

Following the publication of Sir Rupert Jackson's review of civil litigation costs, the offers to attend seminars, fact sheets and synopses from organisations who have an interest in civil litigation costs have come flooding in. AvMA's purpose in this, its extraordinary newsletter, is to comment from its unique position as a charity that campaigns for patient safety and justice. We comment only where Sir Rupert's findings relate to clinical negligence claims.

We welcome Sir Rupert's confirmation that:

"First, patients who have been injured as a result of clinical negligence must have access to justice, so that they can receive proper compensation. Secondly, this huge area of public expenditure must be kept under proper control, so that the resources of the Health Service are not being squandered unnecessarily on litigation costs."

However, we do not support any reforms in which the burden of costs, reasonably incurred, fall back upon a successful claimant resulting in a deduction from damages.

Qualified One-way Cost Shifting

In our submission to phase 2 of Sir Rupert's review, we expressed the willingness to work on a suitably constructed system of one-way cost shifting for clinical negligence cases. However, we have serious reservations about the approach described in the final report and some of the assumptions it makes.

The report recognises that without some form of protection there is an inequality of arms between individual claimants and large insurance backed or self-insured healthcare providers. If there is one way costs shifting the report assumes there will be no need to insure against defendants' costs and that most claimants will not see the need to insure their own disbursements. The assumption is based upon average figures for claimants' disbursements provided to the enquiry. We question whether this assumption is correct.

Sir Rupert is careful to call his reform *qualified partial cost shifting*. His recommendation is that, as with unsuccessful legally aided claimants, the defendant will only receive costs from the losing party in certain circumstances, chiefly after consideration of the means and the conduct of the claimant. Herein lies the uncertainty, not all clinical negligence claimants will benefit from partial costs shifting

It now seems that one way costs shifting will be *qualified and partial*. It is well known that a costs order against a legally aided claimant is rarely, if ever, enforced. And furthermore while a claimant is in receipt of legal aid this rule will apply. But how will a court assess at what level a non legally aided claimant's means will merit such an order? By definition all non-legally aided claimants will have an income above a certain minimum level. Does Sir Rupert consider that a court will take into consideration such a claimant's

savings, equity in the house or future hopes such as from an inheritance? This will result in a huge uncertainty. The prudent claimant will continue to wish to insure against such an eventuality.

Sir Rupert considers that at present the high level of ATE premiums are such that the practical effect is defendants are funding claimants who lose their cases. He opines that this is unfair. He therefore states that those claimants (he considers they will be in the minority) who wish to insure against losses in respect of their disbursements must bear the cost of that insurance premium themselves. As argued above, we believe that claimants in clinical negligence claims will continue to need to insure against the possibility that they will be assessed as of sufficient means to pay the defendants' costs.

Arguably these recommendations leave claimants in a worse position than they are at present. Claimants will still require after the event insurance yet will be unable to recover the cost from the defendants. This is not equality of arms. Most healthcare providers are either insured or of sufficient means to self-insure. This will never be the case for claimants.

Referral Fees

We welcome the report's recommendations that referral fees should be either banned or subject to a cap. However, we note that many have expressed the view that insurance companies and solicitors who have based their practices upon the purchasing of claims will find another way around this ban if it comes into force.

The report considers this possibility, although confident that if there is a ban on paying referral fees, either through statutory prohibition or amendments to the SRA regulations, then solicitors will abide by that ban. It has always been AvMA's policy that claimants' cases should not be bought and sold. We do not believe that this improves clients' access to justice by treating their cases as a commercial entity to be bought and sold.

Recoverability Of Success Fees And Changes To General Damages

We recognise that firms are running businesses and must be profitable, we also know that clinical negligence cases are high risk and often very complex. Hourly rates, success fees, insurance and cost recovery should be set at a rate and form part of a system that will allow firms to provide access to justice to those damaged by medical accidents, taking on difficult cases rather than being forced to cherry pick only the more straightforward cases. We think that greater recognition should be given to the work undertaken by firms to screen out cases that will not succeed. We also think that commentators forget the number of clinical negligence claims is low in light of the number of medical accidents and that the number of claims has fallen over the last 10 years.

We pointed out in our submission that the court already has discretion to challenge excessive hourly rates or success fees, if they are considered to be so. However, our overriding view on success fees and legal costs in general is that they should not, except in exceptional circumstances, form a deduction from claimants' damages. The report recognises that there will be an issue of deductions if its recommendations are accepted. However, a 10% rise in general damages to cover this eventuality is unlikely to avoid claimants suffering a reduction in their damages. High risk and complexity do not always go hand in hand with high value. While a 10% rise in general damages may cover the shortfall in some catastrophic injury cases, we do not believe this will be the same where the damages are less than £100,000. Thus, we believe that a deduction from damages will apply to most clinical negligence claims.

Further, we see no suggestion in the report that this 10% increase in general damages will apply only to those clients funded by a CFA. Yet non-recoverability of ATE premiums and success fees will only affect those claimants funded by CFAs. We question whether the result will be a reduction in damages for those funded by CFAs and an increase for everyone else.

A Database For Valuing Claims Less Than £10,000

Provided there is full open access to the database for all parties, we cautiously accept that a database may be an efficient way of streamlining the settlement of claims below £10,000. We refer in more detail to the NHS Redress Scheme below but at this point simply note that such a database may be of use in association with the implementation of the NHS Redress Act.

However, this tool has up until now been a tool used by defendants. Claimants must be fully represented in any discussions about a database and in decision making. Ongoing monitoring will also be required to ensure that the values keep pace with current judicial settlements and inflation. We strongly oppose any static tariff based system (such as that which applies to CICA claims) which could become quickly outdated. We note with concern that at present evidence submitted to the enquiry states that, in all cases that go to trial, damages awarded are above previous offers based upon Colossus (the main database currently used by defendant insurers).

While at present, Colossus and similar databases are not generally applied to clinical negligence claims, if the use of databases became more widespread and accepted by claimants and defendants, we anticipate that clinical negligence claims may become more commonly included in the database and thus we maintain our stance and qualified acceptance as above.

Process And Procedure

Sir Rupert is rightly concerned at the delays that occur during the course of litigation. We note that some insurance companies speaking candidly have admitted that delays can occur due to the lack of senior involvement at an

early stage. It is said there is a culture of leaving junior staff to deal with the early stages and do as little work as possible in order to save costs, in the hope that the claim will not proceed. Thus the defendant often does not get to grips with the issues until litigation has proceeded some way towards a trial. This has also been the experience of some of AvMA's panel members who have provided us with background information prior to our submission to the inquiry.

We note Sir Rupert's recommendations that a new streamlined process for road traffic accident claims of less than £10,000 is extended to all other personal injury claims. If this were to apply to clinical negligence claims we would oppose it. Road traffic accident claims do not involve the complex issues of liability and causation that are seen in the majority of clinical negligence claims.

It will not be a surprise to any of our members that we do not support the use of medical reporting organisations. AvMA's database provides recommendation of medical experts specifically for individual claimants as one of the benefits of the subscription to the Lawyers' Service. Once solicitors receive our recommendations, they correspond with the medical expert direct which is the most satisfactory way of achieving the best outcome for claimants.

Issues On Early Settlement Of Cases

In pursuing his opinion that clinical negligence cases are unnecessarily drawn out, Sir Rupert cites the following issues:

1. There is no control over claimants' pre-issue costs.
2. Trusts do not notify the NHSLA.
3. Three months is not enough time to investigate a claim following receipt of a Letter of Claim.
4. The NHSLA do not obtain independent evidence early enough.
5. The defence is too slow to get to grips with issues.
6. Non-compliant Letters of Claim or Response.
7. No provision in protocol to settle without an admission.

We would be interested to hear from our members whether or not the NHSLA is unable to settle claims without admission of liability prior to issue.

At first sight the suggestions for controlling claimant's pre-issue costs seem draconian, but there is a mechanism for obtaining approval when pre-issue costs are likely to rise above a certain threshold. The report suggests the threshold should be £15,000 for costs up to the date of the Letter of Claim and a further £15,000 for all work up to the start of proceedings. While this will involve close monitoring of costs, clinical negligence solicitors have long been used to careful budgeting of pre-issue costs in relation to publicly funded cases and all are now very strongly aware of the need to stay within budget. It is also essential that any setting of a budget is done by a judge who is experienced in clinical negligence litigation and not just personal injury.

However, if such a regime were introduced we would watch this process carefully. If solicitors are properly unable to investigate their client's claim pre-issue because of cost restraints, there may be a temptation to issue earlier than would otherwise have been the case. This will run counter to the aims in making these proposals.

We do, however, welcome other smaller recommendations made in relation to the pre-action protocol for clinical negligence claims, including; financial penalties for failure to provide medical records on time; extending time for the response to the Letter of Claim from three to four months taken together with the requirement to obtain independent expert advice; and a limited period allowed for settlement pre-issue.

Hourly Rates

The issues raised in the report relating to hourly rates are in the main predictable. We have already referred to issues of complexity and risk. What perhaps causes us most concern is the statement that the report "questions whether the payment of legal fees at the rates currently claimed is a wise use of NHS resources." We would argue that this is the wrong question to ask. It is not for the courts to ask "Can the defendant afford these costs?" but "Is the claimant justified in receiving these costs when all things are considered?" We accept that many of the report's proposals consist of a shift in previously held attitudes and principles regarding the payment of litigation costs. But, to make affordability the issue, when at the same time recommending that impoverished individuals should pay significantly more towards their litigation is unfair and biased in favour of a large public body.

The point is made in the report that defence costs are much lower than claimant but we would question how these costs are calculated. The principle of success fees is that those successful cases compensate for the lost cases and this will include the cost of the time spent in preliminary investigations of cases that a solicitor does not take on. Trusts and the NHSLA will also incur costs associated with the complaints process and investigating claims that are not issued. It is not clear whether these costs were included in the figures provided to the Jackson enquiry.

NHS Redress Scheme

Although the provisions of the NHS Redress Act 2006 are far from perfect, they did benefit from improvements which AvMA argued robustly for and there is the potential for an NHS Redress Scheme to make access to justice quicker and easier and more conducive to learning patient safety lessons, when it comes to smaller claims.. We therefore welcome the recommendation to bring this act into force, provided it only applies to claims below £20,000. If this happens it will be particularly important to influence the regulations and guidance that will dictate how the scheme operates.

Procedure

We also welcome the recommendation that case management directions for clinical negligence cases should be harmonised across England and Wales. In our private discussions with solicitor members with offices around the country, we have already been made aware of this inconsistency. We also welcome Sir Rupert's offer to carry out a review of the directions and provide recommendations for standardisation himself in the very near future.

Funding

It has long been AvMA's stated policy that the reduction in availability of public funding in the late 1990's was seriously to the detriment of clinical negligence claimants. The introduction of conditional fee agreements with attendant increases in associated costs have not made up for the reduction in access to justice. There was, however, no alternative for claimants who were denied legal aid by the changes in the regulations but to pursue their claim under a conditional fee agreement with their solicitors. We note that, without a trace of irony, all defendant organisations blame conditional fee agreements, with their success fees and additional expenses, as the sole cause of increase in litigation costs while at the same time recommending more individuals take up before the event insurance. No-one apart from Sir Rupert and ourselves suggests considering a return to public funding and Sir Rupert dismisses this thought almost immediately. Despite this lack of debate and dismissive attitude of Sir Rupert's, AvMA believes that compared to conditional fee agreements, legal aid provides the most cost effective way to pursue a clinical negligence claim for both claimants and defendants.

However, we welcome Sir Rupert's recommendation that there is no further reduction in the availability of legal aid. Noting that the costs to the public purse are less in publicly funded work than in conditional fee agreements, the report states "The maintenance of legal aid at no less than the present level makes sound economic sense and is in the public interest."

It is not surprising that Sir Rupert recommends that positive efforts should be made to encourage the take-up of BTE. We also endorse his view in that regard, for those that can afford BTE insurance it is a relatively modest outlay. However, we also note that while stand-alone BTE policies may be available for clinical negligence claims, very few would consider taking this up. Most BTE policies are an add-on to more expensive house insurance policies which may well be beyond the financial reach of families on modest incomes. We do not believe that universal BTE cover is either possible, or affordable for every potential claimant. It is not a panacea and we very much hope that the recommendation regarding maintaining the present level of legal aid will be heeded.

Repealing of the current CFA regulations and a reversion to type 1 conditional fee agreements is a retrograde step. While type 1 CFA's may have been a way of testing the water, if Sir Rupert's recommendations are implemented

and they result in a reduction of damages received by claimants, we would oppose it. The only way firms could run a business under this arrangement would be to cherry pick cases thus reducing access to justice to patients with genuine but more difficult claims.

We are interested to note that some novel ways of funding litigation suggested in the preliminary report have not been dismissed. We are pleased to note that Sir Rupert recommends that financial modelling is undertaken to ascertain the viability of one or more CLAF's or a SLAS. We agree that these forms of funding would not be a complete solution, possibly working more along the lines of small co-operative or mutual associations but they could increase access to justice for a small group of claimants. If in association with the maintenance of public funding at its present level such schemes were implemented whereby claimants were of modest means obtained disbursement funding and protection from partial costs shifting, we would support it.

Public Funding ('Legal Aid')

We regret the political realities mean more attention has not been paid to the possibility of making legal aid more accessible for clinical negligence cases, which most commentators agree would be a significantly cheaper way of settling claims for the State as a whole. We will continue to press for this option to be explored. We are deeply worried by the assumption made in the report that:

“There will be some clients who cannot afford the initial screening costs. Those clients will be eligible for legal aid. They can obtain legal aid to cover the initial screening costs. Thereafter the clients can proceed with any litigation either as legally aided claimants or on CFAs, as may be appropriate.”

We believe it is far from the truth to say that anyone who can not afford to pay for screening costs will qualify for legal aid at present, either because of financial eligibility or in the case of smaller claims, the 'proportionality test'. If, however, access to legal aid was made much more accessible for the screening stage than at present, this would significantly help access to justice.

Hot-tubbing

This novel suggestion has received much coverage and caused much discussion. We would welcome further consideration of this topic as an extension of the present Part 35 for provision of expert meetings. This novel approach may, lead to a more detailed and thorough scrutiny of the issues. It will, however, place a very heavy responsibility on experts who will be denied the more measured approach currently adopted and could lead to similar concerns being raised as in early days of CPR in the context of Part 35.

Docketing

Many clinical negligence solicitors have long preferred to issue their clients' cases in the RCJ. Here the cases are assigned to the clinical negligence masters with their standard directions that provide a sensible order in which to proceed to trial. We welcome the suggestion that there are designated judges in all major trial centres thus developing a system that has begun in Manchester. The recommendation that larger centres deal with routine matters clerically, leaving specialised staff at the main County Courts and District Registries to deal with the more complex cases, can only benefit clinical negligence claims.

Conclusion

We welcome a number of the report's recommendations. In particular, those leading to speedier resolution of clients' claims and reduced delays caused by defendants failing to get to grips with a case in the early stages.

We also welcome the recommendations concerning standardisation of directions, docketing of judges and cautiously welcome the recommendations that a database similar to Colossus is developed. We support further work on alternative funding systems such as CLAF and SLAS.

We are very pleased to read the recommendations concerning NHS Redress and hope that it will be implemented and not just more rhetoric and that there should be no further reduction in public funding, although we would prefer to see it expand.

However, we are seriously concerned that Sir Rupert has qualified his recommendation for partial costs shifting and oppose any of his recommendations in relation to conditional fee agreements (including non recoverability of success fees and ATE insurance) if they lead to an additional costs burden based upon claimants.