

Making Amends – Report of the Chief Medical Officer (CMO)

Response of the Legal Services Commission

The Commission welcomes the proposals put forward by the Chief Medical Officer and supports his aim of seeking to deal with patient concerns within the NHS so that litigation is seen as a last resort. Such an approach is very much in line with the statutory objectives of the Community Legal Service including the aim of achieving the swift and fair resolution of disputes without unnecessary or unduly protracted proceedings in court (Access to Justice Act 1999 Section 44C). This also supports the Government's broad objective of reducing the proportion of disputes which have to be resolved by recourse to the court (Department for Constitutional Affairs Public Service Agreement 3).

For similar reasons we strongly support the Chief Medical Officer's holistic approach to patients who are dissatisfied with NHS treatment. Systems of complaints and systems of claims against the NHS need to be integrated or at the very least closely aligned so that the needs of patients are effectively met.

We also support the CMO's desire to preserve access to the courts in cases which cannot be resolved in any other way. This is important because clinical negligence cases concern claims by an individual against the state. When designing systems of Redress, and the funding rules necessary to support them, the patient's right to a fair hearing under article 6 of ECHR must be fully taken into account.

The CMO's report does not however go into detail as to how his objectives will be achieved. The next stage of work will be to work out practical approaches to the issues raised in the report and to set up a pilot of the central recommendation of a Redress Scheme. We look forward to working with the Department of Health and Department for Constitutional Affairs at official level on the detailed issues. Meanwhile this consultation response serves to provide an update on the current role of CLS funding in relation to clinical

negligence cases and to comment on those aspects of the consultation paper where the Commission has particular experience or interest. This response will seek to cover the general issues raised in the proposals rather than being restricted to responding only to the detailed questions in the consultation paper.

1. Current Role of CLS Funding

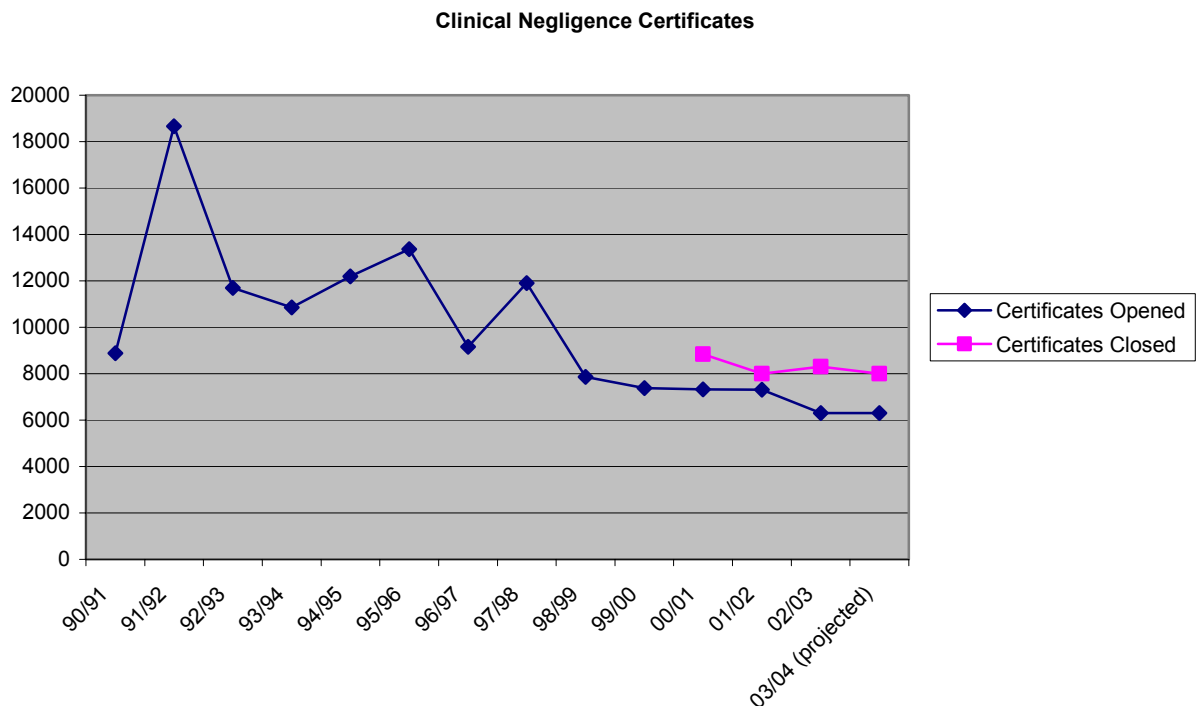
Legal Aid Reforms

- 1.1 There have been fundamental reforms of the system for public funding of clinical negligence claims in recent years. Many of the key changes are listed on page 94 of the CMO's report, the most crucial being the restriction of clinical negligence claims to specialist firms combined with tougher criteria and guidance on the merits of funded cases. As is clear from the figures below these reforms have had a dramatic impact but because of the long lifespan of many clinical negligence claims the full impact of the 1999 reforms have yet to work through. For these reasons great care must be taken in drawing conclusions based on the current cost of clinical negligence claims to the NHS – the claims now being settled are ones which were pursued and funded up to 5 or 10 years previously. The volume of new claims being started against the NHS is therefore a far better indicator of the current system than figures for concluded cases.

Volumes

- 1.2 Legal aid has always been the dominant funding mechanism for clinical negligence claims. We believe from our discussions with leading insurers, the NHS Litigation Authority and others that the number of claims being brought against the NHS under conditional fee agreements, whilst increasing, represents only a small proportion of the total volume of claims, probably fewer than 1000 per year. Therefore the volume of new legal aid certificates issued each year is a good indicator of the level of activity. The following graph illustrates the volume of new certificates issued over the last 14 years and the volume of legal aid certificates closed over the last 4 financial years.

1.3 The volume of closed cases is illustrative only as for certain older cases clinical negligence certificates were not separately recorded from other personal injury cases. The volume of concluded cases may therefore be higher than shown but will inevitably over time fall in line with the volume of new cases. The projected volume of new certificates for 2003-04 is an extrapolation based on the first four months of the year.



1.4 These volumes show that there is no case for reform of the clinical negligence system based upon a perception that the current system is out of control or is driven by a growing “compensation culture” against the NHS. The current system is in control even though the total cost to the NHS is significant. The CMO’s proposals therefore need to be considered on their own merits under a test of whether they will lead to more effective remedies for clients and whether the overall cost to public funds is justifiable, rather than be driven by specific concerns about litigation or legal aid.

Outcomes

1.5 The outcome of legal aid cases for clinical negligence has always been a contentious area because figures for the overall success rate of legal aid certificates do not take into account the two separate roles of legal aid in this area. Firstly legal aid serves to investigate cases to find out whether they are worth pursuing and secondly legal aid funds the active litigation of those which are. Outcome information of legal aid cases is set out at page 68 of the CMO's report. These figures are repeated here including the latest figures for 2002-03.

Success rates of legally aided cases

Year	Cases proceeding beyond investigative stage (%)	Success rate in litigation of those proceeding beyond investigation (%)	Success rate of all cases granted legal aid (%)
1996/97	49	46	23
1999/00	40	61	24
2000/01	41	57	24
2001/02	47	57	27
2002/03	45	60	27

1.6 In April 2003 we introduced new improved outcome reporting codes. The initial figures for the first part of 2003/04 indicate that outcomes are continuing to slowly improve. Just under 50% of cases proceeded beyond initial investigation of which 64% were successful (32% of all certificates). The new codes also give us far more detailed outcome information recording:

- The stage a case reached e.g. before or after issue of proceedings, or at trial.
- What brought the case to an end e.g. settlement or court determination.
- What was achieved for the client e.g. damages or an explanation or apology.

We will be happy to provide detailed breakdowns of any of this information, some of which might be useful when considering the parameters of the Redress Scheme.

- 1.7 The generally improving success rate of legal aid cases is confirmed by figures from the NHSLA database for 1995-2002, which are quoted in the CMO's report, and show that claimants recovered damages in 63% of concluded cases and were successful in 78% of contested trials (although this figure includes a number of cases in which only quantum was in issue).
- 1.8 Our Special Cases Unit has been monitoring firm outcomes and encouraging more effective screening of cases by those firms with April outcome records. This has in turn led to an overall decrease in the number of legal aid certificates in particular from 7308 in 2001/02 to 6307 in 2002/03. Insofar as that decrease is due to improved screening it is likely that the overall success rate of new legal aid cases being funded will continue to improve steadily.
- 1.9 Our Special Cases Unit has also conducted a detailed survey of clinical negligence suppliers for the period 1999 to 2001. This included looking not just at success rates but also at the proportion of costs recovered from the NHS in successful cases compared to those ultimately

payable from the fund. Recovery rates varied considerably between firms, the average being a recovery of 63% costs from the NHS and 37% from the fund.

- 1.10 The combined effect of these various sources of outcomes data suggests that it is no longer accurate to portray the existing clinical negligence litigation system as one which supports hopeless cases or which benefits lawyers more than clients. Indeed net legal aid payments represent only 5% of the total cost to public funds of clinical negligence.

Old Cases

- 1.11 Another of the major concerns with the present system is the time taken to conclude cases. This was highlighted in particular by the National Audit Office in their report 'Handling Clinical Negligence Claims in England' (NC 403 Session 2000-01 : 3 May 2001). Our Special Cases Unit has been co-operating closely with the NHS Litigation Authority (NHSLA) with a view to identifying and bringing these old cases to a conclusion.

2. Complaints and Claims

- 2.1 It is helpful to consider the interface between the Complaints Scheme and claims before considering how a Redress Scheme might work. This interface must now be looked at in the light of the proposed reforms of the NHS Complaints Procedure as set out in the "Making things Right" report (Department of Health, February 2003). These reforms should make the complaints system more effective and independent under the supervision of the Commission for Healthcare Audit and Inspection (CHAI).

- 2.2 If one compares the aims of the improved complaints system with the aims of the CMO's proposed Redress Scheme there is much common ground. Both systems promise thorough investigation of the matter complained of, a full explanation from the healthcare provider as to what happened and, if appropriate, an apology. Presumably a possible outcome of the complaints system may be to ensure that the patient's needs for future care will be properly dealt with within the NHS. Therefore the only fundamental difference between the ambit of the complaints scheme and the Redress Scheme is the ability of the Redress Scheme to award financial compensation.
- 2.3 A dissatisfied patient is almost certainly not in a position to know whether he or she has a legitimate legal claim for compensation at the outset, so it is surely inappropriate to require such a patient to choose at the outset whether to be a "complainant" or a "claimant". This suggests that rather than the two systems merely being "closely aligned" as recommended by the CMO the two systems need to some extent to be integrated and seen as part of one overall system for responding to the needs of dissatisfied patients. We support the work of the Clinical Disputes Forum and others who have advocated reforms along those lines.
- 2.4 The logic of these reforms suggests that the complaints system could be the universal first stage or gateway into any other dispute resolution systems such as Redress. It is however probably unrealistic to consider one single integrated system under which compensation is routinely awarded as part of the resolution of a complaint. Presumably neither local trusts nor CHAI have the necessary facilities or controls to administer such a scheme. Nevertheless would it not be feasible to take the procedures of the complaints scheme and build in appropriate links and referral points into Redress? One approach would be to expect patients to complete the complaints process and then refer cases to Redress either if the patient was still dissatisfied and wanted compensation or if the trust or CHAI thought it appropriate. An

alternative approach which might allow for compensation to be considered more speedily would be to be able to refer a complaint at any stage to the body administering the Redress Scheme. This approach would however involve the same case being considered in two parallel procedures which might cause duplication of effort or misunderstanding. The merits of these different approaches could perhaps be further considered in any pilot scheme.

- 2.5 A co-ordinated approach between complaints and claims would inevitably place some burdens on the bodies dealing with complaints. Local trusts and CHAI would need to be alive to the option of referring patients into Redress. It would be important for CHAI to ensure that patients requiring additional care within the NHS are properly dealt with within the complaints system to avoid the need for the patient to go through Redress separately. We understand that the complaints system will be supported by an Independent Complaints Advocacy Service (ICAS) supervised by the Commission for Patient and Public Involvement in Health (CPPIH). In setting standards for ICAS CPPIH would presumably need to ensure that the support given to patients included identifying when referral to the Redress Scheme would be appropriate.
- 2.6 It follows from the above discussion that recommendation 8 in the CMO's report – namely that the rule in the current NHS complaints procedure requiring a complaint to be halted pending resolution of a claim should be removed – is strongly supported. This rule is an absurdity in the current reform programme and has the effect of pushing complainants towards litigation against the NHS. This change should be made as matter of urgency regardless of the other reforms of the complaints system or the form of any Redress Scheme.
- 2.7 We intend to consult in November 2003 about the future funding of clinical negligence claims in light of the CMO's proposals. We propose to consult on whether in the context of funding claims we should

encourage all potential claimants to first pursue the NHS complaints system before deciding whether to bring a claim. Our current Funding Code Criteria contain a presumption that for cases likely to be worth under £10,000 the complaints scheme should be pursued before litigation is considered. We will consult on making this the approach for all types of claim, whilst also inviting the views of consultees on whether there are particular categories of case which should be an exception to this general approach. We would suggest timing such a legal aid reform to coincide either with the setting up of the new complaints system and CHAI or with the implementation of recommendation 8 of the CMO, whichever comes first.

3. The NHS Redress Scheme

3.1 If a Redress Scheme can be designed which provides effective remedies for the patient within the NHS we would strongly support it. However we find it difficult to respond to the specific questions asked in the consultation without understanding more clearly how such a scheme might work in practice. There are perhaps two alternative approaches which could be considered:

- (i) The legal model. The RESOLVE pilot scheme demonstrated that it was possible to have effective fast track processes for resolving smaller clinical negligence cases. One approach to a Redress Scheme would be to take some of the processes in the RESOLVE pilot but operate the scheme in house thus saving the substantial process costs of an intermediary organisation administering the system. Although it did not involve the courts, the RESOLVE pilot was still a legal process in which claimant lawyers had a key role in investigating and pursuing claims on behalf of the patient.

(ii) The non legal model. Although the CMO refers to building on the experience of existing pilots such as RESOLVE, the proposals for a Redress Scheme only talk of the patient receiving legal advice at the point when Redress has already come up with a compensation settlement proposal. It seems implicit in the CMO's proposals that the Redress Scheme is seen as a "lawyer free zone". If claimant lawyers do not have a role in pursuing a claim through Redress then the body responsible for running Redress will need to take on a controversial new responsibility for championing the cause of patients seeking compensation from the NHS itself. Whether it is possible at all for a body which is internal to the NHS to carry out that role would need to be tested in the pilot.

3.2 Before setting up a Redress pilot it will be necessary to look in detail at all the steps which would normally be taken by a claimant lawyer both in a traditional litigation model and in a fast track system such as RESOLVE. This role involves the tasks of identifying the patient's problems and filtering out cases where there is no potential claim, obtaining medical records, instructing an independent expert, correspondence with such an expert and negotiation with the NHS Litigation Authority.

3.3 For each step it is necessary to ask whether the step is necessary in resolving whether the client may be entitled to compensation and if so whether it is feasible for this task to be carried out by a person who is not fully independent of the NHS.

3.4 The proposed Redress Scheme, if it extends to cases worth up to £30,000, would cover a huge range of claims. It should not be assumed that the same process is appropriate for the full range. On further analysis and piloting it might be the case that an informal non-legal process is appropriate for smaller claims, say those with a traditional valuation not exceeding £10,000, but for larger cases a more

legal process is needed involving claimant lawyers. If so a remuneration system needs to be devised for such claimant lawyers which could either be on a no win no fee basis but with fixed fees (as was set up for the RESOLVE pilot) or by setting up a new limited form of legal aid to provide the support necessary for cases going through the Redress system. For cases where only advice is needed, the Legal Help Scheme could be used.

The Test for Compensation

3.5 We broadly support the criteria for payment set out at page 120 of the CMO's report. However we assume the aim of these criteria is to have a more informal test than the "Bolam" test which is not intended to be more restrictive than the Bolam test in any significant way. The criterion that the adverse outcome must not be "the result of the natural progression of the illness" is open to misinterpretation. Cases of misdiagnosis, one of the most common types of clinical negligence, frequently involve the patient suffering from the natural progression of the illness but in circumstances where that suffering could have been avoided if proper diagnosis and treatment had taken place. To make it clear that such cases come within the test we suggest that the test be amended to read: " ... the result of the natural and unavoidable progression of the illness."

3.6 Whilst supporting an informal test of this type at least for the purposes of any pilot scheme (we do not understand why primary legislation would be necessary to apply this test in a limited pilot scheme) we do question whether the new test will have any significant impact. It seems unlikely that the NHS would ever wish to say in effect:

"You have suffered from serious shortcomings in the standards of care and suffered harm which could have been avoided but I have found a responsible body of medical opinion which states that this sub-standard care is acceptable, therefore you will not be compensated"!

- 3.7 We suggest that one of the aims of the pilot should be to analyse whether there are any cases which would receive compensation under the proposed new test which would not have received compensation under Bolam. In practice the difference may be the extent to which the compensating authority seeks to research whether there exist different schools of thought which might condone a particular practice rather than taking a single opinion and compensating if the opinion suggests sub-standard care.

Minimum Levels of Compensation

- 3.8 We regard this as a far more important issue than the question of where the upper level of compensation should be set. The RESOLVE pilot contained no lower damages limit and as a result was swamped with a large number of very small claims, predominantly those who would not have received legal aid to pursue compensation.
- 3.9 Studies by our Research Unit into the range of damages in clinical negligence cases suggest that very large damages claims are a small proportion of the total of potential claims. In a study of clinical negligence cases funded under the Legal Aid Act 1988 whilst the average level of damages was £33,000 the median level was just £6,500, a large proportion of cases recovering damages under £5,000 (see Testing the Code, LAB Research Unit, October 1999).
- 3.10 Most potential clinical negligence claims with a value of under £5,000 are not brought under the current system as legal aid is not generally available to investigate them. If the Redress Scheme is available to provide small amounts of compensation there are likely to be many thousands of additional claims which would not otherwise have been brought. Typical examples would be where as a result of misdiagnosis or wrong treatment the patient was left in temporary pain and discomfort but suffered no long term effects.

3.11 We therefore believe that if no minimum damages level is set the volume of claims and total cost to the NHS will increase substantially through the introduction of a Redress Scheme. If this is to be avoided a minimum level must be set. This could be set according to the seriousness of the injury, for example injuries which would keep a person off work for at least two weeks, but such a test is likely to lead to much argument over its interpretation. A more objective test would be whether a claim, valued according to the traditional principles, would be worth at least a certain amount. We suggest this should be set at £5,000 if the aim is not to greatly increase the number of claims brought.

The Upper Limit of Compensation

3.12 We do not know the basis on which the £30,000 limit was suggested. We have already suggested at paragraph 3.4 above that if the Redress Scheme is to cover such a wide range of cases different systems and different degrees of investigation will be needed for the more serious cases.

3.13 For the purposes of the pilot it might be appropriate to start with a lower level of compensation, say £15,000 as in the RESOLVE pilot, but to extend it if the Redress mechanisms are working well. Since it appears central to the Redress system that a primary element of any package will be remedial care within the NHS and that compensation will only be given in relation to pain and suffering and care not provided by the NHS, a case which is entitled to £30,000 under Redress may well be entitled to a much higher sum under traditional litigation. There needs to be clarity as to whether any threshold is set according to the amount of compensation which can be paid under Redress or according to the level of damages under the traditional model. Alternatively a threshold could be set in light of the severity of consequences of the injury e.g.

whether a case involved loss of a limb or caused the patient to be off work for more than a year.

Primary Care

3.14 The CMO's proposal is that the Redress Scheme be piloted before its implementation. We suggest that a pilot should start with trusts and hospitals and any decision to extend to primary care should be taken only after significant experience of the pilot. In principle however if the pilot works well the Redress system ought to be applicable to primary care GPs.

Availability of Legal Advice

3.15 It is essential that patients have access to legal advice before accepting a Redress package. Access to such advice should reduce the chance of subsequent litigation if the patient claims to have been misled into signing away the right to litigate.

3.16 If the Redress package is accepted after the client has received advice no doubt the costs of such advice would be met by the NHS. However in cases where the package was not accepted it is less clear whether the NHS should pay. Such cases might subsequently proceed to litigation backed by legal aid if the merits justify this.

3.17 We suggest that advice on the desirability of the Redress package is dealt with through the legal aid scheme so that the advice is provided by franchised expert practitioners. This could perhaps most appropriately be provided under the Legal Help scheme. Payment for such advice could be on a fixed fee basis the level of which should be set only following experience of the pilot.

3.18 We have already explained at paragraph 3.4 above that a more important issue than the availability of legal advice on acceptance of a

package is whether legal advice is necessary throughout the process leading up to any offer being made. We have already made clear that in our view such advice is likely to be needed at least for the most serious claims. The Legal Help Scheme might be the most appropriate vehicle to fund such advice.

Impact of Redress on Legal Aid Availability

3.19 Leaving aside the question of whether some form of legal aid might be necessary to support cases going through the Redress Scheme, the existence of Redress would clearly have an important impact on the availability of legal aid for litigation. It is fundamental to the Community Legal Service that funding should only be provided for litigation where there are no other effective remedies available to the client. The impact would be:

- (i) If legal aid is applied for by a patient who has not pursued the Redress option there would be a strong presumption that legal aid should be refused. Assuming that the Redress Scheme has proved itself to be an effective system which offers remedies which are broadly comparable to those which could be obtained from litigation, legal aid would almost inevitably be refused unless the patient could show that their case fell outside the ambit of the Redress Scheme.

- (ii) In cases where the client had been offered a package under Redress but had not accepted this and wished to litigate the existence of the offer would be highly relevant to any subsequent legal aid application. In those circumstances we would wish to apply a private client test i.e. would a reasonable private paying client proceed to litigate rather than accept the Redress offer? If the answer is no then legal aid would be refused. It is important that an offer from Redress should be kept open at least long enough for the client to take advice and

for the application for legal aid to be determined one way or the other.

- (iii) In cases where the client had pursued compensation through Redress but had been declined any compensation, it would of course be open to the patient to apply for legal aid. However in deciding whether funding was justified we would need to take into account the detailed reasons why compensation was not offered under the Redress Scheme. It will be up to the applicant and his or her solicitors to persuade us that there was merit in litigating despite the refusal of Redress.

3.20 For this approach to work it is essential that the Redress Scheme should produce clear written reasons for all final decisions under the Scheme, whether to offer some compensation or to refuse. Such decision letters would have to be disclosed in support of any subsequent application for legal aid.

3.21 The real impact of Redress on legal aid availability would depend on how effective the Redress Scheme was in practice at delivering remedies which were comparable to those which could be achieved in litigation. If Redress produced offers which were markedly lower than a client would obtain through the litigation route it would be difficult to refuse a subsequent application for funding to litigate. Similarly if a client had been rejected from Redress in a pro forma fashion which did not give clear reasons as to why there was no basis for compensation there might similarly be a strong case for providing funding if the claim appeared to have merit.

3.22 Our existing Funding Code Criteria allow for legal aid to be refused if there are reasonable alternatives to litigation (Funding Code Criterion 5.4.3). For the purpose of a Redress pilot we could use this criterion if it were necessary to withhold legal aid for cases which were proceeding through the pilot. However in the longer term we would

wish to amend the Funding Code to add a specific criterion allowing clinical negligence applications to be refused if the clients had not pursued the Redress option. This criterion would be discretionary but we would in practice operate a firm presumption in favour of Redress as explained above.

Further Issues for a Redress Pilot

- 3.23 A key issue is how cases would be selected for any pilot. In the RESOLVE pilot cases were self-selected by claimant solicitors who not surprisingly predominantly put forward low value cases which would be attractive for the firms operating under a fixed fee basis. If the Redress pilot is entirely voluntary it is inevitable that clients and solicitors will choose to put forward cases which seem advantageous to the Redress pilot. The pilot in those circumstances would not be a useful test of whether Redress could deal with the full spread of cases on a national basis.
- 3.24 A pilot scheme is therefore more likely to be useful if it is compulsory for some description of cases. The pilot can be defined either in geographical terms or by reference to particular hospitals or trusts selected to give a representative sample of different types of clinical negligence case. We do however suggest that once the parameters are chosen, all cases which fall within those parameters should proceed through the Redress pilot. Clients chosen for the pilot would of course not be disadvantaged because the litigation option would remain available if Redress did not produce a satisfactory outcome for them.
- 3.25 To assist in this process and make the pilot effective it is likely to be necessary to prevent cases within the parameters of the pilot from pursuing a litigation route. Legal aid would therefore be refused in such cases using Funding Code Criterion 5.4.3 referred to above.

4. The Redress Scheme for Birth Injuries

4.1 Many of our comments in relation to the Redress Scheme for claims up to £30,000 are also relevant to the proposed no fault scheme for birth injuries. However the birth injuries scheme raises wider issues of policy. Babies born with severe neurological impairment will be either:

- (i) Able to demonstrate their condition was caused by negligence at birth, or
- (ii) Able to show that their condition related to or resulted from birth but cannot show negligence, or
- (iii) Unable to relate the condition to birth, typically because it is due to a genetic or chromosomal abnormality.

4.2 Under the present system those within category 1 receive very substantial compensation whilst categories 2 and 3 receive nothing. Under the CMO's proposals whilst category 3 would still receive nothing those within categories 1 and 2 would be eligible to apply for compensation and care packages under the Redress Scheme with strict limits on the size of the reward. Since the CMO is not proposing that anyone would be deprived of their right to go to court those in category 1 who are likely to be able to prove negligence and recover much higher damages are very unlikely to accept the capped Redress package. The proposals could not be described as cost neutral as there would be substantial increased payments for the NHS in relation to category 2 cases and no comparable savings in relation to category 1. In fact the only scope for saving would be the limited number of cases which are prepared to settle for the Redress Scheme but which would otherwise have gone on to recover higher damages through the courts.

- 4.3 The proposals therefore appear likely to produce substantial increased costs to the NHS. The only way to avoid this would be to deprive cases in category 1 of their right to go to court and operate the Redress panel as a form of tribunal system with capped maximum awards so that the money available is spread over a wider pool of claimants. We express no particular preference as between these options.

Availability of Legal Advice

- 4.4 As with the first Redress Scheme the consultation paper only asks whether independent legal advice should be available to help the client decide whether to accept a Redress offer. Clearly such advice should be available but a more important question is what form of support the patient needs in relation to the work leading up to such an offer being made. Even if it will not be necessary to prove negligence under the Bolam test these cases will raise very difficult issues of causation and otherwise demonstrating entitlement under the scheme. Indeed causation issues are perhaps the most complex issues tackled within clinical negligence litigation. A great deal of work may therefore be necessary before a case even gets to the independent panel. Ideally this can be carried out internally by the successor body to the NHSLA but there remains a question mark whether this in itself will be sufficient to ensure that the patient's interests are protected or whether some form of independent support is needed in the process. This could take the form either of advice from bodies such as AVMA or in the more complex cases could involve independent legal representation within the system either funded under a fixed fee scheme as part of the Redress system or through some new limited form of legal aid. One of the important aims for the pilot should be to test whether such a degree of independent support is needed for patients going through the system and if so how it should be administered and funded.

- 4.5 As with the first Redress Scheme we suggest that for any pilot the existing Legal Help Scheme is used to provide advice on whether a

Redress offer should be accepted. However for serious birth related injuries it is of course more likely that more significant work would be needed before the client could be properly advised and therefore there would be a stronger case for extending the initial £500 cost limit on Legal Help in appropriate cases.

The Interface with Litigation

4.6 Unless the radical option of a tribunal system is adopted patients will retain the right to go to court. However we assume that if a patient goes to court but is unsuccessful they will not necessarily be able to go back and claim compensation through the Redress Scheme. Presumably an offer made under the Redress Scheme will only be kept open for a limited period. It is important that such an offer is kept open long enough for the patient to be properly advised as to whether it is an appropriate and reasonable offer. Indeed if the patient does not wish to accept the offer and wishes to apply for legal aid to fund litigation it is important that the offer is kept open at least until the final decision on funding is made so that if legal aid is finally refused the patient would still be able to accept that offer.

4.7 Even though the right to go to court will remain we do see merit in the proposal that all cases concerning birth injuries should first be considered under the Redress Scheme and should not be able to proceed straight to litigation. This would allow the merits of their case to be considered in a non-adversarial manner through the Redress Scheme. The advantage of the Redress Scheme being administered by the successor body to the NHSLA is that that body whilst considering eligibility under the Redress Scheme could also form a preliminary view as to the merit of the case if it proceeded to litigation. In this way if the offer under the Redress Scheme were not accepted the NHSLA might be in a position to make an early offer of settlement to avoid litigation in a deserving case. This could potentially

significantly reduce the legal costs burden on the NHS compared to the present system.

- 4.8 Where a patient rejects a Redress offer it is essential that the deliberations of the expert panel leading to the offer and the patient's reasons for not wishing to accept it should be disclosed to the Legal Services Commission in any subsequent application for funding. The deliberations of the panel should also be disclosed within any subsequent court proceedings though of course the panel's views would not be binding on either party.

5. The NHS Litigation Authority

- 5.1 We agree that the Redress Scheme should be administered by a reformed NHS Litigation Authority. Indeed there are advantages in the same body dealing with both the Redress Schemes and litigation. This will allow cases which are not finally dealt with under Redress to be identified at an early stage so that in appropriate cases early settlement offers can be made to avoid litigation.
- 5.2 The main concern over the role of the NHSLA is its lack of independence from the NHS. There is clearly a potential conflict between protecting the NHS's position and ensuring that compensation is paid in all appropriate cases. Our concern however is not so much with the appearance of conflict or lack of independence but rather with the practical question as to whether the Redress Scheme will be effective so as to offer a reasonable alternative to litigation. One of the main purposes of the proposed pilot of Redress will be to see whether this role can be performed effectively by the NHSLA.
- 5.3 Any perceived problems of lack of independence would be minimised if other mechanisms existed to support clients going through the Redress process. We have already suggested above that in more complex

cases going through Redress some form of legal support may be necessary, for example in identifying and securing independent medical evidence where there are difficult issues of causation.

- 5.4 Although the NHSLA should be responsible for the Redress Schemes as a whole this should not preclude devolving some decision making to local trusts. Particularly for cases likely to receive compensation of under £10,000 there is much to be said for dealing with the cases at the local level. In such cases formal legal representation may not be necessary but support would be needed for the patient either through an appropriately trained Independent Complaints Advocacy Service or through the services of AVMA.

Repeal of Section 2(4)

- 5.5 This is not primarily a matter for the Commission. We do see the strong policy arguments in favour of repeal of the section so that issues of future care can be dealt with within the NHS. However there may be problems if the section is repealed only in respect of claims against the NHS. This would appear to give victims fewer remedies in relation to harm caused by the NHS than for any other tortfeasors. Consideration may therefore need to be given to repealing section 2(4) for all categories of case.

Mediation

- 5.6 We strongly support wider use of mediation to resolve clinical negligence disputes. Our new outcome recording systems which have been in place since April 2003 indicate that the use of mediation is still extremely limited. Of the 2446 clinical negligence cases concluded since the new codes came into operation the outcomes reported to us by claimant solicitors are as follows:

	Number
ADR not considered appropriate or proposed	2362
Claimant proposed but NHS declined	9
NHS proposed but claimant declined	0
Both sides agreed to ADR but case concluded without its use	39
Case resolved through mediation	11
Mediation took place and narrowed the issues	4
Mediation took place but did not significantly assist	3
Case resolved through other ADR	3
Other ADR took place and narrowed the issue	4
Other ADR took place but did not assist	11

5.7 Therefore over 96% of clinical negligence cases were concluded with neither side even proposing mediation or other forms of ADR. However mediation was beneficial in 83% of the cases in which it took place. Some caution is needed in relation to any figures indicating which side is declining mediation. In contrast to the above figures, reports by defendant solicitors to the NHSLA appear to indicate that reluctance to mediate stems largely from claimant solicitors. Clearly there is a reluctance to mediate on both sides but whatever the reasons we believe that the current use of mediation does not reflect its potential role within the clinical negligence system.

5.8 We have included strong encouragement for mediation in our decision making guidance since April 2001. Experience to date suggests that encouragement is not enough. We therefore need to consult about introducing further degrees of compulsion to at least explore the

possibility of mediation or to set benchmarks for the proportion of cases we would expect our suppliers to mediate.

- 5.9 In support of this work we funded the first stage of the pilot project in co-operation with NHSLA, CEDR and AVMA to establish common standards for clinical negligence mediators. We hope that this project can proceed further with support from the Department of Health.

Control of Legal Costs

- 5.10 The legal costs referred to as a cause for concern within the CMO's report are the levels of costs paid to claimant lawyers in successful cases, which significantly exceed the costs of defending the claims. However such costs are not within the direct control of the Commission. Our role in clinical negligence is to act as banker providing ongoing payments on account and to act as insurer in providing limited payments in cases which are not successful. The rates we pay in unsuccessful cases are tightly controlled, typically limited to £70 per hour for solicitors. This approach creates a strong incentive for solicitors to pursue only meritorious cases.
- 5.11 Further in high cost cases the work and costs of claimant lawyers are controlled by our Special Cases Unit through case plans which identify and approve all the solicitor's work, counsel's fees and disbursements payable for each stage of an action.
- 5.12 We would however be happy to work further with the Department for Constitutional Affairs in any controls over the level of disbursements and the amount of hours which may reasonably be undertaken in clinical negligence cases. For example further encouragement of the use of single experts could be considered together with encouragement of split trials on liability and quantum so that in appropriate cases the extensive costs of quantum do not risk being wasted in cases which are unsuccessful on liability.

- 5.13 We would also support further work by the Department for Constitutional Affairs in controlling inter partes claimant costs provided that a clear differential remains between those inter partes costs and costs payable from the CLS fund.

Summary of Responses to Recommendations

1. **The Redress Scheme.** We support the aims of the proposal provided detailed procedures can be worked out which provide effective remedies for the patient. We suggest that different processes are likely to be needed for different categories of case and some form of independent legal support for the patient will be needed for the most serious cases proceeding through Redress.
2. **The Redress Scheme for birth injury.** We question the aims of the new scheme and the potential additional costs to the NHS. There are pros and cons of any more comprehensive reform which would replace the existing right to go to court with a fixed compensation tribunal system.
3. **The NHSLA.** We agree.
4. **Extending the Redress Scheme.** It might be appropriate to start the Redress Scheme at a level below £30,000 and gradually extend it as experience suggests this is justified. Only in the longer term should extension beyond the £30,000 limit be considered.
5. **The right to pursue litigation.** We agree this should remain but patients accepting a package under Redress would not subsequently be able to litigate for the same injury.
6. **Standard of care.** We have no comment.

7. **Individual responsibility for complaints and claims.** We support the proposal.
8. **Reform of the complaints procedures.** We strongly support the abolition of the current rule requiring that a complaint be halted pending resolution of a claim. However we have suggested that a far more comprehensive reform is needed to link up or integrate the system of complaints and Redress. We suggest that the complaints system should be the universal gateway for dissatisfied patients and that systems of Redress should be constructed as part of that overall system rather than as a separate parallel process.
9. **Improved training for NHS staff.** We support the proposal.
10. **Rehabilitation services.** We support the proposal.
11. **Improved support for neurologically impaired children.** We support the proposal.
12. **Duty of candour.** We approve of a duty of candour but have doubts as to whether it is appropriate to have a rigid rule exempting the profession from disciplinary action. A more discretionary approach may be needed.
13. **Restriction from disclosure in court of documents and information collected identifying adverse events.** We do have concerns about this proposal. Whilst we understand the intention our preference would be for all such documents to be disclosable. It is in any event important that all documents generated through a complaint or Redress should be disclosable to the Legal Services Commission in relation to any application for funding.

14. **Redress to be considered in legal aid decisions.** We strongly support this proposal. It is however essential that when the NHS declines to offer compensation under Redress a clear explanation in writing should be given for this which should be disclosed in a subsequent application for legal aid.
15. **Mediation should be seriously considered before litigation in the majority of claims.** We suggest this recommendation does not go far enough and that mediation should be considered in all potential litigation even if it is only actually used in a minority of cases. We support the creation of a specialist mediation panel and will consult further on whether some degree of compulsion is needed to ensure that an appropriate use of mediation is made.
16. **The presumption in favour of periodical payments.** We support this proposal.
17. **The costs of future care included in any award for clinical negligence made by the court should no longer reflect the costs of private treatment.** We support the proposed reform of section 2(4) of the Law Reform (Personal Injury) Act 1948 but suggest that its repeal should be considered for all cases, not just those against the NHS.
18. **Specialist training for clinical negligence judges.** We support the proposal.
19. **Control of claimant costs.** Whilst we support this proposal in principle it is primarily a matter for the Department for Constitutional Affairs rather than the Legal Services Commission. Any further controls of claimant costs must take into account the fact that, unlike defendant costs, the rates payable to claimant firms are much lower in unsuccessful cases. We believe this differential should continue.