SPEEDY RESOLUTION

SCHEME

Evaluation of the Welsh Assembly Government’s Pilot Scheme for Resolving Low Value Clinical Negligence Claims against NHS Trusts in Wales
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The evaluation team would like to thank Iscoed Chambers, Swansea for their contribution to the assessment of medical reports.

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## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary and Recommendations</td>
<td>1</td>
</tr>
<tr>
<td>Summary</td>
<td>1</td>
</tr>
<tr>
<td>Recommendations</td>
<td>4</td>
</tr>
<tr>
<td>Chapter One: The Speedy Resolution Scheme</td>
<td>7</td>
</tr>
<tr>
<td>Background to the Speedy Resolution Scheme</td>
<td>7</td>
</tr>
<tr>
<td>Summary of the Speedy Resolution Scheme</td>
<td>8</td>
</tr>
<tr>
<td>Chapter Two: Methodology</td>
<td>12</td>
</tr>
<tr>
<td>Scope of the Evaluation</td>
<td>12</td>
</tr>
<tr>
<td>Methodology</td>
<td>12</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>14</td>
</tr>
<tr>
<td>Claimant Issues</td>
<td>14</td>
</tr>
<tr>
<td>Data Analysis</td>
<td>15</td>
</tr>
<tr>
<td>Chapter Three: WHLS and Claim Managers</td>
<td>16</td>
</tr>
<tr>
<td>Key Points</td>
<td>16</td>
</tr>
<tr>
<td>Data provided by the WHLS</td>
<td>16</td>
</tr>
<tr>
<td>The WHLS Perspective</td>
<td>22</td>
</tr>
<tr>
<td>Claim Manager Perspectives</td>
<td>24</td>
</tr>
<tr>
<td>Chapter Four: Claimant Solicitors</td>
<td>26</td>
</tr>
<tr>
<td>Key Points</td>
<td>26</td>
</tr>
<tr>
<td>Solicitor Perspectives</td>
<td>26</td>
</tr>
<tr>
<td>Claimant Expectations and Access to Justice</td>
<td>37</td>
</tr>
<tr>
<td>Chapter Five: Medical Experts</td>
<td>42</td>
</tr>
<tr>
<td>Key Points</td>
<td>42</td>
</tr>
<tr>
<td>Medical Expert Perspectives</td>
<td>42</td>
</tr>
<tr>
<td>Fixed Fees</td>
<td>44</td>
</tr>
<tr>
<td>Chapter Six: Conclusions and Recommendations</td>
<td>48</td>
</tr>
<tr>
<td>Conclusions</td>
<td>48</td>
</tr>
<tr>
<td>Recommendations</td>
<td>54</td>
</tr>
<tr>
<td>Appendix</td>
<td>56</td>
</tr>
<tr>
<td>Review of Medical Reports</td>
<td>56</td>
</tr>
<tr>
<td>Addendum</td>
<td>57</td>
</tr>
<tr>
<td>Public Funding</td>
<td>57</td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY and RECOMMENDATIONS

Summary

1. The Welsh Risk Pool is responsible for meeting the cost of clinical negligence claims against NHS trusts in Wales. Following a report by the Auditor General in 2001 - *Clinical Negligence in the NHS in Wales* - there were concerns about the amount of legal costs and expert fees arising from such claims, and their impact on NHS services.

2. In February 2005 the Welsh Assembly Government Department for Health and Social Services established the Speedy Resolution Scheme (the ‘Scheme’) to provide an alternative dispute resolution mechanism for clinical negligence claims against NHS trusts in Wales.

3. The Scheme is set up to deal with straightforward cases valued between £5,000 and £15,000. There are timescales for completion of different stages in the resolution of a dispute. It is anticipated that claims will be concluded within 61 weeks of admission to the Scheme. Important features of the Scheme are: set timescales; joint instruction of medical experts and counsel; and, fixed fees for solicitors, medical experts and counsel.

4. The primary objective of the Scheme is to provide a quick, proportionate and fair resolution of straightforward low value clinical negligence claims.

5. The Welsh Assembly Government commissioned the School of Law at Swansea University to carry out an evaluation of the Scheme to establish its viability on a permanent basis. The evaluation commenced in January 2008. Evidence was provided by: claimant solicitors; the Welsh Health Legal Service (WHLS); claim managers; counsel; and, medical experts. Relevant information was also provided by the Legal Services Commission (LSC).

6. The aims of the evaluation were established by the WAG. Key amongst these was that the evaluation should assess:
The viability of introducing the Scheme on a permanent basis.

Whether the Scheme has provided an independent alternative dispute resolution mechanism for low value clinical negligence disputes which identifies and delivers outcomes that are important to patients.

The acceptability of the Scheme to all participants.

The extent to which targets established by the Scheme have been met and the quality of medical reports.

Whether the Scheme has produced savings in administration and legal costs and assisted in the process of the NHS learning lessons from incidents leading to clinical negligence claims.

Whether the Scheme has enhanced access to justice for individuals who do not qualify for legal aid.1

7. The Scheme has been well-received by claimant solicitors and the WHLS. NHS claim managers and medical experts support of the Scheme. It is seen as having provided benefits for claimants, claimant solicitors, the WHLS, and NHS trusts. There is support for the Scheme to be continued on a permanent basis, with claimant solicitors, the WHLS, medical experts and counsel having indicated a willingness to continue their involvement.

8. The Scheme has provided claimants with an alternative to litigation in clinical negligence claims valued between £5,000 and £15,000. The Scheme provides an effective mechanism for redress against NHS trusts in Wales in low value clinical negligence claims. The success of the Scheme means that it should be better publicised amongst patients and non-specialist solicitors.

9. The criteria for admission to the Scheme are appropriate: although the upper limit of £15,000 may be an unnecessary barrier to justice. The requirement that cases should be straightforward provides an effective condition on entry. Where claimants have been denied access to the Scheme this has been because the Scheme criteria have not been met. The procedure established by the Scheme rules for dealing with claims is effective to meet the purpose of the Scheme (paragraph 4 above). Whilst some difficulties have been encountered ____________________________

1 Arrangements made for public funding under the Scheme are discussed in the Addendum.
meeting timescales, this has not compromised the overall objective of dealing with claims within 61 weeks.

10. The Scheme has delivered enhanced access to justice for claimants. Claimants who might otherwise have been denied a remedy (because they fear unpredictable and potentially expensive costs of litigation) have been provided with a means of seeking redress. The fixed fee regime established by the Scheme has contributed to enhanced access to justice: in particular for claimants ineligible for public funding.

11. Although the Scheme has been generally well received there is some concern amongst participants over the level of fixed fees, particularly over the fee for a medical report. The comparatively low level of fixed fee for a medical report is seen as limiting the number of experts willing to take instructions under the Scheme. This in turn contributes to delay in obtaining medical evidence.

12. The quality of medical reports prepared for use within the Scheme is good. Medical reports are meeting the quality criteria established for assessing the criteria of medical reports set out in Annex B of the Scheme documents.

13. The introduction of the Scheme has not resulted in any increase in workload for the WHLS or individual claim managers working for NHS trusts. In terms of administrative burden on the NHS, the Scheme appears to have had no significant impact to increase or decrease workload.

14. The cost of individual claims to the NHS in Wales appears to be lower where a claim is admitted to the Scheme. On average the amount of compensation paid to claimants, and the costs incurred by the NHS trusts in individual claims is less than for non-Scheme claims. To this extent the burden of clinical negligence on the NHS in Wales has been reduced. The Scheme has achieved its objective of introducing greater proportionality between compensation and costs.

15. The Scheme has resulted in the preparation of action plans in response to claims brought against NHS trusts. To this extent it has assisted in the process of learning lessons
within the NHS. More may need to be done to ensure the process of learning lessons is enhanced.

16. The evaluation considers the Scheme to be fit for purpose. Key features designed into the Scheme provide substantial benefits for participants. With this in mind we do not make any recommendations for significant change.

17. On reading our report it may be thought necessary to amend timescales to reflect the realities of dealing with claims under the Scheme procedure. The evidence establishes that there have been difficulties meeting the timescale for obtaining expert evidence. However, we have concluded that timescales operate as valid targets and as such should not be amended. Instead we offer some recommendations for increasing the choice of medical experts in order to facilitate the appointment of an expert able to report within the timescales allowed by the Scheme.

**Recommendations**

1. The evaluation found the Scheme to have been generally well received by both claimant solicitors and the WHLS. It also found that the Scheme has provided substantial benefits for claimants, as well as for the NHS in Wales. In our view the Scheme is fit for purpose and is meeting with its primary objective.

   **The Speedy Resolution Scheme established by the National Assembly for Wales as a pilot project in February 2005 should be continued as a permanent scheme.**

2. Participants in the evaluation raised some concerns about the level of publicity for the Scheme. In order to further enhance access to justice information about the Scheme should be made more readily available to the public – in particular to those who make complaints against the NHS.

   **Information about the Scheme should be made available to patients generally, but in particular to those patients who make a complaint against an NHS trust.**
3. Specialist solicitors are well informed about the Scheme. This may not be the case for non-specialist solicitors who may have to deal with a clinical negligence claim. Non-specialist solicitors need to be aware of the Scheme so they can refer clients to specialist clinical negligence practitioners in appropriate cases.

**Information about the Scheme should be provided to non-specialist solicitors.**

4. There is no pressing need to amend the criteria for admission to the Scheme. The lower value limit is essential if costs and compensation are to be kept in proportion. The upper value limit appears arbitrary. Higher value cases may tend toward greater complexity but existing Scheme criteria are effective to exclude complex cases from admission. We see no reason why the Scheme should not be extended to higher value claims.

**The WAG should give consideration to raising the upper value limit for admission to the Scheme and should consult with interested parties about what this might be.**

5. The preparation of joint medical reports at a fixed cost is a key component of the Scheme’s success. Although increasing the level of fixed fees may deter some claimants it is essential to encourage more medical experts to join the approved list.

**The WAG should give consideration to increasing the amount of fixed fee payable for a joint medical report and should consult with interested parties about what this should be.**

6. In our view there is no need to exclude medical experts from within Wales from the list of approved experts available to provide a medical report.

**Medical experts from within Wales should be eligible for appointment to the approved list of medical experts used by the Scheme.**

7. Some concerns were raised over the level of fixed fees paid to claimant solicitors. However, this was not unanimous amongst solicitors. We do not recommend any increase
in the amount of fixed fee for solicitor profit costs. However, in order to ensure that fixed fees remain acceptable we see a need for a review mechanism to be introduced. This applies to all fixed fees.

The WAG should provide a mechanism for regular review of the level of fixed fees for all participants.

8. At the moment the Scheme does not make provision for claimant feedback on their experience of the Scheme. This is a weakness that needs to be addressed.

Claimants should be provided with a closure questionnaire for completion when a claim is withdrawn or concluded in accordance with Scheme rules.

9. Where an Action Plan is prepared in response to a Scheme claim the claimant needs to be advised of its content in accordance with Scheme rules. This does not appear to be happening.

Individual NHS trusts should be required to devise and implement a procedure to ensure that a claimant is advised of the contents of an Action Plan prepared following closure of a Scheme claim.

Dr. Simon Hoffman
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School of Law
Swansea University

July 2008
CHAPTER ONE: THE SPEEDY RESOLUTION SCHEME

Background to the Speedy Resolution Scheme

1.1 In February 2001 the Auditor General for Wales reported an upward trend in the cost of clinical negligence claims to the NHS. The Auditor’s report, *Clinical Negligence in the NHS in Wales*, noted that the management of claims was an expensive, lengthy and complex process. This was seen as having a negative impact on patient care through depletion and diversion of resources.

1.2 NHS trusts in Wales, are responsible for meeting the costs of clinical negligence claims. Welsh Health Legal Services (WHLS\(^2\)) provides legal services to all the Welsh NHS trusts. Higher value claims are met through contributions made by the trusts to the Welsh Risk Pool. In 2001-02 the Welsh risk Pool experienced serious financial difficulties caused by the high value of claims and a shortfall in contributions.\(^3\) As a result a decision was taken to examine the Welsh Risk Pool and to seek advice on the financial and general management of clinical negligence claims against the NHS in Wales.

1.3 A review of the Welsh Risk Pool raised concerns about the rising costs of lawyer and expert fees in clinical negligence claims, delays in settling claims,\(^4\) and the disproportionate relationship between costs and compensation. The National Assembly for Wales’s Counsel General was requested to consider the scope for reducing costs through alternative dispute resolution. It was subsequently agreed that two pilot projects would be established. The first to provide a fast-track dispute resolution scheme for low value claims, the second a mediation scheme for higher value claims.

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\(^2\) The WHLS is administered by the Conwy and Denbighshire NHS Trust.

\(^3\) Claims submitted and approved were to the value of £46.3 million, requiring additional premium payments of around £20 million.

\(^4\) The Auditor General had noted an average of 4½ years between an incident of clinical negligence and settlement of claim.
1.4 The Minister for Health and Social Services approved a pilot project in March 2003. In February 2005 the Welsh Assembly Government Department for Health and Social Services established a Speedy Resolution Scheme (the ‘Scheme’) to provide an alternative dispute resolution mechanism for low value clinical negligence claims involving Welsh NHS trusts.

**Summary of the Speedy Resolution Scheme**

1.5 In February 2005 the Welsh Assembly Government’s Health and Social Care Department launched the Scheme to provide a quick, proportionate and fair way of resolving low value clinical negligence claims against NHS trusts in Wales. In summary, the objectives of the Scheme are:

- To provide a procedure for quick, proportionate and fair resolution of low value clinical negligence claims against NHS trusts in Wales.
- To provide for trusts, where appropriate, to make apologies to patients where the standard of medical care has fallen below the required standard.
- To encourage trusts to give patients an explanation of their treatment and medical state.
- To provide for structured negotiation and settlement of clinical negligence claims.
- To encourage trusts to learn from mistakes to reduce the incidence of clinical negligence claims in the future.

**Eligibility**

1.6 Entry to the Scheme is established by eligibility criteria which set out a number of qualifying conditions. The Scheme is suitable for straightforward claims involving adult patients of full capacity which do not necessitate the involvement of more than two medical experts in areas of different medical expertise. The value of a claim should ordinarily be between £5,000 and £15,000.\(^5\) As the Scheme is intended to operate as a form of alternative dispute resolution claims are pre-litigation and the limitation period is disapplied. Claimants may only take advantage of the Scheme if represented by a solicitor who is: a member of the

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\(^5\) Provision is made within the Scheme for higher or lower value claims to be admitted where this is agreed between the WHLS and the claimant.
Law Society Clinical Negligence Panel; or, a member of Action for the Victims of Medical Accidents.\textsuperscript{6}

**Procedure**

1.7 The decision to seek admission to the Scheme is a matter for the claimant. A written request for admission is sent to the WHLS. Once a claim is admitted a timetable is established for key stages in the resolution procedure. The main procedural steps in the dispute resolution process established by the Scheme are:

- Exchange of case summaries (between claimant solicitor and the WHLS).
- Obtaining expert evidence in the form of a report as required (breach of duty, or, breach of duty and causation, or, causation (including responses to questions)).
- The WHLS accept or deny liability and confirm if the claim is suitable for settlement.
- Where necessary, obtaining expert evidence in the form of a report on the issue of condition and prognosis (including responses to questions).
- Claimant’s solicitor provides details of the amount of the claim.
- The WHLS accepts the claimant’s claim or makes an offer to settle.
- Counsel appointed to advise on quantum in the event of failure by the parties to agree.
- Claimant’s solicitor and the WHLS to decide whether or not to accept counsel’s advice.

1.8 The timescales applicable to these procedural steps are shown in summary in the schematic overleaf. Although there is flexibility within the Scheme for timescales to be extended by agreement it is anticipated that the parties will take all reasonable steps to ensure that all stages are completed not later than 61 weeks from the ‘Start Date’. The Start Date is the date of admission to the Scheme (when confirmed in writing to the claimant’s solicitor).

1.9 All timescales under the Scheme may be calculated from the Start Date, but not all timescales refer back to this date. For convenience, in the summary overleaf all timescales are given by reference to the Start Date.

\textsuperscript{6} Or working under the direct supervision of a Law Society panel of AVMA member.
<table>
<thead>
<tr>
<th>Stage in procedure</th>
<th>Time allowed for completion (from Start Date, see paragraph 1.8 above)</th>
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<tbody>
<tr>
<td>Claimant to submit claim summary</td>
<td>2 weeks</td>
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<tr>
<td>Defendant to submit claim summary</td>
<td>4 weeks</td>
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<tr>
<td>Parties agree appointment of and instruct a joint expert to report on breach of</td>
<td>8 weeks</td>
</tr>
<tr>
<td>duty or breach of duty and causation</td>
<td></td>
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<tr>
<td>Joint expert reports on breach of duty or breach of duty</td>
<td>12 weeks</td>
</tr>
<tr>
<td>Joint expert reports on breach of duty or breach of duty and causation</td>
<td></td>
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<tr>
<td>Parties to submit questions to the expert arising from report on breach of duty or</td>
<td>14 weeks</td>
</tr>
<tr>
<td>breach of duty and causation</td>
<td></td>
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<tr>
<td>Expert to reply to questions on breach of duty or breach of duty and causation</td>
<td>16 weeks</td>
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<tr>
<td>Parties agree on whether separate report is required on causation</td>
<td>17 weeks</td>
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<tr>
<td>Parties agree appointment of and instruct a joint expert to report on causation</td>
<td>20 weeks</td>
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<tr>
<td>Joint expert reports on causation</td>
<td>24 weeks</td>
</tr>
<tr>
<td>Parties to submit questions to the expert arising from report on causation</td>
<td>26 weeks</td>
</tr>
<tr>
<td>Expert to reply to questions on causation</td>
<td>28 weeks</td>
</tr>
<tr>
<td>WHLS to confirm its position on liability and suitability for settlement</td>
<td>32 weeks (this is shorter if the initial report is on breach of duty and causation)</td>
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<tr>
<td>Parties agree if report is required on condition and prognosis</td>
<td>33 weeks</td>
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<tr>
<td>Parties agree appointment of and instruct a joint expert to report on condition and</td>
<td>36 weeks</td>
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<tr>
<td>prognosis</td>
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<tr>
<td>Joint expert reports on condition and prognosis</td>
<td>42 weeks</td>
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<tr>
<td>Parties to submit questions to the expert arising from report on condition and</td>
<td>44 weeks</td>
</tr>
<tr>
<td>prognosis</td>
<td></td>
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<tr>
<td>Expert to reply to questions on condition and prognosis</td>
<td>46 weeks</td>
</tr>
<tr>
<td>Claimant solicitor to provide details of amount of claim</td>
<td>50 weeks (this is shorter if C’n’P report is not required)</td>
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<tr>
<td>WHLS accept claimant’s claim or make an offer to settle</td>
<td></td>
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<tr>
<td>Claimant solicitor to confirm whether offer accepted or rejected</td>
<td></td>
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<tr>
<td>Where offer is rejected parties agree to instruct counsel</td>
<td></td>
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<tr>
<td>Joint instructions to counsel</td>
<td></td>
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<tr>
<td>Counsel to advise on quantum</td>
<td></td>
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<tr>
<td>Parties decide whether to accept counsel’s opinion</td>
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**NB:** The Scheme is non-binding on the WHLS and claimants and participants may withdraw at any time.
**Costs under the Scheme**

1.10 It is an important aspect of the Scheme that costs allowed for the professional fees of solicitors, counsel and experts are fixed in advance.

Fixed fees:

- Solicitor profit costs: £3,500 (ex. VAT)
- Medical expert to prepare a report: £450 (ex. VAT)
- Medical expert to reply to questions: £75 (ex. VAT)
- Counsel fees for an advice on quantum: £225 (ex. VAT)

1.11 Experts are ordinarily selected from an approved list (although flexibility is provided to appoint an expert not on the list). Similarly, counsel instructed under the Scheme are chosen from an approved list.

**Termination of participation in the Scheme**

1.12 Participation in the Scheme is terminated where: the claimant withdraws his or her claim; or, the claimant accepts an offer of settlement by payment of compensation, and fixed costs are paid.

**Learning lessons from cases under the Scheme**

1.13 The Scheme attempts to formalise the process of learning lessons from incidents leading to clinical negligence claims. The NHS trust is required to prepare an action plan in response to successful claims or where breach of duty is admitted.

1.14 Even in cases where settlement is not reached, or breach of duty is not admitted, the NHS trust concerned is required to consider whether an action plan may be useful. NHS trusts are also required to consider whether or not to disseminate any action plan prepared to other trusts to facilitate the process of wider learning from experience.
CHAPTER TWO: METHODOLOGY

Scope of the Evaluation

2.1 The scope of the evaluation was established by the WAG in its Invitation to Tender. The evaluation gives an assessment of the extent to which the Scheme has met the objectives of:

- Providing an independent dispute resolution scheme to identify and meet patient expectations.
- Widening access to justice for patients, in particular those not eligible for legal aid, and to identify reasons for exclusion from the Scheme.
- Encouraging participation by solicitors and medical experts for fixed fees.
- Facilitating savings in administration and legal costs to the NHS in dealing with low value clinical negligence claims.
- Assisting with the process of the NHS learning lessons.
- Meeting quality and timescale targets (as established by the Scheme).

Methodology

Data acquisition

2.2 The evaluation has adopted a mixed-methodology in order to facilitate data collection (and to enable the evaluation to be carried out within the timescale established by the WAG).

2.3 Medical experts and claim managers were surveyed by questionnaire. The design of the questionnaires was such as to facilitate the acquisition of both quantitative and semi-qualitative data. Respondents were asked to answer questions using a Likert scale or by Yes/No selection. Respondents were also given the option to add comments to clarify or expand on their responses.

2.4 Semi-structured interviews were carried out with claimant solicitors. This provided both quantitative and qualitative data. Interviewees were asked questions to which they could respond using a Likert scale, or by Yes/No selection, but also open questions on various
aspects of the Scheme. Quantitative data from the interviewees was aggregated for analysis (this was facilitated as the sample group was eight claimant solicitors).

2.5 A less formal interview technique was used in interviews with the WHLS and the Legal Services Commission (LSC). However no attempt was made to obtain data for aggregation as interviews were conducted with just two interviewees and one interviewee respectively.

2.6 Information on the quality of medical reports obtained from interviews with solicitors was supplemented by a document review of 22 medical reports prepared for use within the Scheme. These were assessed against criteria established at Annex B of the Scheme documents.

2.7 In order to assess whether the Scheme had met with timescale targets data was acquired from the WHLS database of Scheme claims, as well as from a review of a selection of closed case-files. For a comparative perspective the evaluation also undertook a review of closed case-files of cases not within the Scheme.

**Sampling**

2.8 The WHLS provided a list of 10 solicitor firms which had dealt with cases under the Scheme. Arrangements were made to interview representatives from seven of the 10 firms listed, all based in South Wales (two firms based outside of Wales were not included for logistical reasons). It proved difficult to arrange an interview with a representative from one firm therefore a questionnaire modelled on the interview schedule was sent out and the individual concerned was asked to complete relevant sections. This is not as satisfactory as carrying out an interview as the qualitative data is diminished; however, the aggregated quantitative data is unaffected. Representatives of the WHLS and a representative of the LSC were also interviewed.

2.9 Questionnaires were sent to 22 experts on the Scheme list of approved medical experts. Following reminders a total of 14 replies were received representing a 64% response rate. Although a higher response rate would have been preferred, 64% is acceptable for evaluation purposes.
2.10 E-mail questionnaires were sent to 11 claim managers as representing those NHS trusts in Wales which had experience of claims brought under the Scheme. The questionnaires were sent out shortly after the re-structuring of NHS trusts in Wales. 10 questionnaires were returned representing 91% of relevant claim managers. This is a satisfactory response rate.

2.11 Query letters were sent to the six counsel on the Scheme approved list. We received four replies (66% response rate). This is satisfactory.

**Confidentiality**

2.12 To encourage participation those taking part in the evaluation were informed in advance that they would not be identified in our final report. The evaluation team provided a guarantee to the WHLS that it would not identify the names of claimants or details of the content of medical reports, or any information from which it might be possible to identify a claimant.

**Claimant Issues**

2.13 It would not have been appropriate for the WHLS to provide the evaluation team with claimant contact details. Solicitors are not in a position to provide claimant contact information without permission. Several solicitors raised concerns about the possibility of contacting clients for permission, or acting as an intermediary between the evaluation team and claimants (by sending out questionnaires to claimants). A major concern was that solicitors would, in a number of instances, have been required to recall closed cases from archives and to trawl through each one to determine whether it had been dealt with by way of ordinary litigation or under the Scheme. A further concern raised by a number of solicitors was that some clients would not want to be reminded of their dealings with the NHS/WHLS and several expressed a reservation about contacting clients whose cases had been closed for some time.

2.14 These concerns were discussed with the WAG Department of Health and Social Services. It was felt that the objections raised by solicitors were valid, and as a consequence it has not been possible to engage claimants in the evaluation. This is a weakness beyond the
control of the evaluation team. See: *Chapter Six: Conclusions and Recommendations* (Recommendation 8).

**Data Analysis**

2.15 Data received from the questionnaires was both quantitative and qualitative. The quantitative data was processed using SPSS. This is presented where relevant as aggregated statistical information in the form of, e.g. a graph. Alternatively reference may be made to extracted statistical data in context. Similarly, aggregated quantitative data from the interviews was processed using SPSS and is presented in the same way.

2.16 Qualitative data was analysed to identify links between the evidence and the objectives of the Scheme, and in the case of interviews, the data was analysed to identify common themes, experiences, perceptions and understandings amongst interviewees (again as relevant to Scheme objectives). These are commented on in the report and where appropriate illustrated by select quotations.

2.17 The medical reports were assessed using criteria established by Annex B of the Scheme with assessors using a Likert scale for coding and aggregation purposes.

*Presenting our conclusions*

2.18 Conclusions and recommendations are based on our assessment of the evidence having regard to: the aims of the Scheme; and, the aims of the evaluation. We present our main conclusions in the final chapter, along with our recommendations. Otherwise we give our assessment of the evidence in context in relevant chapters.
CHAPTER THREE: WHLS AND CLAIM MANAGERS

Chapter Three: Key Points

- 90% of Scheme claims are resolved within the 61 week timescale set out in the Scheme rules.
- There have been delays obtaining medical reports under the Scheme.
- Scheme claims for clinical negligence are concluded quicker in comparison to non-Scheme claims of similar value.
- For Scheme claims the ratio of compensatory awards to costs is about 1.8 to 1, this compares very favourably with similar value non-Scheme claims.
- Scheme claims result in lower costs and a more proportionate relationship between costs and compensation than in non-Scheme claims.
- The Scheme has not substantially impacted on the workload of the WHLS or NHS trust claim managers.
- The Scheme has led to some use of action plans by NHS trusts.

Data provided by the WHLS

3.1 Defendant NHS trusts are represented by Wales Health Legal Services (WHLS). The WHLS provided statistical information relevant to the operation of the Scheme.

Review of closed claims: claims made under the Scheme

When discussing awards, costs, percentages etc. amounts are rounded up or down to the nearest whole number.

3.2 According to the WHLS database, as at the 21st June 2008, a total of 95 claims had been admitted to the Scheme. The breakdown per annum is as follows.

- Admitted in 2005: 34 claims*
- Admitted in 2006: 23 claims
Admitted in 2007 26 claims
Admitted in 2008 5 claims (to the 21st June 2008)

* A further seven claims which were submitted to the WHLS prior to the Scheme being introduced were admitted in 2005.

3.3 WHLS records show that by the 31st March 2008 a total of 23 Scheme claims had been concluded by way of payment of compensation to the claimant. The total amount of compensation paid to the 31st March 2008 under the Scheme was £152,150. The average amount paid was £6,615.

3.4 By the 31st March 2008 a total of £78,564 was paid by way of fixed fees and solicitor disbursements under the Scheme, with WHLS disbursements of £5,981. On average a claim under the Scheme resulted in £3,676 costs (including all disbursements).

Referring to the above data, the ratio of compensatory awards to costs in claims where compensation was paid to the claimant is about: 1.8 to 1.

By comparison: in non-Scheme claims where compensation was paid to the claimant the average amount of compensation paid, the average costs (including disbursements), and the ratio of costs to awards, was:

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<thead>
<tr>
<th>Period</th>
<th>Compensation</th>
<th>Costs</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st April 2005 – 31st March 2006</td>
<td>£6,877</td>
<td>£7,747</td>
<td>1 to 0.9</td>
</tr>
<tr>
<td>1st April 2006 – 31st March 2007</td>
<td>£6,448</td>
<td>£8,798</td>
<td>1 to 0.7</td>
</tr>
<tr>
<td>1st April 2007 – 31st March 2008 **</td>
<td>£6,889</td>
<td>£6,832~</td>
<td>1 to 1</td>
</tr>
</tbody>
</table>

** Date for all dates taken from WHLS database of closed claims settled at £15,000 or less.

~ The data for this year contains one particularly high award for costs. This has been discounted for the purposes of calculating the average amount of costs.
3.5 Information from the WHLS database refers to closed claims where compensation was paid to the claimant. For a more comprehensive assessment the WHLS was asked to provide a number of closed cases selected at random irrespective from archives of whether or not compensation had been paid. 21 closed files were provided for review. Of these 18 claims were admitted to the Scheme at the request of the claimant’s solicitor, and two were admitted following a suggestion from the WHLS that the claim might be suitable for the Scheme. One claim was not admitted (the reason cannot be given as it might identify the claimant, but it was a proper reason and accepted as such by the claimant’s solicitor).

3.6 The time allowed under the Scheme for the WHLS to decide on admissibility is two weeks from the date that the claimant solicitors requests admission to the Scheme. Of the 20 claims admitted to the Scheme 10 were admitted at a time beyond two weeks. In one case it was unclear when the request for admission was made. The longest delay in admission was seven weeks. Most delays were far shorter and closer to four weeks (i.e. beyond the initial two weeks allowed).

3.7 The WLHS explained the delay as caused by having to take instructions from claim managers, who themselves had to obtain relevant records. In addition the WHLS indicated that NHS trusts require time to give consideration to whether or not to make an *ex gratia* payment. If an *ex gratia* payment is agreed this avoids having to admit a claim to the Scheme: the benefit for the NHS is that fixed costs are not incurred.

3.8 As will be discussed in Chapter Four (see: 4.17), the issue of delay at the admission stage was raised by some claimant solicitors, but this was not a significant issue. See: Chapter Six: Conclusions and Recommendations (6.14 et seq).

3.9 Once admitted to the Scheme it is apparent from the correspondence between the parties that a cooperative approach is adopted, with the WHLS and claimant solicitors working hard to ensure that relevant timescales are met. Aggregate data from the WHLS database does not assist in determining the extent to which the Scheme is meeting its 61 week timescale for resolving a claim. The date on which a claim is settled (an issue of process), and the date on which a case is recorded on the database as closed (an issue of administration)
may (and does) differ significantly. The WHLS database does not distinguish between the date a case is settled and the date it is closed.

3.10 When we reviewed closed claims we found that 11 (55%) of the claims had a recorded closure date a date beyond the expiry of the 61 weeks, but closer examination revealed that in all but two of these claims the case was concluded, i.e. withdrawn or settled by payment of compensation, within 61 weeks. In total, the WHLS and claimant solicitors were able to settle cases within the 61 week period in 18 of the 20 cases reviewed and admitted to the Scheme, or 90% of cases. In the two cases where the 61 week timescale was not met the delays were two months and four months. Delay in both cases was caused by having to wait for medical evidence.

3.11 Our review of closed files revealed the main reason for delay in progressing cases was obtaining a medical report. Medical reports were required in 19 out of the 20 closed claims reviewed. The Scheme allows 12 weeks from the Start Date for the parties to obtain medical evidence from a jointly instructed medical expert on breach of duty (or breach of duty and causation). In 15 out of the 20 closed claims reviewed the medical evidence on breach of duty was delayed beyond 12 weeks, i.e. in 75% of claims. These delays were significant. The shortest was for a period just short of five weeks, the longest a delay approaching 32 weeks. However, as noted in paragraph 3.10 above, delay in obtaining a medical report need not adversely impact on the overall timescale of 61 weeks from Start Date to resolution of a claim.

3.12 Delay represents a compromise of the Scheme’s aim of providing a speedy resolution mechanism. Even if this does not adversely affect the overall timescale it prevents procedural expectations established by the Scheme from being met. We return to consider this issue when discussing the evidence from interviews with the WHLS (below, 3.27 et seq), and with solicitors (4.16 et seq). See: Chapter Six: Conclusions and Recommendations (6.14 et seq).

3.13 Out of the 20 claims admitted to the Scheme a total of 14 were withdrawn by the claimant. A withdrawal rate of 70%. None were withdrawn by the WHLS. One case was withdrawn due to lack of instructions from the claimant, the rest were withdrawn shortly after receipt of an unfavourable (for the claimant) medical report. In all but one of these cases the
medical report was confined to a report on breach of duty and/or breach of duty together with causation. In the exception a report was required on condition and prognosis.

3.14 In all of the claims reviewed the claimant was seeking compensation. The reasons for withdrawal by the claimant were not always expressly stated in correspondence. As mentioned in paragraph 3.13 above, on review of the medical evidence it was apparent that in all the claims withdrawn the medical evidence was not favourable to the claimant. It may be properly inferred that these cases were probably withdrawn by the claimant as a consequence of this evidence.

3.15 Where a case is withdrawn the cost to the NHS is the sum of the cost of a medical report/s (usually limited to £225 (ex. VAT)), together with agreed shared disbursements. In one case which we reviewed medical expert fees of £450 (ex. VAT) were incurred. Agreed disbursements were incurred in two of the 14 cases withdrawn. These averaged less than £150 (ex. VAT). The evidence from our review of closed claims suggests that on an individual basis the cost of claims admitted and then withdrawn from the Scheme is low - on average about £260 (ex. VAT).

3.16 In six (30%) of the closed claims reviewed the claimant was offered and accepted an award of compensation. The highest award was £15,000, the lowest £4,560. The average award was £7,900. One claim was settled by payment of compensation without the need for a medical report, this was the exception. All were concluded within the 61 week timescale.

3.17 Although solicitor and medical expert costs are fixed under the Scheme, allowances for agreed disbursements mean that final costs including disbursements may vary slightly. The highest award of costs in those cases where the claimant was made an award was £4,945, the lowest £4,465. The average amount of costs including disbursements was £4,617.

The ratio of average compensation to average costs in Scheme cases was therefore found to be about 1.7 to 1. This reflects the findings from the WHLS database (above 3.4).
Review of closed claims: Non-Scheme claims

3.18 The evaluation also undertook a review of closed cases where there was no application to join the Scheme, and which were settled between the NHS trust and the claimant. The WHLS provided 19 files randomly selected from its archive having an estimated settlement value within Scheme limits. In one case the amount of compensation eventually paid out was significantly below the financial limit set for admission the Scheme, and two cases were of such complexity that they would not have been admitted to the Scheme. The evaluation was therefore in a position to assess 16 cases as comparable with those admitted to the Scheme by reference to relevant criteria.

3.19 The evaluation considered the length of time taken to conclude non-Scheme claims. The start date was taken as the date on which the claimant solicitor submitted a letter of claim (or similar) to the NHS trust or the WHLS. The date of resolution was taken as the date on which all matters were finally concluded, i.e. all matters including costs. Of the 16 non-Scheme cases reviewed two were not pursued beyond an initial letter of claim.

3.20 Eight of the non-Scheme claims reviewed were concluded within 61 weeks, i.e. in 50% of cases. This is significantly lower than for Scheme claims (90%, 3.10 above). The remainder took between 65 weeks and 2.4 years to conclude (the average delay beyond 61 weeks was 27 weeks). Although some of this time was spent arguing over costs after agreeing damages – a problem which does not impact on Scheme claims – the majority was spent agreeing a compromise.

3.21 In the 16 non-Scheme claims reviewed the highest award paid was £15,000, the lowest was £5,000. Average compensation was £9,710. Claimant solicitor costs in the non-Scheme cases reviewed amounted to an average of £6,615 including disbursements. Disbursement incurred on behalf of NHS trusts (for example where an independent medical report was required) resulted in a total additional cost of £3,260, or £204 per claim. The total average cost per claim was £6,819.

The ratio of average compensation to average costs in non-Scheme cases was found to be about 1.4 to 1. This is better than the findings from the WHLS database (above, 3.4), although not as good as for Scheme claims (above, 3.4 and 3.17).
Another difference highlighted by the review of closed cases was that in four non-Scheme cases costs were in excess of the amount paid to the claimant in compensation: this was not the case for any of the Scheme claims reviewed. On average costs in non-Scheme claims (reviewed) were equivalent to approximately 70% of compensation, in Scheme claims (reviewed) costs were the equivalent of about 58% of compensation.

The WHLS Perspective

Interviews were conducted with WHLS staff. The WHLS response to the Scheme was generally very positive. The WHLS is clear that it would like to see the Scheme continued. It noted several advantages of the Scheme. The WHLS experience is that those cases which are admitted to the Scheme result in a lower costs and compensation burden on NHS trusts. This supports our findings from the review of the WHLS database and closed claims (above, 3.4 and 3.5 et seq). Where a claim is refused admission the WHLS has confirmed that this is usually because it falls outside the Scheme value limits, or it is likely that more than two experts will be required.

The WHLS did not see the Scheme as having had any significant impact in reducing the WHLS workload. It was not the view of the WHLS that the Scheme had simplified the process of resolving disputes; rather it was seen as having structured the settlement process. The WHLS indicated that Scheme claims require the same amount of work as other claims of similar value.

Whilst the workload for the WHLS may not have decreased it was felt that the Scheme should be seen as a positive innovation. Benefits identified included the reduced level of awards and costs, but also that the Scheme had provided a structured method of dispute resolution which had focussed participants’ attention on the need to act promptly and toward particular objectives.

The WHLS experience was that the Scheme had not generated any additional claims. Nor would the WHLS be concerned if more was done to publicise the Scheme: there was no strong feeling that this would ‘open the floodgates’. The WHLS thought that as solicitors are required to make a judgement on the merits of a claim when advising clients this is the
primary consideration influencing the decision on whether or not to seek compensation, and therefore admission to the Scheme. It was also felt that as reports under the Scheme are joint reports this reduces the possibility that solicitors will seek to support a weak case by obtaining a report from a ‘claimant orientated’ medical expert.

3.27 The WHLS confirmed that the majority of Scheme claims are settled within 61 weeks. The perception was that delays are introduced into the procedure at the stage where medical evidence is required. The WHLS gave several reasons for delay at this stage. In summary these were:

- The limited choice of experts on the approved list and the associated difficulty of agreeing an expert from the approved list with the claimant’s solicitor.
- Where an expert is not available from the approved list, problems in identifying another suitable expert and the associated difficulty of agreeing that expert with the claimant’s solicitor.
- The difficulty of getting an off-list expert to act for the agreed fee.
- The difficulty of getting an expert to return a report on-time, especially when other priorities mean the expert’s time is at a premium.

3.28 The WHLS experience is that once a report is received claims settle very quickly. It was therefore thought vital to ensure that experts are readily available from the approved list. The WHLS view is that the use of joint experts is integral to the Scheme as saving expense and time.

3.29 The WHLS suggested that if the fixed fee for a medical expert were increased this might help to expand the approved list by making it more attractive to experts, but also that it would make it easier to persuade an expert to take instructions in any event. The WHLS did not think that increasing the fixed fee paid to expert would necessarily lead to a quicker turnaround between instructions and the preparation of a report - as this will depend on the expert’s workload. Rather it was suggested that by increasing the choice of experts the parties would be better able to identify someone able to undertake the work required within the agreed timescale. See: Chapter Six: Conclusions and Recommendations (6.15 et seq and Recommendation 5).
3.30 The WHLS did not see the need to continue with the policy of only appointing experts from outside of Wales to the approved list. Whilst it recognised the potential for there to be a perception of bias this, it was felt, could be negated by properly formulated joint instructions. In any event, the WHLS see the right of withdrawal from the Scheme as a safeguard for claimants who fear bias. See: Chapter Six: Conclusions and Recommendations (6.18 and Recommendation 6).

3.31 The WHLS did not agree that the lower value limit should be removed or lowered. The reason given was that this would make the ratio between costs and compensation disproportionate. There was support for increasing the upper value limit: based on the assumption that complex cases would not be put into the Scheme. See: Chapter Six: Conclusions and Recommendations (6.12 et seq and Recommendation 4).

Claim Manager Perspectives

3.32 Most claim managers had experience of less than 10 Scheme claims. Out of the 10 questionnaire responses received only one manager reported that the Scheme had resulted in an increase in workload, and one reported that the workload had decreased. It appears that experiences of the Scheme in this respect are mixed, although eight claim managers reported that there had been no overall change in workload. Just one of the respondents reported that their trust (or previous trust) had introduced any special procedures for dealing with Scheme claims. Comments made by some claim managers suggest that Scheme claims are dealt with as part of the ordinary procedure for dealing with clinical negligence claims generally.

3.33 Several claim managers reported difficulties in keeping to timescales established by the Scheme. As mentioned by the WHLS (above, 3.27), the problem of delay was seen as mainly attributable to difficulty in obtaining medical evidence.

3.34 When questioned on whether or not their trust (or, in some cases the previous trust) had introduced a mechanism for publicising the Scheme to patients who make a complaint not one replied that it had. One respondent suggested that NHS trusts should discuss the use of patient information leaflets to pass on information about the Scheme and whether or not this
would result in its greater use. See: Chapter Six: Conclusions and Recommendations (6.10 and Recommendation 2).

3.35 The Scheme requires NHS trusts to prepare an action plan in response to successful claims or where breach of duty is admitted. Four claim managers reported that their trust (or previous trust) had done this. Care must be taken when assessing this evidence and its relevance to the process of learning lessons from clinical negligence claims. More evidence is needed on the use made of action plans and their impact within individual trusts and the NHS as a whole (such detailed analysis is beyond the scope of this evaluation). Also, some trusts may not have had cause to admit liability meaning that action plans were not required.

3.36 Our review of closed Scheme claims did not reveal a single action plan, this despite the Scheme requirement that these should be prepared in all successful claims (six of the closed claims).

3.37 Although data received from claim managers was largely for the purposes of producing aggregated data, a few claim managers commented on the Scheme. Several suggested that it is a useful addition to the procedures available for dealing with patient complaints. One respondent commented: ‘The system would seem to provide patients with a quicker means to obtain compensation for harm caused following clinical treatment.’
CHAPTER FOUR: CLAIMANT SOLICITORS

Chapter Four: Key Points

- Cases dealt with under the Scheme are fairly evenly distributed amongst practitioners with relevant expertise.

- There is a high level of awareness of the Scheme amongst relevant practitioners.

- More information about the Scheme needs to be made available to patients and non-specialist solicitors.

- Fixed fees and speed of resolution are key selling points of the Scheme for solicitors and their clients.

- There is some support for amending the Scheme admission criteria.

- Claimant solicitors have experienced problems in meeting the Scheme’s timescales.

- The Scheme is providing enhanced access to justice.

Solicitor Perspectives

In the text below percentages are rounded up or down to the nearest whole number.

Some general issues

4.1 As shown in Figure 1. Most solicitor firms had dealt with between one and 10 claims under the Scheme. Only 12% (two interviewees) had dealt with less than six claims or more than 25 claims.
4.2 Interviewees confirmed that within individual firms those allocated to deal with claims admitted to the Scheme were either registered as a member of the Law Society’s panel of approved clinical negligence solicitors, or registered with the Association for the Victims of Medical Accidents (AVMA) (or were working under the supervision of a relevant practitioner). See: Chapter Six: Conclusions and Recommendations (6.19).

4.3 As might be anticipated in such a discrete area of legal practice, the interviewees confirmed a high level of awareness of the Scheme amongst specialist solicitors.

4.4 Whilst there is no obvious need for training amongst specialist solicitors a number of interviewees felt that information should be more readily available to solicitors not registered with the Law Society or AVMA to carry out clinical negligence work, but who might from time-to-time be required to represent a claimant in a clinical negligence matter. The fear is that ignorance of the Scheme may lead to gaps in the information provided to clients. Non-specialist solicitors need to be aware of the Scheme so they can refer clients to specialist solicitors in appropriate cases.

Comments on this issue included:

‘I think solicitors who are franchised solicitors would be well aware of the Scheme ... What I am not sure about is whether the non-franchised solicitors, without a legal aid franchise, are aware of it - who may take cases on a speculative basis or contingency basis without knowing the Scheme exists.’
4.5 A point made by several interviewees was that clients were unaware of the Scheme when first seeking advice. In fact solicitors reported a nil level of awareness of the Scheme amongst clients at first interview. A similar point made by several of those interviewed was that there appears to be a general lack of publicity about the Scheme.

What solicitors had to say on these issues:

> ‘I haven’t had a client come to me and say “I know about the Speedy Resolution Scheme”. It has been something that I have raised with clients when I have met them, so I am not aware of the public knowing about it.’

> ‘I think that there is a difficulty generally that the public are not aware of it [the Scheme] ... I think it was intended by the working party that there would be some general publicity for the Scheme, but I think that from the launch onwards the general publicity to bring it to the attention to the man on the street has been very very poor’

> ‘As far as I am aware the Welsh Assembly has done little, if anything, to promote the Scheme, in terms of publicity and information sheets and that sort of thing.’

4.6 Other comments raise the issue of a lack of awareness of the Scheme amongst non-specialist solicitors. This cannot be confirmed as non-specialist were not involved in the evaluation. The concern over the lack of publicity is supported by evidence from claim managers (3.34).

4.7 Another issue raised by some interviewees was that more could be done to keep solicitors informed about progress or developments. This was felt to be particularly important for those involved in the field of clinical negligence.

Comments included:

> ‘I suppose it might be an idea if we were actually reminded about the Scheme. There was a launch which I went to in mid-Wales a few years back, but we have heard virtually nothing since then from the Assembly or any official body.’
To be honest I have just applied fairly recently to get a case put into the Scheme, and when I was putting it in I was wondering whether the Scheme was still going because there has been such radio silence if you like.’

4.8 The Working Party set up to establish the Scheme intended that it should be publicised. This objective has not been met. If the Scheme is to meet with its aims of providing an effective ADR, and of increasing access to justice, the level of public awareness must improve. This applies in particular to patients/claimants. The evidence also suggests that more needs be done to bring the Scheme to the attention of patients in particular, but also non-specialist solicitors. See: Chapter Six: Conclusions and Recommendations (6.9 et seq and Recommendations 2 and 3).

Acceptability of the Scheme (design)

4.9 In order to assist with gauging the acceptability of the Scheme, solicitors were asked about key features designed into the Scheme, and the relevance of these to their role as practitioners. Key features were identified as:

- Speedy resolution (fixed timescales)
- Fixed fees (solicitors and experts).
- Joint experts.
- Informality.

4.10 Solicitors responses were assessed to determine whether or not they agreed or disagreed that these features represent key selling points. Aggregated responses are shown in Figure 2 below.

4.11 The majority of interviewees (75%) agreed that fixing the cost of expert fees is a key selling point. Similarly, a majority (albeit slightly lower at 62%), identified speedy resolution and informality as important features. There was less support for the suggestion that joint experts represent a key selling point (just 50% agreed), whilst interviewees were split over the benefit of fixed profit costs. Less than half (37%) of interviewees agreed that this was a key feature. A minority (25%) disagreed with the suggestion that fixed profit costs represent a key selling point of the Scheme. The issue of solicitor fixed costs is dealt with further below (4.27 et seq).
4.12 Solicitors were asked to identify key selling points of the Scheme for claimants. Here there was unanimous agreement that fixed and predictable costs were important features. Speedy resolution and informality were also seen as important to claimants, but less so than features relating to costs. The findings here are shown in Figure 3 overleaf.

4.13 Interviewees were asked to identify any disadvantages of the Scheme compared to conventional proceedings. The key features already identified were, for the most part, seen as advantages. Some solicitors raised concerns over perceived bias (in favour of NHS trusts) of medical experts, and the quality of medical reports. A number reported that their clients had also expressed some initial anxieties. Despite these concerns not one of the interviewees suggested abandoning the use of joint experts. The quality of medical reports is discussed further in Chapter Five (5.12 et seq).
4.14 In general the benefits provided to solicitors, and in particular to claimants, through the use of joint experts were seen by most of those interviewed as outweighing any perceived disadvantage. Fixed and predictable costs were seen as substantial selling points of the Scheme for claimants.

The view of the majority of solicitors was summed up by one solicitor who commented:

‘... maybe one or two would prefer to have their own experts rather than joint, but the benefits far outweigh that one disadvantage, especially when you discuss all the risks or costs of other ways of pursuing it.’

4.15. Another disadvantage identified by claimant solicitors concerned the level of fixed fee – this is discussed as a separate topic below (4.27 et seq). Three solicitors mentioned the need for caution when dealing with cases under the Scheme to avoid claims being dealt with less than thoroughly.

**Scheme timescales**

4.16 62% of interviewees reported difficulties meeting timescales established by the Scheme in all the cases they had dealt with. Whilst timescales were not always adhered to solicitors were not, as a group, concerned that this was prejudicing the benefits provided by the Scheme. Several interviewees noted that the Scheme provides flexibility to vary
timescales, and that in any event Scheme claims were dealt with promptly by comparison to non-Scheme claims. This is supported by evidence discussed in the previous chapter (3.10, 3.20, and 3.27).

4.17 Although some interviewees commented on delays at the admission stage and up to exchange of case summaries, the main cause of delay was identified as difficulty obtaining medical evidence. Our findings show that just 37% of solicitors rated the speed of response for medical reports as good (the quality of medical reports is discussed in the next chapter, 5.12 et seq and Figure 5). Problems were mainly encountered in obtaining evidence in the form of an initial breach of duty report. 71% of solicitors experienced delays here. Fewer found difficulties at the report on causation stage (57%) (this is probably due to the fact that cases do not often proceed beyond the breach of duty report, above 3.13). See Figure 4 below.

<table>
<thead>
<tr>
<th>DELAY</th>
<th>Yes</th>
<th>No</th>
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<tr>
<td>6 weeks for admission and exchange of case summaries</td>
<td>29%</td>
<td>71%</td>
</tr>
<tr>
<td>16 weeks for medical evidence on breach of duty</td>
<td>71%</td>
<td>29%</td>
</tr>
<tr>
<td>28 weeks up to causation</td>
<td>57%</td>
<td>43%</td>
</tr>
</tbody>
</table>

Figure 4

4.18 Solicitors identified three main problems with obtaining medical evidence. First, the limited number of experts on the approved list; second, (and related to the first) not all specialisms are covered so it is sometimes necessary to seek out an expert willing to prepare a report at the fixed fee; third, problems agreeing an expert with the WHLS (it should be noted that most solicitors did not identify this as a problem caused by the WHLS acting unreasonably); and, fourth, problems getting experts to return reports on time. Several of the interviewees commented on the difficulty of persuading experts (even those on the approved list) to act for the fixed fee. This evidence is supported by evidence from the WHLS (see: 3.27). Fixed fees for medical experts is dealt with in Chapter Five (5.9 et seq).

Comments on the issue of delay included:

‘We’ve found that there have been delays ... I think difficulties have been
encountered predominantly when there has been a lack of an expert identified on the approved list. If we have had to go outside of the list then that’s caused difficulties – either side not being able to agree to the alternative nominated expert.’

4.19 The majority of solicitors agreed that the Scheme is sufficiently flexible to allow timescales to be varied. Where problems are encountered, almost without exception, solicitors reported that these had been dealt with amicably with the WHLS. The informal nature of the Scheme and the flexibility allowed by the Scheme rules has enabled the WHLS and claimant solicitors to negotiate over timescales.

What solicitors had to say on this issue:

‘I haven’t found a particular problem with the timescales. I deal with Welsh Health Legal Services all the time and we don’t all religiously stick to timescales. We are quite reasonable with each other. We try to stick to timescales!’

‘The Scheme itself provides for timescales to be extended. We haven’t had any difficulty with the defendants getting agreement to the timescales being extended.’

4.20 Cooperation between the parties is certainly conducive to the effective operation of the Scheme. But there were also concerns that too much flexibility might lead to timescales being ignored.

For example:

‘I would say sometimes though that it is important when you have a timescale that you attempt to work to it and if you are unable to work to it, that you request an extension in the same way as you would if there was a rule of the court and you are requesting an extension.’

‘The Scheme is extremely flexible. The one frustration of the Scheme for me is that there are no new sanctions really. You can say well “please reply” but there’s no sanction and I am not quite sure what sanctions you could put in the
4.21 Whilst the evidence from solicitors (and the WHLS) of delay in meeting timescales is a concern, it would appear from other evidence that the Scheme’s capacity to deliver its key objective of resolving disputes within 61 weeks has not been prejudiced in the majority of cases. This is probably due to the fact that cases are usually settled once a report is received on breach of duty and/or causation (this means that the overall process is shortened)(see: 3.14 and 3.28).

4.22 We have given consideration as to whether or not timescales under the Scheme should be extended. See: Chapter Six: Conclusions and Recommendations (6.14 et seq).

Scheme criteria

4.23 There was some support for enlarging the Scheme criteria. Whilst all of the solicitors interviewed thought the existing criteria appropriate, half of those interviewed thought that the criteria should be enlarged to include higher value claims. There was, however, uncertainty as to what a new upper limit might be.

Comments and concerns on this issue included:

‘I think it should be higher - £20-£25,000 - and I’m not quite sure why.’

‘The only thing I would way is that as a group, claimant solicitors generally, we agreed that you could increase the upper limit of compensation to £20,000.’

‘You are getting a fairly preliminary report from an expert then and I would be slightly nervous with bigger value claims; who was that going to service really – claimant or defendant - so I think that the level is about right.’

‘I think it would be difficult to increase the value limit because once the value of
4.24 The view from solicitors was that the value limits of the Scheme might be increased but that this ought not to be by too much – although there was a lack of specificity as to what amount might be appropriate as an upper limit. There was a general consensus that if the upper limit of the Scheme value criteria were to be increased, solicitors would look very carefully before deciding whether or not to recommend the Scheme to claimants in higher value claims. See: Chapter Six: Conclusions and Recommendations (6.12 et seq and Recommendation 4).

4.25 Some solicitors suggested that the lower value limit for the Scheme should be removed. This suggestion was not supported by the WHLS (see: 3.31). See: Chapter Six: Conclusions and Recommendations (6.12 et seq).

4.26 When asked whether or not they had had a claim refused admission to the Scheme 13% of interviewees said they had, and for proper reasons. This is in accordance with the evidence from the WHLS (see 3.23).

Fixed fees
4.27 Interviewees were asked about the level of fixed fees under the Scheme. 62% responded that these were set at an appropriate level, whilst 38% disagreed and felt they should be higher. Those who felt a higher fee might be appropriate gave their reason as being the amount of work required on clinical negligence claims. See: Chapter Six: Conclusions and Recommendations (6.21 et seq).

What some solicitors had to say on this issue:

‘Are fees at an appropriate level? Yes, I think they are. It is the first cost limit that you get under a public funding certificate anyway. I think it is about right. I think the trick is practitioners using the right level of hourly rates of staff to carry out the ground work if you like. Last summer we had a couple under the Speedy Resolution Scheme, it was all a bit of a mystery to me and the first one took me ages and then the second one was much quicker. I think they are fairly...’
Review of the evidence from interviews suggests that the acceptability of fixed fees may be linked to capacity issues. Further consideration of this issue is beyond the scope of this evaluation.

There was general agreement that if the Scheme pilot is extended or made permanent a mechanism needs to be devised for increasing the level of the fixed fee over time. See: Chapter Six: Conclusions and Recommendations (6.24 and Recommendation 7).

**General comments**

As a group solicitors were generally satisfied with the way the Scheme has functioned since its inception and had few suggestions for change. All of those interviewed felt the Scheme should be continued, and indicated that if it were they would continue to make use of it/recommend it to clients. See: Chapter Six: Conclusions and Recommendations (6.2 et seq and Recommendation1).

General comments on the benefits of the Scheme included:

‘The simplicity of the scheme; the set time limits particularly for the expert reports, you can advise a client more accurately of how long it is going to take ... and explaining the Scheme is easier than explaining litigation.’
‘My additional comments are that it is very attractive for the clients, I think, it is less attractive for the claimants’ solicitors because of the fixed fees. Seldom do they settle so quickly that you have done less than that amount of work.’

‘I am supportive of the Scheme in principle. I think it is worth pursuing with a few tweaks.’

4.31 Suggestions for change have either already been discussed (above: publicity, fees), or arise from concerns over the level of fees paid to medical experts. These are discussed in the next chapter (5.9 et seq).

4.32 One solicitor mooted whether sanctions could be introduced into the Scheme for non-compliance with timescales. However, the interviewee concluded that this would be unworkable as the Scheme is voluntary. We agree.

Claimant Expectations and Access to Justice

4.33 Figure 5 shows claimant solicitors assessment of client expectations from the Scheme. Figure 6 gives information on claimant the extent to which solicitors see these expectations as having been realised. It is apparent that most solicitors see compensation as the primary objective for claimants (100% of solicitors though this to be the case). Slightly fewer (87%) saw obtaining an explanation from the trust and having matters dealt with speedily as important. Whilst few thought that clients were seeking an apology (37%).
4.34 Solicitors reported that claimants were most satisfied with the outcome of their claim where they were seeking compensation or a speedy outcome. Some solicitors explained that even where compensation is not paid clients are happy with the information provided by the medical report. There was a general feeling that claimants were less satisfied when they were seeking an apology or an explanation from the trust, but this may be due to the fact that the
primary objective is compensation. See: Chapter Six: Conclusions and Recommendations (6.2 et seq).

Comments from interviewees included:

‘The main aim is compensation. An apology they may have already received from the complaints procedure or if they say to me they only want an apology, I advise them to do the complaints procedure.’

‘I think the ones that we have finished have all been very pleased, and I think if you then sat down and told them what it might have been like without it – you know the costs that they might have incurred – I think they would be quite horrified.’

‘... the acid test being if they have received compensation, yes they are satisfied. If they have a negative opinion, are they accepting those opinions – yes they are. If that is how you evaluation their expectations, and whether their expectations are met, then yes I think, yes.’

‘I was interested by the fact that the scheme attempted to be wider than just providing compensation, but I have to admit I haven’t really emphasised that side to clients. I don’t know whether this is the experience of other solicitors. Most of the clients that I’m seeing have already pursued a complaint so they don’t need to use the scheme to pursue a complaint. But that partly could be our failing in not really pushing that side of the scheme enough.’

4.35 When asked whether the Scheme had provided enhanced access to justice a majority (62%) agreed that if a claim had not been brought within the Scheme it would not have been pursued by the claimant. However, the Scheme has benefited from the extension of public funding to support claims that ordinarily would not have attracted public funding. The interviewees were unanimous that this had benefited claimants to bring cases where a lack of funding would have otherwise been a disincentive. For those claimants where no public funding was available, interviewees were also unanimous that the Scheme had enhanced
access to justice. See: Chapter Six: Conclusions and Recommendations (6.9 et seq and Recommendations 2 and 3).

Comments on this issue included:

‘People on low incomes but who aren’t eligible for public funding but who haven’t got a pot of money to throw at it. The cost of the report outside the Scheme is probably going to cost £750, £1,000, £1,200 and you can’t really give them any indication of where their claim is going until you have got that report.’

‘Yes, I can think of a couple of people who wouldn’t have qualified for legal aid, or who didn’t qualify for legal aid, but who did instruct me under this Scheme, I suppose because I was able to explain the Scheme to them and they must have been attracted, I suppose, by the idea of a fixed budget to an extent.’

‘A lot of the clients would not have been able to advance their case in any other way either because of proportionality issues and funding issues because the cases are of limited value so, and in a lot of cases, it was the only route available to them to secure a remedy.’

‘In some cases we would have been prepared to take the cases on or we would have advised the clients of the possibility of taking the cases on, on a no win no fee, but it may have been difficult for them to obtain insurance because of reasons of proportionality. The cases that have gone in to the Scheme a lot of them would not have been able to be advanced outside of the Scheme.

‘...clients that don’t qualify for legal aid they are more willing to pursue a claim ... . There is some reassurance that they have a fixed cost.’

4.36 One issue raised by several solicitors concerned the continuance of public funding. This is summed up by the following comment from one interviewee: ‘I suppose my other point would be if the Legal Services Commission refused to extend legal aid beyond the pilot, I think the main advantage of the Scheme, from my experience, would have gone. These people won’t
*get legal aid at all.*’ It is not part of this evaluation to comment on the continuance of public funding, however some relevant information is provided in the Addendum.
Chapter Five: Key Points

- The majority of medical experts are satisfied with the instructions and client information they receive in cases referred under the Scheme.
- Medical experts agree that they are given enough time to prepare their report.
- The majority of medical experts consider the fixed fee to be too low.
- Solicitors are concerned that the fixed fee is too low making it difficult to attract and maintain experts on the Scheme approved list.
- Most medical experts will continue to accept instructions under the Scheme.
- Medical reports prepared for use under the Scheme are meeting the Scheme quality criteria.

Medical Expert Perspectives

In the text below percentages are rounded up or down to the nearest whole number.

Instructions to medical experts

5.1 Medical experts were asked for their opinion on the adequacy of the instructions provided. Standard form instruction letters are used for referrals under the Scheme. These are used where the expert is asked to advise on:

- Breach of duty.
- Causation.
- Breach of duty and causation.
- Condition and prognosis.

5.2 In general medical experts were satisfied with the content of these standard form letters.
5.3 The majority of experts (79%) rated the quality of instructions on breach of duty as adequate. The position is similar where the experts were asked to rate the quality of instructions on causation (64% rating as adequate), and on condition and prognosis (50% rating as adequate). One respondent commented that perhaps the instruction letter could be shortened. Unfortunately only one medical expert who described the quality of instructions as poor (two in total), commented on this issue, suggesting that instructions should contain a claim summary. This is required as an enclosure with the standard form letter of instruction. We see no need to amend any of the standard form documentation used to instruct medical experts.

5.4 11 respondents had received instructions under the Scheme. These experts were asked whether or not patient information given with their instructions was sufficient. The majority of respondents, (10 out of 11), agreed that it was sufficient, although two respondents commented that the amount of medical records provided was sometimes excessive. The WHLS and claimant solicitors appear to be providing medical experts with sufficient information.

**Timescales**

5.5 Medical experts who had received instructions to prepare a report were asked whether the four week timescale (between instruction and return), was sufficient to complete a report. In total eight experts thought the time allowed sufficient.

5.6 Of those who indicated that the time allowed was not sufficient two respondents thought an extension of between 2-4 weeks appropriate, with just one respondent suggesting that even more time might be appropriate.

5.7 Medical experts who had received instructions were also asked whether two weeks is sufficient time to reply to questions put by the parties. Seven answered yes. The remaining four respondents thought the timescale should be extended by between 2-4 weeks.

5.8 The evidence from the WHLS (see 3.11 and 3.27), and claimant solicitors (see 4.17 and 4.18), has already established that there are difficulties in meeting with timescales established by the Scheme and that these arise most often at the stage where medical evidence is sought.
from relevant experts. This apparent contradiction with the evidence from medical experts (suggesting that the time allowed is sufficient) is difficult to resolve. Notwithstanding, it is clear that in general medical experts do not take issue with the length of the timescales established by the Scheme. This is relevant to our conclusions on this issue. See: Chapter Six: Conclusions and Recommendations (6.15 et seq).

Fixed Fees

Amount of fees

5.9 Amongst medical experts questioned the highest level of dissatisfaction with the present structure of the Scheme is over the issue of fixed fees.

5.10 All medical experts were asked whether or not they thought the fixed fees were set at an appropriate level. Eight experts disagreed that the level of fixed fee is set at an appropriate level: these respondents considered the fee to be too low. The findings here show little variation whether the expert had received instructions under the Scheme or not.

5.11 The same issue was raised by the WHLS (see 3.29), and by solicitor interviewees (see 4.18 and 5.16 et seq below). A number of solicitors questioned whether or not an expert could provide a high quality report at the price of the fixed fee.

Comments from solicitors included:

“You are getting a joint report where an expert is being paid frankly a fraction of what he would be paid otherwise and the fact that it is being done jointly does in itself create day-to-day issues but most definitely the fact that the experts are doing a joint report for a very limited fee does beg the question of how long they spend on it. Say their average fee is £200 per hour and they are being paid £450 in total for what could be a task of looking through a lot of notes, how many hours have they spent on it?”
5.12 Despite these concerns additional evidence from solicitors on the quality of medical reports shows a high degree of satisfaction with the quality of medical reports. As shown in Figure 7.

![Figure 7](image)

5.13 When asked whether the quality of medical reports is comparable with those prepared for use with non-Scheme cases a minority of four said that they were, the remainder thought not. It should be noted that most added the caveat that their expectation of reports prepared for use within the Scheme was not as high as might otherwise be the case, and that in any event the report obtained was sufficient for the purpose required.

5.14 Several solicitors commented on the quality of the medical reports they had read having regard to the price.

For example:

‘In most cases I would expect to get better reports outside the scheme but the report that I had was better than I expected for the money in what was a difficult case ... repeating what others have told me, I am told that generally speaking the reports have been pretty good’
‘You can’t expect them to be as detailed, but they are reasonable and they are good value for money. They are not tick-box format. They are proper reports.’

5.15 In addition to asking solicitors about the quality of medical reports the evaluation undertook a document analysis of 22 medical reports from randomly selected closed files. These were assessed using the ‘Criteria for the Evaluation of Medical Expert Report’ at Annex B of the Scheme. The findings from this assessment, which are set out in tabular form in the Appendix confirm that in the case of the medical reports selected for analysis the relevant criteria were, for the most part, satisfied. See: Chapter Six: Conclusions and Recommendations (6.20).

The approved list

5.16 An issue raised by solicitors arising from the level of fixed fees for medical experts is the difficulty in persuading experts to agree to accept instructions for the present fixed fee. There was general concern that the approved list does not have sufficient experts, or experts in all relevant disciplines. Several interviewees expressed the view that more had to be done to expand the approved list, and for most this included increasing the level of fee payable for preparation of a report.

Comments included:

‘I think we need to do a lot more work on experts because invariably that is where it is falling down. We need to make sure that the list is expanded and that more experts are included in the scheme, that more experts are aware of how the scheme works and that the level of their fees is increased. If we are going to expand the list and include more specialities and more expensive specialities also, then I think we need to rethink the fees and we need to rethink the number of hours and/or rethink the number of hours spent in preparation of the report.’

‘When there hasn’t been a correct speciality on the list so we have had to approach people outside. The list isn’t very extensive so we have had to add specialities to it; but it may be that we could attract more people if those fixed
5.17 The consensus amongst claimant solicitors was that if the approved list of medical experts is to be expanded, and in particular if it is adequately reflect the range of cases taken under the Scheme, the level of fixed fee needs to be increased. See: Chapter Six: Conclusions and Recommendations (6.17 and Recommendation 5).

Medical experts: participation in the Scheme

5.18 Some solicitors suggested during interview that a number of experts whose names appear on the approved list are no longer taking instructions. This is confirmed by the findings from medical experts. Although 11 out of the 14 respondents indicated they would continue to accept instructions, two respondents stated that they would not, with one respondent indicating that s/he was about to retire. Even if it is optimistically assumed that this finding will not repeat itself amongst the remaining eight experts who did not respond to the questionnaire, the figure represents a significant reduction in the number of experts on the approved list. See: Chapter Six: Conclusions and Recommendations (6.17 and 6.18 and Recommendations 5 and 6).
CHAPTER SIX: CONCLUSIONS & RECOMMENDATIONS

Conclusions

6.1 In our view the Scheme is meeting with its objective of providing a quick, proportionate and fair resolution of straightforward low value clinical negligence claims. It is generally fit for purpose. For reasons which we discuss further below, we recommend the Scheme be continued in its present form: Recommendation 1.

Acceptability

6.2 We have found that the Scheme has been positively received, and is seen as providing a realistic alternative to litigation in the field of clinical negligence by key participants. From the perspective of claimant solicitors and the WHLS it is seen as having provided a number of benefits.

6.3 For the WHLS the advantages provided by the Scheme are: it has delivered savings primarily by reducing costs; the Scheme establishes a structured framework for dispute resolution. For claimant solicitors the main advantages are those which provide benefits to claimants, namely: fixed and therefore predictable costs, and access to relatively inexpensive medical report; a speedy resolution; and, in some case, compensation.

6.4 The evidence shows that the Scheme is acceptable to key participants: the NHS and the WHLS; claimant solicitors; and, medical experts. In our view it is reasonable to suggest from the information provided by solicitors that it is also acceptable to claimants. This is because a number of features designed into the Scheme are perceived as advantageous to claimants. In particular: the use of joint experts; clear timescales; and, fixed fees. These design features are responsible for the Scheme’s success. As we consider the Scheme to be generally fit for purpose we do not intend to make any recommendations for substantial amendments.

6.5 The Scheme provides a structured method of resolving disputes. Our assessment of the evidence is that it establishes that the Scheme is capable of identifying and meeting claimant expectations. Although claimants may not always gain compensation the availability of a relatively inexpensive medical report facilitates the process of reaching a satisfactory
outcome. A medical report can provide a claimant with an explanation of what happened in his or her case even if it does not support a claim. To this extent the Scheme has provided an independent alternative dispute resolution system for low value clinical negligence disputes, which identifies and delivers outcomes that are important to claimants.

**Costs savings**

6.6 In our view the Scheme has resulted in some savings to the NHS in Wales. Based on our review of the spreadsheet evidence from the WHLS database of claims, and our review of closed cases we conclude that damages and costs paid out by the NHS trusts in claims settled under the Scheme are lower than where a claim is settled outside of the Scheme. We would add the caveat that care is needed when abstracting from a small sample of cases. Notwithstanding, it may be said with some confidence that in those claims reviewed there have been savings to the NHS, and that having regard to evidence from the WHLS generally, this is most likely reflected in other cases entered into the Scheme.

6.7 We cannot conclude that the Scheme has resulted in any other financial savings to the NHS. The evidence from the WHLS database suggests that the number of claims brought year on year having a value up to £15,000 has remained fairly constant. Further, the WHLS has pointed out that the Scheme has not produced any simplification of the process of resolving disputes, or in the administration of claims. Scheme claims seem to require the same amount of work as other claims of similar value. The evidence from claim managers is that Scheme claims are dealt with in the same way as ordinary claims. On this basis we have to conclude that the Scheme has not produced any readily identifiable savings in administration costs to the WHLS or the NHS.

**Proportionality: costs and compensation**

6.8 An obvious benefit provided by the Scheme is that in those claims where compensation is paid to a claimant the relationship between the award and costs is more proportionate when compared to non-Scheme claims. To this extent the Scheme is meeting with one of its objectives: of providing a proportionate means of resolving low value straightforward clinical negligence claims against the NHS in Wales.
Access to justice

6.9 In our view the Scheme is meeting with another key objective by providing access to justice for claimants. Claimants who previously would have been put off by the unpredictable and potentially expensive costs of litigation have been able to bring claims. The fixed fee regime established by the Scheme has contributed to enhanced access to justice: in particular for claimants ineligible for public funding.

6.10 In the light of our conclusion in 6.9 above, and having regard in particular to the evidence from solicitors, we see a need for more to be done to publicise the Scheme. More should be done to inform patients (as potential claimants) about the Scheme, in particular where a patient makes a complaint against an NHS trust. In order to ensure that access to justice is enhanced and made available to as many patients as possible we recommend wider publicity for the Scheme: **Recommendation 2**.

6.11 We have had regard to the comments of some solicitors who are concerned about the possibility that non-specialist solicitors are not aware of the Scheme. If solicitors are not in a position to inform clients about the Scheme this has the potential to undermine the key benefit of providing access to justice. For this reason we recommend that the Scheme should be publicised to all solicitors in Wales, whether specialising in clinical negligence claims or not: **Recommendation 3**.

Scheme criteria

6.12 Turning to the Scheme criteria. Whilst more claimants could be given access to the Scheme if the lower limit value were removed we agree with the WHLS that lowering the value limit for admission would eventually lead to compensation and costs becoming disproportionate. We do not recommend any change to this criterion.

6.13 The upper value limit appears to be arbitrary. Although there is likely to be some correlation between complexity and value, a low value case may be as complex as one of high value. In our view the primary criterion for admission to the Scheme should be whether or not a claim is sufficiently straightforward. This raises the question of whether there should be any upper value limit, and if so, what it should be. Logic suggests that if complexity is a determining factor there ought not to be any upper limit. But this is intuitively problematic
and goes against the evidence from solicitors, several of whom would support an increased but fixed upper limit. Ultimately we conclude that the Scheme has the potential to benefit more claimants by increasing the upper value limit. As there is no obvious consensus on what this should be we recommend that any increase should be introduced following consultation with interested parties (solicitors, WHLS, NHS trusts): **Recommendation 4.**

**Timescales and delay**

6.14 On the issue of timescales, the evaluation has identified a problem with procedural delay. The Scheme is not meeting its timescale target at the admission stage. Delay at this stage cannot impact on the overall target of 61 weeks from admission to resolution. However any delay represents a compromise of the objective of providing a speedy resolution for the claimant. Notwithstanding there are understandable reasons for delay at the admission stage. The NHS trust concerned will need to consider whether or not to make an *ex-gratia* payment to a claimant, and in order to do so it may need to retrieve patient records (also necessary for the WHLS to take a view on complexity). If an *ex-gratia* payment is offered and accepted this is advantageous to the claimant. Timescales could be amended to more accurately reflect the reality of commencing a Scheme claim. However, in our view timescales provide a target for the WHLS which ought not to be compromised. We do not recommend amending the timescale for admission to the Scheme.

6.15 Delay in obtaining medical reports gives more cause for concern: first, because delays are longer than at the admission stage; and, second, because delay at this stage prejudices the overall objective of meeting the 61 week overall timescale. The procedural timescales established for obtaining medical evidence are integral to the Scheme. The evidence from medical experts suggests that four weeks ought to be enough time to prepare a report. In our view this is correct. It is significant that the Working party which drew up the Scheme included experienced practitioners who presumably had in mind the realities of progressing a clinical negligence claim, and the objective of providing a speedy means of resolving disputes. With these factors in mind the Working Party decided on appropriate timescales for obtaining medical evidence. It is also relevant that any extension of Scheme timescales for obtaining medical evidence would have to apply to all stages where medical evidence might be required (a possible three stages). If timescales were extended to reflect the present reality of obtaining medical evidence under the Scheme this would undoubtedly have the effect of extending the
61 week overall timescale significantly. In our view this would be an unacceptable compromise of the Scheme’s claim to operate as a ‘speedy resolution scheme’.

6.16 There is another reason for not extending the timescales for obtaining a medical report. The evidence suggests that the problem of delay arises through a combination of several factors relating to medical reports. In our view the most significant are: the limited availability of approved experts; and, experts being too busy to prepare a report within the timescale allowed. We believe that if the expert list were enlarged the WHLS and claimant solicitors would be in a better position to instruct an expert able to provide a report within the relevant timescale, or very soon thereafter.

6.17 The evidence strongly suggest that to encourage more experts onto the list the level of fixed fee for a medical report needs to be increased. We are conscious that by increasing the fixed fee for experts this will inevitably increase the overall cost of claims under the Scheme. This will prejudice not only the NHS if a claim is admitted to the Scheme, but also claimants who fund a claim from their own resources. Despite this we see the advantage of an expanded list of experts as outweighing any disadvantage. We therefore recommend increasing the level of fixed fee payable to experts under the Scheme. Once again we suggest that any proposed increase in the level of fixed fee should be undertaken following consultation with interested parties. **Recommendation 5.**

6.18 We have a further suggestion for expanding the number of experts on the approved list. During informal discussions with two solicitors involved with the Working Party we were informed that the approved list only includes experts from outside Wales so as to give claimants confidence that experts will act impartially. In our view this is an unnecessary compromise. Firstly, experts from within Wales can and do advise claimants in respect of clinical negligence claims against Welsh NHS trusts. Secondly, we cannot be sure that this is a concern for claimants that outweighs their interest in obtaining a medical report quickly. Thirdly, if a claimant fears that an expert may be biased there is the option of not agreeing to his or her instruction, or alternatively of withdrawing from the Scheme. In our view medical experts from within Wales should be invited onto the approved list: **Recommendation 6.**
**Quality criteria**

6.19 In our view the way in which the WHLS and claimant solicitors are dealing with claims admitted to the Scheme is appropriate to the value and complexity of the cases involved. Claims are being dealt with by practitioners with relevant experience, and the parties are adopting an approach which is generally co-operative and within the spirit of the Scheme.

6.20 The quality of medical reports prepared for use within the Scheme is of a good standard. Medical reports are meeting the quality criteria established by Annex B of the Scheme documents.

**Fixed fees**

6.21 We have already discussed the importance of fixed fees, and the issue of fixed fees for medical experts. We here consider the issue of fixed fees for solicitor profit costs. Whilst claimant solicitors support the continuance of the Scheme concerns have been expressed about the level of fixed fees for profit costs. There was some suggestion that these should be increased, or alternatively that they should be determined by reference to a sliding scale of compensation. Obviously increasing solicitor fixed fees would mean that the overall cost burden on the NHS would increase where a claim is admitted and succeeds. There is a knock on effect on the relationship between compensation and costs. As interviewees were not unanimous on the need to increase fixed fees, and as solicitors are prepared to continue using the Scheme, we cannot recommend increasing the fixed fee for solicitor profit costs.

6.22 A caveat needs to be added to the last paragraph. Solicitors support the Scheme for a host of reasons, many related to client interests. This evaluation has not entered into detailed (or any) analysis of the profitability (or otherwise) of Scheme claims for those solicitors who undertake Scheme work. It would be unacceptable to expect solicitors to act without the prospect of a reasonable return.

6.23 Responses from counsel (not discussed in the report) suggest that the level of fixed fee for an advice on quantum is acceptable. We see no reason to recommend any increase.

6.24 In general we are concerned that the Scheme does not provide a review mechanism for re-considering the level of fixed fees. This applies in the case of solicitors, medical experts
and counsel. The value of fixed fees will always depreciate over time and account needs to be taken of this if the Scheme is continued. We recommend introducing a review mechanism to determine from time to time whether or not fixed fees should be increased, and if so, by how much. **Recommendation 7.**

**Learning lessons**

6.25 It is part of the rational for the Scheme that it will contribute to the process of the NHS learning lessons from clinical negligence claims. In order to assist with this process trusts are required to prepare action plans. The evidence suggests that this process is being carried out by NHS trusts. It may therefore be concluded that the Scheme is contributing to the NHS learning lessons. However, without detailed investigation of the use made of action plans (which was not within the remit of this evaluation), no conclusion may be drawn about the worth of this contribution. We are concerned that even in cases where the claimant was successful there was no action plan on file, and no evidence that one has been prepared or its contents advised to the claimant as required by Scheme rules.

6.26 Finally, it is unfortunate that there is no facility to enable claimants to give their opinion on the Scheme once a claim is concluded. There is no closure questionnaire. This has proved problematic for this evaluation (see Methodology, 2.13 et seq), but also means that in the future the claimant perspective may be overlooked. For this reason we recommend introducing a closure questionnaire to be used when claimants withdraw from the Scheme, or where a claim is terminated in accordance with the Scheme rules. **Recommendation 8.**

**Recommendations**

1. The Speedy Resolution Scheme established by the National Assembly for Wales as a pilot project in February 2005 should be continued as a permanent scheme.

2. Information about the Scheme should be made available to patients generally, but in particular to those patients who make a complaint against an NHS trust.
3. Information about the Scheme should be provided to non-specialist solicitors.

4. The WAG should give consideration to raising the upper value limit for claims admissible to the Scheme following consultation with interested parties.

5. The WAG should give consideration to increasing the amount of fixed fee payable for a joint medical report.

6. Medical experts from within Wales should be eligible for appointment to the approved list of medical experts used by the Scheme.

7. The WAG should provide a mechanism for reviewing the level of fixed fees for all participants.

8. Claimants should be provided with a closure questionnaire for completion when a claim is withdrawn or concluded in accordance with Scheme rules.

9. Individual NHS trusts should be required to devise and implement a procedure to ensure that a claimant is advised of the contents of an Action Plan prepared following closure of a Scheme claim.
## APPENDIX: REVIEW OF MEDICAL REPORTS

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<th>CRITERION</th>
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<th>Adequate</th>
<th>Poor</th>
<th>Not applicable*</th>
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*N/A applies where an expert is not asked to report on an issue.*
ADDENDUM: PUBLIC FUNDING

1. To support the Scheme the Legal Services Commission agreed to provide funding for claimants whose claims were admitted to the Scheme and who were financially eligible for Investigative Help payable at the Legal Rate up to a maximum of £3,500 (plus VAT).

2. The relevance of the LSC decision is that some claimants were able to proceed with their claim with the support of public funding where otherwise they would not have been entitled to financial assistance (because their claim did not meet the cost/benefit test).

3. It was not part of the scope of this evaluation to consider either the relevance of public funding to the success of the Scheme, or, if public funding should be extended. However, whilst undertaking the evaluation it became very clear that public funding has contributed significantly to the Scheme’s success in providing access to justice. Whilst interviewees reported that the Scheme had enhanced access to justice for claimants not eligible for public funding, all of those interviewed (claimant solicitors) saw public funding as an important contributor to the success of the Scheme.

4. The LSC provided some information on the funding of claims. As at the 23rd April 2008 the LSC had received 91 applications for funding, with 68 certificates issued. (It has not been possible to determine what percentage of claims where public funding was refused were admitted or dealt with under the Scheme.)

5. Where a certificate was issued the LSC reported that 34 cases had been concluded: with 11 of these (33%), were successful; and, 23 (66%) were unsuccessful. In the cases where the claimant was successful the total amount recovered was £53,000. The average recovery was £4,818 (just under the Scheme lower value limit). The average amount of costs met by the LSC in unsuccessful claims was £2,090.

6. When the Scheme was discussed with the LSC the following points emerged:
   o The LSC has not taken any decision as to whether or not the present funding arrangements are to be continued.
A decision would need to be taken on the continuance of public funding if the pilot were made a permanent Scheme.

The LSC has been flexible and generous in deciding whether cases should receive public funding under the Scheme in order to ensure that a range of cases pass through the Scheme.

The probability is that the LSC will adopt a more rigorous approach to applications in the future.

Where funding has been refused this is usually due to financial ineligibility or failure to cooperate by not filling in forms etc..

END OF REPORT