RESEARCH PAPER 06/29
23 MAY 2006

The *NHS Redress Bill [HL]*

Bill 137 of 2005/6

The *NHS Redress Bill*, introduced in the House of Lords and due to have a Second Reading in the House of Commons on 5 June 2006, is intended to reform the way lower value clinical negligence cases are handled in the NHS to provide redress, including investigations, explanations, apologies and financial redress where appropriate without the need to go to court.

The Bill applies to England except for clause 17 which provides for a framework power for the Welsh Assembly.

Jo Roll

SOCIAL POLICY SECTION

HOUSE OF COMMONS LIBRARY

Recent Library Research Papers include:

06/14	The *Northern Ireland (Miscellaneous Provisions) Bill* [Bill 131 of 2005-06]	06.03.06
06/15	The *Education and Inspections Bill* [Bill 134 of 2005-06]	09.03.06
06/16	Unemployment by Constituency, February 2006	15.03.06
06/17	The Palestinian Parliamentary Election and the rise of Hamas	15.03.06
06/18	The *Charities Bill* [Bill 83 of 2005-06]	15.03.06
06/19	The *Housing Corporation (Delegation) etc Bill* [Bill 164 of 2005-06]	03.04.06
06/20	The *Commons Bill* [Bill 115 of 2005-06]	10.04.06
06/21	Unemployment by Constituency, March 2006	12.04.06
06/22	Direct taxes: rates and allowances 2006-07	20.04.06
06/23	The *Northern Ireland Bill* [Bill 169 of 2005-06]	21.04.06
06/24	Social Indicators [includes article: Social statistics at parliamentary constituency level]	28.04.06
06/25	Economic Indicators [includes article: Appointments to the Monetary Policy Committee of the Bank of England]	02.05.06
06/26	Local elections 2006	10.05.06
06/27	Unemployment by Constituency, April 2006	17.05.06
06/28	*Compensation Bill* [Bill 155 of 2005-06]	19.05.06

Research Papers are available as PDF files:

- *to members of the general public on the Parliamentary web site, URL:* ***http://www.parliament.uk***
- *within Parliament to users of the Parliamentary Intranet, URL:* ***http://hcl1.hclibrary.parliament.uk***

ISSN 1368-8456

Summary of main points

- Bringing a claim for negligence through the legal system is the main route to financial redress for patients who have been harmed during the course of NHS clinical treatment, although in practice most settlements are reached out of court.

- Clinical negligence is an aspect of the law of tort, which deals more generally with civil liability to pay compensation for wrongfully caused harm.

- There have been concerns for many years about the law in this area. For example, back in 1978 the Pearson Commission examined whether the law should be reformed, including whether a no-fault system should be introduced. The Pearson Commission generally rejected a no-fault scheme, as have governments since.

- Continuing concerns led the Labour Government to announce in the NHS Plan of 2000 and in its 2001 Manifesto that it would examine the clinical negligence system.

- The present *NHS Redress Bill* is based on the recommendations of the Chief Medical Officer in his report *Making Amends*, published in 2003. The report criticised the complexity, delays and sometimes cost facing patients trying to obtain redress under the present legal system. The report also commented on the costs, both financial and emotional, to the NHS, including in particular the disproportionate costs of low value claims which were often higher than the compensation awarded.

- The Bill provides for a relatively modest scheme that is not intended to change the basis of eligibility for compensation but largely to provide a simpler means of obtaining it in lower value cases. The Bill provides for an upper limit but does not specify what it will be. Government policy statements refer to £20,000.

- The Bill broadens the scope of redress normally available through the legal system by requiring the scheme to provide for explanations and apologies. The Bill also enables the scheme to provide for redress to be received in the form of care.

- Much of the detail of the scheme is left to Regulations but the Department of Health has published a number of documents that explain the Government's intentions.

- Concerns about the Bill have focused on whether the scheme would be sufficiently independent, in particular whether the NHS Litigation Authority, which currently works on behalf of NHS Trusts would be sufficiently independent to oversee the scheme. The NHS Litigation Authority is not specifically mentioned in the Bill but the Government has said that it will be the scheme authority.

- An amendment forced on the Government by the Opposition in the Lords would split the scheme in two (fact finding and fault finding) by providing for independent "patient redress investigators" to be overseen by the Healthcare Commission.

CONTENTS

I Background to the Bill 7

A. Introduction 7

B. The current system 9

C. Arguments for reform 13

II The Bill 21

A. Summary of the Bill before the Commons 21

B. Departures from *Making Amends* and Debates in the House of Lords 26

1. Departures from *Making Amends* 26
2. Debates in the House of Lords 27

III Responses to the Bill 29

1. The House of Commons Constitutional Affairs Committee 29
2. Action Against Medical Accidents, Briefing for House for Commons Second Reading, 23 March 2006 30
3. Association of Personal Injury Lawyers, May 2006 33
4. British Medical Association, 2 November 2005 35
5. Citizens Advice, House of Lords Report Stage, 15 February 2006 38
6. Commission for Patient and Public Involvement, October 2005 41
7. Law Society, Second Reading House of Lords, 2 November 2005 41
8. Medical Protection Society 43
9. NHS Confederation, October 2005 44

I Background to the Bill

A. Introduction

The *NHS Redress Bill* stems from a commitment in the 10 year *NHS Plan* published in July 2000.[1] The Labour Party's Manifesto for the May 2001 General Election, *Ambitions for Britain*, contained a brief commitment to "reform the clinical negligence system" and in the same year, after the Labour Government was returned to power, its Chief Medical Officer (CMO) started a review by issuing a call for ideas on the subject.[2] His conclusions were published in 2003 in a consultation document, *Making Amends*, which included proposals for a new scheme. The present Bill is based on the recommendations in *Making Amends* although it does depart from the Chief Medical Officer's recommendations in some respects.[3]

There was no mention of clinical negligence in the 2005 Manifesto but the Queen's Speech immediately afterwards, which began the 2005/6 Parliamentary Session, announced that: "A Bill will be brought forward to support patients who wish to seek redress should they experience problems with their healthcare". The Bill was introduced into the House of Lords in October 2005 and its Second Reading in the House of Commons has been announced for 5 June 2006.

The Bill is intended to be a framework Bill with details of the scheme to be set out in secondary legislation at a later date. It has, however, been accompanied by a number of documents, in addition to the usual Explanatory Notes and Regulatory Impact Assessment, which flesh out the framework and set the Bill within the context of related Government policies. These documents include (among others):

- Department of Health, *NHS Redress: Improving the response to patients*, October 2005[4]
- Department of Health, *NHS Redress: Statement of Policy*, November 2005[5]
- A set of papers deposited in the House of Commons Library, among which are:

---

1 Department of Health, *The NHS Plan, A plan for investment, a plan for reform*, Cm 4818, July 2000: http://www.dh.gov.uk/assetRoot/04055783.pdf

2 Department of Health, Chief Medical Officer, *Call for Ideas* Document, 2001: http://www.dh.gov.uk/assetRoot/04/07/80/09/04078009.pdf

3 Department of Health, A consultation paper setting out proposals for reforming the approach to clinical negligence in the NHS, A report by the Chief Medical Officer, *Making Amends*, June 2003: http://www.dh.gov.uk/assetRoot/04/06/09/45/04060945.pdf

4 This is available at: http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsLegislation/PublicationsLegislationArticle/fs/en?CONTENT_ID=4123288&chk=9yZpWy

5 This is available at: http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsLegislation/PublicationsLegislationArticle/fs/en?CONTENT_ID=4123281&chk=PijY6W

- *Improving health services for disabled children and young people and those with complex health needs: statement of intent*[6]
- *The NHS Litigation Authority* (Department of Health note)
- *Summary of progress on recommendations from making amends*[7]

- The Explanatory Notes for the Commons version of the Bill, Bill 137 of 2005/6[8]
- The Regulatory Impact Assessment for the Commons version of the Bill[9]

Information about the Government's intentions is also available from its response to the Constitutional Affairs Select Committee's Report on the Bill,[10] the debates during the Bill's passage through the House of Lords[11] and in the letters written by Lord Warner to the Opposition leaders in the House of Lords, which have been deposited in the House of Commons Library.

Apart from clause 17, which contains a framework power for the Welsh Assembly, the Bill applies to England. Clause 17 has given rise to debates about constitutional issues that are not covered in this Paper. Apart from a comment on clause 17 that the framework power is so wide that if conferred on a Minister of the Crown in relation to England, it would be inappropriate even if subject to the affirmative procedure, the regulatory powers in the Bill have been deemed appropriate by the House of Lords Delegated Powers and Regulatory Reform Committee.[12]

---

6 also available at: http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsLegislation/PublicationsLegislationArticle/fs/en?CONTENT_ID=4123289&chk=aTK0Iz

7 House of Commons Library Deposited Paper Number Dep 05/1433

8 http://www.publications.parliament.uk/pa/cm200506/cmbills/137/en/06137x--.htm

9 2 March 2006: http://www.dh.gov.uk/assetRoot/04/12/09/24/04120924.pdf

10 *Compensation culture and Compensation Culture NHS Redress Bill: Government Response to the Constitutional Affairs Select Committee* third and fifth reports session 2005-06 (HC 754 and HC 1009) Cm 6784: http://www.official-documents.co.uk/document/cm67/6784/6784.pdf

11 Second Reading HL Deb 2 November 2005 c204-39; Committee First Day HL Deb 21 November 2005 c327-86GC; Committee Second Day HL Deb 23 November 2005 c387-430GC; Report HL Deb 15 February 2006 c1153-213

12 HL 64 of 2005/6

B. The current system

There are various ways in which errors in the NHS may be dealt with. For patients, there is the NHS complaints system, which has recently been reformed. It now includes the Healthcare Commission as an independent assessor if a patient is dissatisfied with the local attempt at resolution, and could involve an investigation by the Health Service Ombudsman.[13] For organisations, there is the National Patient Safety Agency, which was set up in 2001 to run a national system to record adverse events and near misses so that the NHS could learn from mistakes and problems affecting patient safety.[14] In addition, a range of bodies dealing with quality and standards, such as the Healthcare Commission and the National Institute for Clinical Excellence, are meant to discourage mistakes from happening in the first place.

Bringing a claim for negligence through the legal system is nevertheless the only established route to financial redress for patients who consider that they have been harmed during the course of NHS clinical treatment.[15] Clinical negligence law is part of tort (fault) law, which deals more generally with civil liability to pay compensation for wrongfully caused harm. Discussions about reform (see next section) have sometimes discussed it within this broader context and sometimes specifically within the context of the NHS.

Until 1989, individual practitioners were responsible for claims for clinical negligence against them. Practitioners in England insured themselves against the potential costs through the Medical Defence Union, the Medical Protection Society and the Medical Dental Defence Union of Scotland. In 1990, the NHS took over responsibility for all outstanding and future clinical negligence claims involving medical and dental staff employed by health authorities (but did not take over responsibility for GPs and others not directly employed by health authorities).

When NHS Trusts (which run hospitals) were established from 1991, they became liable for their own claims whilst health authorities remained responsible for claims relating to earlier incidents.[16] In 1995 the NHS Litigation Authority was set up to deal with claims on behalf of NHS Trusts.[17] It is a Special Health Authority and therefore part of the National Health Service. It is not an insurance company. Initially, its sole function was to

---

13 The NHS complaints system is described at: http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/ComplaintsPolicy/fs/en

14 The National Patient Safety Agency's website is: http://www.npsa.nhs.uk/

15 Other forms of financial payment are sometimes possible but these are not usually regarded as compensation. For example, the payments made by the NHS to those wrongly financing their own long-term care following reports by the Health Service Ombudsman (the Commissioner for Health) into such mistakes are regarded as restitution rather than compensation. Details of the issues raised by the health Service Ombudsman in relation to continuing care are on her website: http://www.ombudsman.org.uk/

16 This brief history is based on several of the documents mentioned in this paper as well as on the NHS summarised accounts 2001-2001, National Audit Office.

17 The NHSLA is a special health authority set up under section 11 of the National Health Service Act 1977. Its constitution and functions are governed by SI 1995/2800, The *National Health Service Litigation Authority (Establishment and Constitution) Order 1995* and SI 1995/2801, The *National Health Service Litigation Authority Regulations 1996* (as amended). The primary legislation introducing the scheme was

administer the "Clinical Negligence Scheme for Trusts" (CNST) but very soon after it was formed it took over responsibility for the pre 1995 claims against health authorities and now has a range of other functions such as covering non-clinical claims under two other schemes; an information service to the NHS on the impact of the Human Rights Act 1998; the functions of the former Family Health Services Appeal Authority; and the provision of advice about and assistance with litigation on equal pay claims.

It is to the Clinical Negligence Scheme for Trusts that the NHS Redress Bill would offer an alternative in certain circumstances and is therefore the scheme most directly relevant to the Bill. In England all NHS Trusts are now part of this scheme (which also covers other NHS bodies such as Primary Care Trusts and Foundation Trusts). GPs, by contrast, are still responsible for claims against them and are required to take out insurance. This means that successful claims against a GP are paid out by the insurance company and not by the NHS.

The NHS Litigation Authority does not act on behalf of patients but its website does provide some information for them, including an explanation of what a negligence claim is:

> The role of the NHS Litigation Authority is to act on behalf of NHS bodies when claims of negligence are made against them. We are therefore not able to offer advice to individual patients. However, we have developed this page in the hope that it will provide helpful background information on how negligence claims are handled, and what alternatives there are to legal action when something goes wrong in the NHS.
>
> *Negligence claims*
> Under English law, an individual may be entitled to compensation if they have been injured as a result of the negligence of another person. In order for a patient to obtain financial compensation when something goes wrong in the NHS, the following criteria must be met:
>
> - The doctor (or other health professional caring for the patient) must have acted in a way which fell short of acceptable professional standards. The test is whether the actions of the health professional in question could be supported by a "responsible body of clinical opinion". It will not be enough to show that other health professionals might have done something differently if a "responsible body" of health professionals would support the action taken.
>
> - The harm suffered by the patient must be shown, on the balance of probabilities, to be directly linked with the failure of the health professional to meet appropriate standards. If, for example, there was a good chance that the patient would have suffered the harm even if the health professional had acted differently, then the claim is unlikely to succeed.
>
> If you believe that these two criteria are met in your case and you wish to seek financial compensation, you should seek legal advice. The organisation Action against Medical Accidents can put you in touch with a specialist solicitor.

---

contained in Section 21 of the *NHS and Community Care Act 1990* (which sets out the bodies that may take part in the scheme).

Alternative forms of redress
Alternatively, you may wish to pursue alternative forms of redress. The NHS complaints system is designed to provide explanations of what happened and, where appropriate, apologies and information about action taken to ensure similar incidents do not happen again. Financial compensation will not ordinarily be available.[18]

The Clinical Negligence Scheme for Trusts is described on the Authority's website:

> The Clinical Negligence Scheme for Trusts handles all clinical negligence claims against member NHS bodies where the incident in question took place on or after 1 April 1995 (or when the body joined the scheme, if that is later). Although membership of the scheme is voluntary, all NHS Trusts (including Foundation Trusts) and Primary Care Trusts (PCTs) in England currently belong to the scheme. While Independent Sector Treatment Centres cannot join the scheme in their own right, they can benefit from cover when treating NHS patients via the membership of their referring PCT.
>
> The costs of the scheme are met by membership contributions. The projected claim costs are assessed in advance each year by professional actuaries. Contributions are then calculated to meet the total forecast expenditure for that year. Individual member contribution levels are influenced by a range of factors, including the type of trust, the specialties it provides and the number of "whole time equivalent" clinical staff it employs. Discounts are available to those trusts which achieve the relevant NHSLA risk management standards and to those with a good claims history.
>
> When a claim is made against a member of CNST, the NHS body remains the legal defendant. However, the NHSLA takes over full responsibility for handling the claim and meeting the associated costs. Until April 2002, trusts handled claims within their chosen excess themselves. Such claims were then "called-in" and all CNST claims are now handled centrally regardless of value. The scope of the scheme is set out in the CNST rules, while our Clinical negligence reporting guidelines and CNST claim report form set out how claims should be reported by trusts to the NHSLA. A Guide to clinicians on how claims are handled is also available.[19]

The NHS Litigation Authority website sets out the following "key facts" about its clinical negligence role:

- In 2004-05, 5,609 claims of clinical negligence against NHS bodies were received by the NHSLA. This compares with 6,251 claims of clinical negligence in 2003-04.
- £502.9 million was paid out in connection with clinical negligence claims in 2004-05. This figure includes both damages paid to patients and the legal costs borne by the NHS. In 2003-04, the comparable figure was £422.5 million.

---

[18] http://www.nhsla.com/Patients/
[19] http://www.nhsla.com/Claims/Schemes/CNST/

- The average time taken to deal with a clinical claim under the Clinical Negligence Scheme for Trusts, from notification of the claim to the NHSLA to the date when damages are agreed (or the claim is discontinued), is 1.44 years.

- The NHSLA estimates that its total liabilities (the theoretical cost of paying all outstanding claims immediately, including those relating to incidents which have occurred but have not yet been reported to us) are £6.89 billion for clinical claims.

- An analysis of all clinical claims handled by the NHSLA since its inception in 1995 shows that 38.01% were abandoned by the claimant, 43.1% settled out of court, 1.97% settled in court in favour of the patient (including court approvals of settlements negotiated on behalf of children), 0.5% settled in court in favour of the NHS and 16.42% remain outstanding.

C. Arguments for reform

Concerns about the system of compensation for personal injury in general and clinical negligence in particular have triggered a number of reviews of the litigation process, for example the Royal Commission on Civil Liability and Compensation for Personal Injury (the Pearson Commission), which reported in 1978, and Lord Woolf's report, *Access to Justice*, which was published in 1996.

Apart from the difficulties faced by ordinary citizens trying to bring a case, particularly those who do not have access to legal aid, the tort (fault) based system itself has been one of the major issues. Replacing it with a system where it would not be necessary to prove negligence (fault) in order to obtain compensation for medical errors has been much discussed as a possible solution to present problems. For example, both the Pearson Commission and the *Making Amends* Reports referred to below examined the possibility in depth, although both of these on balance rejected the idea.

Proponents of a no-fault scheme have argued that it would encourage doctors to admit mistakes without the fear of being dragged through courts and that it would be cheaper and simpler both for claimants and the NHS. There have been some attempts by backbenchers to get such a scheme introduced or at least to draw attention to the issue. For example, in 1990, Harriet Harman (then a back bencher) introduced a Ten Minute Rule Bill[20] and in 1991 Rosie Barnes MP introduced a Private Members Bill, which was defeated on Second Reading.[21]

However, both the previous Conservative Government and the present Labour Government have ultimately been reluctant to abandon the fault-based system where clinical negligence is concerned. A recurring argument against doing so has been that it would not necessarily simplify matters in that, for the purpose of financial compensation, it would still be necessary to makes decisions about the cause of the damage, for example, whether it had been caused by the natural progress of a disease or not.

As well as the reports focusing on the legal system, various other reports, such as those of the Public Accounts Committee and the National Audit Office in the early 2000s (see below) have highlighted the cost aspects of the current clinical negligence system. These referred to the long-term increases in the costs to the NHS of clinical negligence claims. For example, the report of the Chief Medical Officer, *Making Amends* in 2003, commented on a rise from £6.33 million in 1974-5 to £446 million in 2001-2 (at 2002 prices) although rises have not continued at this pace throughout the period. Figures published in the Regulatory Impact Assessment on the Bill show expenditure on clinical negligence in recent years:

Year	In year expenditure
1996-97	£235m
1997-98	£144m
1998-99	£221m

[20] HC Deb 25 October 1990 c518
[21] HC Deb 1 February 1991 c1223-1292

1999-00	£373m
2000-01	£415m
2001-02	£446m
2002-03	£446m
2003-04	£423m
2004-05	£503m[22]

A different cost concern that has recurred throughout these discussions has been the disproportionate total cost of a claim in comparison with the actual compensation. The Public Accounts Committee, for example, said in 2002 that in 65% of settlements below £50,000, the legal costs exceeded the sums paid to patients.

From the patients' point of view, many of these reports also pointed to long delays in obtaining a financial remedy. The National Audit Office, for example, quoted a figure of five and a half years as the average time from receipt of a claim to settlement in 1999/2000. Such reports have identified a number of other problems, including failure to obtain the kind of explanation or apology that patients desired and the demoralising effect of the adversarial legal system on NHS staff.

The situation may have improved in some respects since these reports were written and some of the worst fears about the tort system have recently been dismissed by the Government, as well as by the Select Committee on Constitutional Affairs, who have both rejected the idea that an American style "compensation culture" has developed.[23] But criticisms of the present system continue and the Explanatory Notes to the Bill echo the Chief Medical officer's Report of 2003, *Making Amends,* by summarising the problems that the Bill is intended to address in the following terms:

> The current system:
>
> - is perceived to be complex, unfair (as apparently similar cases may have different outcomes) and slow;
> - is costly both in terms of legal fees and in diverting clinical staff from clinical care;
> - has a negative effect on National Health Service (NHS) staff morale and on public confidence;
> - leads to patient dissatisfaction with the lack of explanations, apologies or reassurances that action has been taken to prevent the same incident happening to another patient; and
> - encourages defensiveness and secrecy in the NHS, which stands in the way of learning and improvement in the health service.[24]

References to some of these reports, including the full list of recommendations in *Making Amends*, are set out below.

---

22 The NHS Redress Bill Full Regulatory Impact Assessment, Annex A, based on National Audit Office summarised accounts: http://www.popan.org.uk/downloads/Reg%20Impact%20Assessment.pdf

23 See Section on Reactions to the Bill below.

24 http://www.publications.parliament.uk/pa/cm200506/cmbills/137/en/06137x--.htm

The Royal Commission on Civil Liability and Compensation for Personal Injury (the Pearson Commission)*, *Cmnd 7054, 1978

The Pearson Commission, undertook a wide-ranging review of the arrangements for providing compensation for injuries in a number of fields including clinical negligence, employment and transport. It particularly examined the case for no fault compensation.

Although the Pearson Commission recommended that the no-fault schemes in New Zealand and Sweden should be studied further, it did not recommend that a no-fault scheme for medical accidents should generally be introduced. The Commission considered that social security benefits and services such as those provided by the NHS were the most important source of compensation. It concluded that compensation paid through tort should continue as a supplement to the social security system, but that social security benefits should be offset against tort awards.

Access to Justice, 1996

In 1994 Lord Woolf, Master of the Rolls, was asked by the Lord Chancellor to undertake a review of the civil justice system. *Access to Justice 1996*, the report arising from Lord Woolf's Inquiry, drew particular attention to problems in the area of clinical negligence:

- disproportionate costs in comparison with damages, especially in lower value cases;
- the general delay seen in resolving all cases was regarded as even more unacceptable in this area;
- cases without merit were often pursued and clear-cut claims defended for too long;
- the success rate was lower than in other areas of personal injury litigation;
- the suspicion between parties was more intense and the lack of co-operation greater than in many other areas of litigation.[25]

The National Audit Office report, Handling clinical negligence claims in England, May 2001[26]

The NAO report on handling clinical negligence claims concluded that the rate of new claims per thousand finished consultant episodes rose by 72% between 1990 and 1998. On average claims still took too long to settle. Those closed in 1999-2000 had taken, on average, five and a half years to settle after receipt of the claim; and claims still outstanding were on average already 8.3 years old, with 22% over 10 years old. On patients' access to remedies, its conclusions included the following:

---

[25] as summarised in *Making Amends* http://www.dh.gov.uk/assetRoot/04/06/09/45/04060945.pdf

[26] National Audit Office, Handling clinical negligence claims in England, Report by the Comptroller and Auditor General, HC 403, 2000/1, May 2001: http://www.publications.parliament.uk/pa/cm200102/cmselect/cmpubacc/280/280.pdf

> Research has indicated that claimants often want a wider range of remedies than litigation is designed to provide, for example, an apology, an explanation or reassurance that it would not happen again; but they say they were not offered them. The Litigation Authority has issued guidance promoting the giving of appropriate apologies and information. We saw examples where claims managers had ascertained what patients' requirements were and provided creative solutions to satisfy them. These solutions included providing detailed technical explanations, assurance about how recurrences would be prevented and undertakings to give future remedial healthcare and assistance with transport and childcare; and paying for a patient's legal costs to enable them to obtain an independent assessment of the financial compensation the Trust had offered. In this way, Trusts avoided claims escalating into costly litigation. This approach – an example of which is at Case Study 1 – could be adopted more widely, provided the claims managers are competent and authorised to operate this way. However, the Department of Health have a policy of not permitting complaints to be pursued where the patient wants financial compensation. This can make it difficult for the NHS to enter into such a dialogue with patients who want something in addition to money. It can thus deprive patients and their families of the potential benefits of solutions tailored to meet their needs.[27]

The House of Commons Public Accounts Committee's report, Handling Clinical Negligence Claims in England, May 2002

The PAC Report on handling clinical negligence claims, which drew on the National Audit Office Report, said:

> There has been concern at the scale of current and likely future costs of settling clinical negligence claims and the time taken to resolve them. In the past, a significant number of claims were handled poorly resulting in delays and additional costs. Delays in resolving claims can cause further distress for patients or relatives making claims and clinicians accused of negligence, and also increase costs. Because of the cost and unpredictability of pursuing claims, few people were able to do so unless they qualified for legal aid…..[28]

The PAC Report contained three overall conclusions:

- Clinical negligence involved considerable human costs. Patients who had suffered injury through negligence often faced a long and difficult process pursuing their claims and achieving damages. Important steps had been taken to improve access to justice but the NHS and the legal system had clearly failed to deal with patients with speed and compassion
- The NHS was also suffering. The value of claims was rising and in 65% of settlements below £50,000 the legal costs exceeded the sums paid to claimants. These costs were a drain on scarce resources for improving patient care
- The first major need was to reduce the incidence of negligence in the first place. The review being undertaken by the Chief Medical Officer should, in particular,

---

27 National Audit Office, as above.

28 Public Accounts Committee, Handling Clinical Negligence Claims in England, 37th Report of 2001/2, HC 280 of 2001/2, May 2002: http://www.publications.parliament.uk/pa/cm200102/cmselect/cmpubacc/280/280.pdf

examine the way NHS Trusts handled the interface between complaints and claims; the benefits of a no-blame solution; and alternative ways of handling claims up to £50,000, to speed them up and to cut costs.[29]

Making Amends, a report by the Chief Medical Officer, June 2003

This is probably the most comprehensive single source of information about the system of medical litigation and underlies proposals in the current Bill. It highlighted the importance of the issue by suggesting that untoward harmful consequences of health care are more common than previously recognised: 10% of hospital in-patient admissions may result in some kind of adverse event and 5% of the general population report suffering some injury or other adverse effects of medical care while almost a third of those claim that the event had a permanent impact on their health.

Like the National Audit Office and the Public Accounts Committee, it commented on the rise in costs, saying that annual NHS clinical negligence expenditure rose from £1 million in 1974/5 (£6.33 million at 2002 prices) to £446 million in 2001-02. It also pointed out that a high proportion of this was accounted for by birth-related brain damage (including cerebral palsy), which alone accounted for just over 5% of cases of medical litigation in which damages were paid and 60% of all annual expenditure on medical litigation in 2002-03.

The report discussed and paid tribute to reforms already underway but concluded that the system warranted further action. It discussed at length the case for and against 'no-fault' compensation and described systems of 'no-fault' compensation in several countries but ultimately rejected this option on the grounds that:

- a true 'no-fault' scheme would lead to a potentially huge increase in claims and overall costs would be far higher than under the present tort system. Initial estimates suggest the annual bill could reach £4 billion.
- to be affordable, compensation would need to be set at substantially lower level than current tort awards and would not necessarily meet the needs of the harmed patient;
- it would be difficult to distinguish harm to a patient from the natural progression of a disease;
- no-fault schemes, of themselves, do not improve processes for learning from error or reduction of harm to patients.[30]

Instead, the report made 19 recommendations for reforming the existing system of dealing with claims for clinical negligence:

New NHS-based system of redress

● The establishment of a new system of providing redress for patients who have been harmed as a result of seriously substandard NHS hospital care is proposed

[29] As above, see paragraph 4 in particular.
[30] *Making Amends*, as above, page 15.

(The NHS Redress Scheme). The new arrangements would have four main elements:

- an investigation of the incident which is alleged to have caused harm and of the harm that has resulted;
- provision of an explanation to the patient and of the action proposed to prevent repetition;
- development and delivery of a package of care providing remedial treatment, therapy and arrangements for continuing care where needed;
- payments for pain and suffering, out of pocket expenses and care or treatment which the NHS could not provide.

- Patients would be eligible for payment for serious shortcomings in NHS care if the harm could have been avoided and if the adverse outcome was not the result of the natural progression of the illness. Payment would be made:

  - by a local NHS Trust for reimbursement of the cost of the care leading to harm (or similar amount)
  - by a national body for amounts up to £30,000.

- Families of neurologically impaired babies would also be eligible for the new NHS Redress Scheme if:

  - the birth was under NHS care;
  - the impairment was birth-related;
  - severe neurological impairment (including cerebral palsy) was evident at birth or within eight years. Genetic or congenital abnormality would be excluded.

- A package of compensation would be provided in cash or kind according to the severity of the impairment, judged according to the ability to perform the tasks of daily living, and would comprise:

  - a managed care package;
  - a monthly payment for the costs of care (at home or in a residential setting) which cannot be provided through a care package (in the most severe cases this could be up to £100,000 per annum);
  - one-off lump sum payments for home adaptations and equipment at intervals throughout the child's life (in the most severe cases, this could be up to £50,000);
  - an initial payment in compensation for pain, suffering and loss of amenity capped at £50,000.

- The recommendations in this area apply to England only, as does the whole of this Report. However, I recognise that any proposed changes to arrangements in England for care and compensation for severely neurologically impaired babies could have implications for the rest of the United Kingdom. These issues are currently being discussed with the devolved administrations.

Extension of the scheme

- The new NHS Redress Scheme would be centred on the needs of NHS patients, initially those treated in hospital and community health settings. Further consideration will be given to redress for patients treated under NHS funding arrangements but by independent or voluntary sector providers in the United Kingdom or abroad.

- After a suitable period of operation and evaluation, consideration would be given to extending the scheme to provide higher financial compensation and to encompass NHS primary care services.

Administration of the new schemes

- A national body building on the work of the NHS Litigation Authority would operate the new procedures. In the case of the element of the scheme relating to neurologically impaired babies, a national expert panel would be responsible for determining whether the impairment was birth-related, reviewing the severity of impairment and other factors and reporting to the national body.

Handling of cases which still go to law

- The new NHS Redress Scheme would not take away a person's right to sue through the Courts but:

    - except for cases of children with cerebral palsy, there would be a presumption that they had first applied to the NHS Redress Scheme;
    - those accepting packages of care and compensation under the NHS Redress Scheme would be required to waive their right to go to court on the same case.

- For cases that do not fall within the criteria of the scheme:

    - there would be an expectation that mediation would be used as a first step and pre-action protocols would require mediation to be attempted in specified types of cases. Acceptance of a mediation package would be binding;
    - there would be strong encouragement of the use of periodical payments in larger value cases including 'out of court' settlements;
    - the costs of future care would no longer reflect the cost of private treatment;
    - specialist training would be provided to judges handling clinical negligence cases.

Relationship to other complaints and incident procedures

- The new NHS Redress Scheme would be closely aligned to the new NHS complaints procedure. Making a claim for compensation would no longer be a disqualification from pursuing a complaint.

- A new standard would be introduced for after-event and after-complaint management by the NHS so that there is a full investigation of each case, a clear explanation is provided to victims and any necessary remedial action taken. Staff training should be undertaken to achieve a higher quality response to complaints and incidents.
- An individual at NHS Trust Board level would be required to take overall responsibility to ensure that the organisation rigorously investigates and learns effectively from complaints, adverse events and claims, ending the present fragmentation of these processes. Investigation of complaints and incidents should be co-ordinated under a single senior manager.
- The administering national body would monitor the local and national compensation payments and publish annual listings by NHS providers to act as an incentive for risk reduction and patient safety at local level.

Duty of candour and legal privilege in adverse event reporting

- Statutory provisions would be introduced to encourage openness in the reporting of adverse events. This would encompass:

    - a duty of candour requiring clinicians and health service managers to inform patients about actions which have resulted in harm;
    - exemption from disciplinary action for those reporting adverse events or medical errors (except where there is a criminal offence or where it would not be safe for the professional to continue to treat patients);
    - legal privilege would be provided for reports and information identifying adverse events except where the information was not recorded in the medical record.

Care and support for victims

- The NHS in conjunction with other agencies would be required to develop effective rehabilitation services. The provision of rehabilitation services also features in the cross-Departmental review of Employers' Liability Insurance and will form an important part of the next stage of that review.
- The NHS, together with other agencies, would be required to explore the scope for developing a greater range of high quality facilities and services for severely disabled children.[31]

[31] *Making Amends*, as above.

II The Bill

The Government's objective in bringing forward this measure is set out in the Explanatory Notes:

> To reform the way lower value clinical negligence cases are handled in the NHS to provide appropriate redress, including investigations, explanations, apologies and financial redress where appropriate without the need to go to court, thereby improving the experience of patients using the NHS.

The aim has stayed the same throughout as has the structure of the Bill although it incorporates largely minor amendments introduced by the Government during its passage in the Lords and one Opposition amendment that was a defeat for the Government.

The Bill provides for the establishment of a new redress scheme, specifying some of the content but leaving most of the details to be set out in Regulations. The summary provided in this Paper concentrates on describing the contents of the Bill with a few words of explanation. Members are referred to the Department of Health's statement of policy for further details about the Government's intentions, which may be set out in future Regulations or implemented in other ways.[32]

A. Summary of the Bill before the Commons

Clauses 1–3 on the establishment of the redress scheme

These clauses give the Secretary of State power to establish a scheme by Regulations. The clauses also specify certain characteristics of the scheme. In particular, the purpose of the scheme would be to enable redress to be provided without recourse to civil proceedings and the scheme would apply only where there was a qualifying liability in tort. (In other words, the circumstances in which people would qualify for redress would be as now although if the method of obtaining it becomes easier, this could in practice increase the numbers actually obtaining redress.[33])

The scheme would apply to the actions of healthcare professionals in hospitals or in other settings to be specified in Regulations. The Government has said that the intention is to cover hospital-type settings and not GP practices but that, given the changing dividing line between primary and secondary care, it has left open the possibly of specifying other settings in Regulations. The Bill in effect provides for the scheme to cover relevant NHS treatment regardless of the particular contracting arrangements so that it would cover a Primary Care Trust contracting for treatment abroad or from the independent sector. The Bill specifically rules out certain services, including primary

---

32 See list in the introduction section of this Paper.

33 See, for example, HC Deb 24 April 2006 c963W

dental services, primary medical services, general ophthalmic service and various arrangements for pharmaceutical services.

The scheme would not apply in relation to a liability that is or was the subject of civil proceedings and must ordinarily comprise:

- An offer of compensation in satisfaction of rights to bring court proceedings
- An explanation
- An apology

The Bill also gives examples of provisions that Regulations might include such as contracts for future remedial care or treatment alongside financial compensation.

In relation to financial compensation the Bill says that the scheme must specify an upper limit either on the total amount of financial compensation that may be included in an offer or the amount of financial compensation in respect of pain and suffering (normally referred to as general damages in negligence claims). The scheme may not specify any other limits on the level of financial compensation. The Bill does what the upper limit will be but the Government has said that it expects the upper limit to be £20,000, which represents about 75% of settled claims.[34]

Clauses 4-7: Proceedings under the scheme

The Bill gives the Secretary of State wide powers of discretion to make Regulations as s/he sees fit in relation to proceedings under the scheme, including the way the scheme may be commenced and ended, how liability is to be assessed etc. The Bill also allows Regulations to require NHS bodies to consider whether a case is eligible under the scheme and to specify the steps that the bodies must take if they identify such a case. (The Explanatory Notes suggest that such bodies may be placed under a duty to commence proceedings or notify the relevant scheme member.) The bodies concerned are those that may be liable and the Commission for Healthcare Audit and Inspection (generally known as the Healthcare Commission).

The Bill does include some requirements for the scheme. It must provide for a settlement to include a waiver of the right to bring civil proceedings in respect of the liability to which the settlement relates and it must provide for proceedings to be ended if the liability to which they relate becomes the subject of civil proceedings. A scheme must also make provision for the period during which a liability is the subject of proceedings under the scheme to be disregarded for the purpose of any relevant limitation period. This would mean, for example, that people were not penalised for the time spent under the scheme if they changed their minds and decided to go to court instead.

---

[34] See, for example, Department of Health Press Notice, Better NHS response for patients harmed by healthcare, 13 October 2005 and HC Deb 28 March 2006 c967W

Clauses 8-9: Legal advice and assistance

The Bill gives the Secretary of State discretion to make Regulations for the provision of free legal advice and for other services, including the advice of medical experts in connection with proceedings under the scheme. It requires the scheme to contain provisions to ensure that individuals to whom an offer is made under the scheme have access to free legal advice in relation to the offer and any settlement agreement.

The Bill allows provision to be made for the legal advice to be provided by someone on a specified list. The Explanatory Notes suggest that the Legal Services Commission might maintain a relevant list.

For those seeking or intending to seek redress under the scheme, the Bill requires the Secretary of State to arrange for the provision of assistance and in doing so to have regard to the principle that the provision of such services should, so far as practicable, be independent of any person to whose conduct the case relates or who is involved in dealing with the case.

Clause 10: Scheme members

This clause leaves details about scheme membership to be specified in Regulations. The Explanatory Notes say that it is envisaged that Regulations may, for example, require NHS Trusts, NHS Foundation Trusts, Primary Care Trusts and independent providers in England to be members of a scheme.

Clause 11: Scheme authority

The Bill stipulates that the scheme must include a Special Health Authority as the authority for the scheme, with functions to be provided for in Regulations. The Bill lists possible functions such making payments under the scheme, assessing and collecting contributions from members etc. The Bill does not specify who this is to be but the Explanatory Notes say that it is intended that this will be the NHS Litigation Authority.

Clause 12: Patient redress investigators

The original clause 12 on disclosure of information to the scheme authority was dropped by the Government on the grounds that it was not necessary. This new clause 12 is the result of an Opposition amendment. It represents the Opposition's concern with inserting greater independence into the proposed scheme's procedures. (See next section on Debates in the House of Lords.)

This clause requires the Secretary of State to make provision for the appointment of suitably qualified patient redress investigators who will conduct investigations. It provides that investigation reports may form the basis of the explanation offered under the scheme, and the assessment of liability in tort. It allows for procedures for investigation to be set out in secondary legislation and for functions to be conferred on investigators. It also provides for the Healthcare Commission to maintain and publish a list of approved investigators, and have responsibility for overseeing the carrying out of their functions.

Clause 13: Duties of co-operation

This clause establishes a new duty of co-operation between the scheme authority (not named but intended to be the NHSLA) and the Healthcare Commission (which is named) and between the scheme authority and the National Patient Safety Agency (named).

Clauses 14 and 15: Complaints and the Health Service Commissioner (often known as the NHS Ombudsman)

This clause enables the Secretary of State to make regulations providing for the handling of complaints about the scheme and settlements made under it. Regulations must provide for this procedure to be operated either by the scheme authority or by scheme members. The Regulations may also make provision about who may make a complaint, which complaints are and are not covered by the procedure, to whom complaints are to be made, the timeframe within which complainants must receive a response, the form that a response must take, the procedure to be followed, and the action to be taken as a result. The clause also lists some of the provisions that Regulations may cover such as requiring information to be made available to the public, the relationship with complaints under other procedures etc. According to the Explanatory Notes, the powers under clause 14 are similar to the powers under sections 113 and 115 of the *Health and Social Care (Community Health and Standards) Act 2003* (complaints about health care).

Clause 15 amends the *Health Service Commissioners Act 1993* to broaden the remit of the Health Service Commissioner for England to include complaints relating to maladministration in relation to the exercise of functions under the scheme, in connection with a settlement agreement under the scheme or in the exercise of any functions in relation to complaints made under Regulations under clause 14. The effect is to allow the Commissioner to investigate complaints about such maladministration, and to report on her findings following the investigation of such a complaint.

Clause 16: Regulations and Clause 17: Framework power (Wales)

Cause 16 provides that the first Regulations establishing a scheme (and any subsequent regulations that establish an entirely new scheme) must be laid before and approved by each House of Parliament before they can be made (normally referred to as the affirmative procedure). All other Regulations are subject to annulment in pursuance of a resolution of either House of Parliament (normally referred to as the negative procedure).

Clause 17 provides a framework power for the Welsh Assembly. It has given rise to debates about constitutional issues that are not covered in this Paper.

Apart from a comment on clause 17 that the framework power is so wide that if conferred on a Minister of the Crown in relation to England, it would be inappropriate even if subject to the affirmative procedure, the regulatory powers in the Bill have been deemed appropriate by the House of Lord Delegated Powers and Regulatory Reform Committee HL 64 of 2005/6.

Financial Effects

The financial effects of the Bill as described in the Explanatory Notes (paragraphs 51-54) are set out below:

> Clinical negligence cost the NHS over £500 million in 2004/05. The NHS Redress Scheme is expected to increase spending on compensation payments because it is expected to bring new claims into the system. However, in the longer term, savings on legal costs are expected.
>
> Departmental economists have assessed the financial implications of the redress scheme and estimate that, if regulations prescribe a maximum limit of financial compensation under the scheme of £20k, the financial effect of the scheme would, in the first year, range between an overall saving of £7m (where only small increases in claims were seen) and a projected increased cost of about £48m (if there were large increases in claims). These figures include administration costs and are dependent upon expected savings on legal fees. The annual cost or saving of the scheme will vary as the scheme develops and becomes established. Departmental modelling suggests that the projected financial effect in year ten of the scheme's operation would range between a saving of £15m (small increases in Redress claims) and an increased cost of an extra £80m (large increases in Redress claims).
>
> Departmental economists have assessed the financial implications of clause 12 (patient redress investigators), which was inserted by an opposition amendment at Report stage in the House of Lords (See Hansard Volume 678 No.107 Wednesday 15 February Col. No. 1175-1185). Their assessment is that if all cases under the scheme were subject to independent investigation by independently employed investigators, this would result in a total cost of up to £41 million in year one and that this cost would rise each year as the number of cases subject to proceedings under the scheme increased year on year. However, if an investigator were to be placed in every scheme member, with responsibility for conducting investigations, or if investigators were shared between scheme members, these costs may be reduced.
>
> The scheme will be funded through contributions from scheme members to the scheme authority; it is envisaged that the arrangements for contributions might, for example, be similar to the arrangements for contributions to the Clinical Negligence Scheme for Trusts 9. There will be an increase in the overall allocations made to PCTs to reflect their increased expenditure arising from the scheme. In addition, funding will be made available from the Department of Health to the NHSLA to cover the small increases envisaged in administrative costs for operating the Redress Scheme. Departmental economists have modelled this as an annual cost of between £3.2m and £11.2m (dependent on the number of claims received).

B. Departures from *Making Amends* and Debates in the House of Lords

1. Departures from *Making Amends*

The Bill is based on recommendations of the Chief Medical Officer in the publication, *Making Amends* (described in previous sections of this Paper). The Department of Health has set out in a separate paper the various ways in which either the Bill or related policies fulfil the recommendations. The paper also explains areas where there is a departure from those recommendations.

This section highlights a few of the differences that relate directly to the NHS Redress Scheme. Many of these were particularly mentioned during debates on the Bill in the House of Lords, which are also summarised below. Members are referred to the Department of Health's paper for the full commentary, which also includes the wider recommendations of *Making Amends*, for example, about claims made within the court system.[35]

One of the main departures from *Making Amends* concerns the body that is to be responsible for the scheme at national level. Although the name of the body is not mentioned in the Bill, the Government has said that the NHS Litigation Authority is to have this role. *Making Amends* had envisaged a national body that would build on the work of the NHS Litigation Authority and during debates in the House of Lords Opposition peers repeatedly raised the question whether it could provide the independence necessary to adequately fulfil the needs of the proposed scheme given that its current role is to defend the NHS (see below)

The recommendation that the NHS Redress Scheme should encompass severely neurologically impaired babies and those with cerebral palsy has been dropped. The Government has said that it would be impractical to deliver redress in such cases through a low value scheme, which the NHS Redress Scheme is intended to be, given that in practice these cases tend to receive the highest levels of compensation. The Department of Health has published a statement of intent covering its policies, for example, on developing integrated services, for this group of children.[36]

The need to make provision for a "duty of candour" is another area of difference, which was also picked up in the House of Lords debates. *Making Amends* had suggested that such a duty be introduced together with an exemption from disciplinary action when reporting incidents with a view to improving patient safety. The Government rejected this on several grounds arguing that the medical nursing and midwifery professions already have a duty of candour required by their professional bodies although breach of this duty is unlikely to lead to disciplinary action; these are independent, self-regulatory bodies and the Government felt it inappropriate to require them to strictly enforce an additional duty of candour. It also argued that there were a number of other measures in place, such as the Public Interest Disclosure Act that, supported the same policy objective.

---

35 As above.

36 See list in the Introduction section of this Paper.

The Government has also rejected the recommendation that documents and information collected for identifying adverse events should be protected from disclosure in court. The Government argued that two interests needed to be balanced: the need to encourage health professionals to report adverse events so that their organisation and the NHS can learn from them and the justifiable public or individual interest in accessing information about those incidents. It concluded that ultimately, a patient-focused NHS was the overall objective, not a defensive NHS and rejected the recommendation for that reason.

2. Debates in the House of Lords

The overwhelming concern of Opposition peers at all stages of the debates in the House of Lords was about the independence of the scheme. This focused on the national body that would be responsible - which, as mentioned above, is not stated in the Bill although the Government has said that it will be the NHS Litigation Authority - but also encompassed various other related themes such as the availability of independent legal and medical advice at all stages of the process.

There were suggestions that the Healthcare Commission should be the relevant body[37] but rather than rejecting the NHSLA altogether, the Opposition amendment that was successful at Report Stage focused on separating the redress process into two: fact finding and fault finding. Lord Howe, speaking for the Conservative Party and supported by the Liberal Democrats, argued that it was essential that the NHSLA should have no jurisdiction over fact finding and proposed an amendment, which is now clause 12, to require the Secretary of State to appoint suitably qualified patient redress investigators to establish the facts of a case. The amendment/clause would, among other things, require the Healthcare Commission to maintain and publish a list of patient redress investigators and to have responsibility for overseeing the carrying out of the functions of such investigators.

The Government opposed the amendment. Lord Warner, Minister at the Department of Health argued that in order for it to be cost-effective, it was important that the investigation of cases under the scheme should make full use of the skills and expertise already on the ground. He argued that the amendment would add £41 million to the cost The amendment was carried by a vote of 126 to 125.[38]

On Third Reading, Lord Warner commented:

> …I am grateful to all noble Lords for the constructive spirit in which they debated the Bill. I am, of course, a little disappointed that by the narrowest of margins the Bill leaves the House with a single but somewhat expensive blemish, but I do not doubt that the prospects of that being remedied are good…[39]

---

37 See, for example, Lady Neuberger's speech on the second day in Grand Committee, HL Deb 23 November 2005 c415-6.

38 HL Deb 12 February 2006 c1184-5; a Written Answer provides more detail on how this has been calculated: HC Deb 28 March 2006 c967W.

39 HL Deb 1 March 2006 c259

At Report stage the Government introduced a number of amendments in response to concerns raised. (There was one technical amendment in Committee). Examples of changes include the addition of an apology to the list of scheme requirements; provision on the upper limit were removed in order to remove the possibility of a "double cap" and the provisions on legal advice were amended with the aim of making clear that legal advice in relation to an offer and settlements would be free.

Although the Government continued to reject pressure from peers for primary care services to be added to the scheme, it did introduce provision to allow the scheme to list in Regulations the services over and above hospital services that would be covered by the scheme. In debate the Government explained that this was to allow for the "grey areas" between primary and secondary care and for future changes in methods of provision.[40]

The Government repeated its rejection of the *Making Amends* recommendation of a duty of candour, saying that it had not been "lightly cast aside". It also rejected a number of other suggestions such as the introduction of appeals against the decisions of the scheme authority and restated its view on the inappropriateness of including severely neurologically impaired babies and those with cerebral palsy.

The Government withdrew its original clause 12 on the grounds that it duplicated provisions in the Data Protection Act 1998.[41]

---

[40] HL Deb 15 February c1158
[41] HL Deb 15 February 2006 c1204-5

III Responses to the Bill

The House of Commons Constitutional Affairs Committee has this year produced two reports on the *NHS Redress Bill*, which are briefly described below. The responses of non-parliamentary bodies are set out in alphabetical order after that. They represent those that had been received in the Library at the time of writing. A range of views is also available in the evidence to the Constitutional Affairs Committee. Some of the responses reproduced below were published in October 2005 when the Bill was introduced into the House of Lords and may therefore not reflect all the information that has become available or all the debates that have taken place since then.

1. The House of Commons Constitutional Affairs Committee

The Committee's first report on the NHS Redress Bill was a combined report on the *Compensation Bill,*which is also before the House of Commons,[42] published on 1 March 2006[43] and the second published on 28 March 2006, which deals with three particular areas of concern relating to the Bill.[44] The Government responded in detail in May 2006.[45]

The Constitutional Affairs Committee was concerned whether the Redress Scheme would be sufficiently independent. The two major initial issues that it uncovered were whether claimants would receive independent legal advice and whether claimants would be entitled to independent medical reports. It said:

> We are concerned that if the organisation which is responsible for defending trusts and hospitals is also charged with running the scheme, there may be a perception (whatever the reality) of a conflict of interest….

The committee was also concerned about the lack of detail in the Bill about the way the scheme would be run and recommended that the scheme should be piloted and that more attention should be paid to the proposal for care contracts in the Bill. Its overall conclusion on the *NHS Redress Bill* was:

> On the basis of what we have been able to establish so far, we are not convinced that the NHS Redress Scheme is adequately prepared.[46]

In its second report on the Bill the committee repeated its concern about independence in particular in relation to the use of medical experts paid by the NHS. It also expressed doubt that doctors and lawyers would be willing to provide high quality independent advice for low fees.[47]

---

42 See Library Research Paper 06/28
43 HC Paper 754-I of 2005/6
44 HC Paper 1009 of 2005/6
45 Cm 6784: http://www.official-documents.co.uk/document/cm67/6784/6784.pdf
46 http://www.publications.parliament.uk/pa/cm200506/cmselect/cmconst/754/754i.pdf
47 http://www.publications.parliament.uk/pa/cm200506/cmselect/cmconst/1009/1009.pdf

2. Action Against Medical Accidents, Briefing for House for Commons Second Reading, 23 March 2006

OVERVIEW

Whilst there is widespread support for the stated aims of the Bill, there are also very strong concerns that as currently drafted the Bill would create an NHS Redress Scheme that is not fit for purpose, and which would do more harm than good both for the people affected by clinical negligence and for the NHS itself. AvMA is in a unique position to comment, being the only patients' charity focussing specifically on medical accidents and the just resolution of clinical disputes. However, the same concerns have been expressed by politicians of all political parties in the House of Lords, and the following declaration has the support of 16 national patient/consumer organisations:

"The NHS Redress Bill should be improved to address:

- The need to have an independent means of deciding upon the merits of cases for redress under the scheme, rather than decisions being made by the NHS trusts / the NHS Litigation Authority themselves

- The need for the advice and assistance to be provided to patients/their families during the scheme to be sufficiently expert in medico-legal matters and clinical negligence

- The need for more robust measures to ensure that lessons are learnt from medical errors identified through the scheme and action taken to improve patient safety"

The following organisations are so far formally signed up to the above statement:

Action against Medical Accidents (AvMA)
WHICH? (formerly the Consumers Association)
WITNESS (formerly POPAN)
ALERT
MRSA Support
Patient Concern
National Bereavement Partnership
MIND
The Patients Association
Advice UK
Longterm Medical Conditions Alliance (LMCA)
The Erbs Palsy Group
National Consumer Council
Help the Aged
Rethink
Advice Services Alliance
Association for Improvements in the Maternity Services (AIMS)
The Board of Community Health Councils in Wales

LORDS' AMENDMENTS

AvMA welcomes the amendments passed in the House of Lords. The introduction of "patient redress investigators" was a welcome move to introduce some independent scrutiny to the process of investigating incidents under the NHS Redress Scheme. However, on its own, this measure is not enough. The NHS Redress Scheme would still leave the decision over whether each case should receive an offer of redress (including financial compensation) solely to the judgement of the NHS alone. Patients (or their families) would not be represented or empowered in the process of determining eligibility, and would have to rely on the insight, honesty and fairness of the NHS. This briefing will concentrate on why such a scheme could not work and how the Bill could be improved to address these shortcomings.

THE NEED FOR INDEPENDENCE

Without the opportunity to ensure independent scrutiny is brought to bear in assessing patients' eligibility for redress, the NHS Redress Scheme could not command public confidence. That is clear from the reaction of patients, consumer and other organisations to the Bill. What is more, the NHS Redress Scheme would not add anything significant to the current arrangements. It is already perfectly possible for the NHS to investigate incidents, and where it is clear that there has been negligence to proactively seek to resolve the matter by providing explanations and an offer of compensation without the need to litigate. There are examples of this happening now, but they are rare. The fact is that in the vast majority of cases which ultimately result in an award of compensation to the claimant, the NHS's own investigations had not resulted in an admission of liability. In fact, the majority of cases are stubbornly defended until, with the backing of specialist legal representation and the obtaining of independent expert medical evidence, the claimant's case becomes overpowering.

THE NEED FOR SPECIALIST LEGAL ADVICE

The only legal advice provided for within the Bill, according to Ministers, is to provide advice on the suitability of offers which the NHS has already decided to make. This provision is inadequate in two main respects:-

1) It does not allow the patient to influence the outcome of the process of determining their eligibility for redress through specialist legal representation.

2) Feedback from AvMA's specialist clinical negligence panel of solicitors and the Law Society suggests that solicitors would be unable to provide advice on the suitability of offers alone. Without prior involvement in defining the issues to be addressed by the investigation, it may be impossible to offer such advice without solicitors putting themselves at risk of being professionally negligent themselves.

The Bill does provide for some advice and support to people seeking redress through the scheme. The Policy Settlement describes this as 'PALS or Independent Complaints Advocacy Service (ICAS) type' support. Such arrangements would be inadequate. PALS (Patient Advice & Liaison Services) are not independent. In fact, their strength lies in their position as 'trouble-shooters' within NHS trusts. They are already over-stretched and this role is far too specialist for them. Independent Complaints Advocacy Service (ICAS) provide a generalist service helping people navigate the NHS complaints procedure. ICAS is in a state of considerable instability and is severely

challenged in even delivering this generalist but essential role effectively. The providers of ICAS are in no way competent to advise people on the merits of their case for redress which will be determined by legal definition of liability and causation. ICAS should be no more than an interface between supporting and advising people with complaints and advising them of the availability of the NHS Redress Scheme, and refer those wanting support through the NHS Redress Scheme to a specialist service.

THE NEED TO REASSURE THAT LESSONS WILL BE LEARNT

Ministers have stated that as well as providing offers of redress where appropriate, patients (or their families) will be provided with apologies and explanations, including explanations of what lessons have been learnt and what will be done to help prevent the same errors re-occurring.

This is welcome, as AvMA has consistently campaigned for a more holistic approach and addressing these key desires of people affected by medical accidents, in addition to compensation. However, not to enshrine these principles in the Bill would be a missed opportunity to give the NHS Redress Scheme more creditability and public confidence. There are two main reasons for this:-

1) All this could and should be happening now. Without providing a statutory guarantee, there is little extra that the NHS Redress Scheme guarantees injured patients or their families.

2) Whilst such apologies, explanations and action to improve patient safety may be forthcoming in cases where the NHS has itself identified and accepted those issues, no arrangement is made for empowering patients in the process or dealing with cases where the NHS does not itself identify its own failures without outside help.

A POSSIBLE WAY FORWARD

Many feel that the ideal solution to the perceived problems would be for the NHS Redress Scheme to be run by an independent body such as the Healthcare Commission. However, the Government has signalled its strong opposition to such an arrangement. AvMA is suggesting an alternative arrangement whereby the NHS has first attempt at identifying cases deserving of redress and making an offer itself. The more successful the NHS becomes in achieving an open and fair culture, the more cases might be resolved in this way. However, to add credibility to the scheme and to resolve 'contested' cases (those where the NHS and the patient do not agree on eligibility), the following safety net could be provided:-
Patients could be represented by a specialist solicitor who agrees to do so on a pre-fixed success fee only basis, i.e. the solicitor would only be paid a fixed success fee if the case is assessed as being eligible for redress by an independent medical expert. The medical expert would be jointly agreed and instructed by the patient's solicitor and the NHS. The NHS agrees to provide redress to the patient if the medical expert's assessment of liability and causation is positive. This approach has the following benefits:-

- The process would only be needed if the NHS had not already successfully resolved the case with the patient

- There would be a strong incentive for solicitors to 'screen out' unmeritorious cases, as they would only be paid for representing 'successful cases'
- Costs would be minimised as solicitors would only be paid a capped success fee if the case is successful (the alternative of patients who are unsuccessful through the NHS Redress Scheme having no alternative but to seek redress through the courts would be many times more expensive).
- If the NHS becomes as successful as the Government says it will at identifying its own negligence and settling cases fairly, there should be no such cases where an independent medical expert disagrees, anyway.
- Patient safety could be enhanced by the independent medical expert being asked to identify any risk management issues for the NHS body when they make their report, and the NHS body being required to produce an action plan to address such issues.
- There have already been successful pilots of the above approach on which the NHS Redress Scheme can build. (The 'Resolve' pilot in England and the 'Speedy Resolution' scheme in Wales).
- The public would be much more inclined to have confidence in the scheme rather than turn to litigation than they would if, as at present, the scheme lacks any independence or specialist representation for the patient.

CONCLUSION

AvMA urges MP's of all political parties to support amendments which address the widespread concerns over independence; specialist representation for patients; and ensuring that measures are taken to improve patient safety following incidents. Without such guarantees we do not believe that the NHS Redress Scheme can command public confidence and could do more harm than good. This would be a missed opportunity.

3. Association of Personal Injury Lawyers, May 2006

Introduction

The Association of Personal Injury Lawyers (APIL) was formed in 1990 by claimant lawyers with a view to representing the interests of personal injury victims. APIL currently has around 5,000 members in the UK and abroad. Membership comprises solicitors, barristers, legal executives and academics whose interest in personal injury work is predominantly on behalf of injured claimants.

The aims of the Association of Personal Injury Lawyers (APIL) are:

- To promote full and just compensation for all types of personal injury;
- To promote and develop expertise in the practice of personal injury law
- To promote wider redress for personal injury in the legal system
- To campaign for improvements in personal injury law
- To promote safety and alert the public to hazards wherever they arise
- To provide a communication network for members

GENERAL COMMENTS

APIL has been committed to the review of the clinical negligence system and we believe the primary focus of any reforms must be full and fair redress for patients injured through negligence, and the need to prevent adverse incidents from happening in the first place.

Throughout the consultation process which has resulted in this bill, APIL has sought further detail about how the proposed scheme will work. Unfortunately, the bill does little to remedy the situation and further detailed scrutiny is needed.

There are specific themes of the bill which we feel need urgent clarification before it becomes law.

Lack of clarity

APIL's principal concern with the NHS Redress Bill is its overall lack of detail. The bill gives the Secretary of State the power to establish, by regulations, a scheme for patients to obtain redress when they have been the victims of clinical negligence by the NHS. There are, however, many instances in the bill in which fundamental principles of the proposed scheme are addressed in the vaguest of language. The bill is an enabling bill and, unfortunately, much of the detail will only be provided in secondary legislation. Although the Government has promised to consult on these regulations, this is an inappropriate and unacceptable procedure for a bill of such importance to injured patients. In Clause 9, for instance, is extremely unclear as to who will provide the advice for individuals seeking redress under the scheme and how the provider should be paid. Clause 3 (2) (b) provides for the giving of an explanation but does this mean that there will be a full explanation? APIL suggests that if the explanation is not full, then there will not be adequate redress for the patient, as it will be very difficult for a solicitor to make a recommendation to the patient about the final award, if the full facts of the case are not openly available.

APIL contends that the bill is of great importance to injured individuals and, therefore, far more detail on the workings of the scheme should be available in the text of the bill. The constitutional affairs committee, in its recent report on 'compensation culture' expressed a similar concern: "It is surprising that the Department of Health has brought forward an ambitious Redress Scheme, without setting out in detail how it will be run." The details of how the scheme will actually operate will be contained in comprehensive guidance issued by the Government. APIL submits that the problem with this guidance is it is not mandatory and will be one of three points of reference (along with the Act and the explanatory notes) which will prove confusing.

Independence of the scheme

APIL is profoundly concerned that the National Health Service Litigation Authority (NHSLA) should effectively be responsible for the implementation of the scheme (clause 11). APIL has said from the outset that the over-riding concern in relation to the redress scheme, is that it should inspire public confidence and be built upon transparency and demonstrable objectivity in its operation and functions. The NHSLA is tied to the organisation which caused the initial harm and this would create a clear conflict of interest: the NHS could be perceived to be judge and jury on its own behalf. As the constitutional affairs committee has said, in its 'compensation culture' report: "We are concerned that if the organisation which is

responsible for defending trusts and hospitals is also charged with running the scheme, there may be a perception (whatever the reality) of a conflict of interest." This runs counter to the Government's attempts in other spheres, such as legal services, to separate the regulatory aspect of an organisation from the parent body. People must have confidence that their complaint will be dealt with in an open, accountable and equitable manner.

Clause 12 does provide for 'suitably qualified patient redress investigators' to conduct the investigation into the facts of the case. APIL submits that although this does introduce an element of independence into the scheme, it still raises important questions. Important issues such as the status of the investigators, how they will be trained and the level of legal skill they will possess are not addressed. The case will still be handed back to the NHSLA to determine quantum and liability so the ultimate problem of independence remains unresolved. The investigators will also not provide a suitable substitute for an individual's need to obtain access to proper independent legal advice.

APIL submits that the independence and impartiality of the scheme would be more credible with the public if a body such as the Healthcare Commission was statutorily responsible for administering it.

Provision of legal advice

APIL's fundamental belief is that claimants should always have access to the best quality legal advice. While, in many cases, it may be acceptable for the patient to have legal advice at the end of the case (provided a full explanation is provided at the beginning), there will be many occasions where there are complicating factors, such as liability. As Lord Woolf highlighted, in his Access to Justice report in 1996, clinical negligence is a complex and technical area of law where issues of causation and liability are often difficult to determine. It was for this very reason that he excluded clinical negligence claims from the 'fast track' procedure. It is also further evidence for the need for a full explanation to be provided. Specialist legal advice is, therefore, essential if the scheme is to ultimately work to the benefit of the injured patient and deliver the Government's stated aim of widening access to justice.

Clause 8 (3) deals with who may provide the legal advice. The government, in the grand committee stage in the Lords, indicated that it expected this to be the Legal Services Commission. APIL is concerned that the Legal Services Commission would not be appropriate because it only deals with specialists who act under the legal aid scheme: it does not accredit solicitors who have experience in the clinical negligence field. APIL submits that the legal advice should be provided by practitioners who are accredited by the clinical negligence panels of the Law Society, Action against Medical Accidents (AvMA), or APIL.

4. British Medical Association, 2 November 2005

The Government's NHS Redress Bill is intended to reform the current clinical negligence system, enabling patients to receive redress without having to go through the legal system. The bill gives the Secretary of State the power to establish an NHS redress scheme in England, and sets out framework powers for Wales.

The scheme, which will be operated by the NHS Litigation Authority, is intended to place a duty on providers and commissioners of hospital services to ensure

patients receive a more consistent, speedy and appropriate response to clinical negligence. The scheme will cover only low monetary value claims arising from hospital care provided as part of the NHS, wherever that care is provided. The initial upper limit is expected to be set at £20,000.

This is an enabling piece of legislation with very little detail on the face of the bill. The details of how the scheme will operate are to be set out in secondary legislation which is unavailable for scrutiny at present.

The BMA's initial position on the bill

The BMA welcomes the Bill's objectives and' hopes that the redress scheme can be structured in such a way that will help some patients to avoid the costs, stress and delays of going through the legal system. We hope the scheme will enable claims to be settled more quickly and fairly, and to the satisfaction of patients, doctors and the NHS.

The BMA has long supported the revision of the existing tort-based system when something goes wrong with their NHS hospital treatment or care. The present system is harmful, unpredictable and unjust.

It is the sincere hope of the medical profession that, whatever other benefits might result from a redress scheme, the absence of the threat of litigation will ensure much greater frankness in explaining the nature and cause of any mishap to the patient concerned, encouraging accountability by the doctor to his/her patient. The current adversarial system contributes to the blame culture which prevents health professionals being open about mistakes and learning from them.

Modern healthcare is highly complex and a certain amount of human error is inevitable. Many accidents or near misses are the result of a chain of events and incidents which combine to produce systems failure. Problems are all the more likely because of the relentless pace at which doctors and other healthcare professionals work. We hope that the legislation will create a climate where doctors and other health professionals can all genuinely learn from experience and prevent avoidable harm to patients.

The scheme must be fair to patients but, without having sight of the details, we are unsure as yet whether the redress scheme will receive the confidence of the public and healthcare professionals.

As much of the detail of how the scheme will operate will be outlined in secondary legislation, clarification is needed on various issues, including the following:

It is claimed that the NHS Redress Scheme is expected to increase spending on compensation payments because it will bring new claims into the system. In the longer term however, savings on legal costs are expected. Under the proposed scheme, its operators will still need to establish whether or not there has been a breach of a duty of care in connection with the diagnosis of illness, or the care or treatment of a patient following any act or omission by a healthcare professional.

> What criteria will be used to establish whether the cause of an individual's injury is from negligence? Who is going to advise people whether they are eligible to enter into the redress scheme?

It is envisaged that the upper limit will be set initially at £20,000. This is a low level and the BMA is concerned that the scheme will be able to deal with only the very minor cases. The lower the financial cap, the more the scheme will cost as it will reach people who probably would not previously have resorted to suing. The BMA calls on the Minister to explain how the compensation system will work.

> What proportion of claims settled currently through the legal system amount to £20, 000 or less?
>
> Can the Minister confirm whether the £20, 000 limit excludes costs such as legal fees? Are remedial treatment costs included within this figure?
>
> Where remedial treatment is required, what mechanism will there be to ensure that the treatments and/or rehabilitation are provided to the claimant?

There is no reference in the bill for an appeals mechanism should the claimant disagree with the decisions made under the scheme, such as whether or not the claimant is entitled to redress under the scheme, or the level of the compensation offered.

> What mechanisms will be in place to deal with such appeals?

The most expensive legal claims brought against the NHS are birth injury cases. These produce settlements of up to £5m and cost millions of pounds a year in legal fees. (Handling Clinical Negligence Claims in England, NAO, May 2001)

> Can the Minister give examples of the type of cases that the scheme will cover?
>
> Can the Minister estimate the number of cases that will fall within the remit of the redress scheme that avoid a claimant having to use the legal system?

The BMA is concerned about the possibility of different redress schemes operating in the four countries.

Can the minister explain the process by which redress will be claimed should clinical negligence occur when an NHS commissioner in England refers a patient for treatment to a provider across the border in Scotland?

Background

For many years, the BMA has been concerned about the social injustices of the present tort-based system. The BMA has called for adequate arrangements to provide compensation and support to those who suffer personal injury through medical mishap given according to need and not according to cause.

The prospect of the patient receiving appropriate compensation when injury has been suffered is at present extremely uncertain and, when achieved, may involve many years of stressful legal action, causing enormous expense. For patients not eligible for legal aid, the risk of serious financial damage if the action is unsuccessful often compels them to abandon all hope of compensation and not proceed with a claim.

The need for change to the existing tort-based system for settling cases of medical mishap arises from a number of standpoints and for a number of reasons:

- from the patient's viewpoint, because of the length of time taken to resolve such cases - an average of over six years from issue of proceedings to conclusion - and the resistance of defendants to earlier settlement even where the case is clear cut;
- from the doctor's viewpoint, because cases with little justification or hope of success are pursued with legal aid with often adverse consequences for both reputation and future clinical practice;
- from the point of view of the NHS, because the costs incurred are often disproportionate to the settlement itself. It is sometimes alleged that pressure to contain cost often prompts inappropriate out-of-court settlements.

The present tort-based procedures destroy the proper relationship between patient and doctor, introducing a confrontational element, totally foreign to the mutual trust which should exist. The procedures encourage concealment and lack of frankness on the part of the doctor, just when it is most undesirable.

There is increased concern about recent trends in medical litigation. The position has worsened rather than improved since the Pearson Commission in 1978 declared that "... the tort system is too costly, too cumbersome, too prone to delay and too capricious in its operation to be defensible." (Report of the Royal Commission on Civil Liability and Compensation for personal Injury, Chairman: Lord Pearson, Cmnd 7054-1,1978, paragraph 1715.)

NHS expenditure on clinical negligence was £503m in 2004/05, an increase over the 19992000 expenditure of £373m. The continued growth of conditional or contingency legal fees and other means of funding litigation have undoubtedly contributed to an increase in the cost of clinical negligence cases. (Annex A of the Bill's Regulatory Impact Assessment, October 2005)

The dilemma has been to identify a process which would be fairer, limit exposure to large settlements, trade off cost savings against quicker awards but not leave the service open to those who might be encouraged to pursue a 'costless' but inappropriate case.

5. Citizens Advice, House of Lords Report Stage, 15 February 2006

Summary

- Citizens Advice endorses the need for a redress scheme for medical mistakes or malpractice that does not involve civil litigation.
- however this Bill is largely a piece of enabling legislation, which leaves much of the essential design of the redress scheme to Department of Health regulations and policy;
- there is a total absence of detail about how the scheme is likely to operate, who will operate it, how it will be implemented;
- we have reservations about whether this is an appropriate law-making for the process for clinical negligence redress claims under £30,000.

When the Bill was debated at Lords Committee Stage, some further detail of the Government’s policy intentions became clearer, such as whether the scheme will

require the establishment of a new organisation, or develop the existing roles either of the NHS Litigation Authority, the Healthcare Commission or the NHS Complaints scheme (ICAS). However key questions still needing to be asked include:

- Who will make the determinations about the value of compensation?
- Is there an expectation of increased numbers of complaints?
- What are the estimated effects on levels of complaints?
- How much additional funding will be provided to the organisation(s) managing the redress scheme and organisations affected by the increase in complaints?
- Does the Secretary of State have a timeframe for the commencement of a redress scheme?
- What mechanisms will be in place to ensure that the scheme will be used as an opportunity for the NHS to admit its mistakes, learn from them and take corrective action?

Citizens Advice agrees with many other advice and patients' organisations that the proposed NHS Redress Scheme needs to include:

- An independent means of deciding upon the merits of cases, rather than decisions being made by the NHS Trusts or the NHS Litigation Authority themselves;
- the provision of advice and assistance to patients and their families which is sufficiently expert in medico-legal matters and clinical negligence;
- robust measures to ensure that lessons are learnt from medical errors identified through the scheme and that action is taken to improve patient safety.

Clauses 1 to 3 - Establishing the redress scheme

It seems remarkable that there is so little on the face of the Bill about how the scheme will be established. It is not clear from these clauses whether there will be a single scheme, or several schemes for different health authorities. Nor is it clear what sort of public body will be primarily responsible for the administration of the scheme. We consider it to be essential that the bare framework of the scheme should be established by primary legislation.

Clause 4 to 6 – Proceedings under the scheme

The lack of clarity and detail about who may commence proceedings under the scheme, how proceedings under the scheme may be commenced, and time limits in relation to the commencement of proceedings under the scheme, leaves many crucial questions unanswered. The trigger for entering the redress scheme is professional negligence (the 'Bolam Test'), but it is unclear whether the complainant needs to have exhausted the processes available under the NHS Complaints scheme. If not, will the time limit for the NHS Complaints scheme apply or will instead the time limits be set by statutory limitation periods (three years for civil proceedings)?

Citizens Advice's preference was for a 'no fault' compensation scheme as originally envisaged by the Chief Medical Officer's report, Making Amends – in other words a scheme providing for alternative dispute resolution. In order to achieve a situation in which the process of dealing with issues with poor clinical

and healthcare practices in NHS services can shift from a 'litigious' to a 'redress and rehabilitative' culture, the complaints process should be less about finding fault with individuals, but rather the NHS taking responsibility for its services and addressing bad practice pro-actively. Applying the 'Bolam test' (clinical negligence) retrospectively inevitably leads down a route in which NHS authorities will seek to protect their staff's reputation.

Citizens Advice agrees with the basic position of the government that a redress scheme should offer an alternative option to rather than replacement of civil proceedings before the courts, and that access to one route of redress should not prejudice the other, however what is proposed is a hybrid system which duplicates the legal process. If redress proceedings are to be founded on clinical negligence grounds then the process needs to be rigorous, based on rules of evidence and legal standards of proof. It is hard to see how this could be achieved by an internal investigatory process with limited expert independent oversight.

Clauses 8 and 9 – Legal advice and assistance

The interface between the complaints procedure and clinical negligence will be affected by changes introduced in legal aid eligibility rules. With respect to public funding, the Legal Services Commission has made clear applicants will be expected to pursue any available complaints system before they are funded to take proceedings. This will give the potential defendant public body the opportunity to respond to the matters raised and provide an explanation or apology if appropriate before it is decided whether litigation is the appropriate remedy for the client.

It has been unclear in discussion and debate whether the provision of advice and assistance to patients and their families under the proposed NHS redress scheme might be made available through ICAS services. As the key providers of ICAS services, we have made it clear that we do not consider it to be the role of a complaints service to offer advice and representation on medico-legal matters and clinical negligence, this requires significant expertise that is beyond the capacity of the ICAS service. While all Law Centres and some Citizens Advice Bureaux employ solicitors, clinical negligence is a complex and specialist area in which such solicitors are unlikely to have much, if any, experience. Under current arrangements, and without the resources to recruit specialist advice units, we do not consider that they would be able to provide the "independent legal advice" referred to in the Bill. In our view, such advice can only properly be given by independent specialists in this area.

Clinical negligence is a highly complicated field of law. Indeed ICAS does not deal with complainants seeking financial redress for such matters. Where this is what complainants are seeking ICAS advisers will explain the option of clinical negligence, for which clients would then need to seek legal advice. Currently, the NHS complaints procedure cannot be used in conjunction with legal action.

The "Statement of Policy" published by the Department of Health in November 2005 suggests that the scheme would essentially be run by scheme members, who would identify eligible cases, investigate them, and propose redress where they consider it appropriate, the scheme being overseen and monitored by the NHS Litigation Authority. However, this would fail to meet the key concerns about independence and raises issues about conflict of interest. It essentially proposes

that NHSLA should be advocate, judge and jury. Many questions need answers such as what qualifications will investigators have - will they be medically trained or lawyers or advisors?

The importance of the independence criterion was emphasised by Stephen Walker, Chief Executive of the NHS Litigation Authority, in his evidence to the Constitutional Affairs on the 17th January 2006. Mr Walker made it clear that, where liability or the amount of compensation is in issue, then under a scheme administered by his Authority, there should be a joint referral to an independent expert by the Authority in conjunction with the claimant's solicitor. This follows the procedure adopted in the 'Resolve' Pilot scheme, which was considered by an independent evaluation to have been largely successful.

Clause 10 – Membership of the scheme

Will the scheme apply to Foundation Hospitals, Private Hospitals and/or other private providers? This needs to be made clear.

Clauses 14 to 15 – Complaints under the scheme and the role of the Healthcare Commission.

Without further explanation, it is surely questionable whether different parts of a complaint can be treated differently as suggested by clause 14. These clauses also suggest that the complaints procedure could be the first stage of the process, in which case other parts of the Bill will need significant redrafting. Using the complaints system as the first stage will involve the Healthcare Commission and the way they conduct investigations will have to be modified so they use independent medical reports and apply the Bolam test where appropriate

6. Commission for Patient and Public Involvement, October 2005

The CPPIH welcomes the proposals in the Bill to create a redress scheme for small claims for medical negligence. The length of time taken and the cost involved in securing compensation has hardly been patient centred.

We are pleased that under the new scheme this should happen much more quickly and patients and their representatives should no longer be put through the additional stress of complex, costly and lengthy proceedings on top of that caused by the injury itself.

We are concerned, however, by the apparent lack of independence in the decision-making, which has been left entirely to the NHS Litigation Authority. It is wrong that the NHS, which was the cause of the injury, should itself be the judge.

We hope that the Government will incorporate a measure of independence in the scheme.

7. Law Society, Second Reading House of Lords, 2 November 2005

The Law Society has also produced briefings on amendments for the House of Lords debates.

The Law Society welcomes the basic aim of the Bill, which is to make the process of receiving redress following a medical accident more accessible and effective. The Society has long supported the principle that there should be more openness

between patients and the medical establishment when things go wrong as well as greater encouragement to use mediation to resolve clinical disputes.

The Bill itself gives the Secretary of State the power to establish, by regulation, a scheme for the victims of medical accidents to obtain redress without recourse to legal proceedings. The Society supports the proposed scheme providing there is access to free legal advice for victims and that the right to go to Court is not compromised. While the Bill is light on the detail of the scheme, these requirements appear to have been met, subject to clarification of some areas as the Bill passes through its later stages.

Access to the Courts and legal advice

For the new scheme to protect the interests of victims effectively, it is vital that victims must retain access to the Courts The Society is pleased to note that the Bill does not appear to restrict this (see Clause 6(4)). We note that there is a "waiver" requirement against bringing subsequent legal proceedings where there has been a settlement under the scheme. This is logical, provided that the victim has received proper legal advice. Furthermore, such a waiver should not preclude any applicant from taking further action in the event there is a significant change in his/her condition which was not originally foreseen (e.g. an injury which has deteriorated far beyond that originally anticipated or an injury which had not originally been diagnosed). This must be made clear in the Bill.

With regard to legal advice, the Law Society welcomes the proposal in Clause 8(1)(a) that any victim of a medical accident, or person representing that victim, will be able to obtain appropriate legal advice without charge. Presumably the intention is that the responsible body will reimburse any reasonable legal expenses incurred in obtaining advice, or that funding will be available from the Legal Services Commission. If any funding is to come from the legal aid fund, a full Assessment should be undertaken to ascertain the extent of the effect on the fund, and if this is in excess of the current spend on clinical negligence, annual re-imbursement should be made to the legal aid fund.

Victims must be given the opportunity to exercise their fundamental right of freedom of choice of solicitor. The Society does, however, recognise that due to the special nature of these cases, only those solicitors who have sufficient and relevant expertise in dealing with clinical negligence matters should undertake such work. The Society maintains a panel of suitable solicitors.

Whilst the Society agrees that every effort should be made to reduce the costs of resolving clinical disputes so far as is reasonably possible, this should not result in victims of medical accidents having their rights to access to justice eroded. Any proposed allowance for legal costs, if that is what is intended, should therefore be reasonable and take into account all relevant factors involved in any proceedings brought in accordance with the proposed scheme on an individual claim basis.
There appears to be a provision in Clause 9(1) for the Secretary of State to be given the power to appoint a representative to assist an applicant "by way of representation or otherwise". The Society is not clear what the intention of this clause is. Any applicant under the scheme, if he or she so wishes, must have the freedom to make their own choice of a person or organisation ("i.e. adviser") to assist with any claim. In the absence of freedom of choice, there would be bound to be doubts about the impartiality of the adviser.

Details of the Scheme

The Bill should include full details of eligibility criteria and awards available, including any proposed financial limits and/or benefits and/or treatment arrangements. We have a particular concern that if the claim value limit is initially set too high, then the scheme would not operate efficiently in its infancy stages due to the possible number of claims that would be made. Any financial limit could more sensibly be increased at a later date when the scheme has become fully operational.

The Society's major concern at this stage is that the Bill does not go into sufficient detail as to how the scheme will operate. Whilst the Society supports the general intention of the Bill, the Bill should include much more detail as to how the scheme will actually operate on a day to day basis and who will make particular decisions. The Bill should provide for a panel of experts to assess each case, and for those experts to be competent and totally impartial.

Additionally, legal advisers will not be in a position to assess the appropriateness of an offer made by the Redress Scheme without access to documentation including an independent medical report and an independent report on the evidence on which the claim is based. The Society believes that these are fundamental requirements to the success of any scheme. Anything less will not have the trust or confidence of potential applicants.

8. Medical Protection Society

With over half of all UK doctors and dentists as members the Medical Protection Society (MPS) has a strong interest in the proposed legislation.

MPS is broadly supportive of the initiative. We have been involved in a number of discussions with the Department of Health leading up to the publication of the Bill and are pleased that the Bill largely takes into account the representations we made.

Shifting the balance away from settling clinical negligence claims purely with financial compensation toward a more comprehensive package of redress for patients including an apology, explanation and remedial treatment is a positive development. MPS hopes that the Redress Scheme will help foster a greater culture of openness within the NHS in which lessons can be learned and risks reduced.

There are however some aspects of the Bill which require greater clarification. We appreciate that the detail of how the scheme will operate in practice is promised in secondary legislation however there are points of principle which we believe need to be debated fully during the passage of the Bill through the Commons.

Investigations

A critical measure of the Redress Scheme's success will be its ability to balance quick resolution with thorough investigation. When an adverse incident occurs it is essential that there is a careful examination of the facts. An investigation that fails to consider all aspects of the care provided could lead to doctors and other healthcare professionals being unfairly criticised. This could leave doctors open

to further unwarranted investigations and disciplinary hearings and may ultimately undermine the morale of healthcare professionals.

There has been little mention of the position of healthcare professionals in the discourse surrounding the NHS Redress Bill. Although it is entirely right that the proposed redress scheme is patient focused, the investigation needs to take into account the potentially traumatic impact of the incident on the medical team.

Primary and Secondary Care

The amendments passed in the House of Lords to clause 1, on the scope of the Redress Scheme, will empower the scheme to list, in secondary legislation, those health services over and above traditional hospital services that will be covered by the new scheme. These amendments will ensure the scheme has the flexibility to encompass the increasing diversity of NHS care provision.

Clause 1 of the Bill will now specifically exclude primary medical, dental and general ophthalmic services from inclusion in the scheme by secondary legislation. This is the right approach. MPS and other medical protection organisations manage negligence claims arising from primary care, while the NHSLA manage those claims in secondary care settings. GPs and other healthcare professionals in primary care have fundamentally different professional indemnity arrangements from the NHS hospital indemnity system.

It makes sense that the redress scheme should be thoroughly trialled in secondary care where the NHSLA has experience in handling claims. Any subsequent extension of the redress scheme to primary care must be subject to consultation and rigorous parliamentary scrutiny through primary legislation.

Mixed claims

While MPS believes that it is right for primary care to be initially excluded from the Redress Scheme there may be occasions when primary care providers are implicated in claims under the Scheme. We would like clarification on how redress would be quantified and funded if a qualifying claim also included negligent treatment on the part of a GP. Such a case may occur, for example, where there has been a breakdown in communication between the hospital and GP resulting in a prescribing error. The hospital may not have provided adequate information on the prescription and this may be compounded by a failure to check the prescription in the GP practice.

I appreciate that there are other issues raised by the proposed NHS Redress Scheme and I would be delighted to meet with you to discuss these or any of the issues outlined above if you would find it at all helpful

9. NHS Confederation, October 2005

INTRODUCTION

The NHS Confederation is the only membership body for all types of NHS organisations, with over 90% in membership across the UK.

We bring together the organisations that make up the modern NHS across the UK. Working with our members, we are an independent driving force to transform

health and health services, by influencing policy and wider public debate and connecting health leaders through networking and information sharing.

We are uniquely placed as the authoritative voice of NHS management in England. Our members include Acute Trusts including Foundation Trusts; Primary care trusts; Mental health and learning disability trusts; Ambulance trusts; Strategic Health Authorities and Special Health Authorities. We also have national offices with devolved responsibility for Wales, Scotland and Northern Ireland.

This briefing has been devised through ongoing discussions with NHS Confederation members.

CONTEXT OF THE BILL

The current system:

- is slow, costly, complex, and unfair (similar cases appearing to have different outcomes)
- has a negative effect on staff morale and on public confidence
- leads to patient dissatisfaction (lack of explanations, apologies or reassurances that actions have been taken to prevent the same incident happening again)
- encourages defensiveness and secrecy

Clinical negligence cost the NHS £503m (2004-05 figures). A third of this is accounted by legal costs. Whilst this is less than 1 per cent of annual NHS expenditure it is still a considerable sum: some fear this may significantly rise if a US style compensation culture takes hold.

Making Amends, the Chief Medical Officer's consultation paper set out proposals for reforming the approach to clinical negligence (June 2003). This Bill gives effect to the proposals it sets out: introducing an NHS Redress Scheme to provide investigations when things go wrong, remedial treatment, rehabilitation and care where needed, explanations and apologies, and financial compensation in certain circumstances. The scheme will deal with lower level claims, which will typically cover minor injuries that do not lead to permanent damage.

KEY FEATURES OF THE BILL

The Bill provides for:

- the establishment of a scheme to enable the settlement, without recourse to courts, of certain claims which arise in connection with hospital services provided to NHS patients in England.
- establishes the parameters of the cases to which any such scheme can apply, and which bodies can be members of a scheme,
- gives the Secretary of State powers to set out in regulations the detailed rules that govern the scheme. Those powers include the power to place new duties on scheme members and Healthcare Commission to consider whether cases or complaints fall within a redress scheme and, if they do, to take appropriate action.

The NHS Redress Bill will cover low-value clinical negligence claims, with the limit expected to be set at £20,000. Small claims account for about 10% of all clinical negligence payouts each year.

It will be overseen by the NHS Litigation Authority: they would be responsible for compensation awards, providing explanations and giving apologies.

Patients would still get independent legal advice once an offer of resolution is made.

The National Assembly of Wales is still considering whether system should be extended to Wales, while the Scottish Executive currently has no intentions of taking forward proposals.

KEY MESSAGES

We welcome this enabling Bill that will permit secondary legislation to enable the scheme to be created. We will be working with our members to ensure that the detail of the legislation will be workable for patients and NHS organisations:

- We look forward to working closely with the Department of Health to ensure the current cumbersome compensation process more effective: where patients are entitled to compensation, they should get it more quickly and more efficiently.

- In drafting up the detail of the scheme is will be important to ensure that it does not jeopardise the progress in encouraging NHS staff to report adverse incidents. How the scheme relates (in reality or in perception) to such bodies as the National Patient Safety Agency and the Healthcare Commission will need consideration.

- The scheme will apply to hospital care in the first instance. Whilst acknowledging the difficulties in applying the scheme to primary care (given the independent contractor status of many primary care providers) we look forward to working with the Department of Health to widen the schemes remit.

- The issue of severely neurologically impaired babies still needs to be addressed. This was addressed in Making Amends but has not found its way into this Bill. Whilst understanding that the complexity of this emotive subject resulted in it not being part of this Bill we look forward to seeing subsequent legislation bringing forward a second workable scheme for such babies.

- There is concern around unscrupulous practice of some claims management companies – encouraging negligence claims that serve no one interest not least the patient or their families. Whilst this Bill does not directly address this issue, the availability of a redress scheme should help give patients and their families a clear process when considering lower level claims.

- Over time we would like to see the NHS complaints procedure and the Redress Scheme brought together to ensure that patients have a streamlined and easy to understand process available to them.