Northern Ireland Assembly

Committee for Justice

OFFICIAL REPORT (Hansard)

Damages (Return on Investment) Bill: Health and Social Care Northern Ireland

27 May 2021

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Paul Givan (Chairperson)
Ms Linda Dillon (Deputy Chairperson)
Ms Sinéad Bradley
Ms Jemma Dolan
Mr Paul Frew

Witnesses:

Mr Mark Harvey	Health and Social Care Northern Ireland
Mr Alphy Maginness	Health and Social Care Northern Ireland

The Chairperson (Mr Givan): I welcome to the Justice Committee from Health and Social Care Northern Ireland (HSCNI) Mr Maginness, chief legal adviser, and Mr Harvey, assistant chief legal adviser. The session will be reported by Hansard, and a transcript will be published on the Committee's web page in due course. I will hand over to you to outline some of the key issues, and then we will have some questions.

Mr Alphy Maginness (Health and Social Care Northern Ireland): Good morning, Chairman, and thank you very much. Alphy Maginness is my name, and Mark Harvey is with me. It is good to see you, Chairman. It is a pity that we cannot be there in person, but we will continue via Zoom.

I will explain who we are. We are part of the directorate of legal services (DLS) and are the sole provider of legal services to the health and social care (HSC) sector in Northern Ireland. We provide a broad range of legal services. I will not go through them all, but they include clinical negligence, which is probably the most germane to what we are discussing this morning. We deal with a significant number of clinical negligence claims, and indeed other litigation claims, on behalf of the five large health trusts — the geographical trusts — the Ambulance Service and the Health and Social Care Board (HSCB). The value of those claims ranges from £1,000 to several million pounds, and even tens of millions of pounds. Cases include complex, high-value cases, particularly those that relate to childhood or birth injuries, where compensation is claimed as a consequence of such injuries.

Our view, and that of the legal profession, is that there is reasonable compensation for patients who are harmed owing to clinical negligence but that there is a balancing act. One of the key messages that we want to give to you this morning is that there is a balance to be struck between the legitimate right of plaintiffs to get proper and adequate compensation and the compensator's ability to pay. In our case, the compensator is the health and social care system, so public funds are used to pay the damages.

Mark will go through some examples of cases for your benefit. That will hopefully help you understand our position.

Mr Mark Harvey (Health and Social Care Northern Ireland): Thanks, Alphy. Good morning, Chairman and members of the Committee, and thank you for inviting us along this morning to discuss this important issue. As Alphy said, the directorate of legal services represents the health and social care sector in Northern Ireland. I manage a team of solicitors who specialise in clinical negligence claims and inquests on behalf of our HSC clients, and that is the area on which I focus. Those cases, as Alphy said, range in value from small amounts of money — hundreds of pounds or £1,000 — right up to tens of millions of pounds for the most highly complex and high-value cases in Northern Ireland. Such cases include a failure to diagnose, misdiagnosis, alleged surgical errors, complications, issues regarding consent to treatment and birth-injury claims. Those latter cases represent by far the most complex, sensitive and high-value cases that we see.

The position since 2017 has largely been one of a holding pattern. England, Wales and Scotland moved to alter their discount rates from 2017 and went through subsequent change in 2019. The position did not alter here in Northern Ireland. In order to address the inherent unfairness of the situation for plaintiffs, particularly severely disabled children and persons who have a disability, and with the agreement of our clients and the approval of the court, we have been entering some interim settlements, with review clauses in appropriate cases, ensuring that plaintiffs receive an interim award of compensation, with a balancing payment within a defined period once the discount rate issue is resolved.

It was not envisaged in 2017 that it would be some four years before the rate was revised or at least five years before a new mechanism for setting the rate would be in place. That has meant that we have essentially been in a holding pattern since then, with interim payments, incomplete settlements, uncertainty and instability. The lack of a settled position on the rate has created uncertainty, not just for defendants but for plaintiffs.

The move to -1·75% from 31 May will not resolve that uncertainty, as it is rightly viewed by defendants as being an interim rate. It will soon be replaced by a longer-term rate. Hopefully, that will happen in early 2022. In the interim, however, it is important that the Committee be aware that cases may be difficult to resolve, as some defendants may stall cases or refuse to engage, on the basis of such an unrealistic rate. Moreover, there may continue to be compromise settlements owing to disagreements over the rate. In addition, in appropriate cases, our clients will wish to consider interim settlements again as a holding position, pending the implementation of a longer-term, settled rate. That will inevitably lead to delays, increased costs and contested court hearings.

We note the comments of the Lord Chief Justice in his submission to the Committee that, although courts should not be expected to approve settlements that under-compensate plaintiffs, nor should they be expected to approve settlements that place an undue burden on the taxpayer, who ultimately bears the cost of overcompensation that is awarded against defendants.

One of the defendants most impacted on by the rate change in Northern Ireland is undoubtedly the health service and our clients. The imminent change represents a dramatic move from the outmoded rate of 2·5%. The new rate swings the pendulum away from under-compensation to what can only be viewed as extreme overcompensation. Each of those rates is unsustainable, because, as has been pointed out by others, they are extremes. We acknowledge that the Committee cannot alter or set the rate and that it is only considering the legal framework. We wish to voice our concern, however, on behalf of our HSC clients that, despite the best efforts of the Committee to press ahead with plans to introduce a Bill that contains a new mechanism for setting the rate, if for any reason the passage of the Bill is delayed or is unsuccessful, the planned rate of -1·75% from 31 May will become an indefinite rather than an interim rate, and that will lead to a massive increase in compensation payouts in clinical negligence claims against the health service. That will put significant pressure on the health budget.

It is incredibly difficult to forecast accurately the financial impact of the discount rate change to -1·75%, but, with the assistance of a forensic accountant, we carried out some work last year to assess a sample of our claims with a value over a defined limit. We estimated the value of additional compensation in current claims to be anywhere in the region of £40 million to £136 million. Clearly, the value of each case is difficult and challenging to predict, because it is dependent on a number of factors, including the medical evidence, the accountancy reports, the life expectancy of the plaintiff, the level of future loss claims. It is important that the Committee recognise that that is money that the

health service, in a context in which it is slowly emerging from a pandemic, could be spending on waiting lists and front-line services.

Every case that we deal with that has a future loss element will be impacted on by the rate change. The most significant of those cases will be birth-injury claims, and the figures could be staggering. It is important that I draw the Committee's attention to an example that is in my submission response on behalf of HSC:

> *"Based on the experience of a recent case, a claim settlement of c.£9 million"* —

under the old rate —

> *"would translate into a settlement of £35 million at the new proposed rate of -1.75%. This would be a total increase of £26 million for one individual plaintiff.*
>
> *The gap between the new proposed rate for Northern Ireland against the rest of the UK creates a stark difference which has implications for ... the health budget."*

Members will note that, in my submission, I provide a table that starkly illustrates the difference in the rates across England, Wales, Scotland and Northern Ireland and how that difference will impact on health service cases.

The timing could hardly be worse after such immensely challenging times with the fight against COVID-19 over the past 12 months. HSC faces significant financial pressures because of the latest decision on the personal injury discount rate.

From 31 May, we face further uncertainty in creating adequate reserves against present and potential future claims, and the large difference of £26 million, illustrated in that one case, between the present discount rate and the proposed rate, further emphasises the potential overcompensation to many plaintiffs and the resultant ramifications for public funds.

One safeguard that we have been strongly advocating against overcompensation is to ensure that cases are settled by means of what is called a periodical payments order (PPO) with as many heads of claim or compensation as possible being paid to the plaintiff on an annual basis, thus reducing the need for a lump sum payment calculated using multipliers and discount rates, thereby removing a lot of the uncertainty.

In the highest-value claims that we deal with — injuries suffered at birth, for example — we positively encourage the Department to strengthen the provisions in the Damages Act 1996 dealing with PPOs so that plaintiffs are required to accept our offers of PPOs for future loss, rather than being able to argue before the court for lump sums. That approach would depend on plaintiffs and the court being satisfied that the defendant is in a position to meet the payments going forward, but health trusts are in a position to give that guarantee. In this jurisdiction, the vast majority of high-value cases involve health trusts as defendants. The solution to that problem should therefore take into account that, in most cases, the defendant is a public body that will be in a position to meet future PPO liabilities, and thus the solution to the uncertainty of future investment return and inflation rates involves taking that uncertainty out of the equation and enforcing settlement of future loss claims by way of PPOs.

In summary, I strongly encourage the Committee to consider the timeliness of the passage of the Bill and the importance of its introduction to removing the uncertainty and instability that has existed since 2017, because, if the situation is to continue, the financial impact of a rate change to -1·75% will be stark and result in a significant increase in the value of clinical negligence claims against the health service, at a time when that money would be better spent elsewhere.

I recognise Alphy's point that there needs to be balance, and we agree that it is important that there be reasonable compensation for patients who are harmed owing to clinical negligence, but that must be balanced against the compensator's ability to pay. Thank you.

The Chairperson (Mr Givan): Thank you. We probably do not want to get into a debate around the current interim rate. I want to focus on the new framework. We have been told by the Justice Minister that we have to be absolutely blind to the financial consequences for the health service or any other body. It is about having a framework that ensures the 100% compensation principle. I do not necessarily subscribe to the Justice Minister's view on that, but what she has told the Committee is

that it is not for us to take into account the financial impact on the health service or any other body. The interim rate was consulted on, and the Government Actuary's Department (GAD) approved it. I hope that the health service is not going to now sit on claims as a reason for stalling, in the hope that the new framework will come up with a different rate, because a lot of the public bodies had been under-compensating people, based on the old rate before this interim rate took effect.

To be honest, that is a secondary issue for the Committee. What I am interested in is your views on what the new framework will look like. Is there a view that, based on the Scottish model, there are a couple of slight changes to the Northern Ireland framework and that, rather than taking a 30-year calculation for payment, which the Scottish model uses, the proposal from DOJ is for Northern Ireland to take a 40-year perspective. The framework also removes ministerial involvement in the decision-making process. Instead, that goes out to an entirely independent body, if there is ever such a thing. Ultimately, there will be no recourse to a Minister to amend the rate or strike a different rate, if that is what the new body comes up with. I am therefore keen to know your view on the proposed new framework. Does it build in a scenario, as the Scottish model does, in which there would never be under-compensation? Scotland has a policy in place to ensure that there is never the potential for under-compensation.

Mr Harvey: Thank you for those remarks. Chairman. You raised a fear that the health service might somehow seek to stall cases. I assure you that, as you will have heard in my opening remarks, HSC clients that we represent have come up with creative and innovative solutions since 2017 to address the inherent unfairness of the situation for plaintiffs. That is why we have been dealing with interim settlements by way of paying compensation to plaintiffs on an interim basis, under an old, outdated rate that has been largely ignored in the insurance industry when negotiating claims that it deals with. We have addressed that unfairness by agreeing with plaintiffs and the courts solutions that have largely addressed the problem, because it has been recognised, for some time now, that the rate needed to change. It had not changed since 2001. I feel that we and our clients have stepped up to the mark, dealt with that and addressed the issue. Our clients need to review the position on the new rate, which kicks in on 31 May. Further consideration needs to be given to how cases will be dealt with. The DLS and our clients will approach that in a fair and balanced way.

Mr Maginness: I will go back to the general issue that Mark raised about certainty and stability. For the past four years, the position on the rate has been uncertain and unstable. We welcome the fact that you are bringing forward the Bill. The timeliness of the Bill becoming law is crucial in bringing certainty back to the situation. You are right in the sense that people can take advantage of the fact that it is not helpful for them to settle now, and it may not be helpful to settle when there is an interim rate in place. Everyone therefore hangs around and waits for the certainty that comes with legislation. That speaks more to ensuring that the legislation be put in place as soon as is reasonably possible in order to offset some of the disadvantages and potential discrepancies in the current arrangements, which, I assure you, do make things much more difficult when trying to resolve cases.

You mentioned the specific point about the 43 years. We agree that the 43-year investment period is objective. It is backed up by evidence from the Association of British Insurers (ABI), which concluded that the average investment period is 46 years, so 43 years errs on the side of caution. We have no difficulty with that aspect of it. That was your particular question to us. The more general issue, however, is securing the stability that I referred to previously.

Mr Harvey: Chairman, you also asked for our views on the advantages or disadvantages of transferring responsibility for setting the rate from the Department of Justice to the Government Actuary's Department. We strongly believe that it is a matter of public policy. As such, we believe that the responsibility for setting the discount rate should remain with the Minister of Justice rather than sit with the Government Actuary. We therefore believe that we should adopt the England and Wales model, with parliamentary scrutiny, but that we should also go further and build in consultation with experts such as economists and financial advisers, as well as representatives for claimants and compensators. That would give a more rounded picture of the wider societal impact of a discount rate change, rather than it being an actuarial exercise that is carried out independent of the political scrutiny.

The Chairperson (Mr Givan): What the new legal framework will look like is a very live issue. That is helpful. Thank you for that.

I will bring in other members, and I will then come back in with some questions, if they do not ask them.

Ms Dillon: Thank you to Alphy and Mark for their presentation. I have a quick question, which is based on some of the issues that you raised. I do not disagree with periodical payments. They make sense to me, particularly when there are injuries to babies. That ensures that they will be looked after for their lifetime and will not be relying on sensible decisions being taken on their behalf. I can therefore see the sense in that.

That is fine, however, when payments are from a public body, as people will have a sense of security from knowing that they will have unbroken periodical payments. I wonder how it will work, however, when payments are from a business or an insurance company. How would people have that sense of security in such instances? Is there the potential for the periodical payments to end if, for whatever reason, the insurance company or the responsible business were to be dissolved? I assume that the business would not even come into it, because you would like to think that its insurance company would be paying the compensation, but what would happen if something were to happen to the insurance company?

Mr Maginness: You are right that there are issues there. I do not know whether that could be underwritten by government if there were any difficulties with the insurance company, if the business were to go bust, or if some people were uninsured. It is not a frequent occurrence, but, if people are uninsured, the money comes out of their own pockets, so affordability would not be there. It is a question for the insurance market as to how it would address that. We are here as representatives of our clients: Health and Social Care. I fully accept what you say. You can be assured that any commitments will be honoured for the duration of the life of the baby, child or whoever the plaintiff happens to be.

Mr Harvey: That is a fair point. When it comes to our clients, we advocate the use of PPOs, because they create fairness and balance. In a lump sum situation, if the plaintiff sadly dies early, the vast lump sum goes to the estate, which is not for what the money was intended. There is also a risk of under-compensation if a huge lump sum award is not invested wisely. A lump sum is limited to predictions of life expectancy, whereas PPOs take that risk away. In addition, plaintiffs can exceed their life expectancy, and they then have the security of knowing that the PPO gives them coverage in such circumstances. The difficulty that we face is that, with a discount rate of -1·75% from 31 May, some plaintiffs' advisers will invariably push more and more of the settlements into lump sum arrangements. We will face opposition to any attempt to agree periodical payments orders.

I go back to the point about insurance cases. It is fair to say that we agree much more with PPOs than the insurance industry does. It can speak to that point, but, from discussions with insurance industry representatives, I know that their clients tend to favour a lump sum approach, because that gives them certainty and gets the claim off the books, so to speak, whereas our clients can be given assurances that any liabilities will be met for many years into the future. It is a difficult issue that needs to be grappled with.

Ms Dillon: For that reason, I am not sure that we can grapple with it in the Bill. How would you manage that in legislation? How can we absolutely insist on periodical payments orders for public bodies but not for private bodies? I am not sure how we would do that in the legislation, although I am not saying that there is not some way around it. It is potentially a policy or regulation issue rather than its being included in the legislation. I just want to flesh how it could be done, given that it was a suggestion. I am certainly not opposed to PPOs. They are a sensible approach and give some reassurance, particularly in cases in which the injury is a lifelong one.

Chair, that was my only question, but I just want to make a point about the -1·75% interim rate that is coming in. As a Committee, we have made the point — I have certainly made it repeatedly — that we need to get the legislation and the framework in place as quickly as possible. I absolutely accept what you are saying. Although we have to look at the framework and not at the impact on public bodies or anything else, we are elected to an Assembly that has responsibility for the health service, and the conversations over the past couple of days tell us where we want our money to be going. We are conscious of it. As much as we might say that we have to look at the framework and that it is what has to matter to us, the health service matters to us, as does how we service everybody in our communities, including those who have lifelong injuries and need to be compensated. There are also major issues in the health service, and we do not want money to be going to where it should not be going. We are conscious of that, and for my part — I am sure that other members of the Committee will agree — we need to get the Bill through as quickly as possible, and we will get it through as quickly as possible. I give you that reassurance. There is nothing that we can do, unfortunately, about

the interim rate. The Minister took that decision based on a legal case that had been brought against her, and it was not her first choice.

Mr Maginness: It is reassuring that you will get the legislation through as quickly as possible. That is what is needed in order to bring back certainty.

Ms Dillon: I absolutely agree with you. Chair, that is me for now. Thank you.

Ms S Bradley: Thanks to Alphy and Mark. At the outset, I have to say that I am really pleased to hear about the interaction that you had on setting interim payments, although they are incomplete. Doug Beattie and I have been chasing the issue at the Committee, because, although we are all eager to get it to a final place, it is about the here and now for some people, and those interim payments, albeit they are not complete, will no doubt be life-changing for people who need that help. I therefore commend you for doing that, and I encourage any piece from the Department to make sure that any people who are unfortunate enough to be caught up in this, through no fault of their own, are aware that it is always on the table while we are working our way through the process. That is an important point to start with.

Following on from Linda's contribution, I want to ask a question about making the distinction between settlements against public bodies as opposed to against those in the private sector. You are absolutely right, Mark, to say that there are uncertainties. For the recipients of such a payment, there would be a reasonable nervousness about whether the body — the party against which they are claiming — will be there in future years to honour the payments. Of course, with public bodies, there is a lot of reassurance that they will continue to exist in some form. The name might change, but, ultimately, they will be there. There is that distinction, and I know that Linda tried to drill down into that. Where do you anticipate that distinction sitting? Do you think that the distinction should be made in legislation, or can you work down at regulation level? You were very clear about your idea, but I am not clear about where you think that might sit. Do you have any examples from any other part of the globe? There may be similar examples that we can draw on.

My other point concerns GAD. Ultimately, there is a grey area. We are being told that the framework is there, but, ultimately, the Government Actuary's Department is targeted with hitting 100%. However, your preference is for the other model, and you feel that other stakeholders should be engaged in that process. How do you see other stakeholders adding? You either hit the 100% or you do not. How do stakeholders — I mean stakeholders from across the whole plethora of this — add to hitting the 100%? You either hit it or you do not. I am concerned; whilst I understand the other processes, I do not see that there is real added value in them. It is in everybody's interests that we get this sorted and get a permanent solution. We will be playing our part in that.

I appreciate that I have thrown a bit at you there.

Mr Maginness: I concur completely with you. Everyone wants to get this sorted as speedily as possible. It is extraordinarily difficult to achieve 100% compensation. Actuarial evidence is fine and it helps, but why are there such distinctions in the rates that have been struck? There are distinctions in the rates between England and Wales on one hand, Scotland on another and us on yet another hand, if you had three hands — you know what I am getting at. That is demonstrative of the fact that it is very difficult to strike the right rate.

Mark's point about bringing in other experts was to give a more rounded view of what was payable and what ability there is to pay. You spoke about the insurance companies and businesses — the private sector, if you like — and maybe the unreliability of paying PPOs in the future. The ability of the compensator to actually pay is a factor that needs to be brought into that whole debate. It is not just on actuarial grounds; other factors need to be respected, and societal issues need to be introduced into any debate about what is truly 100% compensation.

Mr Harvey: I agree with Alphy. While we obviously defer to the expertise of the Government Actuary's Department — this is its area — it is not an exact science. A lot of the work that it carries out is essentially actuarial stabs in the dark. We are trying to predict how to give due deference to the 100% compensation principle for a plaintiff who may suffer life-changing injuries and require, for example, an annual payment by virtue of a PPO for the next 40, 50 or maybe 60 years, in the case of a child with a normal life expectancy. It is incredibly challenging for any expert to adhere to the principle of 100% compensation when you are trying to predict the economic climate for many years to come. Our point about bringing in experts from other fields and representatives from wider society is to seek to address

that point and take on board other views, including from representatives on behalf of claimants, defendants, economists, financial advisers, accountants etc. England and Wales have gone some way to addressing that by requiring the actuary to consult an expert group. We and other defence representatives are advocating for a wider panel or group that could be brought to bear and bring its experience to the discussion. Ultimately, that is also subject to parliamentary debate and scrutiny, and, therefore, accountability. I hope that that addresses that point.

The other issue that you asked about was in relation to legislation and how we could deal with the mandated use of PPOs. That goes back to the Damages Act 1996 and beefing up the provisions of the legislation to perhaps mandate that plaintiffs accept the offer of PPOs in appropriate cases. Obviously, I am, narrowly and selfishly, thinking about our health service clients and the really high-value cases that involve tragic catastrophic brain injuries sustained at birth. Although those cases represent a small percentage of the claims that we deal with, they are by far the most expensive and high-value, and they take up the lion's share — roughly two thirds — of the Health budget's central fund for clinical negligence claims. It is important, therefore, to discuss and devise a solution to address that. The only way to do that is to legislate.

We have several multimillion-pound cases listed in the High Court before the end of June in which we will face opposition from plaintiff representatives; I can foresee, in the weeks ahead, that with the rate as low as it is now for 31 May, they will push for as much as possible to go into a lump sum. We are talking about millions of pounds here. I can give you one example: we had a recent case in which a balancing payment of £400,000 to £500,000 suddenly rose to £2 million because the payment is required to be made after 31 May. That is a stark illustration of the financial impact of this.

I accept the point that there are challenges ahead in how you distinguish between private and public bodies and give assurances to plaintiffs that private bodies can make those payments. I do not know how they can be distinguished, but there is a conversation to be had, and we are keen to be part of that conversation.

The second issue that you raised concerned other examples from elsewhere. There was some discussion in England and Wales in recent years about legislating for courts to be able to order PPOs. Prior to the pandemic, Scotland had legislation in 2019, which, I understand, has yet to be passed, giving the courts power to order PPOs. Some thought has already been given to this across the water, and there is possibly a regional discussion to be had about how Northern Ireland can similarly tackle the issue. I hope that that is some assistance.

Ms S Bradley: Thank you. That is very helpful. Chair, I will not hog him. I hope that someone will pick up on the GP situation. Thank you, Mark and Alphy.

Ms Dolan: Thanks, Mark and Alphy. Just as Sinéad said, I am wondering why GPs in the North are the only ones responsible for providing their own indemnity.

Mr Maginness: I am actually not sure what the answer is, Jemma. GPs go through the BMA. They are indemnified in the same way that a private clinician is indemnified. An obstetrician who does private work has their own indemnity. It is different when they work in the NHS. There is a distinction. I understand that it is a very similar arrangement. A hospital doctor is an employee of a trust, and, under the principle of vicarious liability, therefore, the trust is the defendant in any civil action. A GP, however, is named personally in those actions. The actions are against an individual, and, therefore, that individual has to have a form of insurance or indemnity for which they pay a premium. It is quite costly. In the BMA's response to the consultation, the cost was between £12,000 and £20,000 for some individuals, which is quite a chunk out of their annual salary.

Mr Harvey: If it helps, Jemma, in England, as I understand it, they moved to change the system whereby, as you say, there is an NHS indemnity for GPs, and they have come within the umbrella of the health service. I am not sure whether there have been similar discussions in Northern Ireland to bring GPs under the health service's umbrella here, but that position has been adopted across the water. As Alphy says — you have seen it in the submissions from other defence organisations and the BMA — the premiums for indemnity provision for GPs could as much as double, if not more, for GP practices, which will be incredibly challenging from a financial perspective for them. We represent the health trusts as opposed to the general practitioners, who are separately represented by their own legal providers. I am sure that you will hear from GP representatives on the issue.

Mr Maginness: Representation is through their indemnity organisations.

Ms Dolan: OK. Thank you.

Ms Dillon: I have a very quick question, but first, on the back of what Jemma said, maybe we, as a Committee, should write to the Health Minister and ask whether he is considering that. We have a particular situation — I am not saying that it is not the same across these islands, because it is — and a particular challenge in the North about GPs. I would not want us to lose more GPs because of an insurance issue. We need to refocus some of our attention on the insurance companies. They are making billions out of us all, and we should not make claimants pay the prices of, sometimes, very greedy private insurance companies. We probably need to focus on that.

I just want to ask a question of Mark and Alphy going back to that point around the difference between public bodies and private insurance companies. Is there potential — I may be way off the mark; it might not be possible — for that to be done via a policy of the Department? Chair, should we, as a Committee, ask whether that is possible? It would probably be a question for the Health Minister. Alphy and Mark may be able to tell me that it cannot be done. If that is the case, that is fine, but if it is possible, we should ask that question.

Mr Maginness: I think that that is a good point. You could bring in a policy, but the problem is that it is not law. We can have a policy, but when we go to court, the judge will make a determination based on the law, having listened to the representations of both parties. It would not provide you with absolute protection, if you like. It could certainly guide us in that direction. We strive to go down the PPO route as frequently as possible, but it takes two to tango. On the other side, you have to have an agreement or the courts making an order or a determination. Do you have any thoughts on that, Mark?

Mr Harvey: The other point, Linda, is that the courts have a role to play. The judiciary is the ultimate arbiter of approving settlements for children and persons under a disability. When these high-value birth-injury cases, for example, come before the court for approval, it is ultimately only at the direction of the judge that the case is approved and the settlement agreed. In practice and in principle, most practitioners on the plaintiff's side will work with us and cooperate to agree suitable settlement arrangements for those children or people under a disability who have been harmed as a result of clinical negligence. The court then has a role to play in agreeing and approving those settlements. Certainly, the judges robustly deal with that issue in court and will challenge plaintiff representatives when the settlement is not, for whatever reason, appropriate. As to whether it is policy or legislation, I think that it is more likely to be legislation, but I am happy to engage in that conversation. A discussion with the Health Minister would be a prudent step, I agree.

Ms Dillon: Yes. Again, I am not ruling out legislation. As Sinéad also said, I cannot see how we work it out between the public bodies and the private insurance companies. I think that we should ask the Justice Department about it and see whether there is a way around it. Thank you. I appreciate your presentation.

Ms S Bradley: Just a quick point, while we have Mark and Alphy, to develop my thoughts further on the PPO proposals. When a settlement happens — I appreciate that, thankfully, the numbers of people are relatively small — and the lump sum payments go out, the framework that we talk about is based on a notional portfolio that is not very high risk. In reality, however, when a person receives a large lump sum, is the Department aware of whether the lump sum is ever, always or never managed well and lasts the claimant through their lifetime? Is the Department aware of situations where, years later, that person turns up back in the system and in need of access to public funds for care because the money was, perhaps, mismanaged or overestimated or underestimated? What is the long-term trajectory and reality of a lump sum in the health service?

Mr Maginness: There is a potential for it to be squandered, if that is what you are getting at. I do not know whether the Department tracks it. I do not think that there is an ability to do that. One of the advantages of the PPO is that you know that the money is going annually to the person who needs it. Quite often, that person will lack capacity and someone else is looking after the money for them. That is another major benefit of a PPO system. I am not aware of any ability to track lump sum payments. Once it is gone, it is gone.

Mr Harvey: Our experience has been that the majority of the high-value cases involving children and persons under a disability have been settled by way of PPO. In the insurance industry, there might be vastly more lump sum arrangements. The Office of Care and Protection will have a role to play within the court if there is a lack of capacity. The reason that we do not advocate the use of lump sums is the astronomical sums of money involved. We are talking about tens of millions of pounds in the hands of

a plaintiff and family who are going to require quite significant expert investment advice, and managing those huge sums of money brings a risk for vulnerable people and their families. We believe that the appropriate vehicle for compensating those people over the duration of their lifetime is the PPO, to remove that risk. There is risk and reward on both sides. For defendants, it obviously draws out the process, as they will be making payments for decades to come. However, it is a fair way of dealing with compensation. We believe that it strikes the right balance in the interests of both parties.

Ms S Bradley: Thank you, Alphy and Mark.

The Chairperson (Mr Givan): Everyone has asked their questions. Before we move to the next session, I thank Mr Maginness and Mr Harvey for spending time with the Committee. It has been much appreciated and is very helpful. Thank you.

Mr Maginness: Thank you.

Mr Harvey: Thank you.