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Our ref: CMT/PT/3/55A

Your ref:

Date: 16th October 2003

Department of Health
Complaints and Clinical Negligence
Policy Team
Room 5C07
Quarry House
Quarry Hill
Leeds SL2 7UE

MDU Services Limited
230 Blackfriars Road
London
SE1 8PJ

Dr Christine Tomkins
Professional Services Director

Telephone: 020 7202 1500
Fax: 020 7202 1668

Email: mdu@the-mdu.com
Website www.the-mdu.com

(email makingamends@doh.gsi.gov.uk)

Dear Sir/Madam

Re: “Making Amends: A Consultation Paper Setting out Proposals for Reforming Clinical Negligence in the NHS”

I. INTRODUCTION

The MDU commented in detail on the CMO’s consultation paper “Clinical Negligence Reform – A Call for Ideas”. Our key points in response to the 21 questions raised in the “Call for Ideas” are attached for ease of reference (see Annex A).

We should point out at the outset that the data attributed to us on page 63 of the report is not our data and does not accurately reflect our data.

We are pleased to have the opportunity to comment on the comprehensive and innovative recommendations made in “Making Amends” and applaud the aims of the reform, ie. to ensure that:

1. Harm and injuries resulting from healthcare are fairly and efficiently recompensed;
2. The system of compensation is affordable and reasonably predictable in the way it operates;
3. The emphasis and processes of the NHS are directed at preventing harm, reducing risk and enhancing safety;

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4. Any compensation payments act as an incentive on healthcare organisations and their staff to improve quality and patient safety.

We make our comments on “Making Amends” in the context of these aims, and consider the third point above to be the central and most important aim.

Key Points on the Recommendations

Recommendation 1:

An NHS redress scheme should be introduced to provide investigations when things go wrong; remedial treatment, rehabilitation and care where needed; explanation and apology; and financial compensation in certain circumstances.

- The recommendation is welcome in principle. A number of key questions need to be addressed and we support the suggestion that the scheme be piloted.
- The qualifying criteria should be based on patient need.
- The Bolam/Bolitho test should be retained. It is a straightforward expression of common sense and justice, and there is a large body of decided cases to assist in application of the test, which does not necessitate litigation in most cases.
- In the interests of the proportionality there should be a minimum qualifying level for entry to the scheme.
- Currently an upward financial limit of £30,000 is suggested, but as it is not clear what the £30,000 is intended to compensate, it is difficult to comment decisively on whether this sum is a suitable threshold or not.
- We see no merit in a financial limit for a package of care, which the NHS has an obligation to provide.
- In principle an NHS redress scheme should apply to all patients treated by the NHS, including those in primary care. In practice, very careful thought would have to be given to how this might apply to NHS primary care delivered mainly through independent contractors.
- Whether or not patients/claimants should be entitled to funding for legal advice to assess the fairness of the redress package depends on how the redress package is to be determined and by whom.
- We believe it inevitable, if the end point of an NHS redress scheme is seen as financial compensation, that this would draw people into making applications for the scheme, with all the cost consequences for the NHS which may ensue.

Recommendation 2:

The NHS redress scheme should encompass care and compensation for severely neurologically impaired babies, including those with severe cerebral palsy.

- We support a no-fault scheme for cerebral palsy and brain damaged cases in conjunction with repeal of Section 2(4) of the Law Reform (Personal Injuries) Act 1948. We support recommendation 2. It will result in some hard cases in which the eligibility criteria may not be met. Undoubtedly there will be difficult issues of interpretation, for example, in the definition of “resulting from birth”, but we believe it is an innovative recommendation which has the interests of badly damaged patients at the heart of it.
- This recommendation should mean that money can be retained within the NHS and used to fund first class, specialist facilities for severely neurologically impaired babies.
- It may be argued that the scheme will be prohibitively expensive, but society has an obligation to care for the vast majority of neurologically impaired babies now, with or without implementation of recommendation 2.
- Although it remains an artificial distinction, we think birth related neurological impairment is a reasonable test for the initiation of this scheme.
- We do not believe a qualifying birth should be restricted to one in an NHS Trust.
- We do think patients/claimants should be entitled to funding for legal advice to assess the fairness of the redress package.
- We do think parents should be able to go straight to court and not use the scheme if they believe they can prove negligence, though in practice we expect claimants will investigate the possibility of proving negligence in parallel with an application to the NHS redress scheme.
- We believe that the Legal Services Commission and, where appropriate, the Court, should have access to the deliberations of the expert panel if a compensation package is rejected and the claimant pursues legally aided litigation.

Recommendation 3:

- **A national body building on the work of the NHSLA should oversee the NHS redress scheme and manage the financial compensation element at national level.**
- The body established to oversee the NHS redress scheme would have a conflict of interest if it was both the judge of those cases which merit inclusion, and responsible for funding these. We believe these functions should be separated.

Recommendation 4:

Subject to evaluation after a reasonable period, consideration should be given to extending the scheme to a higher monetary threshold and to primary care settings.

- In principle we think the proposals could be extended to the primary care sector, and to the independent sector, and made accessible to all personal injury indemnifiers.

Recommendation 5:

The right to pursue litigation would not be removed for patients or families who chose not to apply for packages of care and payment under the redress scheme. However, patients accepting a package under the scheme would not subsequently be able to litigate for the same injury through the courts.

- We support recommendation 5, but suggest arrangements would have to be put in place under redress schemes 1 and 2 for court approval of infant “settlements” under the redress scheme.

Recommendation 6:

A new standard of care should be set for after-event/after-complaint management by local NHS providers.

- We support this recommendation as sensible and, to some extent, the detail of the recommendation reflects already established procedure.

Recommendation 7:

Within each NHS Trust an individual at Board level should be identified to take overall responsibility for the investigation of and learning from adverse events, complaints and claims.

- We agree, and understand Trusts should already have a Board member with overall responsibility for investigation of and learning from adverse events, complaints and claims.

Recommendation 8:

The rule in the current NHS complaints procedures requiring a complaint to be halted pending resolution of the claim should be removed as part of the reform of the complaints procedure.

- We agree, and have publicly supported this idea for some time.

Recommendation 9:

Training should be provided for NHS staff in communication in the context of complaints, from the initial response to the complaint through to conciliation and providing explanations to patients and families.

- We believe this is one of the most important recommendations in the report. Much of the dissatisfaction with current complaints procedures arise from lack of training for NHS staff in NHS complaints procedures.
- We believe there should be support for staff who are the subject of complaints.
- The nature and purpose of the complaints procedure and what can be achieved should be better communicated to patients and relatives.
- Patients and relatives should have free and easy access to specialised advocacy services to assist and support them with the complaints procedure.

Recommendation 10:

Effective rehabilitation services for personal injury, including that caused by medical accidents, should be developed.

- This is a vitally important recommendation, which we support. It should take precedence over other recommendations, since the effectiveness of the redress schemes will depend upon the ability of the NHS to deliver adequate care.

Recommendation 11:

The Department of Health, together with other relevant agencies, should consider the scope for providing more accessible, high quality but lower cost facilities for severely neurologically impaired and physically disabled children, regardless of cause.

- We agree, and suggest this recommendation should be extended to severely, neurologically impaired and physically disabled people, regardless of cause.

Recommendation 12:

A duty of candour should be introduced together with exemption from disciplinary action when reporting incidents with a view to improving patient safety.

- The inference of the recommendation is that no effective duty of candour currently exists. NHS employees have a duty of candour under the provisions of clinical governance, and registered medical practitioners also have an ethical duty imposed by the GMC.
- A factual duty of candour differs from a statutory duty to inform patients when a healthcare professional or manager becomes aware of a possible negligent act or omission. The legal sanction envisaged under such a statutory provision is not clear and it is difficult to see where the line would be drawn in deciding whether or not a healthcare professional or manager had “become aware of a possible negligent act or omission” because, usually, they will not be in a position to make a judgement about what is a legal test.
- The Law Society’s Code of Professional Conduct for solicitors carries no statutory endorsement, as far as we are aware.
- We do not support the recommendation that there be exemption from disciplinary action when reporting incidents. Any such exemption would be illusory. Doctors (and other healthcare professionals who are registered with a professional registration body) are subject to disciplinary action by their registration body regardless of whether or not an employer may choose to pursue disciplinary action.

Recommendation 13:

Documents and information collected for identifying adverse events should be protected from disclosure in court.

- We do not support this recommendation. It runs contrary to the general principles of disclosure and privilege.
- An adverse incident report should be a factual account of the sequence of events, devoid of comment or observations on blame.
- In the event of a civil claim the facts must be disclosed.

Recommendation 14:

Where a claimant is seeking legal aid to pursue a claim for clinical negligence, the Legal Services Commission should take into account whether or not the case had already been pursued through the NHS redress scheme.

- We support this recommendation. The Legal Services Commission’s decision whether to grant legal aid must be informed by any offer which has been made under an NHS redress scheme.

Recommendation 15:

Mediation should be seriously considered before litigation for the majority of claims which do not fall within the proposed NHS scheme.

- We support this recommendation. We would like to see revision of the pre-action protocol to allow for pre-action exchange of factual witness statements and expert reports, along with provision that there be pre-action meetings of experts.
- The parties in contemplated litigation should be required to indicate that they have considered mediation or some other form of alternative dispute resolution at the pre-action stage, and to explain, if they have chosen not to use these routes, why not.

Recommendation 16:

The expectation in paying damages for future care costs and losses in clinical negligence cases not covered by the new NHS redress scheme should be that periodical payments will be used.

- We do not support this recommendation in that there are good arguments why no expectation or presumption that damages should be paid through periodical payments should exist. These are rehearsed in the response to the Lord Chancellor's Department's consultation on "Damages for Future Loss: Giving the Courts the Power to Order Periodical Payments for Future Loss and Care in Personal Injury Cases", November 2002.
- A means of providing peace of mind in respect of future care for claimants damaged by the NHS may be through contractual guarantees of necessary future NHS care.
- We would encourage the parties to consider periodical payments in appropriate cases.

Recommendation 17:

The costs of future care included in any award for clinical negligence made by the courts should no longer reflect the cost of private treatment.

- We strongly support the recommendation that Section 2(4) of the Law Reform (Personal Injuries) Act 1948 should be repealed for clinical negligence cases arising from NHS treatment, and for all personal injury claims.
- We suggest there be further research into how damages are currently spent.
- Recommendation 17 supports recommendations 10 and 11, allowing for the preservation of funds within the NHS to provide better care, particularly in the areas of rehabilitation and long term care, and represents better use of public funds than under current arrangements.

- If evaluation of future care included in any award for clinical negligence is made on the basis that the care will be provided by the NHS, then we believe the NHS will need to provide guarantees of treatment.
- We would support a system of independent case managers to facilitate the assessment and quantification of necessary care. We suggest reformation of the Care Working Group.

Recommendation 18

Special training should be provided for judges hearing clinical negligence cases.

- We support this recommendation in principle, but in practice the practicability of the recommendation is a matter for the judiciary and those responsible for their deployment and training.

Recommendation 19:

The Department for Constitutional Affairs (DCA) and the Legal Services Commission should consider further ways to control claimant's costs in clinical negligence cases which are publicly funded, and the DCA and Civil Justice Council should consider what further initiatives could be taken to control legal costs generally.

- We support this recommendation .Claimants' legal costs have risen steadily and are now about double the defendants' costs.
- Successful defendants cannot recover their costs in legally aided cases. This is inherently unjust. If the defence were able to recover their costs in legally aided cases, this may promote more rigorous assessment of the probability of succeeding in the context of the likely damages as a proportion of the costs.
- Tests of proportionality and reasonableness should be rigorously applied by the Legal Services Commission and the Courts.
- A tariff for experts applicable to defendants and claimants should be established.

General Comments

We agree that changes should be aimed at using the money currently spent on the clinical negligence bill much more effectively and to the direct benefit of a greater number of patients. As discussed in "Making Amends", there have been a number of market changes and procedural changes in recent years, including:

- Introduction of a limited panel of specialist claimant’s solicitors.
- Introduction of the Legal Services Commission, providing central funding for clinical negligence claims, with the application of a stronger merits test and a proportionality test.
- Introduction of conditional fee arrangements.
- Changes to the Civil Justice system in England and Wales, under the Civil Procedure Rules, which followed the 1996 report on “Access to Justice”.

Changes which are currently in contemplation include those suggested in “Making Amends”, and:

- The Courts Bill (currently Section 100) which will allow the courts to order reviewable periodic payments.
- The Health & Social Care (Community Health & Standards) Bill (currently Section 146-151), which will require insurers indemnifying personal injury claims to reimburse the NHS for NHS costs incurred prior to settlement as a result of a compensatable injury.
- Review of the interest on past pecuniary losses by the Legal Services Commission.
- Challenges to the discount rate through the courts.

“Making Amends” suggests wide ranging reform and rejects an option for change solely based on continuing tort reform because:

- **It remains a lottery who can and cannot prove negligence.**
It is the MDU’s experience that from the clinician’s viewpoint the tort system is by no means a lottery. The aim of a clinical negligence claim is to gain monetary compensation for the damaged patient in circumstances where the patient can prove, on the balance of probability, that he satisfies the tests imposed by the law. This may mean that a patient who has injuries caused by a negligent act may receive compensation, whereas another patient who has similar injuries caused by a disease process may not, but this is not directly comparable with a random system such as a lottery.
- **It does little to support patients making complaints and claims.**

It is true that the tort system does nothing to support patients making complaints and we commented in detail in our response to the “Call for Ideas” on ways in which the complaints procedure could be changed to improve support for patients, and on the importance of keeping complaints and claims as separate procedures.

- **The current legal system provides little or no incentive to report, learn from and reduce errors.**

This is correct, and as we observed in our response to the “Call for Ideas”, clinical negligence claims are not a good indicator of the quality of clinical care nor, because of their long timescales, are they the most effective way to learn from mistakes. Rather adverse incident reporting fulfils this role and the National Patient Safety Agency (NPSA), established in July 2001, has as its remit a national patient safety programme providing a clear focus on patient safety issues.

- **The adversarial system undermines the relationship between the patient and healthcare profession, reduces trust in the NHS as a whole and diverts staff from clinical care.**

There is, as far as we are aware, no evidence that individual one-off clinical negligence claims reduce trust in the NHS, whereas major NHS inquiries, and the multiple claims which accompany them, which achieve widespread and prolonged media coverage, and have been a feature of the last 5 years, may well have done so.

In the absence of an across the board no-fault system, issues of apportionment and fault will inevitably continue to arise and in themselves may undermine the relationship between the patient and healthcare professionals. Finally, any system which seeks to address adverse incidents in a more comprehensive manner will inevitably divert staff from clinical care, albeit that this will be time well invested in improving patient safety.

- **If a litigation culture takes hold, as in the USA, costs will spiral out of control and the practice of defensive medicine will increase.**

The definition of “defensive medicine” is a moot point. One practitioner’s defensive medicine is another practitioner’s good practice and exactly what amounts to defensive medicine and how this relates to the tort system in the UK is unclear. The way to control claims is to reduce the incidence of adverse incidents through comprehensive risk management programmes. The factors driving the litigation culture in other jurisdictions include:

- Contingency fees for lawyers.
- Changes in the burden of proof generating the expectation of compensation in the event of an adverse outcome.

We suggest it is these factors which need to be understood, and changes of this nature resisted, to avoid a litigation culture developing in the UK.

- **An independent evaluation of the small claims pilot supported by the DoH and NHSLA found that patients who receive compensation often remain dissatisfied, as they do not also receive the explanations or apologies they seek or reassurance about the action taken to prevent repetition.**

This reflects the fact that the purpose of the tort system is only to provide compensation. The purpose of compensation is to put the patient back in the position he would have been in had the negligence not occurred, in so far as it is possible for money to achieve this. On the other hand, the purpose of the complaints procedure is to provide patients with an explanation in response to their complaint, an apology where appropriate, and information about steps which will be taken to ensure that the adverse incident which was the subject of the complaint does not recur. A system where compensation may become a continuum of the complaints procedure will not achieve this. It will result, in many cases, in patients considering their complaint has not been upheld or taken seriously should compensation not be forthcoming. Patients are more likely to be satisfied with a prompt explanation about the nature and purpose of the complaints procedure, what it can achieve and a specialised advocacy service to support them through the complaints procedure, than if compensation is the end point of the complaints procedure, for some complaints but not others.

We suggest that the aims of the proposals for reform set out in “Making Amends” can be achieved with a combination of measures which do not try to combine procedures which have separate and distinct aims, and which allow the benefits of recent tort reform and market and procedural changes, and the establishment of the NPSA, to work through. This is not to reject change, but to put the proposals for change in the context of current developments, and to continue to look at how the goals of fair and efficient recompense, affordability, prevention of harm and incentives on healthcare organisations to improve quality and patient safety can be achieved.

II. PROPOSALS FOR REFORM

Chapter 8 of “Making Amends” begins with the assertion that “Legal proceedings for medical injury progress in an atmosphere of confrontation, acrimony, misunderstanding and bitterness”. This may be a description of a minority of claims but it is not our general experience, nor do we believe it is a description which those who act for claimants and those who hear clinical negligence cases in the civil courts would apply to most cases. We do, however, agree that there is a much wider problem, not confined to legal proceedings, whereby the system of accountability in clinical practice encourages a climate of blame and retribution, fuelled by the multiple jeopardy which a practitioner faces as a consequence of an adverse incident. All of this is exacerbated in cases where the events attract intense media interest. This is damaging to the morale of clinicians, fails to provide support for patients and encourages mistrust in the services provided by the NHS.

We do not argue that the tort system is the best framework for dealing with medical injury. An effective complaints procedure should provide a swift investigation and, wherever possible, a resolution of grievances. Where issues of financial compensation arise, cause and fault need to be examined and resolved, unless a no-fault system is to be adopted.

We appreciate the attraction of an integrated system but we suggest that trying to achieve the best of all possible worlds by removing the boundaries between a complaint and a claim will unleash a large number of complaints from a new category of complainants who are not interested in non-pecuniary compensation, an explanation and an apology, ie. those things which we know lie behind the majority of complaints, and even claims, now.

A system aimed at providing the greatest good for the greatest number should concentrate on providing explanations and apologies to those who have suffered an adverse event which may not amount to a compensatable injury, and also to those who have suffered an adverse event which may amount to a compensatable injury where, in the interests of proportionality, financial compensation is inappropriate. Such financial resources as may be available, since these are not limitless, should be expended on improving the standard of care the NHS is capable of offering, and providing financial compensation in cases where the patient’s injuries and the

adverse effect on the patient's life are sufficiently severe to attract substantial damages which will make a significant difference to the patient's quality of life.

Turning now to the recommendations:

Recommendation 1:

An NHS redress scheme should be introduced to provide investigations when things go wrong; remedial treatment, rehabilitation and care where needed; explanation and apology; and financial compensation in certain circumstances.

The recommendation is largely welcome in principle, but we are not clear whether this is or is not intended to be a "joined up" complaints/claims procedure. If it is we do not support that element of it.

We applaud the requirement to reach a decision on a case within six months of the initial approach from the patient. This will be easier to achieve with some of the routes of access suggested than others, and patients will need information and support so they understand how the system operates, their expectations are managed and the means of access to the scheme and the way it performs thereafter is truly centred on the needs of NHS patients, and encourages local ownership and resolution.

The recommendation is based on the idea that the role of tort should be removed from its current central position to the outer perimeter of the NHS. The number of claims brought in respect of NHS treatment is very small in comparison with the number of complaints. Figures quoted for all claims reported to the NHSLA amount to 6000 for the year 2002/2003, compared with approximately 130,000 complaints a year in respect of NHS treatment. We, therefore, question the premise that tort occupies a central position in response to adverse incidents and suggest that, quite properly, it is the complaints system which does this. Any change to the complaints system should not, in our view, be skewed to encourage greater emphasis on financial compensation. It should prompt investigation of the incident, provision of an explanation to the patient of what has happened and the action proposed to prevent repetition, and remedial treatment, therapy and arrangements for continuing care, where needed. It is, after all, the obligation of the NHS to provide remedial treatment, therapy and arrangements for continuing care, in any event,

whether or not these requirements arise from an avoidable adverse incident or from an unavoidable disease process.

Turning to the criteria for payment, these may ostensibly keep complaints and claims distinct but their existence under the same “banner” suggests that they may not be perceived as distinct by patients and others, to the detriment of the very constructive recommendations to improve the complaints procedure.

It is by no means clear what will constitute “serious shortcomings” in the standard of care. The “Bolam test” is and always has been an attempt to define what is and is not “an acceptable clinical standard”. There is to be a causation test since the criteria include avoidability of the harm which must not be the result of the natural progression of the illness.

It would, therefore, appear that the suggested criteria for payment are exactly those which currently apply to the tort of negligence. As such it is difficult to see how the provision for payment supports the proposals of the reform in a manner which is not already met by the tort system, bearing in mind the great majority of claims are resolved by negotiation, without litigation. The proposed system would be susceptible to exactly the same criticisms as the tort system, but with the added disadvantage that it will cause confusion and dilute the effectiveness of the proposed complaint and care systems, which appear to be the core of recommendation 1, and which have the potential to meet the needs that patients express when an adverse incident has occurred. The right to sue remains, so those who have a robust claim under the tort system may pursue this route in the expectation of gaining greater compensation than that available under the redress scheme, but retain the reasonable expectation that they will receive a package of care, remedial treatment, therapy and arrangements for continuing care where needed from the NHS.

We agree with the concept that for those injured by NHS treatment the NHS itself should be under an obligation to put right the damage caused. Although money is now the traditional response, a comprehensive care package, non-financial compensation, promptly provided and efficiently delivered, is an obvious and more effective alternative. We also agree that the obligation to organise quality care, potentially from a variety of private sources rather than simply paying the money to a private source, could lead to a better understanding of and a sense of responsibility

for the long-term effects of medical injuries on patients, and could provide an incentive for initiating measures to prevent recurrence of the problem.

We do not understand what is envisaged in terms of the financial element of compensation to include “the notional cost of the episode of care or other amount as appropriate, at the discretion of the local NHS Trust”. The patient makes no direct payment for the cost of the service so it is not clear why the patient needs to be financially compensated for the “notional cost of the episode of care” from the NHS.

Neither are we clear what the payment of up to £30,000 is intended for. Would it include, for example, payments to purchase private packages of care not available under the NHS, or is it exclusive of those costs? Would payment for “out of pocket expenses” include loss of earnings? If not, it would exclude a substantial proportion of even low value claims.

We are sure it is right that the scheme should be thoroughly piloted. The obvious questions raised by the recommendation will, no doubt, be addressed in these pilots such as, for example:

- Should the scheme extend to primary care/private care and if so, on what basis?
- Will the care packages be available to personal injury (PI) indemnifiers who are not NHS hospital and community healthcare providers and if so, on what basis?
Arrangements which allow other PI indemnifiers to purchase NHS care packages may assist in developing NHS care packages at the outset. The principle is consistent with the arrangements for recovery of NHS costs, currently under consideration in the Health & Social Care (Community Health and Standards) Bill.
- If other indemnifiers can have access to NHS care packages, how might they be valued?
- Will a patient who chooses to litigate and fails under the traditional tort system be able to go into the redress system thereafter?
- Will investigation under the redress system be a prelude to a claim using a conditional fee arrangement, which will serve only to inflate the cost and number of claims?
- Will legal aid be available if a redress package is offered but declined by the patient?
- Will an offer of redress be treated as a part 36 offer should the patient chose to litigate and, if so, how will the redress be valued?

- Which body will investigate adverse incidents under the redress scheme? Will such a body be seen to be sufficiently independent and adequately clinically informed in order to make judgements which are fair to all the parties?

Questions for consultation arising from Recommendation 1

1. **What should be the qualifying criteria: The “Bolam test” currently used in assessing clinical negligence or a broader definition of sub-standard care?**

We suggest the qualifying criteria should be based on patient need. Patients require delivery of a package of care, remedial therapy and arrangements for continuing care, however the injury occurs. If the NHS cannot provide the care itself then, as already happens, it is open to the NHS to purchase these services from private providers. It would seem invidious to provide a package of care for patients who have suffered an avoidable adverse event which is in some way superior to the package of care provided for a patient with exactly the same needs who cannot claim they have suffered an adverse event, but whose needs arise from the progression of the disease process. We are not clear whether this is what is contemplated under recommendation 1?

If financial compensation is to be offered, then we suggest this should be a clear and separate process from the investigation of the adverse incident alleged to have caused harm. If it is not a separate process, then patients’ expectations will not be met. This will result in ever increasing dissatisfaction with the NHS when adverse incidents arise. Overall costs and the clinical compensation bill for the NHS will be far higher if a lower threshold for claiming compensation is introduced.

The “Bolam/Bolitho test” is a straightforward expression of common sense and justice. There is a large body of decided cases to assist in the application of the test and the test can be applied in many cases without involving lawyers and without the need to litigate. The great majority of cases settled by the MDU are handled in precisely this way. Clearly indefensible claims are settled by MDU claims handlers before the matter has ever been litigated. Lawyers are not instructed. The facts of the matter are considered in accordance with the pre-action protocol and cases which should be settled are settled quickly. Most cases

which are defensible are discontinued before litigation, on receipt of the defendant's response to the allegations made under the pre-action protocol. In the cases where the issues are finely balanced, litigation may ensue. These are generally more complex cases in which, even under a redress scheme, patients would need specialist advice of the kind currently provided, which would presumably be publicly funded, as occurs now, in the context of the tort system.

2. What will be the preferred formulation?

We believe the "Bolam/Bolitho" test should be retained.

3. Should there be a minimum qualifying level in terms of the extent of the disability, eg. in terms of days off work or in hospital, or in terms of the level of disability?

In the interest of proportionality there should be a minimum qualifying level, for example, for current benefits schemes of a minimum qualifying long term disability of 10%. We should emphasise that best practice in terms of proper investigation, explanation, apology and preventative steps should be followed for every adverse incident, and this needs to be achieved through embedding those practices in the organisational and cultural aspects of day to day NHS activity.

4. Should there be an upper financial limit to the cases being dealt with under the scheme? If so is £30,000 the right starting point?

Since it is not entirely clear what the £30,000 is intended to compensate, it is difficult to comment decisively on whether £30,000 is a suitable threshold or not. We can say that for UK medical and dental negligence claims settled by us between 1995 and 2001 damages of below £10,000 were paid in between 50-60% of medical cases and between 80-90% of dental cases (see Annex B).

5. Should the financial limit for the scheme apply to the whole package of care and the cash or cash only element only?

We see no merit in a financial limit for a package of care when the NHS has an obligation to provide this care in any event. Quantification of the package of care offered becomes important,

- if the package of care is to be purchasable by other personal injury indemnifiers,
- in the context of provision of legal aid, if the patient who has been offered a redress package proposes to reject the package and bring a claim under the tort system and if,
- in that event, the redress package is to be treated as a Part 36 offer.

6. **Should consideration be given to including primary care from the outset?**

No. In principle, an NHS redress scheme should apply to all those patients treated by the NHS. In practice very careful thought would have to be given to how this might apply to NHS primary care delivered mainly through independent contractors. The pilots conducted in the context of NHS hospital care will doubtless inform consideration of inclusion of primary care. The redress packages themselves will presumably have to include some primary care provisions and we can see that redress packages might, for example, be purchased by hospitals from primary care and vice versa.

7. **Should patients/claimants be entitled to funding for legal advice to assess the fairness of the redress package? If so, what limit should be set on the amount of funding available?**

This depends on how the redress package is to be determined and by whom. If the national body charged with administrating the scheme is independent and acts as a fair assessor for claims and/or recommendations for NHS compensation payments, and such packages and compensation payments to be made by another body, then there may be no need for yet another source of advice to assess the fairness of the redress package. We appreciate this is not precisely what is envisaged in recommendation 3, but suggest this may be a reasonable way forward which may avoid conflicts of interest which otherwise arise.

8. **Will making it easier to obtain a package of care and support plus modest financial compensation reduce or increase the number of people making applications to the scheme? Why? Could this be mitigated?**

We believe it inevitable, if the end point of the NHS redress scheme is seen as financial compensation, that this will draw people into making applications to the scheme.

Recommendation 2:

The NHS redress scheme should encompass care and compensation for severely neurologically impaired babies, including those with severe cerebral palsy.

In our response to “Clinical Negligence Reform – A Call for Ideas”, we supported a no-fault scheme for cerebral palsy and brain damaged cases in conjunction with repeal of Section 2(4) of the Law Reform (Personal Injuries) Act 1948.

We appreciate that the recommendation as it currently stands would result in some hard cases in which the eligibility criteria may not be met. As “Making Amends” points out, the cause of cerebral palsy is not fully understood and a wide range of factors may be implicated, including genetic predisposition. In this context, exclusions of genetic or chromosomal abnormality, and indeed exclusion of other conditions which may not fall into the eligibility criteria, are clearly open to criticism, but it is a situation in which “you have to start somewhere”. Undoubtedly there will be difficult issues of interpretation, eg. in the definition of “resulting from birth”, but despite the difficulties this is an imaginative, innovative recommendation which has the interests of badly damaged patients at the heart of it.

Current arrangements mean millions of pounds are diverted from the NHS to set up care and rehabilitation arrangements for a tiny number of individuals at public expense. This in turn sets up a vicious circle whereby more litigation is encouraged, diverting more money earmarked for NHS services, thus further impairing the quality of service the NHS can deliver and increasing the incentive to set up privately funded care through litigation. These cases are almost entirely funded through legal aid which, as the report demonstrates, achieved a “success rate” of only 27% in 2001/2002 (with lower percentages pertaining in preceding years). This must in itself represent a significant expenditure of public money which fails to achieve the objective it is aimed at achieving. This makes no sense, particularly since the vast majority of neurologically impaired babies need to be cared for by the NHS in any event.

It is too easy to deride suggestions of this kind as too radical or based on utopian idealism, but this recommendation combined with reform of the Law Reform (Personal Injuries) Act 1948 would mean that money can be retained within the NHS and used to fund first class specialist facilities for all severely neurologically impaired babies, regardless of whether the eligibility criteria for the reform package are met or not. This begs the question of whether a package of compensation is actually required. If the NHS is capable of delivering a managed care package in which NHS treatment is either preferable or at least as good as that which may be available privately, then the answer is no. However, quite clearly this is not the situation today and as such we believe the package of compensation to be appropriate, though issues of what it encompasses need to be clarified, eg. does it include physiotherapy, occupational therapy, speech therapy etc, or just care as usually narrowly interpreted?

No doubt the argument will be advanced that the scheme will be much more expensive than current arrangements, since patients will retain the right to sue. Therefore, those who do not feel they can succeed in demonstrating that their injury was negligently inflicted will seek compensation under the NHS redress scheme, whereas those who feel they can succeed in their claim for negligence will follow this route. As far as we are aware, the cost of providing care for neurologically impaired babies throughout their lives via publicly funded services has not been quantified, and in a society which accepts that these children must be cared for at public expense, this expenditure will occur with or without recommendation 2. The effect of recommendation 2 will be to divert those who have a significant litigation risk but might otherwise pursue a claim for negligence into the redress scheme, saving them the uncertainty of litigation and retaining such damages as they might have been awarded through litigation within the NHS to be spent on delivery of care.

Questions for consultation arising from Recommendation 2

1. Is birth related neurological impairment a reasonable test?

Yes, though it remains an artificial distinction in terms of need and difficulties of interpretation will arise.

2. Should a qualifying birth be restricted to one in an NHS Trust?

We believe not. If a patient suffers severe neurological impairment, whatever the cause, and wherever it is caused, be it NHS hospital, primary care or privately, then they are entitled to seek NHS treatment free of charge. The managed care package should be available to these patients, and if there are services which cannot be provided through a care package, it seems reasonable to expect the NHS to provide these, if they are necessary, by purchasing them from those who are capable of providing them.

The scheme has to start somewhere, but it is particularly difficult to see on what basis a distinction might be drawn between a baby suffering from severe neurological impairment who meets the eligibility criteria, who happens to have been born in an NHS general practice setting, from a baby with similar disabilities who similarly meets the eligibility criteria who happens to have been born in an NHS hospital.

- 2. Should patients/claimants be entitled to funding for legal advice to assess the fairness of the redress package? If so, what limit should be set on the amount of funding available?**

We believe that parents should have as much assistance and advice as they need in order to be satisfied that the steps they are taking for their child are in that child's best interests. We assume that for any redress package, in relation to both recommendations, amounting to "settlement" for an infant claimant, approval of the court would be necessary. We cannot envisage those with parental responsibility would feel able to proceed without the benefit of legal advice and we think there is a strong argument that funding should be available. We have no strong view concerning the limit.

- 3. Should patients be able to go straight to court and not use the scheme if they believe they can prove negligence?**

Yes, though in practice we expect claimants will investigate the possibility of proving negligence in parallel with an application to the NHS redress scheme.

- 4. Should courts have access to the deliberations of the expert panel if a compensation package is rejected and the case subsequently goes to court? What might be the impact on numbers claiming compensation?**

The majority of claims for severely neurologically impaired babies are legally aided. We suggest that the Legal Services Commission should have access to the deliberations of the expert panel if a compensation package is rejected and the claimant seeks legal aid to pursue litigation. This will assist the Legal Services Commission in applying the merits test in respect of provision or otherwise of legal aid to pursue litigation.

The court will need to see the deliberations of the expert panel to quantify the package of compensation if the package of compensation is to be treated as a Part 36 offer in the context of civil litigation.

We cannot predict what impact this may have on the numbers claiming compensation. We would speculate that an adequate package of compensation, as envisaged in recommendation 2, should reduce the number of patients who choose to pursue a claim down the civil litigation route substantially. However, much may depend upon whether or not the redress scheme, as detailed under recommendation 2, will still be open to a claimant, making the application within 8 years of the birth, even if the litigation route has been pursued and failed. It is not clear whether this is to be allowed or not.

5. Should the right to go to court be removed in favour a new, speedier, more responsive tribunal system for all cases of severe neurological impairment?

Any attempt to remove the right to go to court may be susceptible to challenge under the Human Rights Act. We support the concept of extension of the redress scheme in recommendation 2 to neurologically impaired children and adults, whatever the cause of their injury, in conjunction with repeal of Section 2(4) Law Reform (Personal Injuries) Act 1948. A new fast and responsive tribunal system may be an effective way of achieving this.

Recommendation 3:

A national body building on the work of the NHSLA should oversee the NHS redress scheme and manage the financial compensation element at national level.

Questions for consultation arising from Recommendation 3

1. **It is proposed that the new body established to oversee the NHS redress scheme should be modelled or developed from the existing NHSLA.**

What mechanism will be needed to ensure that a body with this structure would not have a conflict of interest in administering the NHS redress scheme and retaining responsibility for assessing claims or recommendations for NHS compensation payments?

The body would have a conflict of interest if it was both the judge of those cases which merit inclusion in the redress scheme, and responsible for funding these. We believe it essential that these functions are separated and that the body responsible for administering the redress schemes is constituted in a manner which is and is seen to be truly independent and able to provide an objective assessment in respect of the recompense packages to be provided.

There would appear to be no particular need to change the current arrangements in respect of the NHSLA, since there will need to be a body with expertise in claims handling to continue to handle existing claims arising from NHS hospital practice and those which will arise in the future. Accordingly, while the new national body may be charged with managing the first six functions set out in recommendation 3, we would suggest the final two should be retained by the NHSLA as a separate entity.

2. **Should this body be a Special Health Authority or a Non-Departmental public body?**

We have no particular preference.

Recommendation 4:

Subject to evaluation after a reasonable period, consideration should be given to extending the scheme to a higher monetary threshold and to primary care settings.

In principle we agree, after a reasonable “pilot” period, the proposals should be extended to the primary care sector and to the independent sector, and accessible to all personal injury indemnifiers.

Whether it should apply to higher monetary thresholds should be considered in the light of the findings from the pilots.

Recommendation 5:

The right to pursue litigation would not be removed for patients or families who chose not to apply for packages of care and payment under the redress scheme. However, patients accepting a package under the scheme would not subsequently be able to litigate for the same injury through the courts.

We agree, but question whether a waiver barring a patient from litigation once an NHS redress scheme has been accepted, would be binding upon an infant claimant, unless arrangements for infants under both redress schemes 1 and 2 had been approved by the court.

Recommendation 6:

A new standard of care should be set for after-event/after-complaint management by local NHS providers.

This seems entirely sensible, and to some extent the detail of the recommendation reflects already established procedure. How it will interact with other initiatives such as the NPSA’s new scheme for patient safety incident reporting, aimed at ensuring there is a consistent standard of investigation and reporting that is factual and does not attribute blame etc, is not clear. Recognition of the concept of the “near miss” should be included. The additional workload for clinicians and senior managers will be considerable and must be adequately resourced.

We support the approach suggested in recommendation 6 for achieving improved “after care”, but this should not be confined merely to those receiving a very bad outcome of care, but for all those who need “after care”, arising from their condition, be it caused by an adverse event or by the disease process. In the majority of these cases the provision of remedial treatment at an early stage can reduce suffering and the long term effects of any harm, whether it is caused by an adverse event and/or by disease.

Recommendation 7:

Within each NHS Trust an individual at Board level should be identified to take overall responsibility for the investigation of and learning from adverse events, complaints and claims.

We agree, and understand that Trusts should already have a Board member with overall responsibility for investigation of and learning from adverse events, complaints and claims. It would be important in the context of this recommendation that the complainant is provided with the facts and reassured that if anything further needs to be done the Trust will ensure that it happens, or that the matter will be referred to whoever else is appropriate to deal with it.

If actions are taken against any particular practitioner as a result of an incident, such as disciplinary procedures, this should be a private matter between the practitioner and the employing NHS Trust.

Mechanisms will need to be put in place to address cross-organisational boundaries, and to address service deficiencies identified through root cause analysis which relate to organisations not directly included in the adverse event itself.

Recommendation 8:

The rule in the current NHS complaints procedures requiring a complaint to be halted pending resolution of the claim should be removed as part of the reform of the complaints procedure.

We agree and have publicly supported this idea for some time.

Recommendation 9:

Training should be provided for NHS staff in communication in the context of complaints, from the initial response to the complaint through to conciliation and providing explanations to patients and families.

We believe this is one of the most important recommendations in the report. Much of the dissatisfaction with current complaints procedures, and with litigation, arise from lack of training for NHS staff in the NHS complaints procedure, and on how to resolve complaints. Staff should be trained to deal with complaints. It should be recognised

how stressful and even threatening these can be for staff, who should be provided with help and support. We also believe the nature and purpose of the complaints procedure and what it can achieve should be better communicated to patients and relatives, who should have free and easy access to specialised advocacy services to assist and support them with the complaints procedure.

Recommendation 10:

Effective rehabilitation services for personal injury, including that caused by medical accidents, should be developed.

We agree. This too is a vitally important recommendation and should take precedence over other recommendations, given that the effectiveness of the redress schemes suggested will depend upon the ability of the NHS to deliver adequate care packages, including the provision of remedial treatment therapy and arrangements for continuing care where needed. This provision compliments recommendation 17. Early independent evaluation of the current NHSLA pilot scheme to offer early rehabilitation may well prove informative, but will require an accurate system of identifying rehabilitation needs and evaluating outcomes.

Recommendation 11:

The Department of Health, together with other relevant agencies, should consider the scope for providing more accessible, high quality but lower cost facilities for severely neurologically impaired and physically disabled children, regardless of cause.

We agree and suggest that this recommendation should be extended to severely neurologically impaired and physically disabled people, regardless of cause.

Effective implementation of recommendations 10 and 11 has potential to generate income for the NHS from personal indemnity insurers, who may choose to purchase rehabilitation and long term care facilities from the NHS for those suffering from neurological and physical disability rather than, as currently, having to search for suitable provision, which is often unavailable, and which may result in setting up private one man institutions which are less than ideal for patients' needs but the best that can currently be achieved. We would welcome exploration of this issue with interested parties.

Recommendation 12:

A duty of candour should be introduced together with exemption from disciplinary action when reporting incidents with a view to improving patient safety.

The inference of this recommendation is that no effective duty of candour currently exists. Registered medical practitioners are under an ethical duty, imposed by the GMC. The GMC's booklet "Good Medical Practice" states, *"If a patient under your care has suffered harm, through misadventure or for any other reasons, you should act immediately to put matters right, if that is possible. You must explain fully and promptly to the patient what has happened and the likely long and short term effects. When appropriate you should offer an apology"*.

The MDU has been so advising members for decades and in 1987 we set this out in explicit terms in the MDU Journal. It has been suggested that while this is all very well for registered medical practitioners, other members of the clinical team and management should also have a duty of candour imposed on them, the inference being that they lack such a duty now. However, managers have just this duty under the provisions of clinical governance. Presumably it is not intended that patients should learn of adverse incidents from multiple members of the clinical and/or management team without reference to those responsible for the patient's clinical management? Usually responsibility for discussing adverse incidents and issues of patient safety with the patient fall upon the senior clinicians responsible for the patient's care, and it is they who must provide clinical advice regarding the necessary steps consequent upon an adverse incident. In the light of this we cannot see that a statutory provision is necessary. What is necessary is training on what constitutes an adverse incident and on what the reporting mechanism is, to ensure comprehensive adverse incident reporting.

It is also further suggested that healthcare professionals and managers must inform patients when they become aware of a possible negligent act or omission and that this should have statutory force. This is different from a duty of factual candour. We are not clear what sort of legal sanction is envisaged, nor indeed how this might be enforced. Adverse incidents are not always instantly apparent, and it may only be as the clinical sequence unfolds, sometimes over a period of months or years, that it becomes evident an adverse incident has occurred in the course of a patient's treatment. There are occasions when adverse incidents are unavoidable and, even in the case of avoidable

errors, admitting such an error does not inevitably indicate incompetence or negligence. It is very difficult to see where the line would be drawn in deciding whether or not a healthcare professional or a manager had “become aware of a possible negligent act or omission”, not least because, usually, neither will be in a position to judge. Whether or not an act or omission is negligent is a legal test depending upon a strict assessment of liability and causation.

A parallel is drawn with the Law Society’s Code of Professional Conduct for solicitors. Solicitors who are trained to make an assessment of legal concepts should be in a position to do so. Even so, as far as we are aware, the Law Society’s code of professional conduct carries no statutory endorsement.

This recommendation also suggests exemption from disciplinary action when reporting incidents. We do not support this. While doctors need help and support when they unintentionally harm a patient, patient safety is of paramount importance and sometimes that means disciplinary action is necessary. Any such exemption would be largely illusory anyway. Doctors have an ethical duty, in circumstances where patient safety is at risk, to report their concerns to the GMC, which is bound to investigate practitioners whose practice may pose a risk to patient safety. A doctor whose fitness to practise may be impaired can be disciplined by the registration body regardless of whether his/her employer chooses to pursue disciplinary action.

Recommendation 13:

Documents and information collected for identifying adverse events should be protected from disclosure in court.

We do not support this recommendation. It runs contrary to the general principles of disclosure and privilege. An adverse incident report should be a factual account of the sequence of events, devoid of comment or observations on blame. We have advised our members for many years that adverse incident reports are disclosable in the context of civil proceedings, and as far as we are aware there is no evidence that this acts as a disincentive to the reporting of errors. In the event of a civil claim the facts are the facts and must be disclosed in any event. The recommendation is particularly difficult to understand considered in conjunction with the suggestion that protection from disclosure of adverse event reports would only apply when full information on the event is also included in the medical record.

We have experience of handling claims in Australia, amongst other jurisdictions, and are not aware of any arrangements which afford protection for adverse event reports there, nor indeed any difficulties which have arisen in the absence of such protection.

Recommendation 14:

Where a claimant is seeking legal aid to pursue a claim for clinical negligence, the Legal Services Commission should take into account whether or not the case had already been pursued through the NHS redress scheme.

We agree, since the Legal Services Commission in deciding whether or not to grant legal aid must have in mind what a prudent person might do were they spending their own money to pursue a case. A prudent person's decision would certainly be informed by any offer under an NHS redress scheme before making a commitment to spend their own money to pursue a claim.

Recommendation 15:

Mediation should be seriously considered before litigation for the majority of claims which do not fall within the proposed NHS scheme.

We agree. We would like to see revision of the pre-action protocol to allow for pre-action exchange of factual witness statements and expert reports, along with the provision that there be pre-action meetings with experts or independent expert adjudication. If the claim then turns on factual issues these can be negotiated, mediated or arbitrated. The parties in contemplated litigation should be required to indicate that they have considered mediation or some other form of alternative dispute resolution at the pre-action stage, and explain, if they have chosen not to use these routes, why not.

At present the pre-action protocol does not require disclosure of witness statements or expert reports, or even a medical report on condition and prognosis. Mediation can only take place when both parties have access to relevant evidence, especially medical expert evidence. Currently the medical expert evidence is exchanged at the last stage of the timetable, ie. too late to avoid costs and entrenchment of attitudes.

Questions for consultation arising from Recommendation 15

1. **Are there alternative way of encouraging greater use of mediation and other alternative dispute resolution procedures?**

We would like to see the pre-action protocol revised as suggested above. We also suggest a case management conference before proceedings are issued. District judges and Masters should not tolerate parties who will not give alternative dispute resolution proper consideration, and should impose cost sanctions.

Recommendation 16:

The expectation in paying damages for future care costs and losses in clinical negligence cases not covered by the new NHS redress scheme should be that periodical payments will be used.

The Courts Bill is addressing the issue of periodical payments. There are good arguments why no expectation or presumption of the kind suggested should exist and these are rehearsed in the LCD's consultation response to "Damages for Future Loss: Giving the Courts the Power to order Periodical Payments for Future Loss and Care Costs in Personal Injury Cases", November 2002. Practical issues arise such as reviewability or otherwise of periodical payments, how an offer might be quantified for the purpose of Part 36 of the Civil Procedure Rules, and in circumstances where the indemnifier is not a "pay as you go" government funded body, whether or not the insurance market will find the provision of annuities to fund such payments an attractive proposition.

A preferable means of providing peace of mind in respect of future care for claimants damaged by the NHS may be through contractual guarantees of necessary future NHS care. In the absence of any such arrangements, we would encourage the parties to consider periodical payments in appropriate cases.

Recommendation 17:

The costs of future care included in any award for clinical negligence made by the courts should no longer reflect the cost of private treatment.

We agree that Section 2(4) of the Law Reform (Personal Injuries) Act 1948 should be repealed for clinical negligence cases arising from NHS treatment, and for all personal injury claims.

We discussed the benefits and adverse consequences of this in detail in our response to “Clinical Negligence Reform - A Call for Ideas” (key recommendations attached at Annex A) and we will not repeat these here. We believe, however, that the advantages to negligently damaged patients and to other NHS patients outweigh the disadvantages. This is particularly so if the principles of NHS reimbursement, set out in the Health & Social Care (Community Health and Standards) Bill, are taken into consideration. New arrangements following the repeal of Section 2(4) may allow for generation of additional NHS funds and avoid the anomaly whereby settlement is currently required to ignore the availability of NHS care, whether or not this is available, whether or not a reasonable person might be expected to use it, and whether or not the claimant does use it once settlement has been agreed.

Paragraph 30 on page 83 of “Making Amends” reports that research to test whether the NHS was effectively paying twice for cases of clinical negligence showed no evidence, in 40 cerebral palsy cases, that money awarded was not being spent on a range of care, therapy and other assistance identified as necessary at the time of the award. We are not clear whether this amounts to evidence that money was being spent on the range of care, therapy and other assistance identified as necessary at the time of the award, and it is reported that many relied on interest from the lump sum to provide the care needed, rather than the lump sum itself, implying that the full extent of the care envisaged by the court in making the award was not being purchased. We are not clear whether this means that the full care was not being received by the patient, or whether the NHS was delivering that care. This is an area which merits further research.

We wholeheartedly support recommendation 17, and we believe it supports recommendations 10 and 11, preserving funds within the NHS to provide better care, particularly in the areas of rehabilitation and long term care, and representing better use of public funds than under current arrangements.

Questions for consultation arising from Recommendation 17

- 1. If an NHS cost basis is used to calculate damages for future care costs, should the NHS be required to provide guarantees on this treatment? How might it do this? Would a system of independent case managers be required?**

If evaluation of future care included in any award for clinical negligence is to be made by the courts on the basis that that care will be provided by the NHS, then

the NHS will need to provide guarantees of this treatment on the basis that the treatment will be provided in NHS facilities or, where specified packages of care or treatment are not available on the NHS, through resourcing of the necessary care and treatment from a range of providers, that treatment to be funded by the NHS to defined timescales.

A system of independent case managers may well be a useful way of assessing and quantifying care. Reformation of the Care Working Group with the development of protocols aimed at assessing care needs, and future care costs could be a means of developing this ideal and taking it forward. We attach Annex B of our response to “Clinical Negligence Reform – A Call for Ideas”, which summarises the objectives and work of the Care Working Group (see Annex C).

Recommendation 18

Special training should be provided for judges hearing clinical negligence cases.

On the face of it this appeared to be a sensible recommendation, but whether or not this is practical in the context of arrangements for hearing clinical negligence cases, is a matter for the judiciary and those responsible for their deployment and training.

Recommendation 19:

The Department for Constitutional Affairs (DCA) and the Legal Services Commission should consider further ways to control claimant’s costs in clinical negligence cases which are publicly funded, and the DCA and Civil Justice Council should consider what further initiatives could be taken to control legal costs generally.

We agree. It is long overdue that attention be paid to the level of claimant’s costs which often exceed £300 per hour. We have seen a steady rise in claimant’s legal costs compared with a steady fall in defendant’s legal costs from 1994 to 1999. There may be some fall off in claimant’s costs as a percentage of the total amount paid from 1999 onwards, following the introduction of the new Civil Procedure Rules, but they remain about double the defendant’s costs (see Annex D).

Questions for consultation arising from Recommendation 19

1. **Are there any further steps that can be taken to control legal costs in clinical negligence cases?**

As “Making Amends” highlights at paragraph 38, page 62, the earning potential for claimants’ lawyers is significant at limited risk to themselves as, even if they lose, they are guaranteed legal aid rate fees. Differential rates whereby lawyers are paid more in successful cases than in unsuccessful ones are cited as a means of discouraging lawyers from pursuing poor cases, but the success rate reported by the Legal Services Commission suggests that too many unsuccessful cases are being pursued at public expense, so more effective means of dissuading lawyers from pursuing poor cases are needed. It is notable that 43% of cases funded through legal aid to litigation do not succeed. This is a much higher percentage than one might expect were the litigation being funded by a prudent person spending their own money. There is the further anomaly that successful defendants cannot recover their costs in legally aided cases. This is inherently unjust and, were the defence able to recover their costs in legally aided cases, this may tip the balance in favour of more rigorous assessment of the probability of succeeding in the context of the likely damages as a proportion of the costs. Tests of proportionality and reasonableness should be rigorously applied by the Legal Services Commission and the Courts.

Expert fees are another area in which costs have escalated on the claimant’s side in recent years. We suggest a tariff for experts applicable across the board for defendants and claimants, and the resurrection of the Care Working Group referred to above, which was formed to develop a standard approach to quantification of care claims, thereby controlling the often enormous costs and delay involved in this, without compromising the interests of claimants and defendants and without compromising the objectivity and the expertise of the experts, who have an overriding duty to the courts.

Yours sincerely

Dr C M Tomkins
Professional Services Director