important piece of work, not least because medical expert fees are an unavoidable part of the clinical negligence litigation process and contribute to the costs incurred.

17. AvMA receives regular concerns from claimant firms about how the NHS LA and its Panel Firms operate in practice, there is often considerable disparity between the NHS LA's stated position and how it is reported to operate in practice. A particularly contentious area appears to be the reason for delays in settling claims; greater transparency would enable this area to be explored in more detail.

QUESTIONS

What more could NHS LA do to improve patient safety and the quality of patient care?

Please consider:

- **Wider opportunities for the NHSLA to contribute to patient safety and the quality of patient care.**
- **The development of NHSLA's safety and learning service.**
- **How patient safety data held by NHSLA is currently used.**
- **Whether there is more learning that could be derived from the patient safety data held by the NHSLA**
- **How learning from class actions for individual members or across the whole of England could be used in improving patient safety as well as improving efficiency**

Response:

18. The Marsh Report recommended that the NHSLA utilise the large and unique data set that they hold in order to provide wider analysis of claims over a range of clinical specialities. It suggested that its database of clinical negligence claims should be leveraged to enable the NHSLA to understand the drivers of clinical negligence and to guide strategy (page 11).

19. The Marsh Report also recommended that there be a link-up between the mandatory reporting of all serious patient safety incidents by NHS Trusts to the CQC and with data held by the NHSLA. The aim was to enable a timely analysis of information and identification of trends emerging from incidents and claims data (page 61).

20. AvMA feels that not enough has been done to implement this recommendation. This observation is made from knowledge of settled cases we have access to through our AvMA Panel Accreditation scheme. As part of the accreditation process lawyers must submit six case reports on the initial application, a further six reports must be submitted after five years as part of the reaccreditation process.

21. The accreditation process gives AvMA access to a reliable stream of information, including the nature of cases settled by claimant lawyers and the value of the damages secured. Our review of these cases has left us with the general sense that the NHS LA's efforts to harness opportunities to identify patient safety issues, trends and common issues of negligence has, at best been slow. It is AvMA's view that the NHS LA's task will have been hampered by the fact the National Patient Safety Agency (NPSA) has been disbanded.

22. Other than the cases we are able to review from AvMA Panel applications we also see cases directly from members of the public through our Advice and Information Service, Pro Bono Inquest Service, Lawyers Service and Clinical Risk. Our Advice and Information Service, has noted an improvement recently in the number of cases where a Serious Incident Report (SIR) has been prepared. We have seen examples of where the SIR has been disclosed to the family without them having to make a formal written complaint or a request for disclosure of the SIR.

23. However in relation to our inquest work we see a continuing reluctance by trusts to make available to the family any serious incident reports where the patient has died. We are aware of situations where the triggers for a serious incident report appear to have been met but the trust has failed to produce such a report.

24. AvMA would argue that early investigation is not only key to identifying weaknesses in a trusts service and or systems but is also in line with the duty to advise a patient at the earliest opportunity that something has gone wrong with their treatment. This need to be open and honest is at the heart of the statutory duty of candour.

25. We have not seen any cases where the family have been invited to comment on the terms of reference for a SIR, Root Cause Analysis or similar document. This in our view is a failing in that it often means the trust is missing an opportunity to put itself in a position where it is aware of the patient and or their family's perception of the poor quality of the patient's care.

Complaints

26. AvMA observes that there is a correlation between poor complaint handling and cases that become legal claims. There are wider opportunities for the NHS LA to contribute to patient safety and assess the quality of patient care by insisting that

trusts put greater emphasis on the importance of their complaints departments. This would mean encouraging trusts to invest greater resources in the complaints process, including training their staff.

27. It is our view that if the NHS LA were to put greater emphasis on trusts addressing issues at the earliest stage, such as the complaints stage and putting the patient and or the family at the centre of the investigation they would put themselves in a position where they could become aware of patient safety issues long before they become legal claims.

28. It follows on from this, that there needs to be a more effective means of communication between NHS trust's complaints departments and the NHS LA so that greater information on patient safety and the quality of patient care can be identified at the earliest stage. The NHS LA could invest in analysing letters of complaint, letters of claim and any proceedings which are subsequently issued and the commonalities between those documents. This will enable the NHS LA to identify core weaknesses in a trust, alert the trust to those weaknesses and enable them to remedy those weaknesses.

The Coroner's Court

29. There are opportunities for the NHS LA to develop its safety and learning by having a better link up with trusts on the outcome of an inquest, in particular the coroner's findings at the conclusion of an inquest.

30. The NHS LA would benefit from identifying a way for trusts to systematically provide copies of any Action Plan prepared in response to a death and submitted to a coroner as part of the investigation. This would then enable the NHS LA to consider the trust's failings, and ensure that the steps set out in the Action Plan were implemented. By overseeing the implementation of the recommendations of an approved Action Plan the NHS LA would be able to see that action had been followed through by the trust. This contributes to patient safety by trying to ensure that lessons have been learned and preventing those weaknesses that were instrumental to the death from recurring.

31. Where an inquest has been held but a trust has not produced an Action Plan, alternatively where the Action Plan has been insufficient for the Coroner's purposes and the Coroner makes a Prevention of Future Death (PFD) report it should be mandatory for the trust to send this to the NHS LA.

32. Similarly, where a coroner makes a finding that neglect contributed to the death it should be mandatory for a trust to report this to the NHS LA.

33. These steps provide the NHS LA with additional information on a trust's performance and serve as another opportunity for the NHSLA to identify weaknesses in any particular NHS trust. In turn this information should feed into the existing patient safety data already held by the NHS LA.

34. Through its inquest service, AvMA has identified some perennial weaknesses with NHS trusts, such as: nurses failing to routinely monitor a patient's vital signs (heart rate, respiration, pulse rate, blood pressure and so forth); failure to properly document observations; failure to communicate properly with handover staff; failure to communicate properly or at all with doctors, in particular consultants on duty. All of these matters at the very least contribute significantly to fatal outcomes.

35. However, these are also matters which can readily be addressed and which apply to many trusts, if not all trusts at any one time. These lessons, could be disseminated to all trusts and although basic, can serve as reminders which may lend itself to improved patient safety and the quality of patient care.

Patient Safety Alerts

36. AvMA has done considerable work on patient safety alerts. We first reported on this in February 2010 when 2,124 instances of non-compliance were identified. We reported again in August 2011 when we identified 455 instances of non-compliance and then again in January 2014 when 141 instances were identified. Although there has undoubtedly been dramatic improvement since 2010, we take the view that 141 incidences of non-compliance is too high and represents an unnecessary risk to patients. It also represents a potential risk of a claim being made.

37. The NHS LA could insist on trusts providing them with an update on all of the patient safety alerts they had not yet implemented, setting out whether they were outside of the time recommended for action to be taken. This would provide additional information to the NHS LA on the quality of care being offered by individual trusts and identify risks to patient safety through non implementation of the alerts.

Conclusion

38. AvMA is not aware of how and or in what way the NHS LA has developed a safety and learning service. If such a service is in existence then this has not been apparent to us through any of the patient experiences shared with us through either our Helpline, Advice & Information and/or Inquest Service. If a patient safety and learning service has been developed and launched then it needs a higher profile and greater patient involvement.

What are your experiences of working with the NHSLA?

Please consider:

- **Where members have experience of other providers/insurers how the schemes compare.**
- **Whether NHSLA consistently meets member expectations.**
- **How well does NHSLA work with scheme members, legal firms and other stakeholders to improve the NHSLA service offering.**

- **Areas where the NHSLA performed well or where it could improve its performance.**

- **Indicators that could be used to illustrate the NHSLA's performance?**

- **Any other evidence you have on the NHSLA's performance and capability.**

Response:

As this question refers to the experience of those contributing to the CNST Scheme we are unable to respond to this question in any meaningful way.

How might NHSLA adapt its approach to improve the quality of its service for members?

Points to consider:

- **Where the NHSLA engages members in the development of its services.**

- **Where the services offered represent good value for money?**

- **Where the NHSLA would benefit from additional regulatory or market freedoms or flexibilities.**

- **Would other corporate forms / governance arrangements support the functions?**

- **Whether NHSLA's services offer value for money**

Response:

As we do not directly engage with the NHSLA as a member we are unable to respond to this question.

What other delivery mechanisms could be used to successfully administer the schemes?

Please consider:

- **Where there might be economies of scale from partnering with other claim handling functions elsewhere in the public sector.**

- **Any existing providers – in any sector – that could operate the scheme wholly or as a joint venture or whether the schemes could be mutualised or delivered via community interest companies / social enterprise, what would be the financial implications of such a model – please provide evidence as to the practicalities of benefits of doing so.**

- **The risks, benefits or opportunities of the scheme being run within the health and care system.**

Response:

39. As we are not recipients of any claims handling functions of the NHS LA we do not consider it appropriate for us to respond to this question.

This part of the Call for Evidence asks stakeholders to feed in on the NHSLA's performance, capability and efficiency.

Is there anything else NHSLA could do to be more efficient in its member operations?

Please consider:

- **Whether there is scope for NHSLA to further improve its pricing methodology and how this might be achieved.**
- **Any barriers experienced in joining or exiting the schemes and, if appropriate, how these might be changed.**
- **The NHSLA's approach to claims which lack merit and to exaggerate its claims for damages and costs.**
- **The time taken to resolve claims and the balance between resolving cases with or without damages against those which are contested in court.**
- **The NHSLA's ability to strike the right balance in contesting cases to trial or settling.**
- **The NHSLA's role in co-ordinating legal actions and setting legal precedents in the interests of the NHS.**
- **Whether the NHSLA's interaction with members has improved and is proportionate.**

Response:

40. The NHSLA has reported a significant increase in the number of claims in the last financial year (18% rise). It is understood that the increase in claims can be linked to two significant factors. First the reduced scope of legal aid as introduced by Legal Aid Sentencing & Punishment Offenders Act 2012 (LASPO) in April 2013 and the changes to conditional fee agreements.
41. AvMA do not support claims that are without merit being pursued, such an approach is not in the client's best interests and only serves to raise expectations which cannot

be met. However, AvMA believes that if the NHS LA were to encourage members of the public to seek representation from lawyers who hold accreditation (demonstrating expertise and experience) in clinical negligence claims, then there will be a reduction in claims which lack merit being brought.

42. In considering this, it is important to recognise the part played by the reduced scope of legal aid in opening up the clinical negligence market to lawyers who do not have any recognised experience or expertise in bringing clinical negligence claims.

43. The reduction in scope of legal aid is significant in that prior to April 2013 firms specialising in clinical negligence claims were able to offer eligible clients legal aid funding. Legal aid could only be offered by solicitor firms which held a legal aid contract.

44. The Legal Aid Agency (LAA) (formerly the Legal Services Commission (LSC)) had a number of requirements that had to be met before a contract could be awarded, one of which was that the firm employed a solicitor who was accredited by either the AvMA Panel or the Law Society Panel. By securing a legal aid contract, firms were able to display the Legal Aid Quality Mark. Quality Mark became a standard recognised by many consumers looking for a solicitor.

45. Panel membership reflects the fact that a solicitor has particular expertise and experience in clinical negligence work. With the reduction in scope of legal aid there has been increased numbers of lawyers offering services to the public for work previously covered by legal aid, these cases are being financed on a Conditional Fee Agreement (CFA). There is no corresponding requirement for solicitors to be able to demonstrate expertise and experience in clinical negligence work where the work is funded on a CFA.

46. This has been a retrograde step for consumers and we believe for the NHS LA. With legal aid funding becoming less relevant so too has the legal aid Quality Mark. Consumers do not necessarily know about the benefits and importance of instructing a solicitor who has a specialist accreditation mark. By way of example, the Legal Services Consumer Panel report entitled **"Accredited Schemes – progress report"** published in April 2014 found that ***"only 5% of respondents in the general public sample had used a quality mark to help choose a legal provider"***

47. We believe that the NHSLA would be more efficient in its operation if it were to recognise that experienced claimant solicitors have well established and practised screening procedures which help to ensure that only claims with merit are brought. We believe it highly likely that there is a correlation between the increased number of claims which allegedly lack merit and lawyers who do not have the requisite expertise and experience in clinical negligence litigation entering into the clinical negligence market.

48. The NHSLA could easily and cheaply help to make the public aware of the importance of instructing accredited solicitors through for example, its complaint's

departments and PALS. In return the NHS LA are likely to see fewer spurious claims being issued and those which are issued and are progressed are run more efficiently.

49. The second reason for the increased number of claims, relates to the change in the conditional fee agreement (CFA) regime, in particular loss of the 100% success fee being payable by the losing party and the loss of the losing party being responsible for the cost of After the Event (ATE) insurance premiums. The trigger date for the change in CFA regulation was 1st April 2013, it is understood that a number of solicitors entered into CFAs with their client prior to this date to preserve their own position and that of the client. From the client's perspective, under the old CFA regime no success fee was payable out of their damages, this of course changed after the 1st April 2013. We believe that given time this position will settle, and that the increased number of claims arising as a direct consequence of the change in CFA regulations will plateau.

50. The Marsh Report identified that some trusts perceive the NHSLA as settling claims too quickly, rather than defending cases, other trusts saw NHSLA as being too adversarial (see page 1). One of the Marsh recommendations was there to be ***"less focus on speed of settlement, to ensure NHSLA are not seen as "soft touch" for claimants' solicitors***" (page 2). AvMA considers this approach to be erroneous.

51. AvMA is not directly involved in litigation however from the reports we have received from our panel solicitors, there appear to be many, unnecessary delays between the claimant solicitors reporting claims and settlement. There is little doubt from the data we have seen that the longer it takes to settle a claim, the higher the costs involved.

52. It does appear that there is scope for the gap between notification of a claim and settlement to be closed considerably. A common complaint is that the NHSLA frequently requests additional time to respond to a letter of claim. When the response is received and liability is denied there is often little detail to substantiate the denial. It would appear that it is often the case that the NHS LA deny liability in the letter of claim in circumstances where they have not obtained their own independent expert evidence.

53. Claimant solicitors have recently been criticised for investigating a case before sending a letter of claim and running up what are said to be unnecessary costs. However, the burden is on the claimant alleging negligence to prove their claim. In order to ascertain whether there is a prima facie case and the merits of a claim it is necessary to obtain independent medical expert evidence on the issues of liability and causation. Contrary to running up costs this enables claimant lawyers to substantiate their case and prevents unmeritorious claims being brought.

54. If the NHS LA is going to deny liability and or causation at the time of writing their letter of response, this should be done with the benefit of independent medico legal expert evidence. If independent evidence is not obtained at an early stage then it is inevitable that opportunities for early settlement will be missed.

55. The impression is that the request for additional time to respond to a letter of claim is requested not due to the NHS LA case handler investigating the claim but because their case loads are too high to enable them to produce a response within the 3 months expected.

56. We are aware of one case where a number of requests were made to extend time for service of the letter of response. The time was granted due to the fact that the claim was low value and the solicitor was under the impression that the NHS LA were in the process of obtaining their own medical evidence. Subsequently liability was denied. The Claimant solicitor suggested mutual exchange of expert evidence on a without prejudice basis, at that point it became clear that the NHS LA had not obtained any medical evidence, this was now some 2 years after the letter of claim had been sent. The matter subsequently settled for circa £7,000 immediately prior to proceedings being issued.

57. From the information we receive this is not an uncommon scenario. It is recognised that low value claims can be difficult to resolve economically and swiftly. We believe the challenge to the NHSLA is to address this problem thereby keeping costs to a minimum and ensuring that access to justice can continue for those patients who are entitled to damages for injuries sustained without argument on proportionality being deliberately invoked.

58. The gap between the time when the letter of claim is sent and subsequent settlement of cases may well be narrowed if the NHS LA were to apply sufficient resources to employing more case handlers.

59. In January 2014 the NHS LA released information on firms where there was a significant difference between the damages recovered and costs claimed by the claimant firm. However, for those figures to have real meaning they need to be looked at in context, setting out how much of the money paid out in costs was in relation to the success fee and how much represented base costs.

60. Claimant solicitors regularly report situations where their attempts to negotiate settlement have been rebuffed resulting in delays in settlement and consequently higher costs. It would be useful for the NHS LA to look at the relationship between the amount of the agreed settlement and any part 36 offers made and when they were made by the trusts representatives. The relationship between the amount settled and any Part 36 offers made by the Claimant's solicitors is also relevant as is the time taken between notifying the NHS LA of the claim and settlement. It would be equally beneficial for the NHS LA to look at nature of the advice given by the trust's medical expert at the outset and what the contentious medico-legal issues were at the time of settlement.

61. It is difficult for us to comment on the NHS LA's ability to strike the right balance in contesting cases to trial or settling as we do not have statistics on this. Our view is that very few clinical negligence cases go to trial which does appear to be indicative of the fact that where the issues are straight forward the NHS LA will settle them. However it may be beneficial for the NHS LA to look at whether settlement in issued

cases is agreed at the earliest possible stage rather than at the latest stage or court room door settlement when considerable costs have already been incurred.

62. We have received reports of round table meetings where trust representatives have attended without authority to settle cases at all. If that is correct, than this simply serves to incur additional costs and prolong difficulties for the claimant. The NHS LA may find it valuable to analyse the amount of costs claimed by claimant within the context of how the litigation as a whole has been conducted. This might be an area for the NHS LA to explore further in an attempt to settle matters as timeously and proportionately as possible.

How might NHS LA collaborate with others in the NHS or wider public, private or social enterprise sector to develop commercial opportunities?

Please consider:

- **How NHSLA could better collaborate with members of others to develop innovative solutions that could then be brought to market.**
- **What economies of scale in claim handling NHSLA could offer others in the public sector?**
- **Innovative ways the NHSLA might take advantage of commercial opportunities?**
- **Any evidence to illustrate the NHSLA's operating more, or as efficiently than others (at the same or reduced costs) or where there is learning for NHSLA on further opportunities for greater efficiency.**

Response:

63. AvMA considers that there are commercial opportunities for the NHS LA to take advantage of and AvMA is willing to work with the NHS LA to develop appropriate innovative solutions that are both economical and improve the patient/clamant experience when seeking redress.

64. These opportunities might be more readily identified by further developing existing relationships and communication with organisations outside of the NHS.

65. AvMA has engaged in discussions with the NHS LA but would welcome more dialogue and collaboration on schemes, particularly in exploring alternatives to litigation.

66. To date we have had discussions with the NHS LA on a range of matters including the possibility of a small claims scheme, a mediation scheme and leaflets to be produced for Litigants in Person. As the leading patient safety charity we consider our involvement to be important as a means of representing the patient voice and interests.

67. AvMA welcomes open discussions with the NHSLA about some of the possible solutions available. However, the dialogue needs to be consistent and continuous, unless it has obviously broken down. For example the NHS LA recently launched a mediation scheme which is currently being piloted, we were advised early in 2014 of the plans for the scheme and the intention to roll it out in April, however we did not receive any further information about the scheme until it was actually rolled out in July.

68. We consider the scheme could have been improved on by providing a more level playing field for members of the public and a more obvious commitment from the NHS LA on ensuring parity between parties. The failure to continue to engage with ourselves and organisations like us means that there are weaknesses in the scheme that might have been addressed if we had been invited to collaborate further.

69. AvMA supports mediation and considers it to have the potential to be an effective medium in resolving disputes. However, the current scheme, in our view, falls short of being fair, particularly to patients who may be entering the scheme without independent legal advice and/or support. With continued dialogue and collaboration we believe that some of the more significant difficulties with the scheme could have been overcome.

70. It may be that our relationship with the NHS LA could be improved if we were to have a Memorandums of Understanding between us as this could clearly set out how we could work together. It is anticipated that this approach may be of benefit to the NHS LA in their communications with other third parties.

What might be learnt from other organisations doing similar work?

Please consider:

- **Examples and other sectors and/or internationally**
- **Similarities and key differences in member engagement**
- **How other organisations adapt to changing sector or market environments.**
- **Where legal or other action was co-ordinated and precedents set in the interests of members/clients**

Response:

71. AvMA does not feel that it is able to refer to other organisations doing similar work to the NHSLA and is therefore not in a position to respond to this question.

How can NHS LA adapt its approach so the schemes offered can better withstand the changing market environment?

Please consider:

- **The trends in litigation and likely future trends in the clinical negligence and Employment Liabilities/Public Liabilities market.**
- **The NHSLA's response to trends in litigation**
- **Responsiveness to a changing legal landscape.**
- **Responsiveness to changes in the wider health and care system**
- **How the scheme operates across care pathways**
- **Whether there are policy changes outside NHSLA control that could lead to improved value for money.**

Response:

72. We have already referred above to the need for greater dialogue and collaboration, we are of the view that a collegiate approach with a range of organisations, not just those representing medics but also ensuring discussion with patient safety organisations such as ourselves can lead to open, cost effective and fair schemes being developed.

73. It is in the interests of the NHSLA and all NHS trusts to put the patient/consumer at the centre of their business. This should not be limited to considerations on medical services being provided by trusts although this is of critical importance but so is having regard to overall consumer/patient satisfaction, including when things go wrong. We have already referred to how improvements can be made to patient safety by putting greater resources and funding into complaints.

74. It is AvMA's belief that the complaints process is a significant early warning sign of poor service whether at the hands of the doctors, surgeons and other providers and in relation to patient expectation generally. By valuing those early markers the NHS LA should, through careful monitoring be able to identify what it is that patients want and suggest schemes to meet those needs.

75. AvMA recognises the changing legal landscape in particular the growing relationship between trusts and private enterprise in order to deliver services required. It is likely that future trends in clinical negligence cases will include issues around liability particularly where care is provided by a third party contracted by the NHS to deliver services. Although recent case law suggest that some NHS duties may be non-delegable, the NHSLA could adapt a more open approach to such issues by making it clear that they will not seek to avoid responsibility for negligence arising as a result of care provided by a third party contractor.

76. This more open approach would be in line with the existing policy of openness.

77. There should also be a commitment to ensuring that any third party with whom the NHS contracts would share the same duties as would arise if the patient were treated by the NHS directly. In particular the duty to carry out Serious Incident Reports and to have the same obligations to file those with the NHSLA as an NHS trust might have. This will enable the NHSLA to keep track of adverse incidence arising by third party providers and manage them.

78. An open and clear declaration of the patient's position with regard to third parties is likely to result in a reduction in litigation particularly in satellite litigation.

79. Taking this stance will also improve the patient/consumer experience and will lead to greater trust and confidence between parties which will also lead to improved relationships and greater likelihood of early settlement where appropriate.

80. It is equally important that the NHS LA maintains good relationships with claimant clinical negligence firms. We refer to our comments on accreditation above, however we also consider it important to ensure that where costs are agreed that firms receive prompt payment of those costs. We have mixed reports about NHS LA's handling of costs – some lawyers report inordinate delays in receiving cheques in settlement of costs even after agreement. Where such allegations are substantiated we would comment that this does not bode well for good relations with claimant firms. In a fast changing market we consider it important that NHS LA fosters good relationships as this will build trust and improved communication between parties.

If there is other evidence on the NHS LA role, functions, performance, efficiency or governance that you would like to submit as part of this Call for Evidence, please attach it and state what it relates to.

Response:

81. None submitted by AvMA

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

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