DEPARTMENT OF HEALTH

CLINICAL NEGLIGENCE: WHAT ARE THE ISSUES AND OPTIONS FOR REFORM?

A RESPONSE BY THE ASSOCIATION OF PERSONAL INJURY LAWYERS

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EXECUTIVE SUMMARY

The following document forms the response of the Association of Personal Injury Lawyers (APIL) to the Department of Health's call for ideas on ways in which the system of clinical negligence compensation can be reformed.

The document deals with the major issues currently under discussion and it is the aim of the association to continue to work with the Government in examining these issues in further detail throughout the consultation process.

We welcome the fact that the Government has recognised the key to reducing clinical negligence claims is to prevent negligence from happening in the first place and call for a co-ordinated, less fragmented, approach to patient safety in the NHS.

We have said from the outset that the association recognises concerns raised about the current system and the need for review. In examining the options available, however, the needs and wishes of patients injured through negligence must remain paramount.

The essence of APIL's submission is that any person injured through clinical negligence within the NHS must continue to be entitled at common law to:

- litigate his claim if he wishes; and
- receive full compensation for his injuries to put him in the position he would have been in had the negligence not occurred.

The victims of clinical negligence within the NHS should not be treated any less favourably than the victims of clinical negligence within prison or private hospitals or indeed, other types of negligence.

Current procedures for allowing patients, who suspect they have been injured as a result of adverse clinical outcomes, to pursue their concerns and seek suitable remedies are unsatisfactory. Firstly, it is unclear to NHS staff, and so to their patients, how they should react when they suspect a patient has been negligently injured. Secondly, research suggests that the NHS complaints system fails to adequately address the concerns of injured patients. We believe that this leads patients to resort to litigation. Thirdly, the legal process can be slow, expensive and distressing and still not provide an injured patient with the range of remedies he is seeking.

APIL recommends:

- The NHS complaints system should be reformed to ensure that it fully addresses the concerns of injured patients and provides the remedies sought by them. This would include thorough and independent investigation of

complaints, the provision of explanations and apologies and reassurances that the same mistakes will not happen again. This will reduce the number of people having to resort to litigation and so reduce costs to the NHS and be less distressing for both patients and NHS staff;

- Financial compensation of up to £10,000 should be available through the NHS complaints system to those patients who seek compensation but who do not wish to litigate. This will reduce the number of low value claims that are litigated and so costs to the NHS as it is these low value claims that are disproportionately expensive to litigate;

- The litigation system should be improved to create greater efficiency and cost effectiveness. Improvements could include building upon the success of the new civil procedure rules and the pre-action protocol for the resolution of clinical disputes by, for example, reinforcing the use of sanctions for non-compliance with set timescales or unreasonable conduct and also improvements to the court system to prevent delay;

- Greater use of mediation should be encouraged as mediation can address the real causes of a dispute and increase the possibility of the provision of non-monetary remedies.

We believe claimants should be free to choose from the various ways in which compensation can be awarded – in a lump sum on a once and for all basis, periodically following a review of the claimant's circumstances or through a structured settlement – as all have their advantages and disadvantages to both injured patients and the NHS.

Claimants should retain the right to turn to the private sector for treatment following an incident of clinical negligence – no one should have to rely for further treatment on a health service which has injured them in the first place and in which a patient's trust has been broken. APIL is also committed to the provision of timely rehabilitation which can be provided in the context of a clinical negligence claim provided both sides deal with the issues in the claim expeditiously and early admissions of liability are made where appropriate.

We cannot support calls to introduce a no-fault compensation scheme. Whilst such a scheme may initially look attractive, deeper analysis reveals that it would have several deficiencies in practice. Compensation would not, in fact, be paid regardless of 'fault' - claimants would still be required to establish causation. In addition, the scheme would be prohibitively expensive unless compensation awarded under the scheme was extremely limited.

We are committed to working with all interested parties to resolve the issues identified above but believe it is imperative that discussions and reforms are based on reliable and accurate information, especially relating to the cost of clinical negligence claims.

CLINICAL NEGLIGENCE: WHAT ARE THE ISSUES AND OPTIONS FOR REFORM?

1. INTRODUCTION

1.1 The Association of Personal Injury Lawyers (APIL) was formed as a membership organisation in 1990 by claimant lawyers committed to providing the victims of personal injury with a stronger voice in litigation and in the marketplace generally. We now have around 5,000 members across the UK and abroad, and membership comprises solicitors, barristers, academics and legal executives.

1.2 To ensure that our position is clearly stated, we have included our general submissions on the issues in this paper rather than a series of answers to the specific questions raised. Our answers to the questions do appear, however, within the body of the text below.

2. BASIC PRINCIPLES UNDERLYING APIL'S RESPONSE

2.1 Reforms Must Focus on the Needs and Wishes of Injured Patients

2.1.1 Many concerns have been raised in relation to the pursuit and handling of clinical negligence claims against the NHS – some relating to economics, some to the effect on openness within the NHS and some to the effect on NHS staff. We are committed to reviewing the current systems for dealing with NHS patients injured as a result of adverse events and agree that NHS staff should be treated fairly, that openness should be encouraged and that taxpayers' money should not be spent unnecessarily. Any reforms in this area, however, must focus on meeting the needs and wishes of injured patients. In addition, if progress is to be made in reforming the way in which clinical negligence claims are handled it is vital that all interested

parties in the debate stand back from entrenched views and media images of claimants, lawyers, NHS staff and the NHSLA.

2.2 Reforms Must be Based on Reliable Information

2.2.1 It is imperative that any reforms are based on reliable factual information and not on mere assumptions or pre-conceptions. There is, for example, a widely held view that the NHS is suffering from what the media terms a "compensation culture". On deeper analysis of the rate of claims, however, Paul Fenn discovered that the rate of closed claims increased during the 1990s by about 7% per annum which he noted was "a substantial rate of growth but not the uncontrolled explosion sometimes alluded to in the wider media."[1] Thorough research and properly informed analysis of the relevant issues must be conducted before final decisions and recommendations are made.

2.3 Prevention is the Key

2.3.1 It is estimated that in NHS hospitals alone, adverse events in which harm is caused to patients occurs in around 10% of admissions or at a rate in excess of 850,000 patients a year.[2] Such adverse events are costly but not only because people pursue claims for compensation. It has, for example, been estimated that such adverse events cost the NHS £2 billion a year in additional hospital stays alone, without taking account of human or wider economic costs.[3] The most effective way of reducing the costs of adverse clinical outcomes is through effective and thorough prevention strategies.

[1] Paul Fenn, 'Current Cost of Medical Negligence in NHS Hospitals: Analysis of Claims Database', British Medical Journal, June 2000
[2] Department of Health, 'An Organisation with a Memory: report of an expert group on learning from adverse events in the NHS chaired by the Chief Medical Officer', 2000
[3] Ibid.

2.3.2 It will never be possible, however, to eliminate adverse clinical outcomes completely. Errors will always occur. Where they do, fair and effective procedures must be in place to allow injured patients to pursue their concerns and access a range of suitable remedies.

2.4 Economic Concerns Should Influence the Reform Debate to a Limited Extent Only

2.4.1 We are extremely concerned about the extent to which economic considerations may influence the shape of reforms introduced by the Government. We accept that the procedures in place to deal with injured patients' concerns and claims must be as cost effective as possible provided such procedures are fair. We also accept that the current legal system is not always cost effective and we make suggestions as to how this can be remedied below.

2.4.2 We cannot accept, however, the suggestion that the amount of compensation awarded to claimants should be reduced because of the effect of such awards on NHS resources. The common law dictates that where a personal injury victim can establish that his injury was caused negligently, he is entitled to full compensation to put him in the position he would have been in had the negligence not occurred. The common law has developed in this way following much judicial analysis of complex issues relating to corrective and distributive justice. Those negligently injured in the NHS should not be treated any differently from those injured within prison hospitals, private hospitals or indeed those injured in road traffic accidents or at work. The NHS owes the same common law duty to its patients, as employers to their employees and road users to other road users. Economic concerns should not lead to their separate treatment.

2.5 The Cost of Clinical Negligence Claims Needs Further Analysis

2.5.1 We are also concerned about the influence of economics on this debate because the information that is currently available on the costs of clinical negligence does not appear to be completely reliable. This may lead policy makers to introduce disproportionate reforms unnecessarily. The collation of costs information in this area by the Government has been limited. This is demonstrated in written answers to recent parliamentary questions[4] in which the following table, citing figures on the amounts included in the National Audit Summarised Accounts for clinical negligence expenditure for the latest available years, has been reproduced:

Accounting Period	£ million
1996 – 1997	235
1997 – 1998	144
1998 – 1999	221
1999 – 2000	373

The figures in the above table suggest a rise in expenditure on clinical negligence claims, but in written answer it is accepted that the above amounts are not directly comparable because of different accounting policies in the various accounting periods. In addition, the summarised accounts do not identify the figures for compensation payments and legal costs separately.

2.5.2 Paul Fenn, having noted the increasingly vague and imprecise estimates of the overall costs of negligence to the NHS during the 1990s, conducted analysis to discover the actual position. In commenting on press reports in 1999 quoting the auditor general's figure of £2.8 billion as an indicator of the amount spent or still owed on clinical negligence by the NHS he stated:

[4] House of Commons Hansard (Written Answers): 19 July 2001, col. 735W; 25 April 2001, col. 286W

> "We regard estimates of the outstanding liability of the NHS, such as the 2.8 billion [pounds sterling] quoted earlier, as deeply misleading. We have shown that this represents the aggregate estimated cost of outstanding claims, most of which will never be paid a single penny and some of which will not be paid for many years, if not decades."[5]

2.5.3 The most recent figures have been quoted by the National Audit Office (NAO)[6] which states that the estimated net present value of outstanding claims at 31 March 2000 was £2.6 billion (up from £1.3 billion at 31 March 1997) and that in addition there is an estimated liability of a further £1.3 billion where negligent episodes are likely to have occurred but where claims have not yet been received. Paul Fenn's earlier research shows the care with which such broad estimates should be treated and we urge the Advisory Committee to analyse the NAO's conclusions and the figures on which they are based.

2.5.4 Having looked at the NAO's methodology, outlined in appendix one to its report, we are concerned that its conclusions are partly based on the analysis of claims closed since 1 April 1995 for events occurring before that date. We strongly suspect that the costs in claims of that age are not representative of the costs in claims conducted more recently, especially following the introduction of the new civil procedure rules and the pre-action protocol for the resolution of clinical disputes. Nor does the analysis of such claims reflect the number of measures introduced to improve the value for money achieved in clinical negligence cases funded through the Legal Services Commission. For example, since August 1999 only clinical negligence specialists holding licences with the Commission have been able to provide publicly funded services in new cases. David Lock, in response to a parliamentary question on these issues, noted that as a result of such reforms the number of new certificates issued annually for

[5] Fenn (2000) op cit.
[6] 'Handling Clinical Negligence Claims in England, National Audit Office, HC 403, session 2000-2001, 3 May 2001

clinical negligence claims by the Commission was just over half the number being issued five years ago. Indeed, he added that the net cost of clinical negligence cases to the Legal Services Commission fund fell from £64.6 million in 1998-1999 to £60.6 million in 1999-2000.[7]

2.6 Reform in Context

2.6.1 Finally, in considering reform of the way in which clinical negligence claims are handled we believe it is necessary to consider the general procedures in place for dealing with patients who suspect that something has gone wrong with their treatment and not just the legal system. This includes both the response of the relevant NHS staff and the NHS complaints system. This is important because the legal system does not operate in isolation and injured patients rarely consider litigation automatically or immediately.

3. PREVENTION

3.1 With over 850,000 patients suffering injury as a result of adverse events every year the Government must prioritise the prevention of such events as far as possible. This must include proper investment within the NHS and also the implementation of clear and effective risk management systems. Where adverse events have not been prevented it is vital that systems are in place that allow the NHS to investigate how such events occurred and how they can be prevented in the future. The NHS must learn from its mistakes. The most effective way of reducing the costs of adverse incidents is to avoid them happening in the first place.

3.2 We are encouraged by the Government's increasing interest in this area but are concerned that too many bodies exist with overlapping interest in, and

[7] House of Commons Hansard (Written Answers): 10 May 2001, col.313W

responsibility for, patient safety and the accountability of NHS staff. All of the following, for example, have responsibilities relating to patient safety: Commission for Health Improvement, National Patient Safety Association, National Institute for Clinical Excellence, NHS Litigation Authority, Medical Defence Union and the National Clinical Assessment Authority. Indeed, the establishment of a further body, an Office for Information on Healthcare Performance, has recently been recommended by Professor Kennedy following his inquiry into children's heart surgery at Bristol Royal Infirmary. The relationships between these various bodies and the extent to which information is exchanged between them are unclear. As has been demonstrated on the railway network, where safety systems are fragmented and the lines of responsibility for safety unclear, avoidable accidents can still occur. We believe that a more co-ordinated, less fragmented approach to patient safety should be adopted within the NHS.

4. ANALYSIS OF THE CURRENT SYSTEM FOR DEALING WITH ADVERSE CLINICAL OUTCOMES

4.1 Response by the Relevant NHS Staff

4.1.1 In considering how the current systems for dealing with adverse clinical outcomes should be reformed, the problems within them must firstly be identified. One of the initial problems is that it is unclear to NHS staff how they should react when they suspect a patient has been negligently injured. Both staff and patients, therefore, will have different expectations as to what should be said and the action that should be taken. This problem was recognised by the National Audit Office:

> "Patients may not claim because they do not know that they have grounds for doing so. It is the Department of Health's policy that patients should be told where they have suffered an adverse medical incident and should be offered remedial healthcare, a factual explanation and an apology. But the

> Department of Health have told us that they do not see it as the business of the NHS to advise patients that there might on the fact of it be grounds to believe an adverse medical event may have been due to negligence, or suggest patients seek legal advice, or admit liability. There is, however, no clear departmental guidance to staff about this policy and there are cases where staff give indications to patients that there are grounds for suspecting negligence was a factor in an adverse incident or advise them to consult a solicitor."[8]

4.2 The NHS Complaints and Legal System

4.2.1 Where adverse events occur which cannot be resolved by the relevant NHS staff, procedures must be in place that allow injured patients to pursue their concerns with or against those they believe to be responsible for their injuries. It must always be remembered that injured patients do not complain or litigate for the sake of it – they do so to access a range of remedies. A survey of 117 claimants conducted by Mulcahy revealed that at the outset of litigation claimants have an extensive range of aims some of which are listed below:

- The responsible party to admit fault
- To prevent a recurrence
- To have an investigation into what happened
- An apology
- To be told what happened
- Compensation[9]

4.2.2 To obtain those remedies the injured patient can pursue a complaint through the NHS complaints procedure or a legal claim for compensation.

[8] National Audit Office (2001) op cit, executive summary, paragraph 12
[9] 'Mediating Medical Negligence Claims: An Option for the Future?', Linda Mulcahy, Marie Selwood, Ann Netten (1999), paragraph 2.15

The complaints and legal system operate alongside each other but are mutually exclusive. Indeed, a patient often has to make a choice between them.

4.3 Shortcomings of the NHS Complaints System and the Implications of Those Shortcomings

4.3.1 The complaints system generally leads only to "soft" remedies and not to financial compensation. Some Trusts do make ex gratia payments to patients but there is no consistent or established process for doing so. A patient determined to claim even small amounts of compensation will, therefore, often be required to pursue a legal claim. The complaints system has been studied and criticised by many groups including the Public Law Project[10], Health Which?[11], the Consumer's Association[12], the House of Commons Health Committee[13], the House of Commons Select Committee on Public Administration[14] and most recently a "national evaluation" has been conducted by the York Health Economics Consortium[15]. It is apparent from the conclusions of these groups that the complaints system is ripe for reform. A stark conclusion drawn following the national evaluation was that "[c]urrent mechanisms are inadequate to ensure that complaints are adequately addressed or that necessary action follows from a complaint."[16] The common findings from the several studies are as follows:

- Many complainants are generally unhappy with the overall way in which their claims are handled (40% of respondents to the Consumer's

[10] 'Cause for Complaint? An Evaluation of the Effectiveness of the NHS Complaints Procedure, H Wallace & L Mulcahy, The Public Law Project, 1999.
[11] 11 April 2000
[12] Survey conducted in 1997, the results of which were given in evidence to the House of Commons Health Committee in 1999
[13] Sixth Report of the Health Committee: Procedures Related to Adverse Clinical Incidents and Outcomes in Medical Care, 23 November 1999
[14] Second Report of the Select Committee on Public Administration, session 1998-1999
[15] 'NHS Complaints Procedure National Evaluation', March 2001
[16] Ibid, executive summary, paragraph 11

Association survey; 51% of respondents in the Health Which survey and in the national evaluation only one-third believed that their complaint had been handled well[17]);

- Initial investigations into complaints are often poor. The House of Commons Health Committee recommended that initial investigations of a complaint needed to be much more thorough[18];

- Complainants often experience difficulty accessing information, including their own health records;

- The complaints system is often perceived as biased and unfair (in the national evaluation 75% of complainants who requested an independent review thought that the system was biased[19]);

- There is often poor communication between staff and patients (in the national evaluation over 25% thought communication between patients and staff was the most important area for reform[20]);

- Complaints handlers would benefit from improved training

- Complainants often feel that appropriate action has not been taken to prevent the same problems happening again.

4.3.2 Problems within the complaints system do not only cause distress for those pursuing a complaint but may also lead patients to litigate their claims. Mulcahy noted:

> "A recurrent theme during the telephone survey of claimants was respondents' assertion that the attitude of staff towards their claim had fuelled their pursuit of compensation."[21]

[17] Ibid, paragraph 5
[18] Second Report, op cit, paragraph 79
[19] (2001) op cit, paragraph 5

4.3.3 The Association of Community Health Councils for England and Wales (ACHCEW) in giving evidence to the House of Commons Select Committee on Public Administration "pointed to the connection between the effectiveness of the complaints procedure and the volume of litigation in the National Health Service".[22] The ACHCEW argued that "the alternatives to the complaints procedure (taking legal action or taking a complaint to the relevant professional body) are often more daunting, more time consuming and, in the case of legal action, more expensive for people to pursue. An improved NHS complaints procedure could prevent complainants taking inappropriate legal action or taking the complaint inappropriately to a professional regulatory body."[23]

4.3.4 This link has also been recognised by the House of Commons Health Committee which noted:

> "One of the main problems we came across was the lack of information which is forthcoming from the hospital or medical authorities to the families. As we have already stressed, patients want a full and frank explanation but this is rarely given. This lack of information, and other problems with the initial complaints stage, means that families become suspicious and feel they are forced to consult solicitors to obtain information. Also many patients and relatives are encouraged to go down the litigation route as they see it as the only way that doctors are held to account…"[24]

[20] Ibid, paragraph 6
[21] (1999) op cit, paragraph 2.4
[22] Sixth Report, op cit, paragraph 27
[23] Ibid
[24] Second Report, op cit, paragraph 119

4.4 Shortcomings of the Legal System

4.4.1 Obtaining remedies through the legal system, however, can take time and be expensive. It is believed that the pre-action protocol and civil procedure rules, introduced in 1999, have improved the litigation system considerably, though the extent of any such improvements are still not yet clear. The Lord Chancellor's Department has conducted an early evaluation of the civil justice reforms[25] and has found that the pre-action protocols are working well to promote settlement before the issue of proceedings and to reduce the number of ill-founded claims[26]. In addition the time between issue and hearing for those cases that go to trial has fallen.[27] It is noted, however, that it is too early to provide a definitive view on costs as "the picture is still unclear with statistics difficult to obtain and conflicting anecdotal evidence."[28] Research amongst our members suggests that whilst some of the expense and delay in litigation is unavoidable, further reforms could be introduced to increase the efficiency of the legal system.

4.4.2 In addition to the above, the law generally results only in the award of financial compensation and may not address other needs or concerns of injured patients. Mulcahy's research revealed that less than half of those litigants who wanted an investigation, apology or to be told what had happened actually received those remedies by the end of the legal process[29], stating:

> "The current system seems ill equipped to provide remedies to claimants – such as an explanation and investigation of what has occurred – which rely on effective communication between disputants…It is not surprising that all claimants do not receive financial compensation. What is surprising is the

[25] 'Emerging Findings: An Early Evaluation of the Civil Justice Reforms', Lord Chancellor's Department, March 2001
[26] Ibid, paragraph 3.12
[27] Ibid, paragraph 6.1
[28] Ibid, paragraph 7.1

number of 'soft' remedies, such as an explanation, that they do not receive, whether or not their case is substantiated. Regardless of whether the claimant's case can be proven, the figure reveals that undue emphasis may be being placed on risk avoidance strategies at the cost of effective, responsive and fair claims management."[30]

4.5 Problems Caused by the Mutual Exclusivity of the NHS Complaints and Legal Systems

4.5.1 In addition to problems within both the complaints and legal system, problems are also caused by the relationship between them. Even if an injured patient only wants a small amount of financial compensation, he must pursue a legal claim, as compensation is not available through the complaints system. The system, therefore, actively encourages low value claims that are often disproportionately expensive to litigate. For those who neither qualify for public funding nor are able to obtain affordable after-the-event insurance, compensation is simply not available.

4.5.2 It is clear from the above, therefore, that claimants are not currently served well by either the complaints or legal systems due to problems within each system and the relationship between them. Following an adverse event, claimants are often required to follow time consuming, expensive and distressing procedures and yet still do not receive the remedies that are important to them.

[29] (1999) op cit, figure 2.2
[30] (1999) op cit, paragraphs 2.12 – 2.18

5. PROPOSED PROCEDURES FOR DEALING WITH ADVERSE CLINICAL OUTCOMES

5.1 A Duty of Candour

5.1.1 Reform of this area must focus on the interests of injured NHS patients and create a system which meets their needs and wishes. We believe it would be in the interests of injured patients if health professionals had a duty of candour. This would enable both health professionals and injured patients to be clear about the action that should be taken when an adverse clinical outcome occurs. The National Audit Office has recommended that the Department of Health should give clear guidance on the information they may give to patients who have suffered adverse incidents, including those who may have suffered adverse harm.[31] Such clear guidance exists for solicitors where they discover an act or omission which would justify a claim against them – such solicitors are under a duty to inform the client that independent advice should be sought.[32]

5.1.2 Such a duty would encourage greater openness within the NHS which is traditionally blamed on litigation. As stated by the Health Committee:

> "Trusts and health authorities must be reassured that giving information to patients early on is more likely to prevent litigation than spark it."[33]

5.1.3 The beginnings of such a duty appear within the pre-action protocol for the resolution of clinical disputes which includes a good practice commitment that healthcare providers should:

> "[A]dvise patients of a serious adverse outcome and provide on request to the patient or the patient's representative an oral

[31] National Audit Office (2001) op cit, recommendation (iv)
[32] The Guide to the Professional Conduct of Solicitors, chapter 29, principle 29.09
[33] Second Report, op cit, paragraph 121

or written explanation of what happened, information on further steps open to the patient, including where appropriate an offer of future treatment to rectify the problem, an apology, changes in procedure which will benefit patients and/or compensation."

5.2 Maintaining the Right to Litigate

5.2.1 Whilst litigation can be distressing, we believe it is imperative that NHS patients who suspect they have been injured negligently should continue to have the right to pursue a legal claim for compensation in the courts, should they wish to do so, regardless of the value of their claim. This option is, and would still be, available to the victims of other types of negligence including those injured in prison or private hospitals. NHS patients should not be treated any less favourably.

5.2.2 To remove the right to litigate in these circumstances because of the perceived cost and effect on the medical profession would be to attack a symptom, rather than the cause of the problem. The cause of the problem is that over 850,000 adverse events resulting in harm occur annually. The NHS patient will already have suffered once at the hands of the NHS and should not be made to suffer again by having a limited range of remedies available to him. Some injured patients will wish to hold NHS Trusts accountable in law and should not be denied the opportunity of having their claims determined in this way. Even low value claims can be of considerable importance, for instance, adverse events causing a fatality are of importance to both the victim's family and society generally.

5.2.3 We accept, however, that the current complaints and legal systems are far from ideal and make the following proposals:

- Complaints handling and early claims management within the NHS should be much more effective and pro-active so that as many legal claims are avoided as possible;

- Financial compensation of up to £10,000 should be available through the complaints system so that low value claims are diverted from the litigation system where appropriate (although the injured patient should always have the option to litigate if desired);

- The civil litigation system should be further reformed to increase its efficiency and cost effectiveness;

- Increased use of mediation should be encouraged where it is appropriate.

5.3 Improving the NHS Complaints System

5.3.1 We believe there is a clear link between the effectiveness of the complaints system and the number of people who resort to litigation. It is clear that the current NHS complaints system is not particularly effective in resolving patients' concerns and that it is ripe for reform. Research has indicated that injured patients often do not just want financial compensation but want a wider range of remedies. It is highly likely, therefore, that fewer people would resort to litigation if they felt confident that:

- Their complaint would be handled in an independent manner;
- Their complaint would be thoroughly investigated and the "truth" discovered;
- A full and clear explanation would be given;
- An apology would be given where appropriate;
- Accountability would be achieved;
- Steps would be taken to prevent the same mistakes or problems arising again.

5.3.2 Reducing the number of people who resort to litigation by improving the NHS complaints system will benefit all involved – patients, NHS staff and NHS Trusts. Concerns could be dealt with much more quickly and at less cost. Both the Department of Health and the Welsh Assembly are consulting on reform of the complaints system following the national evaluation and so the time is certainly right to introduce sweeping changes.[34]

5.4 Providing Compensation Through the Complaints System

5.4.1 Above we have suggested that increasing the effectiveness of the complaints system is likely to reduce the number of people resorting to litigation. We believe a reduction could also be achieved by allowing financial compensation to be awarded up to a value of £10,000 through the complaints system. This would reduce, though not eliminate, the need for those with low value claims to litigate. This would hopefully allow patients to recover compensation more quickly and with less stress. It would allow those who would otherwise be unable to afford litigation to obtain compensation where appropriate. Such a system would also reduce costs to the NHS as it is these low value claims that are disproportionately expensive when litigated.

5.4.2 The virtues of allowing patients to access financial compensation where appropriate through the complaints system has been recognised by many, including the Clinical Disputes Forum. The Select Committee on Public Administration has noted:

> "[The Association of Community Health Councils of England and Wales] told us that they would welcome a more explicit mechanism in the NHS complaints procedure for financial compensation to be awarded. There is nothing in the

[34] Department of Health, Reforming the NHS Complaints Procedure: A Listening Document (September 2001); Welsh Assembly, NHS Complaints Procedure Evaluation Report Consultation

> statutory directions on the NHS complaints procedure to preclude a Trust or a panel from recommending financial redress, but there is a widespread belief that it is not considered appropriate…The Ombudsman has said that it should be made easier for financial redress to be paid under the complaints procedure."[35]

In conclusion the Committee recommended as follows:

> "We accept Sir Alan Langlands' warning against turning the NHS into a small claims court but we think the best hope for avoiding an ever increasing resort to litigation is the creation of a proper code of practice for the payment of financial redress in the NHS, as there is in other Government departments and we recommend that the Government should introduce such a code."[36]

The Health Committee later supported that recommendation.[37]

5.4.3 Injured patients with potential claims of less than £10,000 should, as noted above, however, still be able to bring their claim within the legal process if they would prefer. For this reason, public funding should still be available to such claimants as is now.

5.4.4 In this response we have concentrated on the advantages of allowing compensation, up to £10,000, to be awarded through the NHS complaints system. We recognise that such a system will raise several complex issues, such as the basis on which compensation should be paid. We do not believe, however, that these issues are insurmountable and we are committed to working with all interested parties to resolve them.

Document (September 2001)
[35] Sixth Report, op cit, paragraph 28
[36] Ibid.

5.5 Improving the Legal System

5.5.1 We have stressed that all injured NHS patients should be able to resort to litigation if they wish. We accept, however, that clinical negligence litigation can take time and be expensive. This, more often than not, however, is not the fault of the claimant or his lawyers but the result of the nature of the law. The claimant has the burden of proving that the Trust was negligent on the balance of probabilities in accordance with a rigorous test.[38] This includes establishing that the Trust's negligence actually caused the claimant's injuries, which often involves complex medical and scientific issues. In most cases, however, the responsible NHS Trust holds the relevant information and the claimant is required to use experts to construct his case from scratch. This requires an awful lot of investigative work. In addition claimants usually receive their damages in a lump sum and on a once and for all basis. This means that damages cannot be awarded until the claimant's prognosis is clear, which may take several years.

5.5.2 The civil justice system has recently been reformed but research amongst our members suggests that further improvements could be introduced to make the system more efficient and cost effective. Such improvements could include:

- Introducing measures to encourage NHS Trusts to investigate claims (and so admit liability where appropriate) at an earlier stage than currently occurs;

- Reinforcing sanctions for non-compliance with timescales within the pre-action protocol for the resolution of clinical disputes and civil procedure rules or unreasonable conduct (such as withholding documents, information and so on). The CDF recently conducted research into how satisfactorily the pre-action protocol is working in

[37] Second Report, op cit, paragraph 133

practice. The main findings were very positive but it was discovered that judges need to be much more robust and proactive in applying sanctions for non-compliance;

- Improving the efficiency of the court system. Research amongst our members suggests that delays are caused by problems obtaining court appointments and trial dates. A single national trial list for fixing trial dates (based on the system in operation within the Royal Courts of Justice) could assist;

- A general acceptance amongst both claimant and defendant representatives that split trials should be the general rule;

- Reinforcement of the pre-action protocol requirement on claimant solicitors to notify Trusts when claims have been discontinued (whether proceedings have been issued or not);

5.5.3 More fundamental reforms could also be introduced such as reversing the burden of proof. Defendant Trusts are in the possession of most of the information relevant to the case. Requiring the Trust to prove that it was not negligent would, therefore, reduce the investigative costs currently incurred by the claimant. This could involve reversing the burden on some issues only. For example, the claimant could have the burden of proving the Trust was in breach of its duty and, if successful, the burden on causation could shift to the Trust. Alternatively the burden of proof could be reversed on condition as occurs in The Netherlands. In that jurisdiction, the claimant has the burden of proving his case but if the relevant hospital fails to provide the information required by the claimant to prove his case, the burden of proof is reversed and placed on the hospital.[39]

[38] The "Bolam" test: Bolam v Friern Hospital Management Committee [1957] 2 All ER 118, [1957] 1 WLR 582
[39] Timmer v Deutman, HR 20 November 1987, NJ (1988) 500

5.6 Increased Use of Mediation

5.6.1 The legal process could also be improved with the increased use of mediation which can:

- Be constructive and less adversarial than litigation thereby reducing the alienation of the parties and restoring relationships;

- Increase the possibility of non-monetary remedies and creative remedies to suit the individuals involved;

- Address the real causes of the dispute;

- Be set up speedily;

- Allow injured patients to feel that they have some control over their claim.

5.6.2 Following the mediation pilot scheme, Mulcahy stated:

> "Mediation is not a life-changing event and parties to the mediations did not come away having had all their grievances addressed, but on the whole those who participated in the mediations tended to be very positive about their experience. Some aspects of the arrangements were criticised, but many of these were capable of being remedied…Claimants were particularly complementary about the way mediation allowed them to participate in a way that may not otherwise have been possible. The solicitors involved also recognised a variety of instances in which negotiations are transformed and enhanced by being focused and scheduled for one day. Representatives of the trusts or health authorities expressed satisfaction at

being able to close a claim and work towards a restoration of trust with a member of their client population."[40]

5.6.3 Views on the kinds of claim for which mediation is suitable differ considerably. Mulcahy found that there was an overall preference amongst experts for referring simple, low and medium value claims to mediation.[41] It is clear that mediation can only work if the parties have sufficient information available to them and provided there is no point of legal principle at stake. The extent to which mediation can save costs, however, is unclear. CEDR, in evidence to the Health Committee stated that it believed mediation to be faster and cheaper than litigation - in 1998 the average cost saving amongst those using CEDR's mediation was £86,000 per party per case.[42] Mulcahy has, however, stated:

> "…throughout this chapter the large range of costs of medical negligence has been emphasised. This, and the very limited data available from the pilot mediation cases, makes a comparison of costs extremely tentative…The costs of mediation form a much higher proportion of the total legal costs for the defence than for the claimant (whose legal costs are higher overall). If there are any savings to be had from introducing mediation they are most likely to accrue to claimants' legal costs through reducing the length of cases and costs involved in those few cases that would otherwise have reached court. But for the defence, mediation would seem to cost more because it brings case preparation forward and involves the medical profession more directly. The increased participation of the doctor may increase satisfaction amongst claimants and facilitate greater accountability. A

[40] (1999) op cit, paragraphs 6.33 – 6.34
[41] Ibid, paragraph 4.4
[42] Second Report, op cit, paragraph 128

more pro-active and speedy preparation of defences may also be desirable. However, both are achieved at cost."[43]

5.7 Why No-Fault Compensation is Not Recommended

5.7.1 Some argue for the introduction of a no-fault compensation scheme. We admit that initially such a scheme looks very attractive. It would appear to allow for compensation to be paid to an increased number of injured patients. Further analysis of such a scheme, however, highlights its deficiencies in practice and demonstrates that the term "no-fault compensation" is misleading. Such a scheme would not truly operate on the basis of "no fault" as does our social security system. Nor would the monetary awards through such a scheme be compensatory in the sense of being restitutionary as under the common law.

5.7.2 Firstly, whilst the administrative costs per claim could probably be reduced through a no-fault scheme, more people would qualify for compensation and so it would become more expensive. This would especially be so if the scheme encapsulated the compensation of babies suffering from cerebral palsy. The prohibitive costs of a no-fault scheme were discovered in New Zealand where the scheme was made affordable by firstly, restricting access to the scheme and secondly, reducing the amount of compensation available to those claimants who were able to access the scheme. We do not think this would be acceptable and our arguments for the retention of full compensation are expanded upon below.

5.7.3 Secondly, we do not believe such a scheme would actually solve the problems outlined above. We have noted that claimants do not simply seek financial compensation following negligence but a whole host of other remedies. As noted by the Health Committee:

[43] (1999) op cit, paragraph 7.49

> "Perhaps most importantly, [a no fault compensation scheme] may result in patients being "fobbed off" with compensation, rather than achieving full satisfaction, apologies and remedial action for their complaint."[44]

5.7.4 Neither would such a scheme completely eliminate the lottery of injured patients receiving compensation. Claimants would still have to prove causation. This is one of the most complicated and keenly contested issues in clinical negligence litigation and one of the most difficult aspects of a negligence claim to prove. Many injured patients may still, therefore, go uncompensated.

5.7.5 Nor do we believe that a no-fault compensation scheme would necessarily make NHS Trusts and the staff within them more open. Our impression is that lack of openness within the NHS is a cultural problem, with a cause much more deep rooted and long standing than the threat of litigation.

5.7.6 The fact that no-fault compensation schemes have been introduced elsewhere does not mean that such a scheme would operate well within this jurisdiction, as the success of such schemes depend very much upon socio-economic conditions. Neither the New Zealand nor Swedish models could, therefore, be directly imported into this country. Working out whether a no-fault compensation scheme would even be feasible in this jurisdiction would be extremely complex and would require extensive and thorough research into the following:

- The number of adverse clinical outcomes within the NHS;
- The distribution of such adverse clinical outcomes;
- The nature of the adverse events;

[44] Second Report, op cit, paragraph 132

- The definition of adverse clinical outcomes that would be included in the scheme;

- The extent to which compensation would have to be reduced in order to be able to operate the scheme economically and the extent to which this would satisfy the electorate;

- The tax and social security systems in those jurisdictions in which no-fault compensation schemes exist;

- The procedures to be used to prevent accidents;

- The means by which doctors would be held accountable.

6. REMEDIES

We have already stressed the importance of injured patients having access to a range of suitable remedies through both the complaints and legal systems. We would, however, like to make some additional points in relation to the remedies that should be available.

6.1 Retention of Full Compensation

6.1.1 We strongly believe that full compensation should remain available through legal claims. It should not be limited through the introduction of caps on damages or a tariff scheme, as exists for criminal injuries. Personal injury victims are entitled to full compensation by virtue of the common law and despite media portrayals it is not awarded as a 'bonus'. Compensation is currently awarded following careful calculation and to meet actual expenses and losses caused by the injury. As already stated on several occasions, the victims of negligence within the NHS should not be

treated differently from the victims of other negligence who would continue to be entitled to full compensation.

6.1.2 We also have doubts about the effectiveness of any tariff scheme for adverse clinical outcomes. When people enter the NHS they are already ill. It can be difficult in clinical negligence litigation to decipher which injuries have caused by negligence and which injuries would have occurred in any event. This requires close and careful analysis and we believe it would be difficult for a clear tariff of compensation to be constructed in these circumstances.

6.2 Retention of s.2(4) Law Reform (Personal Injuries) Act 1948

6.2.1 At the moment a victim can recover damages for the reasonable expense of private health care rather than be required to obtain that future health care on the NHS under s.2(4) Law Reform (Personal Injuries) Act 1948. We are aware that some organisations have questioned the need for the retention of this section and have suggested its abolition. Such calls stem from concern for the cost of private health care and the perception that claimants whose compensation includes the cost of private healthcare receives that healthcare free from the NHS in any event.

6.2.2 We strongly believe that s.2(4) should remain. There is little, if any, evidence to suggest that the abolition of s.2(4) would have a significant impact on the economics of clinical negligence claims. In contrast, there are important reasons why a claimant should be able to recover for private health care. Claimants may not wish to obtain treatment from an NHS Trust which has already let them down – they may have no confidence in the treatment provided, relationships with key NHS staff may have been damaged. In addition, or alternatively, claimants may fear or know that the NHS will be unable to meet their needs.

6.2.3 Professor Hazel Genn conducted a survey of claimants following the conclusion of their claims on behalf of the Law Commission. She found that a significant proportion opted for some private medical treatment, often using physiotherapy or osteopathy to assist in the rehabilitative process. The choice of private care was based on perceptions of its speed and quality as well as the fact that the type of service might not have been available on the NHS.[45]

6.3 Rehabilitation

6.3.1 APIL fully supports the provision of timely rehabilitation as it allows victims to achieve a better ultimate recovery, adapt to their family and social environment and achieve employability as far as is possible. Rehabilitation is successfully used in Sweden where people suffering from serious injuries have a one in two chance of getting back to work, compared with a one in ten chance in Britain.[46]

6.3.2 We have been committed to increasing and encouraging the use of rehabilitation within the context of litigation. The advantages of rehabilitation have been recognised by the insurance industry within the context of personal injury litigation. Successful rehabilitation can lead to reduced compensation as victims' losses and expenses are reduced. APIL played an integral part in the development of the Code of Best Practice on Rehabilitation, Early Intervention and Medical Treatment which calls for both claimant and defendant representatives to work together in the context of litigation and focus on the early release of adequate funds to enable to claimants to access rehabilitation at an early stage when it will be of most benefit.

[45] Personal Injury Compensation: How Much is Enough? A study of the compensation experiences of victims of personal injury, Law Com No. 225 (1994), paragraph 3.13
[46] This statistic was used by John Monks, General Secretary of the Trades Union Congress in a TUC conference entitled "Creating a healthier nation: getting Britain back to work" in May 2000

6.3.3 We would also encourage this approach in litigation with the NHS. Rehabilitation in the context of litigation can only work, however, if issues are dealt with quickly and early admissions are made where appropriate. Suitable rehabilitation services, however, more often than not have to be purchased. This is because rehabilitation services are poorly provided within the NHS and within the community. This was revealed by the House of Commons Health Committee's inquiry into the organisation and availability of rehabilitation for head injured adults. The Committee stated:

> "In practice it is usually left to charitable bodies to pick up whatever individuals they can before people are forced into crisis situations by their problems, much later along the line."[47]

6.3.4 The Health Committee's inquiry revealed the Department of Health's limited appreciation and understanding of the benefits of rehabilitation[48] and also the poor organisation and financing of rehabilitation for head injured adults within both the NHS and the community. We suspect that a similar picture would emerge in relation to rehabilitation for other injuries.

6.3.5 Rehabilitation should certainly be considered in the context of clinical negligence claims. No initiatives or reforms should be introduced, however, on the assumption that timely and adequate rehabilitation will be available on a free basis to all injured victims through the NHS or statutory services.

[47] House of Commons Health Committee, Head Injury: Rehabilitation, Third Report, session 2000-2001, paragraph 28
[48] Ibid, paragraph 50

7. METHODS OF AWARDING COMPENSATION

7.1 Claimants Should Be Free to Choose the Way in Which They Receive Their Compensation

7.1.1 There are various ways in which compensation can be awarded to a claimant – in a lump sum, in periodic payments following a review of the claimant's circumstances or through a structured settlement. All methods have their advantages and disadvantages for both claimants and the NHS as noted below. In view of this, we believe that all three methods should be available to claimants but that claimants should be free to choose between them.

7.1.2 The claimant, as the injured person, should be free to choose the method of receiving compensation that would best suit his circumstances. No one should have the power to require a claimant to receive his compensation in a certain way. This system would operate, therefore, in the same way as the current procedure for provisional damages[49], which allows claimants with an unclear prognosis to receive damages on the assumption that their condition will not deteriorate, but return for further damages in the future if it does. The claimant is the only party entitled to make an application for provisional damages.

7.2 Lump Sum

7.2.1 Traditionally compensation is awarded in a lump sum and on a once and for all basis. The traditional justification for doing this is that it allows finality of litigation – claimants can move on and look to the future and defendants are certain of their liabilities. Hazel Genn found that there was a strong preference for being paid a lump sum, except amongst

[49] s.32A Supreme Court Act 1981

respondents who had received settlements of £100,000 or more.[50] Reasons provided for this were as follows[51]:

- Personal control over money
- For the benefits of investments / savings
- Greater purchasing power
- End of claim process
- Better able to plan for the future
- Settlement too small for instalments
- Easier to manage
- Financial security.

7.2.2 The problem with awarding damages in a lump sum and on a once and for all basis, however, is that the award will almost certainly either be too low or too high as so many predictions relating to prognosis and life patterns must be made at the time of settlement or other conclusion. In addition, delays can occur in concluding the claim because compensation cannot be calculated until prognosis is clear which can take some time. For NHS Trusts, awarding compensation in lump sums may cause cash flow problems.

7.3 Periodic Payments Following Review of the Claimant's Circumstances

7.3.1 Awarding compensation in a series of periodic payments, however, may ease some of the cash flow problems experienced by NHS Trusts as a result of paying compensation. In addition, if the payments are made periodically following a review of the claimant's circumstances, the NHS could feel assured that the claimant is not being awarded compensation to which he is not entitled. Similarly, the claimant would not have to fear running out of money as if, following review, it appeared that he was in fact entitled to more compensation, he would be able to recover it.

[50] Law Com 225 (1994) op cit, page 181

7.3.2 Hazel Genn found that among the small number of respondents who said that they would have preferred instalment payments, the chief reasons given were either that respondents valued the security of having regular payments coming in or because they felt the money would last longer since they would not be able to spend it all at once or whenever they felt like it.[52]

7.3.3 There are, however, some disadvantages to awarding compensation periodically following review. Awarding compensation in this way would result in a lifetime relationship between the claimant and the NHS Trust that the claimant may not want. It is important, therefore, that periodic payments following a review of the claimant's circumstances should not be imposed on the claimant. In addition, whilst such a system may help the NHS Trust's cash flow, there is considerable debate about whether such a system would actually save any money in the long term. Some argue that periodic payments with reviews would increase administrative costs because files would be kept open, while others suggest costs would be reduced because lawyers would not have to engage experts to look so far into the future and predict, for example, life expectancy.

7.4 Structured Settlements

7.4.1 The structured settlement also provides an alternative to lump sum damages that allows claimants to receive regular payments for life. This, again, lessens the burden of financial management on the claimant and reduces argument on issues such as life expectancy.

7.4.2 A distinction must be drawn, however, between "top down" structures and "bottom up" structures. Top down structures still involve the calculation of the compensation as a lump sum. That lump sum is then used as

[51] Ibid, table 1008
[52] Ibid, page 183

consideration for "self-funded" periodical payments from the Treasury. The problem is that the Treasury require self funded payments to match annuity rates and as annuity rates are currently low, such settlements do not appear as if they will meet the future needs of claimants. Much, therefore, depends on the financial market at the time of settlement. Bottom up structures do not involve the calculation of a lump sum but instead involve the defendant replacing recurrent losses and/or expenses with periodic payments. The annuity rate is, therefore, irrelevant making this method of settlement much more attractive. Both methods, however, are inflexible in that they are incapable of changing to reflect the actual needs of a claimant once settlement or other conclusion of the claim has been achieved.

8. CONCLUSION

8.1 We have, at this early stage, provided a general analysis and outline recommendations only. We are committed to working with the Government and all interested parties on the detail of the above if our recommendations are accepted in principle. We believe it is firstly necessary, however, to conduct an in-depth analysis of the systems in place for dealing with clinical negligence claims and to collate reliable information relating to, for example, the costs of clinical negligence claims. It is essential that any reforms are well informed and that they address problems actually being experienced.