Contemporary Issues

Policy Brief

The Rapid Resolution and Redress Scheme for Birth Injuries: An Alternative Scheme Design

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Executive Summary

The recent consultation on a Rapid Resolution and Redress (RRR) Scheme for serious brain injuries occurring at birth was prompted by the recommendations of the National Maternity Review's Better Births report. The Department of Health's objectives for the RRR Scheme were:

- reducing the number of severe avoidable birth injuries by encouraging a learning culture;
- improving the experience of families and clinicians when harm has occurred;
- making more effective use of NHS resources.

These are important objectives, and three key areas were identified in which the RRR Scheme design could be improved to enable it to meet these objectives:

1. eligibility;
2. the use of panel investigations;
3. NHS-Resolution as scheme administrator.

The consultation proposes to investigate only brain-injured babies, not intrapartum stillbirths nor early neonatal deaths. This is despite an overlap in the causes of these three events. By not investigating intrapartum stillbirths and early neonatal deaths, a quarter of potential harm reduction lessons are ignored.

Additionally, the consultation proposes to compensate only brain-injured children who are at least eighteen months old. For a year and a half, families are uncertain if they will even be able to apply for compensation.

Panel investigations are slow and costly, requiring three medical professionals and administrative support. As birth injuries are rare, these investigators will have limited investigatory experience. By contrast, single investigators can be onsite promptly, do not require administrative support, have extensive investigatory expertise, and are cost-effective.

The scheme administrator needs to be independent and trusted by families and clinicians. NHS-Resolution acts to defend the NHS in litigation; inevitably it is associated with blame. The potential for conflicts of interest (perceived or actual) is high. Families do not want NHS-Resolution to administer RRR.

An alternative, less expensive scheme design addressing these three points and based on an ombudsman model is detailed in this policy brief.

The Rapid Resolution and Redress Scheme for Birth Injuries:

An Alternative Scheme Design

Introduction

A recent Government consultation proposed a model for a Rapid Resolution and Redress (RRR) Scheme for serious birth injuries.[1] This policy brief addresses possible alternative governance and operating models for the Rapid Resolution and Redress Scheme for serious birth injuries. The policy brief focuses on the structure of the proposed scheme and the alternative scheme presented herein. The policy brief is divided into the following sections:

- A critique of the proposed model and a suggested alternative scheme
- A business process for this alternative scheme
- A delivery and costs outline for the alternative scheme

The following sections are available at http://www.fljs.org/content/rapid-resolution-and-redress-scheme-birth-injuries-alternative-scheme-design:

- Appendix 1. Eligibility numbers for the RRR Scheme
- Appendix 2. A breakdown of the ombudsman costings
- Appendix 3. Details of potential associated redress costs

Rapid resolution and redress for serious birth injuries

Ministers are giving consideration to setting up a redress scheme for dealing with birth injuries as an alternative to the current litigation-based approach. The key public objectives for such a scheme include:

- providing a route to support and compensation for families which is quicker and less contentious than the current system;
- increasing the learning from such incidents in order to drive improvements in clinical and operational practice;
- introducing a no-blame culture in order to increase reporting rates and reduce defensiveness.

The consultation suggested siting the scheme within the NHS Resolution (NHSR, previously known as the NHS Litigation Authority or NHSLA).[2] This has the advantage of providing a base for the scheme within an existing body and reducing set-up costs. However, it carries with it a significant number of risks. Risk considerations include:

- ***cultural corruption*** — the existing legalistic and defensive culture of the NHSR could dominate the new scheme, subverting its purpose;
- ***lack of credibility*** — neither families nor external observers would consider a scheme sited in the organization with a statutory duty to defend the NHS against claims to be truly independent;
- ***court decisions*** — linked to the above, there is a risk that the courts would consider that any redress decisions made by a scheme based in the defence agency will have little legitimacy, leading to no reduction in the level of legal challenge in birth injury cases;
- ***cost issues*** — a scheme employing staff on existing statutory terms and conditions and based in London may not be as cost-effective as it might be. In addition, there are initiatives to which the NHSR is already committed which would unnecessarily inflate costs;
- ***independence*** — individual redress decisions and/or redress policies may be subject to influence for political or cost reasons;

- ***failure to build learning*** — the NHSR has little track record in driving improvements, and siting it there risks cutting across the Each Baby Counts initiative, which has proved very successful in gathering information and improving learning.[3]

This policy brief seeks to propose a governance and operational model for a Department of Health (DoH)–based scheme which minimizes the above risks while still seeking to achieve the objectives for the scheme.

Governance

Key to avoiding many of the above risks is devising a governance model which guarantees the independence of decisions made by the scheme and which commands the trust of external observers. There is extensive research supporting the importance of true independence. Fortunately, such models exist, particularly in the statutory ombudsman schemes which have been set up in recent years.

The principles which the governance of such schemes seeks to follow are those set out by the Ombudsman Association. These allow a scheme to be responsible to the Government department (or, in private sector schemes, the business sector) who may ultimately be responsible for the cases which they are considering, but only if there is an intervening governance structure, such as an independently chaired Board, between the department sector) and the ombudsman (or other decision-maker). While the members of this Board may be appointed by the department (or sector) concerned, it is expected that these members should be broadly drawn from a range of stakeholders, including representatives from those bringing the claims. The Board has the ultimate duty not only to oversee the scheme and appoint the ombudsman, but to guarantee the independence of the scheme, protecting it from interference from the department or sector concerned.

Public sector examples of such structures include the Parliamentary Ombudsman, the Financial Ombudsman, and the Legal Ombudsman. The last two are ultimately accountable to individual Government departments — the Treasury and the Ministry of Justice, respectively — which agree the rules by which they operate and have some levels of financial oversight over them; however, both have independent Boards which guarantee them operational independence from Government. That level of independence has been accepted by the courts as sufficient to guarantee the integrity of individual ombudsman decisions; the courts have largely declined to intervene to overturn such decisions save when they are seen to have been Wednesbury unreasonable.[4] In contrast, the Prisons and Probation Ombudsman, who reports directly to the Ministry of Justice without any intervening Board structure, is not recognized by external observers (including, for example, the Ombudsman Association) as truly independent and its decisions are regularly subject to court challenge.

The Prisons and Probation governance model may prove suitable for the birth injuries scheme. This structure would give the DoH ultimate responsibility for the scheme, allowing the department to be sure that it had the power to intervene should the scheme go wrong, and also giving some measure of control of operating budget and the broad rules by which the scheme operates. However, the presence of an intervening Board, with members drawn from key stakeholder groups (medical experts, birth injury families, claimant representatives etc.), would guarantee day-to-day operational independence and protect the decision-maker from undue pressure or interference.

It is important to emphasize that although these sorts of governance arrangements will be sufficient to guarantee the independence of a scheme reporting directly to the DoH, they may prove insufficient to convince stakeholders or the public that a scheme reporting direct to the NHSR is truly independent. There are numerous schemes reporting to Government departments or regulators, yet there are no examples of which we are aware of schemes reporting to litigation authorities. While it may be possible over time for the NHSR to develop into a more neutral organization, as long as it remains the case that its statutory function is to defend the NHS from legal claims, no governance arrangements are likely to be sufficient to guarantee (or be seen to guarantee) that the scheme is truly a neutral arbiter between those using the scheme and the NHS.

Transparency

A second key requirement of successful schemes is transparency and consistency of process. In the main, this is usually provided via the publication of, and adherence to, a set of rules by which the scheme operates. The more that these rules can be subject to prior consultation and be specific in describing what those using the scheme can expect, the more both users and other parties, such as legal representatives and, potentially, the courts, will trust the scheme. Over time too, a successful scheme will build up a library of case examples and case law. The best schemes, such as the Financial Ombudsman, publish case summaries or even full findings.

For schemes which are fully independent, such arrangements should not prove problematic. However, for a scheme based in a litigation authority, this is likely to be more difficult. Given that those running the scheme may also find themselves in a position of defending the NHS against litigation arising from the very events which are subject to the scheme's investigation and findings, it may prove difficult for them to publish findings about events which then become the subject of court challenge. There will inevitably be a temptation for the scheme to redact findings, which could weaken the NHS's defence against a court challenge. Similarly, the rules by which the scheme will operate will inevitably be influenced to some degree by the need of the NHSR to ensure that the process being followed does not weaken its legal position as a result of a personal injury claim being pursued or the position adopted by the scheme.

Trust

Vital to the success of the scheme will be the trust of the participants — scheme users and medical staff alike. If scheme users do not trust the scheme, they are likely to continue to look for legal solutions to their issues. Not only does this risk that the NHS receives the same number of personal injury challenges that they are currently receiving; but if the somewhat complex process model envisaged in the consultation fails to operate cleanly in every case, the scheme itself could give rise to its own complaints and legal challenges.

In the case of medical staff, trust in the scheme is vital in order to encourage both early reporting and openness in response to scheme investigations. That in turn requires that a robust no-blame culture is established in the investigations and resolution of incidents. The absence of a strong no-blame culture has been shown to impede staff recording and communicating all relevant information about the underlying events. The substantive move to a no-blame culture is a major departure from the current response to such cases and will require a significant shift in thinking. This will be particularly difficult were the scheme to be sited in a body whose very purpose is to defend and whose experience is rooted in an adversarial rather than a no-blame culture.

Trust can be engendered by the sorts of transparency and good governance arrangements described above. The adoption of arrangements and language with which potential service users and their representatives are familiar — such as the term ombudsman, for example, would also help to build credibility.

However, it is also essential that the views of medical staff and representatives of those who may use the service be fully taken into account. In this respect, the decision to hold an open consultation about the siting of the scheme was immensely helpful. The results of that consultation are not yet public. However, prima facie, one would expect that siting the scheme within the NHSR, the body charged to defend the NHS against claims by families of damaged babies, is likely to be unpopular with families and if such a decision were to be taken against the prevailing view of respondents, particularly family representatives, that would be highly damaging to public trust and would therefore substantially undermine the success of the scheme.

Speed and simplicity

Good investigation and resolution schemes work quickly and simply, with the minimum of formality and in a manner which enables stakeholders to engage with the minimum of effort. They are almost always inquisitorial in style, meaning that there is no need for participants to be legally represented, and investigations are undertaken by trained, specialist staff, who are expert in conducting such investigations and are able to deploy a range of skills and tools, including Alternative Dispute Resolution (ADR) mechanics such as mediation and conciliation.

These staff are experienced in the issues under investigation, and although they are rarely subject matter experts, they have access within the organization or from outside to specialist expertise when required.

The consultation presupposes that investigations are undertaken by specialist medical staff on secondment. However, it is worth noting that all the established public sector schemes, including the Legal Ombudsman, the Local Government Ombudsman, and the Financial Services Ombudsman, work in the manner described above. While it may be the case that medical incidents are complex, involving matters of professional judgement and expertise, the same can be said of legal cases, complex financial dealings, child care cases, etc. The experience from other schemes in the UK and beyond is that efficiency, accuracy, and low cost are more likely to result from the use of specialist investigators with experience in the sorts of issues involved than subject matter experts with limited investigative skills.

Speed in responsiveness is a vital element of success. Research into the views of service users has repeatedly emphasized the importance of early resolution of their issues, and if this is true of service users generally, it is certainly true of the families of damaged babies. In addition, it is vital that investigations are undertaken and completed quickly in order to enable families to access support quickly, to secure evidence and interview participants while memories are fresh, and in order quickly to identify the necessary learning in order to forestall possible repetition of mistakes elsewhere.

These features are not necessarily in tune with the assumptions in the consultation and would be a challenge for a scheme sited in the NHSR. The timescales for decisions hinted at in the consultation are extremely lengthy — far lengthier than in any other such body (ombudsman cases are usually completed in a matter of weeks, with even the most complex cases lasting no longer than nine months) — and would force families to wait for a decision nearly as long as they do now. This is simply unnecessary and would seriously undermine confidence.

The consultation proposals also risk failing to deliver on the principle of simplicity. There is, for example, a proposal that families will be legally represented, hinting at a continued commitment to an adversarial rather than inquisitorial style of operation (which would perhaps be inevitable in a legalistic culture such as the NHSR). It is, however, worth noting that the senior judiciary is increasingly encouraging the use of inquisitorial rather than adversarial techniques, particularly in its tribunal system, and has explicitly endorsed the unrepresented, inquisitorial approach of UK ombudsman schemes. The use of panels in decision-making is also problematic; the contrast in efficiency and cost between the Legal Ombudsman in England and Wales, which uses single decision-makers, and the Scottish Legal Complaints Commission, where a panel is used, is striking.

Minimizing institutional overlaps

One of the risks of the consultation proposals is that there is a lack of clarity about responsibility and a significant danger of overlap between different institutions. For example, it is not clear from the proposals how the investigation to be undertaken by the Rapid Resolution and Redress (RRR) Scheme relates to the local investigations undertaken by the Trust involved in the original incident. The notification system recently introduced by the NHSR also cuts across the Each Baby Counts notification process, which appears to be working well, and further confuses the line of responsibility for liaison with the family.

These overlaps also risk significant cost inefficiencies. The panel envisaged for the RRR investigation reflects the normal practice of local panel investigations, with the inevitable duplication of cost. Far simpler and cheaper would be to have the single independent investigator undertaking the RRR investigation embedded in the local team, providing specialist investigation expertise and external, independent scrutiny. The cost and confusion created by the NHSR Early Notification process (which envisages a substantial number of additional NHSR staff) could be avoided by continuing to use the Each Baby Counts process as the notification system and giving the RRR Scheme the responsibility for any necessary family liaison.

Interestingly, NHSR themselves have indicated that they have no empirical evidence that a litigation agency is able to drive harm reduction. Despite this lack of evidence, they have taken the decision to introduce their Early Notification Scheme. NHSR's Early Notification Scheme requires that NHSR is notified of all 684 incidents which meet the Each Baby Counts Criteria. They then investigate them. The proposed RRR Scheme will investigate these cases and is supported by empirical evidence that ADR schemes can drive harm reduction. Assuming that 90 per cent of eligible cases will be resolved by RRR, then NHSR will litigate around a dozen cases a year. Running the Early Notification Scheme for the sake of a dozen litigated cases per year seems hugely inefficient and costly. Removing NHSR's Early Notification Scheme would produce significant cost savings over the current proposals.

Dissemination of learning

One of the key intentions of the scheme is to reduce the number of birth injuries by improving the dissemination of learning via the scheme. There is substantial evidence from other countries of schemes achieving that aim in relation to medical incidents, and within the UK in relation to other disciplines. However, while the track record of ombudsman schemes driving improvements in practice is very positive, we are not aware of any example of a scheme based in a litigation authority having achieved such an objective.

Given the role and skills of the NHSR, it would therefore be surprising if it were to prove immediately successful in driving improvements in practice in this way. It has neither the networks nor established credibility to do so. Far better would be to build upon the existing quality improvement influencers, such as the Royal Colleges, who are already active in this area, and use the scheme to feed to them real case examples and a stream of research and analysis emanating from the work they are undertaking. That is the model used by actors in existing public and private sector schemes, who are experienced in undertaking such analysis and developing partnerships with behavioural or standards influencers such as regulators, professional bodies, and training agencies.

In practice, as suggested above, investigations could be undertaken jointly by the RRR investigator and the Trust's own local review team using the established Each Baby Counts framework. In this way, the local team could provide context within the local area and local ownership, and the RRR investigator could provide expertise in investigations, independent credibility, and wider knowledge of similar cases elsewhere. Support and expertise could be provided via the Royal Colleges, who would ensure that the learning from the investigations was more broadly disseminated and the results were fed into the Each Baby Counts process.

Potential appeal to scheme users

As a voluntary scheme, RRR has to be more attractive to potential scheme users than the alternative available to them of litigation. International examples show that this can be achieved, for example, in Sweden there is a voluntary patient injury scheme which is widely used, and litigation for patient injuries is very rare. However, to achieve this the RRR Scheme must offer potential users an equivalent or better product.

The consultation proposes reducing by one year the average time from incident to compensation, yet the process is still a matter of years rather than months. It is claimed this length of time is required to enable causation and extent of injury to be settled. International examples, however, show that eligibility into a birth injury compensation scheme or into a patient injury scheme can indeed be determined in a matter of months. An ombudsman model would enable a quick determination of avoidability, within six months for the vast majority of cases, and redress could then be determined when the extent of the injury, and hence the need for compensation, became apparent. This would mean families would have the security of the knowledge that they would receive compensation from an early stage. Under the consultation plans, a child would not even be eligible to be considered for entitlement to redress until at least eighteen months-old. Given families may well have costs, for example, loss of income due to giving up work to care for the child, it is questionable whether they

would want to wait for a year and a half, uncertain as to whether they will or will not be eligible for any financial redress.

The consultation RRR Scheme does not make any provision for children who die, either during birth or in the eighteen months afterward. This is clearly at odds with the litigation position, whereby if a family can demonstrate negligence they will be able to claim compensation.

The decision to cap the compensation offered at 90 per cent of the value that a court would award has caused considerable controversy. However, we consider that the care provided is more important to families than the value of the award. The Law Reform (Personal Injuries) Act 1948 obliges courts to award the value of private healthcare even if the claimant then goes on to use the NHS for free. Healthcare is a substantial portion of the settlements for brain injuries, so there is scope to make a saving without impacting upon care. Additionally, the RRR Scheme will have many members, so in instances that a court order has to provide sufficient funds to enable an individual to purchase care, RRR will have the advantage of economies of scale. What is not clear from the consultation is whether the 90 per cent cap proposed in the consultation would have an impact upon the care an individual receives. Further clarification of this from the DoH would be welcome.

Business process

On the basis of the above, the proposal is for the scheme to be run by a separate body, headed by an ombudsman and reporting via an independent Board to the DoH. The business process to be followed would be as follows:

- ***Notification*** — incidents would be notified to the scheme via the Each Baby Counts process. There would be no necessity for early notification to NHSR, avoiding the costs involved in that scheme. However, NHSR would be informed of the incident.
- ***Investigation*** — investigations would begin as early as possible, ideally within a month of the incident. The investigation would be undertaken jointly by the local Trust team and a specialist scheme investigator. The aim of that investigation would be to establish the factual chain of events and determine the extent to which the treatment of the birth was in accordance with the standards expected. The investigation would rely not only on witness evidence from those involved and medical records, but also on wider data about practice within the Trust generally. It is anticipated that this investigation would in most cases take no longer than three months.
- ***Family liaison*** — the responsibility for liaising with the family would be shared between the local Trust and the RRR Scheme, with the latter acting as a guarantor of independence in the event of any lack of trust on the part of the family following the incident. Thus, for example, the family could be allowed to give evidence direct to the RRR investigator if there were any nervousness about criticizing the Trust itself.
- ***Eligibility decision*** — once the factual part of the investigation had been completed, the investigator, taking into account (but not bound by) the views of the local Trust team, would prepare a report for the ombudsman on whether the care fell short of the standard expected and whether, therefore, the case was eligible for the redress part of the scheme. The report would also be considered in draft form, by the family and Trust who could, if they consider it necessary, make representations on its content (in the case of the Trust, the views of the NHSLA could be sought). Ombudsman would consider that report, calling for additional evidence if necessary, and then make an eligibility decision. A copy of that written decision would be sent to NHSR. It is anticipated that in most cases this decision would be made within six months of the incident occurring.
- ***Learning dissemination*** — once the factual investigation had been completed, the conclusions of the local team and the redress investigator would be made available to the local Trust and Royal Colleges using the Each Baby Counts framework. Those investigating such incidents may also choose to make recommendations for local (or even national) improvements in practice. Over time, the production of standardized outcome information would allow for a significant improvement in understanding and the standard of care.

- ***Redress quantification*** — in cases deemed eligible for redress, there would then be a further process to determine the impact of the incident on the baby (and wider family) and the necessary redress. In some cases, it may be that this process would be relatively easy and quick; in cases where care was substandard but there was no significant physical damage, for example, an apology could be ordered or a small element of compensation awarded to cover emotional distress and additional expense. However, in others, the process of impact and redress quantification would take some considerable time. Where harm was potentially substantive but difficult to quantify until the child was older, it may take some years to establish definitively what redress would be appropriate.

  Redress quantification would rely on medical and other evidence on the harm and disability caused. However, it would also be necessary to seek evidence about the level of support required and the availability (and cost) of that support. Quantification would be undertaken by a scheme investigation, liaising with the family and medical staff as necessary; however, it may also be necessary to seek expert evidence.
- ***Interim redress*** — in cases where it is clear that sizeable redress would be payable but some time must elapse before it is possible to determine the ultimate size of that redress, the scheme would have the power to make interim payments. In order for this to happen, there would be a process of asking the ombudsman to order that redress. As with other ombudsman decisions, that would require the collection of evidence, the submission of a written recommendation on the part of the investigator, the opportunity of the parties to comment on that recommendation, and a written, reasoned ombudsman decision.
- ***Final redress decision*** — once the investigator had completed the redress quantification, a written recommendation would be prepared for the ombudsman. A copy of that recommendation would be made available to the parties, including the NHSLA, and the ombudsman would take their comments into account in making the final determination. While that determination would normally focus on the financial element of the necessary redress, the ombudsman would also be able to include non-financial elements in the determination.
- ***Payment and care coordination*** — a proportion of the determined redress would be paid as a lump sum at an early point. However, the scheme would also be required to administer annual payments, based on a regular assessment of ongoing needs. Families would also be assigned a care manager to ensure that they were helped in picking their way through the local authority and health bureaucracy.

Delivery and cost

The above would be delivered by a dedicated, separate agency focusing only on the administration of the scheme. This is consistent with the way that such redress schemes operate in other areas of UK governance and builds on the success of similar redress schemes abroad.

The costings for the current proposals are, in some areas, difficult to understand and, in addition, there are activities (such as the Early Notification Scheme recently introduced by the NHSR) the costs for which are not public. It is nevertheless clear that the cost of the sort of scheme outlined above are substantially lower than would result from the current proposals.

The RRR consultation was prepared using provisional numbers from the Each Baby Counts programme. These have been subsequently updated.[5] For the purposes of these calculations, the new figures will be used.

The consultation proposes that only babies who fit the Each Baby Counts definition of Serious Brain Injury will be investigated, 729 children. The prognosis for these children is mixed; some die, some recover, and some survive with abnormal neurological function (see Appendix 1 for a detailed breakdown of outcomes for these children). Eligibility and numbers for the consultation scheme and the alternative scheme are detailed opposite.

Table 1: Number of eligible children

	2015	England (85.4% of total)
Reports to Each Baby Counts	1136	970
Intrapartum stillbirth	126	108
Early neonatal death (0–7 days)	156	133
Brain injury	854	729

Table 2: Alternative Scheme costings

	RRR Consultation		Maternity Review's Better Births	
	Investigate	Allowed to seek redress	Investigate	Allowed to seek redress
Intrapartum stillbirths (n =108)	No	No	Yes	Yes
Early neonatal deaths (n = 133)	No	No	Yes	Yes
Die between 7 days–18 months (n = 119)	Yes	No	Yes	Yes
Survive to 18 months abnormal neurology (n = 312)	Yes	Yes	Yes	Yes
Survive to 18 months normal neurology (n = 298)	Yes	No	Yes	No

See Appendix 2 for a detailed breakdown of the costs of the Alternative scheme proposed, with a brief synopsis below.

Avoidability assumptions

The consultation proposal assumed that of the 249 cases who survived to eighteen months with abnormal neurology, 162 would be judged to have an avoidable injury using the Experienced Specialist test. Thus, the consultation assumes that 65 per cent of the cases were avoidable. The consultation figure of 162 was based on analysis of rejected cases by lawyers, using an avoidable harm test. English lawyers do not use this test. It appears that the consultation supposes that 162 children a year will be eligible based on this assessment, rather than assuming that avoidable harm occurred in 65 per cent of cases. If this is the assumption, then an increase in investigations will not lead to an increase in compensation numbers. The increases from the new Each Baby Counts figures appear to suggest that 313 cases will be taken to stage 2, so if 162 of these are compensated then 51 per cent of cases are found to be avoidable.

This alternative proposal uses an avoidability figure of 76 per cent, which is substantially higher. This is taken directly from the Each Baby Counts assessments, which indicate that different care could have meant the baby had a different outcome.

These are not, therefore, directly comparable, since this alternative scheme assumes avoidability at the high end, where the consultation assumes it at the lower end.

For the purposes of modelling the additional compensation bill, this policy brief includes three avoidablility percentages:

- 40 per cent based on figures from the Swedish Compensation Scheme Löf;
- 65 per cent based on the initial consultation figure;
- 76 per cent based on the Each Baby Counts findings.

The other key difference is that the consultation scheme does not finally determine avoidability at the investigation stage; avoidability is re-examined and determined at stage 2 when a case is considered

for redress. Hence, in the 313 cases where a child is brain injured and survives to eighteen months, avoidability can only be considered in stage 2 after the child reaches eighteen months, and of these 313 children, only 162 will be compensated.

Under these proposals, avoidability will be determined during the investigation, and only eligible cases will go forward for a redress assessment.

Investigations

According to the latest figures, the RRR consultation assumes that there will be some 729 investigations a year, and 313 cases considered for compensation, of which 162 will result in compensation (see above). The current DoH proposals cost that at £15k per case (arriving, it seems, at a total cost of £11m p.a. on investigations). These costs appear to cover only the direct costs of investigative staff and administration of the investigations.

A figure of £15k per investigation is extremely high. With the exception of the Parliamentary Ombudsman, where the basic scheme model is very different, no significant ombudsman scheme spends more than £2k to complete an investigation. At the Legal Ombudsman, where some cases are extremely complex, case costs never exceeded £7k, and the average was £1.5k. The two largest schemes — the Financial Ombudsman and Ombudsman Services — have costs in the region of £400–600 per case.

The cost differential is partly the result of the fact that the cases envisaged will be far more complex than most routine ombudsman cases. However, in the main, the excessive costs are the result of an assumption of panel investigations, long case timescales, low case holdings, and panel decisions. The adoption of the business process suggested above, with single investigators working alongside local Trust teams to produce evidenced recommendations for consideration by an ombudsman, would produce substantial savings with no loss of quality.

Estimating the cost of such a process for determining eligibility depends on the following assumptions:

- single investigator;
- access to specialist advice as necessary; and
- three-month initial timeframe for eligibility/liability investigation.

On the basis that each investigator can manage a case holding of four to five current cases, completing on average one to two per month, eligibility decisions on 729 cases will require 54 investigators. Given the complexity of the work, it could be necessary to pay good quality investigators some £50k p.a., giving a total cost (including on-costs) of £3.4m p.a. for first-stage investigations.

Redress assessments

The position for quantification of redress is more complicated. Under the alternative scheme proposals, two redress streams are envisaged, one for support following the death of a baby and the other for ongoing support for a living child.

Redress following a bereavement is likely to be simpler to quantify, and may involve capped or fixed sums (see Appendix 2). As such, it is assumed that a redress assessor will be able to close three such cases a month. Assuming 76 per cent of cases are avoidable, then numbers indicate that there will be 273 such cases a year.

238 redress assessments for ongoing support will be undertaken each year. The timescale for decisions about the level of damage and compensation and/or care packages is more difficult to predict and may, in practice, vary from case to case. These factors necessarily impact upon the possible performance expectations for those quantifying redress. Nevertheless, it is reasonable to assume that redress assessors will close one ongoing support case per month.

Overall, this gives a requirement for 28 assessors. On the assumption of payment of £50k each p.a., that adds a further £1.75m to the investigation costs.

Decision-making

It is not clear from the existing proposals if the £15k per case includes the cost of avoidability decisions. If it does not, given the fact that panel decisions require the employment of more staff and take

much greater time than ombudsman decision-making, the additional costs will be considerable.

In relation to the cost of the alternative proposal, individual ombudsman decision-makers (@£85k pa) can aim to make three eligibility and one–two care/cost decisions per week; given a total of 1,481 decisions per year to be made (970+511), that means a total of 20 decision-makers (including a Lead Ombudsman @£125k p.a. and three Deputy Ombudsmen @£100k p.a). Adding the usual staffing on-costs (25%), direct decision-making staffing costs are therefore some £2.3m p.a.

Other costs

Included within the other costs for the alternative scheme is provision for a main office and four regional offices and all the associated back office costs, as well as provision for an independent Board (see Appendix 2). These 'other costs' total £4.6m p.a., and the IT costs are £480k p.a.

Total costs

Start-up costs of up to £2.9m are expected. The total annual running cost of this alternative scheme is estimated at **£12,243,500 per year**.

We understand that this is less than the £13m annual running cost of the scheme that was consulted upon, which ignores all stillbirths and early neonatal deaths, thereby missing the learning and potential harm reduction from these cases. Moreover, the consultation proposals will only compensate families who have ongoing needs from eighteen months onwards.

Were our model to be applied to the case numbers envisaged in the consultation, then the annual cost would be just under £9.5m. We would not endorse the use of this model with the consultation case numbers — one of the major flaws in the consultation proposals are the eligibility criteria — this is purely so a like-for-like cost comparison can be made.

There would be an additional compensation bill associated with the inclusion of stillbirths and early neonatal deaths, but this can be managed to protect against exposure to risk of unexpected spikes in payment (see Appendix 3 for details).

Ongoing family support/assessment/award management

One of the issues with calculating the cost of this part of the work is that each child will presumably have the right to a care manager and a regular reassessment throughout their life (although the consultation only has payment for twenty-one years). If this is the case, the number of staff required will increase inexorably as new cases are received, until the earliest cases begin to die out, when costs will reach some sort of equilibrium. The overall costs involved will therefore increase and the final costs will depend on the patient mortality rates.

It would be desirable for case managers and assessors to continue to sit as part of the scheme, separate from NHSR, in order to ensure that decisions about the quantum of compensation are made separately from the NHS, for both perceptual and governance reasons. It is difficult to estimate potential workloads.

The costings in the Impact Assessment of £998 p.a. on assessment and £2,600 p.a. on case management seem reasonable.

Twelve sessions of counselling p.a. at £122 per session seems reasonable. The cost of counselling is relatively insignificant (just under £1m in total for every Each Baby Counts–eligible family to receive a year's counselling). Given that there will inevitably be a delay between the event and a decision about whether it was avoidable or not, this proposal would recommend offering counselling to all parents who meet the Each Baby Counts eligibility criteria, irrespective of whether the incident was avoidable or not. That would enable the counselling to begin immediately and would help parents earlier in the process.

This scheme would not restrict the right to litigate. As the children concerned will have significant brain injuries they will never have capacity, so will never face limitation. There is no rationale for providing funding for legal advice. Families do not currently receive funding for legal advice, and the option to undertake litigation is not changed by these proposals. It is unclear why legal advice would be required. Under these proposals, an ombudsman would be created, and there is no other UK

ombudsman scheme under which legal representation is needed. For the purposes of these calculations, the provision for legal advice has been retained, clearly, if it were reconsidered and removed, a cost saving could be achieved.

An ombudsman-style scheme would provide a better more functional scheme for all participants, and could achieve considerable cost savings over the current proposals. This would allow for the inclusion of stillbirths and early neonatal deaths, which are essential for learning.

Notes

[1] https://www.gov.uk/government/consultations/rapid-resolution-and-redress-scheme-for-severe-birth-injury
[2] http://resolution.nhs.uk/
[3] https://www.rcog.org.uk/eachbabycounts
[4] https://uk.practicallaw.thomsonreuters.com/6-200-9152?transitionType=Default&contextData=(sc.Default)&firstPage=true&bhcp=1
[5] Royal College of Obstetricians and Gynaecologists. *Each Baby Counts: 2015 Summary Report*. London: RCOG, 2017.

The Foundation

The mission of the Foundation is to study, reflect on, and promote an understanding of the role that law plays in society. This is achieved by identifying and analysing issues of contemporary interest and importance. In doing so, it draws on the work of scholars and researchers, and aims to make its work easily accessible to practitioners and professionals, whether in government, business, or the law.

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