DEPARTMENT OF HEALTH

"FIXED RECOVERABLE COSTS" PROPOSALS FOR CLINICAL NEGLIGENCE:

Implications for patients' access to justice and for patient safety

Briefing by Action against Medical Accidents (AvMA)

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Background

The Department of Health has announced that it proposes to bring in, via the Ministry of Justice, a "fixed recoverable costs regime" for clinical negligence cases. This would limit the amount of legal costs that could be recovered by solicitors who win clinical negligence claims on behalf of their clients to a set proportion of the damages (compensation) awarded to the injured patients or their families. They would also put a limit on the amount any claimant could recover for the cost of medical expert evidence. The proposals would cover all clinical negligence cases in England and Wales, whether in the private sector; and whether the indemnity is provided by the NHS Litigation Authority or medical defence organisations.

The announcement was made initially via the media at the end of June 2015 without any discussion with external stakeholders. A short "pre-consultation exercise" was held in August 2015 with a small selection of stakeholders to inform them of the proposals and how (not "if") they should be implemented. The Department of Health intends to consult formally on its proposals in late 2015 with a view to the measures being brought into force in October 2016.

Action against Medical Accidents ("AvMA" – the charity for patient safety and justice) has grave concerns about the proposals, which we believe would have serious unintended consequences both for access to justice for patients and families affected by clinical negligence, and for patient safety. The proposals should be considered in the context of additional proposals, by the Ministry of Justice, to make the costs of after-the –event insurance (ATE) non-recoverable, and the Legal Aid Sentencing and Punishment of Offenders Act (2012), the full impact of which is still to be seen or analysed. This briefing sets out the reasons for our concerns about the Department of Health proposals and makes constructive suggestions for alternative approaches.

Our main concerns

- **The proposals, if implemented, would mean in effect that many serious cases of negligence (particularly those involving older people, child death and stillbirth cases) would be impossible to take forward**

- **The proposals would compromise patient safety by creating a perverse incentive for health providers to deny liability unreasonably and diminishing the opportunities for learning from incidents where failures have not initially been recognised**

- **The proposals would create a more uneven playing field in litigation between the claimant and the defendant, with limits being placed on the costs claimants could recover for medical expert evidence, whilst the defendant could spend as much as they like**

- **No consideration has been given to the potential for saving legal costs by improving defendants' behaviour, such as recognising when liability should be admitted much earlier and settling claims expeditiously, which would save the majority of legal costs. The proposals are focused almost entirely on claimants.**

- **The proposals would inevitably drive specialist solicitors out of clinical negligence and encourage non-specialist solicitors and disreputable "claims**

farming". This is the opposite of what the Department of Health and others would like to see, and would be likely to increase costs and be less satisfactory for claimants.

- **The proposals are premature. An assessment has not been made of the effect of the Legal Aid Sentencing and Punishment of Offenders Act on reducing the cost of litigation, which will be huge. There has not been any meaningful engagement with stakeholders over whether the proposals are necessary or justified; or discussion of alternative ways of reducing the cost of clinical negligence litigation**

- **The Department of Health are driving these proposals as a cost saving measure in its own interests. The Ministry of Justice, which should be even handed and uphold access to justice, seems to be content for the Department of Health to develop policy for it, which is inappropriate. The Department of Health may even consult for a shorter period than the normal three months expected for major policy changes**

Rationale for the proposals

The proposals are driven by the need for the Department of Health to make financial savings. They are part of a raft of measures "to save the NHS up to £80 million a year". Our discussions with the Department of Health during the "pre-consultation exercise" confirmed that no assessment had been made of the potential effect on access to justice or on patient safety, or of the effects of the Legal Aid Sentencing and Punishment of Offenders Act (which saw the removal of legal aid for the vast majority of clinical negligence cases and other measures which will result in very significant savings on legal costs).

The Department of Health asserts (without supporting evidence or any independent analysis) that legal costs being recovered by solicitors in successful cases are unreasonable and disproportionate. In our discussions with them, the Department of Health confirmed that they had not made any assessment of or taken account of the contribution that defendant solicitor behaviour has on increasing costs (for example unreasonable denials of liability or delays in settling claims). Nor did the Department of Health take into account that if and when legal costs are considered to be unjustified, the courts already have the power to reject them which they do exercise when appropriate, and that it is a core role of the NHS Litigation Authority to challenge any perceived unjustified costs (which the NHS Litigation Authority boasts in its annual report that it already successfully does, when appropriate).

Implications for Access to Justice

The central proposal that the legal costs recovered by solicitors could only be a proportion of the damages secured for the patient/family would mean that many would-be claimants would not be able to get a solicitor to represent them in cases where the damages are relatively low. For example in serious cases where there has been a fatality of an older person or a child or a still birth and there are not any dependents or loss of earnings the financial damages awarded can be very low. However, the medical and legal arguments are just as complex and costly to pursue as cases where there are much larger damages. The burden of proof in clinical negligence cases lies with the claimant, and so costs are necessarily higher than with the defendant.

AvMA is already hearing from callers to our helpline that they are finding it difficult or impossible to find solicitors to represent them as a result of the measures in the Legal Aid Sentencing and Punishment of Offenders Act. Our discussions with specialist solicitors confirm that if the fixed costs regime is brought in, the vast majority of them will not be able to take on cases like these. Victims of serious neglect and negligent treatment of older people such as we have seen at Mid Staffordshire and elsewhere, and child death cases such as those seen at Morecambe Bay and elsewhere would simply be unable to have access to justice.

The NHS Litigation Authority has previously accepted that legal costs in such cases, especially when they have been defended, can completely reasonably exceed the amount of damages awarded and do not challenge the majority of them.

The fixed costs regime proposals contain a proposal to limit the amount of costs of medical expert evidence that can be recovered by the winning claimant solicitor. There would be no limit on the amount that the NHS defendant could spend on medical expert evidence. This would create a completely uneven playing field, with it becoming difficult or impossible for the would-be claimant to obtain the necessary expert evidence – an absolute necessity in any clinical negligence claim.

It must be remembered that the costs these proposals seek to reduce are only recoverable by the claimant if they win their case. In many of these cases the vast majority of legal costs could be averted if the NHS had recognised and admitted liability (negligence) earlier. Under the proposals, there would be a perverse incentive to defend every case in the knowledge that it would not be viable for a claimant's solicitor to take the case further.

Implications for Patient Safety

It should go without saying that every penny of the costs which the Department of Health aims to save through these measures would be avoided anyway had there been appropriate patient safety and the negligent treatment itself was avoided. Also that the human cost of these incidents far outweighs any financial cost, as does the human cost of being denied access to justice when damage has been caused through clinical negligence.

Litigation is something which in our experience injured patients and their families go into very reluctantly – usually when the NHS has denied that the treatment has been sub-standard or that patient safety had been compromised. Taking legal action is often the only way that patients or their families can challenge these assumptions and bring about recognition that patient safety has indeed been compromised. In an ideal world litigation would not be needed for this, but the fact is that without the ability for patients and families to make a legal challenge the NHS left to its own devices would not recognise its own failings and opportunities for learning to improve patient safety (to prevent the same thing happening to other patients) would be missed.

It is well accepted in the patient safety movement that an "open and fair culture" is an essential element of a successful approach to patient safety. The Secretary of State for Health has made this a core priority and introduced measures such as the Duty of Candour and other measures to improve safety. An unintended consequence of the fixed costs proposals would be the creation of a perverse incentive for NHS organisations to adopt a deny and defend culture, safe in the knowledge that simply defending and denying liability in many cases will mean that an injured patient or their family cannot take things further. A consequence of this is that important learning opportunities about lapses in patient safety will be lost. Often, when errors have not initially been appreciated or admitted by the health provider, it is only the litigation process which brings these errors to light.

Would the fixed costs regime actually save the money envisaged?

It is impossible to be sure whether the proposals would actually save the money envisaged without a more thorough analysis of the effects of the Legal Aid Sentencing and Punishment of Offenders Act. The figures which the department of Health are quoting mostly relate to cases run before the Act came into effect. The evidence suggests that claimant legal costs are actually falling. Consideration is also needed of the effectiveness of existing powers of the courts and of the NHS Litigation Authority to refuse or challenge perceived unjustified costs; and of the potential unintended consequences of the proposals and alternative options.

One unintended consequence is that the proposals would open the door to non-specialist lawyers and "claims farmers" to get involved in clinical negligence cases. The NHS Litigation Authority and the Department of Health both recognise that the increased involvement of such firms as a result of the Legal Aid Sentencing and Punishment of Offenders Act is already causing unnecessary costs due to the inability or refusal of such firms to conduct proper assessment of the merits of claims or handle them efficiently.

Alternative ways to save costs in clinical negligence cases

1. **AvMA have offered to get around the table with the Department of Health, the Ministry of Justice and other stakeholders to identify the real reasons for any unnecessary or unjustifiable costs associated with clinical negligence litigation, and how these can be avoided or reduced. Key to this we believe would be a full analysis of the effect that the Legal Aid Sentencing and Punishment of Offenders Act is beginning to have.**

   The imposition of a fixed costs regime as intended is premature and reckless without a full analysis of implications of the Legal Aid Sentencing and Punishment of Offenders Act, and consideration of the potential unintended consequences and alternative approaches outlined in this briefing and made by other stakeholders. We are calling for the Department of Health to put on hold the development of their fixed costs regime proposals and consultation on them until these discussions and analysis can be completed.

2. **We are not opposed to the idea of fixing costs in principle in some ways, where appropriate. If a fixed cost regime were to be introduced it should only apply when there has been an admission of liability.**

3. **Any consideration of a fixing or reducing costs must give equal consideration to reducing costs caused by defendant behaviour in denying liability and causing unnecessary delays in settling meritorious claims. Creating a more uneven playing field in clinical negligence litigation must be avoided.**

4. **Consideration should be given to alternatives to litigation and their potential role in reducing costs whilst preserving access to justice. These should include mediation, and other alternatives such as the NHS Redress Scheme provided for under the NHS Redress Act 2006 (which has not been implemented in England); or other schemes designed to settle smaller value clinical negligence claims in an efficient and fair way. Until recently, the NHS Litigation Authority was itself proposing such a lower value claims scheme, which AvMA had contributed its thinking to.**

5. **Consideration should be given to improving the efficiency of clinical negligence litigation by enforcing the pre-action protocol and the recommended guidelines on hourly rates for solicitors (or a reviewed version of them).**

6. **The reintroduction of legal aid as a way of funding clinical negligence claims should be considered. The NHS Litigation Authority itself recognised that legal aid was a far more efficient way of funding clinical negligence claims than conditional fee agreements ("no-win, no-fee" agreements). Rupert Jackson, in proposing his civil litigation legal reforms supported the continuation of legal aid for clinical negligence cases, but the Legal Aid Sentencing and Punishment of Offenders Act took the vast majority of clinical negligence claims out of scope for legal aid.**

7. **Consideration should be given to how legal representation in clinical negligence cases could be restricted to accredited specialist solicitors in clinical negligence, and/or how this can be encouraged. One of the positive aspects of legal aid was that licenses were restricted to accredited specialists solicitors. It is accepted that the involvement of specialist solicitors leads to better assessment of the merits of claims and more efficient handling of them.**

8. **Consideration should be given to removing the requirement for solicitors to charge VAT on their legal costs. This in itself would save the NHS vast amounts of money.**

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