Written evidence submitted by The Centre for Effective Dispute Resolution (CEDR) (NLR0036)

Introduction

The Centre for Effective Dispute Resolution (CEDR), a not-for-profit Dispute Resolution Centre, has been in existence since 1990 and over that time assisted in the resolution of over 450,000 of disputes and complaints. We operate our services in the UK as well as globally. Accordingly, we use our experience in informing our answers below.

CEDR set up and serviced the pilot mediation scheme initiated by NHS Resolution in 2014 to test out the usefulness of mediation as an appropriate process for resolving clinical disputes. As a result of that pilot NHS Resolution set up a permanent scheme and CEDR has been one of the two service providers who successfully tendered for the provision of a panel of suitable mediators for the scheme. CEDR's panel was reappointed for a further three years as service provider through another tender process in 2019. CEDR's clinical panel comprises of 17 experienced mediators.

CEDR is also recognised as a thought leader organisation in the field of dispute resolution generally and frequently contributes to calls for evidence from governmental organisations both in the UK and internationally. Representatives from CEDR were, for instance, invited to contribute to Sir Liam Donaldson's investigations which led to his 2003 report *Making Amends*, which is of considerable relevance to the HSCC's current inquiry.

CEDR has asked one of its most experienced mediators, Tony Allen, to prepare this submission on their behalf, and they have seen and approved it as their submission. He is the author of *Mediating Clinical Claims,* enclosed with this submission, and also of *Mediation Law and Civil Practice* (2nd edition Bloomsbury Professional). He is a solicitor who retired from over 30 years in private practice handling clinical and personal injury claims to become a full-time director at CEDR in 2000 for 11 years. He is now a self-employed mediator and trainer and writes extensively on mediation. He has mediated over nearly 500 cases, including over 220 clinical negligence mediations since first involved in this sector in 1997 in the first NHS mediation pilot. He was a member of the Civil Justice Council Working Group which produced the report *ADR and Civil Justice* in 2018. In 2011, he was awarded the Lord Slynn Memorial Prize by the Civil Justice Council for his contribution to the development of mediation in the UK.

The call for evidence on NHS litigation reform by the HSC Committee (HSCC)

CEDR is particularly well placed to make submissions about the place of mediation as a valuable and successful process for resolution of clinical claims within the current litigation process. But it is appreciated that the HSCC's current survey is considerably wider than that, looking at entirely different ways beyond the civil litigation process of resolving clinical complaints and claims effectively, in a less costly way, and ensuring that the NHS learns lessons from what goes wrong. These are very familiar themes in mediation, a process which was established for the very purpose of making earlier resolution possible, by offering a better designed process to participants than they are likely to be offered by a court trial. It is a process that delivers what research, and indeed repeated anecdote and basic common sense, all suggest that many participants want:

- An opportunity to talk in a safe environment about what happened so that the underlying feelings of complainants and clinicians can be properly heard and responded to

- Apology or acknowledgement, even where there are matters in dispute as to breach of duty, causation or quantum
- Further explanations as to why decisions were or were not made
- (Extremely importantly) to hear about the implementation of lessons learned both by the Trust and clinicians in question and the NHS generally (through the work of the Safety & Learning Arm of NHS Resolution.
- Closure for claimants and clinicians under scrutiny, neither of whom welcome being ensnared in the civil litigation process
- Resolution of any issues of compensation as well, though often the above points seem more important to claimants.

However, we feel that in our role as thought leaders in dispute resolution generally we may be able to suggest ideas about some of the areas where we are not so fully or directly involved, and about the wider concerns and more radical solutions under discussion by the HSCC. We hope these thoughts will be helpful. After an initial commentary on mediation in civil litigation claims, we will respond point by point to your call for evidence where we feel we can contribute thinking.

1 Mediation and clinical claims

In order to buttress our submission that mediation is an excellent process for dealing with clinical claims, we enclose a paper entitled *The Future of Clinical Negligence mediation: the mediator's view*, written by four leading CEDR mediators on their clinical negligence panel, who between them have mediated hundreds of clinical claims. We hope this underlines the success of the NHS mediation scheme, giving "success" a very broad definition. Our views will no doubt be buttressed by a submission from NHS Resolution, who can give you more statistical information about the NHS Mediation Scheme as a whole. Their report *Mediation of healthcare claims – an evaluation,* published in early 2020, is already a useful appraisal of the scheme.

We also include two copies of a book written by CEDR's leading mediator of clinical claims, Tony Allen, in case any member of the HSCC would like to explore the field in greater depth. This book also contains a number of anonymised anecdotes which describe mediation in action.

We need not add much more to what these enclosures say, other than to underline several really important points:

- There is a clear recent trend for earlier mediation of clinical claims, which, if fostered, is bound to save substantial legal costs and also deliver earlier and better focused opportunities for party engagement and earlier outcomes, with savings on time and stress for all. Widespread mediation before issue of proceedings can be simply achieved by enforcement of proper compliance with the requirements of the Pre-action Protocol for Clinical Disputes (PAP). Courts should be much readier to inquire why mediation was not deployed before issue in accordance with the existing obligation to consider it seriously before issue, based on the exchange of information required by the PAP. There is no evidence that cases are harder to settle prior to issue. In our experience, many claimants are relieved to be given the opportunity to decide whether to settle quickly.
- The mediation process consists of a conversation facilitated by a neutral mediator. This is an inherently valuable way to conduct conversations about medical mishap, and is readily transferable to the earlier and better handling of serious complaints. To have a neutral to chair such meetings to ensure fairness of process and respectful assertions and response

could be used more readily by the NHS. Time and again, our mediators hear claimants say "if only this had been handled better in the first place, I would never have thought of bringing a claim". This is such a repeated theme that we cannot see why a proper pilot of independently chaired complaints meetings is not highly desirable to see if this would indeed reduce the dissatisfactions which so often emerge from the complaints process and turn into expensive litigation.

- We are also sure that a more elaborate version of the mediation process would help with the earlier and better resolution of major birth injury claims. This is explained more fully in the paper enclosed with this submission.

We now turn to the responses to your request for evidence.

2 What is the impact of the current cost of litigation on the financial sustainability of the NHS and the provision of patient care?

This is not a topic to which we can contribute usefully – information provided directly by NHS Resolution will be more valuable, such as their report: https://resolution.nhs.uk/wp-content/uploads/2020/02/NHS-Resolution-Mediation-in-healthcare-claims-an-evaluation.pdf. Such enormous sums are paid out and reserved by the NHS as set out in each NHS Resolution Annual Report that if a large proportion could be diverted to patient care instead of patient compensation, it would make a huge difference. Doing so will not be easy or quick.

Then in considering changes to be made by government in this area:

3 What changes should be made to the way that compensation is awarded in clinical negligence claims in order to promote learning and avoid the same problem being repeated elsewhere in the system?

This is a very difficult question, and needs to be considered in the light of the history of such discussions. It is a debate that was initiated by Sir Liam Donaldson which culminated in his report *Making Amends* in 2003. Several of his recommendations were implemented eventually, including especially the duty of candour. He debated the issue of no-fault compensation fully and came down firmly against it in favour of tortious compensation.

But his main recommendation for an NHS Redress scheme was never implemented, and the NHS Redress Act 2006 remains gathering dust in the DHSC library. That report suggested that NHS Trusts might be able to deliver the soft remedies outlined in section 1 above, maybe utilising mediation, plus compensation of up to £30,000. However, the path to litigation remained open if preferred. In the end, Government feared then that there would be a huge increase in claims for redress and that the scheme would be entirely unaffordable.

In considering wholesale reform, *Making Amends* also looked at the schemes in place in Sweden and New Zealand, but rejected them. Both are countries with smaller populations than England (let alone the UK). New Zealand has it seems generated the expectation among its people that you are not generously compensated for tortious injury caused by negligence. Whether that could possibly work politically in the UK is highly debatable. As to the Swedish model discussed in the HSCC call for

evidence and its earlier report *Safety of maternity services in England,* the system is summarised as follows:
Compensation is awarded based on whether an incident was considered avoidable rather needing to prove negligence. The decision about whether an incident is considered avoidable is taken by an experienced specialist.

The Chief Medical Officer of the relevant Swedish commercial insurer explained that:
under the Swedish system compensation is paid if it had been established that care had not been given "according to best practice" which negates the need to prove negligence.

Given that explanation, and comparing it with the English *Bolam* test, requiring the opinion of a reasonable (and logical) body of practitioners to justify an act or omission, it is hard to see how that differs from showing that harm was "avoidable". The real difference is that the decision over "avoidability" is taken by a single joint expert rather than by a judge. Again, whether in this jurisdiction expectations of all concerned could be managed to accept such a determination without the right to challenge it or to appeal must be highly questionable. Once such a determination becomes challengeable, the costs generated by adversariality begin to spiral upwards again.

4 How can clinical negligence processes be simplified so that patients can receive redress more quickly?

In our view, underlining what we said above in Section 1, by:

- Setting up independently chaired complaints meetings as soon as investigations by RCA/SI report or any inquest have been concluded; note that provision would have to be made in a continuing tort-based system for claimants to get legal advice over settlement terms - such a process should be piloted urgently in several Trusts, in collaboration with NHS Resolution. CEDR is confident that suitably qualified and experienced neutrals can be provided to service such a pilot.
- (While litigation remains the compensation process in place) requiring every clinical claim to go to mediation before issue of proceedings. There will be a few that cannot be resolved within the normal three-year limitation period (where prognosis is unclear) but far more cases than now – despite the upward trend - are capable of settlement before issue as a result of proper PAP compliance.
- In heavy birth injury cases – very often incapable of early settlement - making sure that communication is good from the earliest stages between family and the NHS (perhaps as suggested in our paper with an independent neutral facilitating such communication), thus extending the scope of the Early Notification Scheme.

5 How can collaboration between legal advisors be strengthened to encourage early and constructive engagement between parties?

Mediation is an excellent process for encouraging collaboration between parties and their lawyers. Our experience almost uniformly is that lawyers experienced in clinical claims have rapidly adjusted to the different atmosphere generated by mediation and work very sensibly even while their professional obligation to their clients, and that the moderating presence and influence of a mediator assists considerably. We can also ensure that claimants and their families have the chance

to say what they wish and are responded to thoughtfully and respectfully by the NHS, and have seen some remarkable reconciliations emerge from tragic and painful situations, enabling both claimants and clinicians to move on, having restored a sound relationship between patient and NHS. Each mediator could give a wealth of anecdotes to substantiate this, and a number appear in the book *Mediating Clinical Claims* enclosed with this submission.

6 What role could an expanded Early Notification Scheme play in improving transparency and efficiency system-wide?

Our views on this are best explained in our enclosed paper. We would point out that, not unlike NHS Redress, the Rapid Resolution and Redress Scheme has remained largely unused, whereas we see promising signs emerging from NHS Resolution's Early Notification Scheme. The problem with RRR surely is that it does not bar recourse to tortious litigation. No clinical negligence lawyer will feel able to advise use of RRR if their client would almost certainly get better compensation from the courts - indeed it would probably be negligent to advise use of RRR! The same would probably be true of NHS Redress if introduced.

Whether an entirely separate statutory scheme for serious birth injury cases, with no access to the continuing tortious system, is capable of being devised, afforded or getting accepted is hugely problematic. Can such a separate scheme really co-exist next to clinical claims dealt with on a normal tortious basis? And can an entirely statutory scheme for all clinical claims co-exist with all other normal tortious claims arising out of public and employers' liability claims, road traffic accidents and so on? And no government is going to have the appetite for abolishing the entire system of tort compensation for all types of claim.

We do think, however, that the ENS could be extended and improved as we have suggested in the enclosed paper, and would deliver for the time being, pending root and branch reform of the system, better outcomes and earlier and better learning within a process that enables parties to communicate freely and respectfully.

7 The Government has reiterated its intention to extend fixed recoverable costs, which limit the amount that can be paid out to meet legal costs, to clinical negligence cases with settlements of less than £25,000. At what level should these fixed recoverable costs be set, and are there any circumstances in which they should not apply to low value clinical negligence cases?

So long as fixed recoverable costs allow for reasonable costs of mediation, we have no comment to make about this. NHS Resolution has rightly negotiated sensible levels of fee for clinical negligence mediators at far lower rates than those sought by commercial mediators.

We would add that lower value claims are often those generating high emotion. Claims for still birth and the early death of child, related psychological damage to parents, and for the death of elderly non-dependent adults may not attract high damages, but they are important claims to those involved and benefit from careful handling by empathetic mediators seeking to restore the fractured relationships between the NHS and patients and their families.

8 To what extent does the adversarial nature of the current clinical negligence system create a "blame culture" which affects medical advice and decision making?

It is striking how any initial wish to "blame" which may have existed when a complaint or claim was first made will almost always translate into wishes to have an apology (and not regulatory disciplining), an explanation of what went wrong, and above all a desire to see that lessons have been learned, so that what is perceived and alleged to have gone wrong is less likely to happen to anyone else. Claimants and families with in a mediation have a well-prepared chance to tell the NHS what impact the events in question have had and the NHS then will respond empathetically and seek to answer the questions raised. After these exchanges, while agreeing compensation still takes time, we are sure that a good experience in dealing with these softer issues in a respectful way encourages settlement on both sides usually taking proper account of the fact that neither side will win everything is it went to court. A sensible acceptable settlement value emerges, which takes account of risks on each side, and the case is brought to an end on or shortly after the mediation day.

Of course, advocates argue their own client's case during the mediation, but the mediator also encourages openness and honesty about risks. The ability of parties to discuss these in private, with or without the mediator, and whether the mediation is in person or online, ensures that settlement is given the best possible chance, without its ever being compulsory to settle. It must always be possible for a good faith disagreement to end up before a judge. However, as NHS Resolution's statistics show, 99.7% of claims against the NHS settle at some point and markedly less than 1% go to court. What we are urging is that, if settlement is overwhelmingly the likely outcome, it should be conscientiously considered at the earliest possible time.

9 How important is it that any clinical negligence system encourages lesson learning and commitment to change as the result of any action?

This is already an important part of what is transacted at mediations. We have increasingly seen members of NHS Resolution's Safety and Learning Arm in attendance at mediations very ready to contribute and explain what they do to claimants and families and offering continued contact after the mediation. Sometimes this amounts to further and better explanation. Sometimes claimants and families are recruited to share their own personal experiences with NHS Resolution or the Trust involved, so as to contribute their insights to the learning of the NHS. Experienced mediators always make sure that these extra-legal issues are considered in advance of a mediation, the right people are in attendance and all possibilities for extra-legal benefits are explored, agreed and put in place.

10 What changes should be made to clinical negligence claims to enable a move away from a blame culture and towards a learning culture in the NHS?

As the above answer shows, this is already happening and is almost certain to grow, even within the existing system.

11 How can the Healthcare Safety Investigation Branch work to improve short term responses to patient safety incidences and therefore reduce the number of those who are forced to pursue litigation as a means of obtaining non-financial remedies?

We are interested in what the HSIB is very properly doing and would be very interested in an exchange with them to see how mediation might enhance their role. We feel sure for instance that we could arrange for the attendance of HSIB staff at mediations, so long as all the parties are comfortable with that. Clearly their task is to head off litigation if possible, and our comments about the complaints process may be of interest to them. Whether they might establish their own panel of neutrals for this purpose may be worth considering.

We would emphasise that NHS Resolution made an early and very sensible decision to appoint panels of independent mediators from mediation provider organisations known in the marketplace as being independent and neutral. It is very important that any neutral is perceived as truly neutral, managed fairly by someone perceived to be external. We suspect that part of the problem with NHS complaints procedures is that they run "in-house" and are therefore seen as less than independent and thus less than fair. .

12 What legislative changes would be required to support these changes?

Huge legislative changes will be required, even if a self-contained system, either for serious birth injury claims or for clinical negligence claims as a whole, is contemplated. Even then, debates will doubtless arise as to why clinical tort should go when other tortious claims in negligence for other kinds of injury remain. And to reform the whole law of tort would be an impossible undertaking.

In our view, like Sir Liam Donaldson in *Making Amends* in 2003*,* we are unpersuaded that a no-fault system is likely to be better than the tort-based system that we currently have, either at promoting learning or reducing costs (assuming that "avoidable" mistakes were to remain compensable in any replacement system) Obviously if the right to sue the NHS were simply abolished, huge savings would be made, but we cannot see that such a step is remotely feasible. We see reform as taking a long time, even if an unlikely consensus emerges that it should be essayed. However, there are many things that can be done to improve the status quo, and we hope that this submission highlights a number of these.

Should you require oral evidence from a representative of CEDR or an experienced clinical negligence mediator, we would be happy to help further.

We end this paper by a quotation from *Do No Harm* by the late Henry Marsh, a distinguished neurosurgeon who has written movingly of his career at the very edge of dangerous clinical interventions which sometimes go wrong, giving rise to allegations of fault:
Doctors need to be held accountable, since power corrupts. There must be complaints procedures and litigation, commissions of enquiry, punishments and compensation. At the same time, if you do not hide or deny any mistakes when things go wrong, and if your patients and their families know that you are distressed by whatever happened, you might, if you are lucky, receive the precious gift of forgiveness".

Every mediator of clinical claims has seen something like this happen, and it is a precious event indeed for all who are there.

Additional evidence

Under separate cover:

1. ***The Future of Clinical Negligence Mediation: the Mediator's View***, a report published in October 2021 by CEDR Mediators Alan Jacobs, Tony Allen, Neil Goodrum and Heather Allen. Viewable online https://indd.adobe.com/view/e1227c9e-f6c4-4205-a53c-424ff27f0919
2. Two copies of ***Mediating Clinical Claims***, by Tony Allen, published Bloomsbury Professional, 2018

END

CEDR
100 St Paul's Churchyard
LONDON EC4 M 8BU

Oct 2021