

**National Health Service Litigation Authority (NHSLA)
Action for Victims of Medical Accidents (AVMA)
and
Centre for Effective Dispute Resolution (CEDR)**

**Report on the Initial Phase of the
Clinical Negligence Mediation Project**

1. Introduction

- 1.1 Towards the end of 2000, Arnold Simanowitz, Director of AVMA and Steve Walker, Chief Executive of the NHSLA, discussed the use of mediation for dealing with clinical negligence disputes. Mediation was perceived to be an excellent way to deal with some clinical negligence disputes but the number of such cases being referred to mediation was very low. AVMA could see the potential value of mediation but had certain reservations about recommending its use on a generalised and widespread basis.
- 1.2 Over the following months, AVMA considered how to address its reservations and to develop procedures that would enable it to support the wider usage of mediation. Some further months of discussion and consultation between AVMA and the NHSLA then followed, working also with Henry Brown, a solicitor and mediator, as consultant. They concentrated on the following three areas of concern, namely:
- 1.2.1 The complexities of clinical negligence disputes and the needs of the parties (including patients who had experienced clinical accidents and clinicians against whom allegations were made) required a level of specialist expertise and skill from those mediating such disputes. If mediation were to be more widely used for clinical negligence disputes, there would need to be a significant body of specialist clinical negligence mediators with an understanding of and sensitivity to these complexities and needs.
- 1.2.2 The need for a procedure that would afford parties the opportunity to explore in the particular circumstances of their case (rather than on any generalised basis) whether mediation was appropriate for their case, at that stage or at all or whether some other process might be more suitable. Other possibilities might include for example some form of non-binding evaluation, use of complaints machinery, round-table or other negotiation or indeed proceeding with litigation. If mediation was being contemplated, this procedural review could be used as a preliminary step in the mediation process. Parties could examine and perhaps agree on mediation procedures, timetable, documentation and issues such as who might attend (parties, clinicians, experts, lawyers) and how and to what extent representatives would be expected to argue their respective cases and face any kind of evaluation.
- 1.2.3 Those representing parties in the mediation process, especially the lawyers, would need to appreciate how they could best and most effectively represent their clients in the mediation process and the preliminary process review. Mediation was unfamiliar to many lawyers and this was particularly so in relation to clinical negligence cases. Not just the mediators but also the parties' lawyers needed specialist understanding and skills.

- 1.3 It became clear that specialist training, both of mediators and parties' representatives would be central to addressing these concerns. AVMA and NHSLA decided that it would be essential to involve an ADR organisation in the development of these ideas, particularly one with a training arm and involvement in clinical negligence disputes. CEDR was actively involved in the clinical negligence field and its Director Tony Allen was an experienced clinical negligence mediator. CEDR was accordingly invited to join NHSLA and AVMA in further exploring and developing these ideas.
- 1.4 During the summer and autumn of 2001 further discussions took place and steps were taken to seek funding for the first phase of a project to explore the practicality and viability of these ideas. It was necessary to crystallise the concepts into practical shape and to consult with a wide range of stakeholders in the field of clinical negligence disputes to establish whether there would be support for the introduction of any new procedures based on these ideas.
- 1.5 Funding was sought from the Legal Services Commission (LSC) and the Kings Fund. As outlined below, the LSC provided a grant to enable this first phase to go ahead and the initial phase ran from May to September 2002, and has just concluded. This report amplifies the nature of the project and the consultation that was undertaken with the stakeholders and outlines how it developed and crystallised during the initial phase. It further sets out the work that now has to be done in the next stage of the project.

2. LSC Funding of the Initial Phase

- 2.1 The project team is grateful to the LSC for agreeing to fund, by way of a grant of £15,000, the initial phase of this project. The application for funding was made by, and granted to, AVMA and CEDR jointly, with NHSLA approval. The purpose of the funding was "to support the development of a specialist panel of senior mediators, who have advanced training and accreditation, to provide top quality mediation services in health disputes and a neutral, non-binding process consultancy to those involved in such disputes". It was also to include "a facility for lawyers and others involved in representing parties in clinical negligence cases to obtain specialised training in using mediation, evaluation, the procedural assessment consultancy and other processes effectively and constructively".
- 2.2 The grant was to be used to fund a work plan as set out in the grant application. This included confirming the appointment of a consultant to work with a Director from each of AVMA and CEDR in close consultation with a representative of the NHSLA as a project team to research and draft proposals. Pursuant to this, Henry Brown was confirmed as the project's consultant. It also included appointing an Advisory Group to monitor the progress of the project team. This was done, as set out in section 4.
- 2.3 The grant provided among other things for formulating the proposals and establishing their viability, liaising with interested bodies including leading mediation providers and developing the outline content and methodology of the training courses. A Code of Practice and other regulatory matters would need to be addressed. There was provision for testing elements of the project by way of a pilot scheme.

All work funded under this grant was required to be in line with the LSC's work of developing quality standards. At the end of the initial phase, a report would have to be written with a view to sharing the work of the project with other interested bodies throughout the NHS and legal world. This is the report in question.

- 2.4 Funding of the project was for 20 weeks starting on 22 April 2002, though in fact the work of the project was only able to commence substantively with effect from the first meeting of the Advisory Group on 6 June 2002. In the interim period, preliminary work was undertaken.

3. The project team

A project team was established, comprising Arnold Simanowitz of AVMA, Steve Walker and Alison Clarke of the NHSLA, Tony Allen of CEDR and Henry Brown as project consultant. They met together periodically during the initial phase, though much of their work was done by way of e-mail, telephone and fax communications, and exchanges of documents. The consultant reported to the rest of the project team from time to time on the various matters outlined in this report, and sought their views as the project developed.

4. The Advisory Group

- 4.1 AVMA, CEDR and the NHSLA had originally suggested that an Advisory Group should be established in order to have the views of a wide range of bodies working within the field of clinical negligence. The LSC adopted this as a term of the grant. Consequently, one of the first actions of the project team was to invite a number of organisations to join the Advisory Group.
- 4.2 The Advisory Group had its first meeting on 6 June 2002, chaired by Tony Allen. The project was explained and its aims confirmed. It was generally accepted that mediation was a process that should be more widely used for clinical negligence disputes and that the aims of the project should be pursued. It was agreed that interim communications would be by e-mail and a further meeting was fixed for 12 September 2002 to review progress.
- 4.3 The project team liaised further with the Advisory Group by e-mail and during August 2002 sought guidance both generally and on certain specific issues, primarily with regard to the neutral process review procedure.
- 4.4 Then at a further meeting on 12 September, the Advisory Group met with the project team and fully discussed and expressed its views on all aspects of the project. This was very constructive and supportive, and helped the project team to finalise its decisions about the further development of the project. Although some differences of view were expressed, especially with regard to the preliminary process review, (as to which, see section 8 below), there was a broad consensus on all matters.
- 4.5 The Advisory Group comprised:
- Association of Personal Injury Lawyers (APIL) (Kevin Grealis)
 - Bar sub-committee on ADR (Philip Naughton QC)
 - British Medical Association (BMA) (Barry Christie)
 - Clinical Disputes Forum (CDF) (Susan Polywka)
 - Law Society of England & Wales (Simret Parmar)
 - Legal Services Commission (LSC) (Colin Stutt)
 - Medical Defence Union (MDU) (Christine Tomkins and Stephen Fash)
 - Medical Protection Society (Gerard Panting)

The Patients Association was also invited.

4.6 Advisory Group meetings took place jointly with AVMA, NHSLA, CEDR and the project consultant.

5. ADR organisations and independent mediators

5.1 As an important part of the consultation process, Henry Brown also contacted twelve ADR organisations apart from CEDR as well as a group of independent mediators. Nine ADR organisations and the independent group responded substantively.

5.2 The following ADR bodies responded to the consultation:

ACI: (Elizabeth Birch and Hugh Caldin)

ADR Chambers: (Jonathan Dingle)

ADR Group: (Michael Lind)

ADR Training and Technical Services: (Andrew Fraley)

Association of Northern Mediators: (Peter Maughan and Mark Tempest)

Chartered Institute of Arbitrators: (Alan Connarty and Christopher Gardner QC)

Independent Mediation for Clinical Disputes: (Jacqueline Way)

In Place of Strife: (Mark Jackson-Stops)

InterMediation: (John Gunner and Peter Ashdown-Barr)

Panel of Independent Mediators (PIM)

5.3 There was strong support for the project, for the concept that clinical negligence mediators should have specialist knowledge and skills and for a training programme for lawyers and others representing parties in clinical negligence disputes.

5.4 It is clear that at present, parties working in specialist fields commonly seek mediators with an understanding of their specialist area. ADR organisations accepted the principle that mediator specialism in clinical negligence disputes was appropriate, though some questions were raised about the way in which the mediator's expertise would be used, and whether it was intended that only specialist accredited mediators would henceforth be used in clinical negligence disputes. There was also a view favouring process rather than content specialism and a view that proper initial skills training and specialist experience sufficiently provided the necessary mediation expertise. These issues are further mentioned in section 7 below.

5.5 There was enormous support for a course that would provide specialist training for parties' representatives in clinical negligence disputes. There was a recurring theme that lawyers representing parties would benefit from such a course. A few respondents indeed felt that that this was vital. The sense was that this would enhance their role and widen their existing skills as "experts in dispute resolution... [rather] than merely litigators".

5.6 The concept of a process review attracted interest and support but also reservations. This concept has developed and changed through the consultation process, and ADR bodies responded to an earlier version that envisaged a form of non-binding neutral "consultancy", "assessment" or "guidance". Doubts about this related to the role of a neutral in making assessments or giving guidance, placing the responsibility for process decisions on parties' lawyers. The project team has noted these points and will have regard to them in further developing this aspect of the project, which will be explored and considered by way of a pilot scheme. See further section 8 below.

- 5.7 As will be clear, CEDR is directly and prominently involved in the creation and development of this project and will be creating the initial training courses and helping to pilot the preliminary process review scheme. Its involvement and support is considerable and appreciated. However, as CEDR itself readily acknowledges and supports, the project has a wider aim, which invites the support and involvement of other ADR organisations as well.

6. Other individual communications

- 6.1 There were also a number of communications and enquiries about the project from individual practitioners. Some were interested to know more about the project or to become involved in some way and some very helpfully agreed to act as “sounding boards” for the concepts under consideration by the project team.

- 6.2 The project team wishes to acknowledge and thank all of these individuals:

James Adeley, Hempsons
Richard N. M. Anderson, Advocate, Scotland
David Cornes, Winward Fearon
Tim Holman, Hempsons
Jeremy Irwin-Singer, Linnells
Linda Johnston, Francis Hanna & Co, Belfast
Shlomo Levin, Mediator
Gary McFarlane, Veale Wasbrough
Lisa O'Dwyer, Russell Jones & Walker
Tim Palmer, Penningtons
Andrew Paton, Pinsent Curtis Biddle
Geoffrey Reed, Browne Jacobson
Christopher J Smith, Wilson Browne
Quentin Smith, Addleshaw Booth & Co
Verity Stauffer, Woodford Stauffer
Roger Tabakin, Mediator
Andrew Taylor, Mediator

7. Specialist clinical negligence mediators

- 7.1 The original concept was to establish a “panel” of specialist clinical negligence mediators approved by NHSLA/AVMA. While the concept of specialist mediators has been retained and indeed endorsed by the Advisory Group and most respondents, the project team has moved from a “panel” route to a “qualification” route. This is virtually identical in effect to the original concept, save that instead of NHSLA/AVMA (in consultation with MDU and MPS) establishing and regulating a panel of mediators, individual mediators will receive accreditation as clinical negligence specialists and will offer their services through ADR organisations and/or independently, without being on a specific panel as such.

- 7.2 It is now envisaged that there will be two routes to specialist accreditation:

7.2.1 The primary route will be by way of attendance on and satisfactory completion of a specialist clinical negligence mediation course, as outlined below.

- 7.2.2 Exceptionally, mediators who can demonstrate expertise and significant experience of mediating clinical negligence disputes, may apply for accreditation on the basis of a “passported” route involving attendance on an abbreviated core training workshop and complying with an assessment procedure that will be devised.
- 7.3 Mediators who have been accredited as such by a recognised ADR organisation will ordinarily be considered for training and specialist accreditation. Further consideration remains to be given as to the basis on which ADR organisations that train and accredit mediators will be recognised. Provisionally it is envisaged that organisations whose training has been approved by the Law Society in relation to its specialist civil/commercial mediation panel will be recognised for this project, subject to such ADR organisation having machinery and procedures for regulating membership. Alternative criteria for the recognition of training will be considered during the next phase of this project, as well as provision for individuals to apply even if their training bodies have not been recognised.
- 7.4 The specialist clinical negligence mediation training programme will be based on a modular structure, so that mediators who already have expertise in certain fields will not be required to spend time on undertaking training in those fields. The following modules are envisaged:
- 7.4.1 The core module, which all mediators will be required to undertake (though those seeking “passporting” may undertake an abbreviated version). It is anticipated that this module will involve no less than two and no more than three days, as well as additional reading and distance learning elements. This will cover matters such as: the special factors in clinical negligence cases including the needs and sensitivities of those affected by clinical accidents; the range of applicable ADR processes; PPR (see below); facilitation and evaluation; preparing parties for mediation including risk analysis; difficulties in clinical negligence cases; issues on accountability; and dealing with non-pecuniary issues.
- 7.4.2 The law module for non-lawyer mediators. Those on a specialist clinical negligence panel (Law Society, AVMA or NHSLA) will be exempt from this. An abbreviated version of this may be created for lawyers who do not have specific clinical negligence experience. This module may involve one to one and a half days, but no more than one day for the abbreviated version. This will cover matters such as relevant basic law (duty and standard of care; breach; proof; causation; consent; limitation); damages; procedure (protocol; experts; CPR); complaints machinery; funding and indemnification; and costs, conditional fees agreements, insurance and proportionality.
- 7.4.3 The medical module, for mediators who do not have a medical or medico-legal background. This will involve no more than one day. It will cover matters such as patients’ needs; technical aspects (medical records, terminology and evidence); and basic medical understanding in selected areas such as gynaecology and obstetrics, oncology, orthopaedics, surgery, accident & emergency and general practice.
- 7.5 So, for example, a lawyer mediator with a clinical negligence practice and who has an understanding of medical issues relevant to clinical negligence disputes would only be required to undertake the core module, or perhaps an abbreviated version of it if exceptionally s/he has significant experience of mediating clinical negligence disputes.

- 7.6 CEDR will have primary responsibility for creating the first course, which will need to be finally approved by NHSLA and AVMA in consultation with the medical defence organisations. CEDR will be supported as far as practicable by the project consultant, Henry Brown. AVMA and NHSLA will contribute to the course material, as it is expected will the MDU and MPS. This first phase of the project does not envisage actually drafting the course, but rather creating a viable framework and identifying what the course will cover. After the first course, training criteria and requirements (already prepared in draft for the initial course) will be standardised to enable any other ADR training provider to deliver an equivalent course should it so wish.
- 7.7 The course will be conducted on an assessed basis, with trainers and assessors having regard to various factors such as role-play exercises, written work, contributions to discussion and exercises, self-assessment and other specific and transparent criteria, to be formulated and published. Such assessment will be necessary both for the credibility of the accreditation and for the purpose of public funding.
- 7.8 The project team is clear that the mediator's expertise should not be inappropriately used in mediation. In particular, the mediator will not be expected to become a quasi-arbitrator nor to promote his or her views to the parties. Rather, expertise will enable the mediator to understand and effectively explore the issues and complexities of the dispute and to have particular regard to the special needs and sensitivities of parties in clinical negligence disputes, both claimants and defendants.
- 7.9 Any training will need to address the importance of the specialist mediator not adopting an inappropriately directive approach. Consideration will be given to the question of evaluation (both as a separate ADR process and insofar as it takes place in the mediation process, for example, informally in "reality testing"). Mediators will need to be aware of the relevance of formal neutral evaluation, though this is likely to be provided by a different neutral. Further consideration may need to be given to this whole issue. See also section 10.
- 7.10 Consideration has been given to the possibility of seeking academic accreditation for this programme, but preliminary indications are that this is not likely to be practicable.
- 7.11 The project team is aware of the fundamental importance of process expertise in mediation, hence the pre-requisite that anyone wishing to become a specialist clinical negligence mediator must be an accredited mediator. There is no question of substance expertise prevailing over process expertise. However, for the reasons outlined above, one of the aims of the project is to ensure that mediators with process expertise also have knowledge of the special issues and needs inherent in clinical negligence disputes.
- 7.12 The project team is also aware that many clinical negligence lawyers who mediate could well be drawn from backgrounds that are either claimant or defendant based, and that there may sometimes be concerns about neutrality in these circumstances. This point has been made by a number of respondents to the consultation. Attention will be given to this aspect in the training insofar as necessary, to ensure mediator sensitivity to all issues irrespective of practising background. Whatever the perceptions may be, there is also some evidence that mediators from either claimant or defendant backgrounds are well able to mediate fairly and effectively. One of the aims of this project is to support acceptance of accredited specialist mediators, whatever their backgrounds, by both claimants and defendants.
- 7.13 It is not envisaged that the proposed specialist clinical negligence accreditation would at this stage be an exclusive basis for the appointment of mediators in such disputes.

It would though be a significant factor in the appointment, and both NHSLA and AVMA would expect their panel members to have regard to it, while retaining freedom to appoint anyone they considered competent. This might change in the future, but is not presently envisaged.

- 7.14 The project team has provisionally resolved that the qualification will be for indefinite duration once granted, subject to meeting prescribed continuing professional development and practising criteria periodically, probably every 2 years. It is contemplated that renewal administration and complaints machinery will be the responsibility of the ADR training body that trained and accredited the specialist mediator, subject however to all complaints being notified to NHSLA/AVMA and (insofar as may be appropriate) the relevant medical defence organisations

8. The preliminary process review (PPR)

- 8.1 This concept originated as “a preliminary neutral, non-binding assessment function in individual cases”. Its aim, as initially set out, was “to help parties assess whether mediation is suitable for their case or whether it might be premature, whether a case may be more likely to require non-pecuniary terms (such as an apology) or whether some further preparation is required. Neither party will wish to use a process that may be unsuitable and may perhaps even feel potentially prejudicial.”
- 8.2 Initial reactions to this concept were mixed. Certain elements had support, such as the opportunity for preliminary “screening” of cases to assess their suitability for mediation, at that stage or at all, and the desirability of having a preliminary meeting where parties and/or their lawyers could consider how to make mediation more effective. However, doubts were expressed about the neutral appearing to have the responsibility for deciding on process, which was properly the responsibility of the lawyers representing the parties. It had never been intended that the neutral would assume that responsibility from the lawyers, and so the terminology shifted from “assessment” to “guidance”; but even this left some doubt as to the respective functions of the neutral and the respective lawyers. Concerns have also been raised in relation to the cost of the process.
- 8.3 Other changes developed during the consultancy period. The procedure was initially viewed as being “pre-mediation”, but it was felt that this might imply a bias towards mediation, which will not necessarily be appropriate in every case. The procedure would certainly examine suitability for mediation, but other processes should also be considered. These might for example include some form of neutral evaluation, the use of complaints machinery, round-table or other negotiations, mediation or indeed litigation.
- 8.4 The concept of a “process review” became clearer, and this terminology was adopted. A neutral would meet with the parties and/or their lawyers and, in the circumstances of their particular case, would help them to review process. This was not to detract from the function of the lawyers to advise their clients, but was rather to work with them in arriving at the most suitable way forward for that case. This procedure would be available to either party or to both (or all) parties, and the neutral would meet the parties and/or their lawyers jointly and/or separately as appropriate. Parties could personally raise process questions or concerns.
- 8.5 The Courts have placed an obligation on lawyers to consider the use of ADR with an increasing onus on them to do so rather than to litigate. Courts in clinical negligence cases are adjourning cases so that parties may consider ADR.

The project team considers that the PPR is ideal to enable this consideration to be effectively given if the parties wish it or a judge considers it appropriate. Cases can be adjourned for process review and the consideration of ADR. Proper compliance with this might allow parties to avoid the risk of being penalised as to costs for not properly considering ADR.

- 8.6 It may be that the clinical negligence protocols and the CDF mediation guidelines may need to be amended so as to make provision for the option of the PPR procedure. Parties should not have to wait for a Master or District Judge to order them to do so before undertaking a process review.
- 8.7 Some ADR organisations and mediators indicate that they already offer this service, by discussing process issues with the lawyers; alternatively, that they sometimes have preliminary meetings with parties before substantive mediation. However, the project team does not understand that this is done in the way that the PPR envisages. Firstly, the PPR would be conducted on an informed individualised basis, and the neutral would have relevant information and preliminary documentation available. At present, any discussions that may take place are conducted on a generalised basis. Secondly, this procedure would be used on a preliminary non-binding basis, and without any commitment to proceed to mediation or indeed to any other kind of process.
- 8.8 Where both or all parties agree to mediation, the PPR can serve the purpose of a preliminary meeting in the mediation. The neutral can consider with the parties or more probably their lawyers the structure of and procedures for the mediation. This might for example include questions about timetable and documentation. The PPR can also consider whether there are any non-pecuniary issues such as explanations or apology and how these can be addressed, also who might attend on both sides, as to parties, clinicians and legal teams. There can also be discussion as to how differences will be dealt with and whether lawyers will be expected to argue their cases in any way, also how experts' differences might be addressed.
- 8.9 These would not be intended to limit the scope, flexibility or creativity of the mediator in the substantive mediation, but rather to inform parties in advance as to the broad structure and approach that they might expect and how to prepare effectively for the mediation.
- 8.10 A Code of Conduct has been drafted for the PPR and for use in relation to clinical negligence mediation generally. This draft remains to be finalised. A preliminary information form has also been prepared, which may be used to facilitate obtaining information from the parties for the PPR in an effective and cost-efficient way.
- 8.11 Questions have been raised by some respondents as to whether the PPR neutral can properly be appointed as the substantive mediator should the parties decide to mediate. The advantages of being able to do so are that the time and cost of the PPR would not be duplicated if the neutral, having read the papers and met the parties and/or their lawyers, was asked to become the substantive mediator; and the parties would not be precluded from choosing the neutral to mediate if they so wished. The disadvantage would be that the neutral might have or be perceived to have an incentive to encourage the parties into mediation. This issue has not been finally decided, but the advantages do appear to outweigh the risk of a neutral acting improperly. If both or all parties wish on an informed basis to choose the PPR neutral as the mediator, then arguably they should be free to do so.

- 8.12 Some respondents have questioned whether the cost of the process would be sustainable. This is a legitimate concern and clearly a balance must be struck between providing a useful and effective service and not creating machinery that is over-elaborate, bureaucratic and costly. Indeed, some concern has also been expressed that this procedure might be bureaucratic. The project team would not wish this to be the case, and considers it essential for this to be a positive resource and not a layer of bureaucracy.
- 8.13 Having noted the support and the reservations about this procedure and having reviewed this with the Advisory Group, the project team has decided to test the PPR procedure by way of a pilot scheme during 2003. That will afford the opportunity to see how it operates and whether it is considered to be a useful, effective and economically viable resource. The details of the scheme remain to be finalised, but once the first mediators' course has taken place, mediators and perhaps ADR organisations will be asked whether they would be willing to participate in a pilot scheme that will monitor the use and outcome of this procedure.

9. Specialist mediation training for parties' representatives

- 9.1 There has been widespread support for this from lawyers and mediators. Lawyers face pressure from the courts to use ADR (see for example the cases of *Cowl v. Plymouth City Council*; *Dunnett v. Railtrack*; and *Hurst v. Leeming*). It is essential that they should have a clear understanding of what this entails and how to function effectively in clinical negligence mediation. A lawyer respondent in the consultation process has welcomed this as "a half way house geared at those who want to go no further than advise clients in relation to options and assist them during the process" rather than undertaking full mediation training.
- 9.2 Some clinical negligence lawyers are knowledgeable about mediation and use it effectively. However, this is by no means universal and the lack of adequate understanding of mediation among lawyers generally is a recurring theme of the responses received.
- 9.3 Lawyers are understandably and properly concerned to ensure that their clients achieve the best outcome possible in the circumstances. This generally involves the use of processes that are familiar and understood rather than those that are unfamiliar. There is a perception among many respondents that lawyers' unfamiliarity with mediation and other ADR processes is inhibiting the use of mediation. Another reason attributed to lawyers' reluctance to consider mediation is a perception that lawyers are concerned about loss of control of the case. While there may be understandable reasons for caution, this project aims to meet all such reservations by providing for specialist mediators, introducing a process review mechanism and providing specialist training for lawyers in the effective use of mediation in clinical negligence cases.
- 9.4 The aim of the course (provisionally expected to cover one day plus reading and perhaps some distance learning) will be to equip experienced claimant and defendant clinical negligence practitioners with skills for effective representation in mediation and in preparing for it. Lawyers have a significant role in the mediation process, though it is different from the traditional bilateral negotiating role with which they will be more familiar.
- 9.5 The course will be practical and will deal with preliminary issues of process design, venue, documentation, team composition, getting clients ready, dealing with mediator queries, risk and preliminary analysis. PPR will be explained and its usage

considered. In the substantive mediation, lawyers will know what to expect, both in relation to facilitation and any evaluative aspect, how best to present their case in different circumstances, client involvement and using the framework of mediation to best advantage. The mediator's role will be considered, as well as negotiation, dealing with non-pecuniary issues and addressing the parties' needs. Helpful and unhelpful lawyer behaviours will be examined. Any special considerations that arise in time-limited mediation will be considered.

- 9.6 This representatives' course will have an experiential element, including role play, but will not be assessed.

10. Other matters arising

- 10.1 Some other matters were raised with the project consultant and the project team during this initial phase of the project.
- 10.2. One such aspect was that of on-line dispute resolution and related matters. A Liverpool solicitor, Anne Irving, met with the project consultant to explore the possible use of an on-line (or perhaps off-line) settlement resource called WeCanSettle.com of which she is managing director. The system uses Internet technology to facilitate on-line settlement negotiations. Although this system is not applicable to the project, the company expressed interest in developing a mediation screening function.
- 10.3 The ADR Group has also done work on mediation screening and has offered to consider with the project team how this might be developed for clinical negligence disputes.
- 10.4 Another idea that emerged during the initial phase was the concept of designing a dispute system for dealing with clinical negligence complaints and disputes. Representatives of the School of Legal Studies at the University of Wolverhampton with experience in designing dispute systems met with the project consultant to explore this possibility. The project team felt that this fell outside the scope of the project and could best be taken up directly with the Chief Medical Officer, who is considering this whole aspect.
- 10.5 An aspect that the project team would like to explore further is that of short, focused mediation, whether or not time-limited. There are circumstances where this would be appropriate (and indeed some where it would not be), as might be identified at the PPR, and the project team felt that this should be included as part of the project and perhaps in the training programmes. Andrew Fraley of ADR Training and Technical Services has outlined to the project consultant how he has used this process with positive effect.
- 10.6 Another aspect to be explored is non-binding neutral evaluation. This is one of the ADR options that will be included in the PPR, and its use in clinical negligence disputes needs to be further addressed. One respondent has described this as "grossly underused in this country" and says that in its non-binding form it offers a "pathfinding opportunity for case management and parties to see how a matter should be contemplated".
- 10.7 The project team has also been invited to consider arbitration in relation to clinical negligence disputes. The arguments in its favour include the ability to select an expert arbitrator and to agree on appropriate procedures and timetable and of course the confidentiality of the process. Disadvantages may include possible additional costs (though these might be contained by simplified procedures) and the absence of an appeal.

- 10.8 Consideration was given to the possibility and relevance of conducting a survey among clinical negligence practitioners from different backgrounds (and not exclusively lawyers) to try to establish their views on various matters applicable to this project. Limited resources meant that this could not be a high priority for the project. However, the Legal Services Commission is considering undertaking some form of survey in the clinical negligence field and has agreed to liaise with the project team in formulating the questions for that survey.

11. Conclusion

The project team is satisfied from the work done and consultation undertaken during the initial phase that this project should now move forward to implementation. This will involve the following steps:

- 11.1 The specialist clinical negligence mediator accreditation training programme can now be implemented. This will involve the following:
- 11.1.1 CEDR, in conjunction with the project consultant insofar as practicable, must now create the initial course programme and material based on the criteria and requirements stipulated by NHSLA/AVMA (which have been drafted but which remain to be finalised). This will also include liaising with NHSLA, AVMA and the medical defence organisations to obtain and co-ordinate their contributions to the course.
 - 11.1.2 Arrangements for the mediator course must be established including dates, venue, trainers and other practicalities. Costings must be undertaken to ensure the viability of the course, which needs to be self-financing.
 - 11.1.3 The course must be advertised to afford all interested parties an opportunity to apply to participate. The initial course will probably be limited to about 24 participants. The project team will need to prioritise applications based on objective and transparent criteria. It is expected that CEDR will run more than one such course in 2003.
 - 11.1.4 Criteria must be established for recognising ADR training bodies for the dual purpose of acknowledging the general accreditation of mediators applying to participate in the specialist course and of approving applications that may be made by such bodies to undertake specialist training courses. In addition, procedures may need to be devised to consider applications for the specialist course by mediators whose training bodies have not been recognised.
 - 11.1.5 Arrangements must be set up for assessing the first course. This will involve creating and publishing assessment criteria and appointing one or more assessors to support the trainers. NHSLA and AVMA are likely also to wish to be involved in the assessment process, initially at least.
 - 11.1.6 It has not been possible before the end of the initial phase of the project to finalise the question of academic accreditation of the specialist mediator training course. This needs to be done and if this route is to be followed, intensive liaison with the relevant academic institution will be needed.
 - 11.1.7 Special arrangements must be created for the abbreviated training and the assessment of experienced clinical negligence mediators who may seek to be "passported" to accreditation.

- 11.1.8 Ancillary matters must be addressed including for example establishing machinery for dealing with complaints and providing for re-accreditation criteria (CPD and practice levels) and administration.
- 11.1.9 Following the first mediators' course, training standards and requirements will need to be reviewed and amended and finalised for publication so that any ADR training organisation wishing to offer the course would be able to do so. The project team will need to establish machinery for considering and approving applications by ADR training bodies to undertake such training, which would also be subject to such standard terms as NHSLA/AVMA may stipulate (and which remain to be formulated).
- 11.2 The preliminary process review (PPR) can now be further crystallised with a view to its being included in both the mediator and the representative training courses. This is likely to include the following:
- 11.2.1 The draft Code of Conduct prepared during the initial phase of the project will need to be finalised.
- 11.2.2 Practical procedures for the PPR will also need to be finalised including the draft form for the provision of preliminary information and the mechanism for incorporating the Code into an agreement with the parties. All details of the PPR will need to be clearly formulated for the purpose of inclusion in both training programmes (mediators and representatives) and for future practice.
- 11.2.3 The range of processes to be considered in the context of PPR must be explored and developed. This will include identifying and creating explanatory material for procedures such as neutral evaluation, roundtable negotiation and the various complaints mechanisms that apply to different circumstances.
- 11.2.4 A pilot scheme to test the PPR procedure, approved in outline, will need to be prepared in detail for implementation. This is likely to include arrangements for piloting by individual mediators and by participating ADR organisations.
- 11.2.5 As the PPR becomes crystallised, its availability needs to be more widely notified including to the LCD, the courts and practitioners generally. Steps will also have to be taken to incorporate provision for it into the relevant protocol and as necessary to amend the guidelines published by the Clinical Disputes Forum.
- 11.2.6 A decision remains to be made as to whether the neutral conducting the PPR can act as the substantive mediator if the parties decide to mediate and wish to make that appointment. This question must be addressed and if the neutral is to be precluded from appointment as substantive mediator, a system to co-ordinate the exchange of information between the neutral and the mediator may perhaps need to be devised.
- 11.2.7 There is a critical relationship between devising an effective PPR procedure and keeping the costs to a sustainable level. This cost factor will need to be borne in mind throughout and special attention must be given to the way in which PPR is costed, both during the pilot phase and thereafter.
- 11.3 The specialist training course for those representing parties in clinical negligence mediation can now be implemented. This will involve the following:

- 11.3.1 CEDR, in conjunction with the project consultant insofar as practicable, must now create the initial course programme and material based on the criteria and requirements stipulated by NHSLA/AVMA. This will also include liaising with NHSLA, AVMA and the medical defence organisations to obtain and co-ordinate their contributions to the course.
 - 11.3.2 Arrangements for the initial representatives' course must be established including dates, venue, training faculty and other practicalities. All necessary costings must be undertaken to ensure the viability of the course, which needs to be self-financing.
 - 11.3.3 The course must be advertised to afford interested parties an opportunity to participate. This course is likely to be repeated (by CEDR and/or other ADR training bodies) as frequently as required and there are not likely to be any application criteria, though obviously the course will be geared to clinical negligence practitioners.
 - 11.3.4 Following the first representatives' course, training standards and requirements will need to be reviewed and amended and finalised for publication so that any ADR training organisation wishing to offer the course would be able to do so. The same factors for approval as set out in 11.1.9 above will apply to this course.
- 11.4 The following further elements of this project now need to be dealt with:
- 11.4.1 It is necessary to liaise with the ADR organisations that have responded to the project consultant, to follow up the first phase of the project and communicate with them with regard to the next stage.
 - 11.4.2 Similarly it is necessary to keep in touch with members of the Advisory Group with regard to the further development of the project. Apart from collectively informing the group of developments, individual group members are likely to have different contributions to make to the next stage.
 - 11.4.3 The project team will also need to maintain contact with the individual practitioners who have expressed interest in the project, to inform them of developments and establish how they might be further involved in the future.
 - 11.4.4 In addition to the specific matters outlined above, it will be necessary to liaise with others who have a role in the clinical negligence dispute system. For example, the Lord Chancellor's Department must be kept abreast of developments and consulted as necessary. Judges and Masters who deal with clinical negligence cases will similarly need to be kept informed. Issues arising from these communications may need to be taken into account in developing the project and the training.
 - 11.4.5 The project team will need to liaise with the LSC in relation to the proposed survey, both in relation to setting it up and as to outcomes. It will also need to analyse the implications of the survey results to consider whether they have any impact on the project.
 - 11.4.6 Attention must be given to short-term (perhaps time limited) mediation in the context of clinical negligence disputes. Guidelines for using this form of mediation may be needed and arrangements made for incorporating this resource into both forms of training.

- 11.4.7 Although on-line processes may not be immediately required, some form of on-line screening may become appropriate in the future and the project team will need to consider whether, when and how to incorporate a facility for this into the PPR.
- 11.4.8 Inevitably, in the course of implementing the project, further matters are likely to arise that will require the attention of the project team, who will in any event need to continue liaising and no doubt meeting periodically.
- 11.5 Finally, the question of further funding for this project needs to be addressed. The LSC grant was given on the basis that the Commission would not be expected to provide further funding to the project, but would in the long term expect the project to become self-financing. Certainly, two major elements of the project are now likely to be self-financing, namely the creation and presentation of the specialist mediators' training programme and the course for parties' representatives. Furthermore, it is indeed the long-term aspiration of the project that all other elements will be self-financing in accordance with the LSC's expectations.
- 11.6 However, it is clear that in the medium term, this project will require funding to enable the various matters apart from the creation and presentation of training courses to be properly implemented as outlined above. Funding will be needed to enable the whole project team (that is to say, the organisations and the project consultant) to carry out all further necessary work and to devote their time and resources to this project.
- 11.7 The initial phase of this project has crystallised the project team's original concepts into a clear and coherent programme. The consultation process with the Advisory Group, ADR organisations and individual practitioners has helped considerably both to achieve this clarification and to establish the significant level of support among stakeholders for the project. The project team is very grateful to all those who contributed their time and thoughts to this initial phase and now looks forward to implementing its plans in the next phase.

Henry Brown
For the project team
30 October 2002