RESPONSE TO CONSULTATION :

"FIXED RECOVERABLE COSTS IN LOWER VALUE CLINICAL NEGLIGENCE CLAIMS"

April 2022

1. About AvMA

Action against Medical Accidents (AvMA) is the national patients' charity for patient safety and justice. We provide free independent specialist advice and support to patients and families who have been affected by avoidable harm in any kind of healthcare. This provides us with a unique and extensive insight into the experience of patients and families following such patient safety incidents. We use this experience and our knowledge of the healthcare system to work with others to develop policies, systems and practice to improve patient safety and the way that patients and families are treated following avoidable harm.

Although most of the people AvMA helps do not go on to make a clinical negligence claim, such claims are a vitally important option for many who need compensation to help cope with the implications of the injury or loss that has been sustained, and/or have exhausted other attempts to resolve their concerns and hold the organisation responsible for the injury to account. We have therefore always taken a strong interest in clinical negligence and have extensive in-house knowledge of how the system works. We accredit specialist claimant solicitors and provide training for lawyers practising in clinical negligence. We get useful intelligence from the claimant lawyers we work with and from medical experts. However, our focus is always on the needs of injured patients and their families and on representing their interests.

2. Our response – Key issues

We have provided detailed answers to the consultation questions in the section below, and we also attach a letter from nine patients' / service user organisations expressing jointly held concerns about the proposals. We note that there are no questions asked in the consultation about the desirability or otherwise of the overall proposals; alternative potential approaches; potential negative / unintended consequences of the proposals or how any changes could enhance learning for patient safety. However, we feel it important to comment on these issues here.

- **The proposals would badly affect access to justice for many injured patients or their families**. Either they will be unable to obtain a lawyer to represent them, or if they do, they will lose substantial amounts of their damages as lawyers will have to recover some of their costs which they would no longer be able recover from the defendant. Effectively, the very people the NHS has injured through negligent treatment would lose their access to

justice in order to save the Government money. The most vulnerable and disadvantaged people in society would be disproportionately affected.

- **The proposals would harm patient safety.** These proposals are the antithesis of what one would expect in a 'just culture'. A just culture is widely seen as an essential part of improving patient safety. The proposals would encourage a deny and defend culture in the NHS when harm has been caused. Defendants would know that claimants could be priced out of a claim if it is defended. The inability of some would-be claimants to challenge denials through legal action will lead to lost opportunities for learning for patient safety, that are currently provided from successful claims. The unfairness of the proposals will damage public confidence in the NHS and create a bad atmosphere for staff and patients alike.

- **The proposals will cause unintended other costs which could outweigh any 'savings'.** Specialist solicitors who currently 'screen out' the majority of claims enquiries are unlikely to be able to afford to work under the fixed costs proposals. Non specialist solicitors will be less effective in screening cases out and less effective in running cases, meaning extra cost for the NHS.

- **The proposals are unsuitable for fatal cases and those where there are capacity issues.** Fatal cases are profoundly important both for families and for the learning opportunities they bring. They are often complex, even though the 'value' in terms of damages can be low. The proposals would mean that it would be even harder for families to get legal representation at inquests. Cases where the claimant lacks mental capacity are very time consuming, with the claimant needing a lot of care and attention. These sorts of cases are not suitable for the kind of dumbed-down scheme proposed.

- **The proposed 'early neutral evaluation' way of determining cases is untried and untested in clinical negligence**. These cases, though of low monetary value are vitally important for the people concerned and can be just as complex as 'high value' cases. The Government should not gamble with people's access to justice. Any new scheme should be piloted and independently evaluated before it is rolled out.

- **There are better and fairer ways of saving costs.** The best way to save money as well as the human cost of clinical negligence is to invest more in patient safety – preventing the mistakes happening in the first place. Even when harm is caused most of the legal costs can be avoided if the case has been investigated properly and early admissions and offers made. Currently, the NHS defends too many cases for too long, causing high legal costs to be

run up. It is a fact that around 80% of cases where legal proceedings have been issued settle in favour of the claimant.[1]

- **Co-operation rather than imposition is the way forward. Let's talk.** The Department of Health and Social Care held a similar consultation in 2017. The majority of respondents to that consultation were opposed to the substantive proposal of fixed recoverable costs on the basis of the negative effect that this would have on access to justice and on patient safety. Many respondents, including AvMA, have continually offered to work with the Department to find better ways of reducing legal costs in clinical negligence cases without damaging access to justice and contributing to rather than harming patient safety. AvMA have proposed a 'patient safety letter' be required following any claim, stating what has been learnt and how safety will be improved. The Department has refused to engage in meaningful discussion with stakeholders about this, or about the root causes of high costs and alternative ways of reducing them and instead seems intent on imposing fixed costs, at any cost. We hope the Department of Health and Social Care will reconsider this approach and remain committed to work constructively with the Department and other stakeholders, given the opportunity.

3. Detailed response to consultation questions

Question 1: Do you agree or disagree with the proposed definition for claims falling within the FRC scheme?

• Agree

• Disagree

• Don't know

Why?

It is accepted that this is the definition used by the CJC working party when discussing a fixed costs process. However, it should be noted that there was no discussion and therefore no agreement about how a low value FRC scheme for clinical negligence should be described.

The definition of a low value claim was never discussed by the CJC working party, rather it formed part of the terms of reference for the working group. The terms of reference can be found here: https://www.judiciary.uk/wp-content/uploads/2019/10/appendices-fixed-recoverable-costs-in-lower-value-clinical-negligence-claims-report-Oct-2019.pdf

The terms of reference were presented to the working group, the relevant part is described as follows: "***1.To consider and recommend an improved process for clinical negligence claims, where the claim has a value of £25,000 or less..***"

[1] House of Lords written answer, 6th August 2020, Lord Bethell to Lord Hunt of Kings Heath

Footnote 5 of this consultation defines a lower value clinical negligence claim as:

"5 "Lower value claims", as referred to in this document and within the definition for claims included in this FRC scheme, are clinical negligence claims where the value is estimated to be in excess of the small claims limit for non-road traffic accident (RTA) personal injury claims, up to £25,000. The current small claims limit for personal injury claims (non-RTA), is £1,000. This is set to rise to £1,500 in April 2022. However, certain unusually complex claims with an estimated value below the small claims limit may also be included in the FRC scheme, as set out in chapter 6 of this consultation document

AvMA, together with the Law Society and APIL had suggested terms of reference (dated 30.11.2017) which included looking at the drivers giving rise to high costs in low value claims up to £25,000. That suggestion was not accepted.

Claims that do fall within a FRC would be better defined by reference to their complexity or lack of complexity than to their value. A low value claim is just as likely to be complex as a high value claim. Although there are some safeguards in that cases requiring more than two expert reports on liability fall outside of the scheme this does ignore cases involving those who lack capacity. Please see our response to question 10 below.

Question 2: Do you agree or disagree that the proposed scheme should incorporate a twin track approach, following the CJC model, to enable simpler, less contentious cases to progress more quickly to resolution?

• Agree

• Disagree

• Don't know

Why?

Please refer to 'Chapter 7: A twin track approach' and Figure A of Annex C in the consultation document and give any reasons for your answer.

As a matter of principle, we agree that a light track is appropriate for cases where there is a clear admission of breach of duty and the only outstanding issue is quantum.

AvMA has long advocated for proper early investigations to take place in all clinical negligence cases where there has been an adverse outcome, not just those cases that resort to litigation. Our mantra has been "investigate once, investigate well". Where trusts and defence organisations follow this advice and make early admissions of liability it is sensible, cost effective and in a claimant's best interest for these cases to be referred to a process which is geared towards resolving the claim fairly and as quicky as possible. In fact, if this approach is followed and applied well, it could help avoid litigation altogether and obviate the perceived need for an FRC scheme

Question 3: Do you agree or disagree with the proposed criteria for claims being allocated to the light track?

• **Agree**

• **Disagree**

• **Don't know**

Why?

Please refer to 'Chapter 7: A twin track approach' in the consultation document and give any reasons for your answer

To ensure that the criteria for this category is clear and easy to use only cases where there is a full admission of liability (breach of duty and causation) should be included in the light track.

There are categories of case which it is proposed fall into the "light track" which cause concern to AvMA. The reference to a category of cases where:

"There is a Serious Incident Report which identifies care below a reasonable standard of care (including investigations under the Welsh Putting Things Right redress scheme"

AvMA is aware of cases where a damning Serious Incident Report has been prepared but subsequently the trust and/or NHS Resolution has rowed back from what appears to be straight forward and obvious on paper on the basis that SIRs are not prepared for the purposes of litigation.

Page 9 of The Serious Incident Reporting Framework:https://www.england.nhs.uk/wp-content/uploads/2020/08/Serious_Incident_framework_NHS_England_.pdf makes clear that:

"***Investigations carried out under this Framework are conducted for the purposes of learning to prevent recurrence. They are not inquiries into how a person died (where applicable) as this is a matter for Coroners. Neither are they conducted to hold any individual or organisation to account as other processes exist for that purpose including: criminal or civil proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as the Care Quality Commission and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council…"***

A more up to date version of this framework is in the process of being introduced:

https://www.england.nhs.uk/wp-content/uploads/2020/08/200312_Introductory_version_of_Patient_Safety_Incident_Response_Framework_FINAL.pdf

This version also makes it clear at page 13, that:

"A patient safety incident is investigated or reviewed under this framework to understand the circumstances that led to it, for the purpose of system learning and improvement, and not:
• to determine the cause of death (where applicable); that is for coroners

• to hold any individual or organisation to account; this includes judgements on avoidability, preventability, liability, predictability, etc.
In view of this, some incidents may require separate review and/or investigation beyond the scope of this framework, eg investigation by the coroner, police or human resources."

That being the case, AvMA envisages considerable push back on cases which fall under this category being seamlessly included in the light track. The serious incident reporting investigation is an important one. AvMA would like to encourage as much openness and honesty in these investigations as possible. There is a risk that by including this category of case into the light track that investigators and authors of these reports will inevitably become more cautious in the way they investigate and write these cases up lest they inadvertently indict themselves into an admission of civil liability.

AvMA does not support action or processes which will encourage these investigations becoming more cautious. On the contrary they need to be more robust and open, and this approach should not be compromised by including this category of case in the light track.

However, AvMA is fully supportive of NHS Resolution or other defence organisations legal representatives being obliged to consider the contents of the SIR and taking a view on liability based on the investigation and report which has already been carried out by the NHS provider. The healthcare provider's legal representatives become responsible for taking a pragmatic view on the evidence and simply make clear at the outset that they admit liability and that no further evidence is required on breach of duty and causation. In cases where there is a SIR which either strongly suggests or admits that care fell below a reasonable standard it is for the healthcare representatives to take a view, admit liability early on so these cases can and should be included under light track.

Other cases to be included according to the consultation document are where ***"There has been an inquest and the coroner has determined either that care amounted to neglect or that death would not have occurred but for the identified neglect"***

Similarly, there should be no reason for an additional category for cases where the coroner makes a finding of neglect to be included under light track. As with the SIR it should be incumbent on the organisation's legal representatives to take a robust view of the evidence and conclusion generated by the coroner's inquest and make a clear admission of liability.

The purpose of the inquest is specifically to find how and in some cases in what circumstances the deceased came about their death. It is not the purpose of the inquest to find civil liability.

AvMA would not dispute that the coroner's finding of neglect is a damning indictment of the care provided but it may not be appropriate for it to follow that a case concluding with a rider of neglect should be become a civil claim in clinical negligence.

There is a real risk that healthcare providers will increase their access and reliance on counsel to represent them at inquest to ensure so far as possible that the coroner is dissuaded from concluding a finding of neglect. Healthcare providers already have ready access to counsel to represent them at inquest where families do not. If the approach suggested by the consultation is adopted, it will increase the inequality of arms that already exists for families attending healthcare inquests.

Hospital trusts and healthcare organisations are already routinely sending counsel to attend healthcare inquests. This provision will cause the inquest process to become adversarial and aggressive. Inquests should remain as inquisitorial as possible.

Families find the inquest daunting, not just because they must manage their grief but they are unrepresented. Increasing the adversarial nature of the inquest will not serve the purpose of the inquiry process and will put up even more barriers for a family who is not able to obtain representation making the process even more daunting.

AvMA would encourage an approach that requires legal representatives of healthcare organisations to take an honest, open, and robust approach to the evidence produced during the coroner's enquiry with a view to making an admission of liability. That would be straightforward and effective, it takes the consequences of the outcome of an inquest or SIR away from those conducting those investigations.

The light track proposals should include punitive sanctions for healthcare providers who do not admit liability in light of the available evidence, whether that is evidence from the coroner's investigation or a SIR.

This approach mirrors CJC proposals on the pre action protocol set out in their consultation published in November 2021. That there should be a "good faith" obligation to resolve or narrow issues in dispute. The good faith obligation is intended to require that each party "***meaningly engage with each other, with the benefit of having exchanged the key information and documents about their dispute as require by the protocols, with the aim of exploring whether a resolution is possible or alternatively, whether the issues in dispute can be narrowed"*** paragraph 2.13 "Review of pre action protocol: Interim Report"

Question 4: Do you agree or disagree with the proposals for streamlined processes in the standard track?

• Agree

• Disagree

• Don't know

Why?

Please refer to 'Chapter 8: Streamlined processes for standard track and light track claims', and Figure B of Annex C in the consultation document and give any reasons for your answer

There is no objection to the principle of a streamlined process but the suggestion this should include sequential exchange and Mandatory Neutral Evaluation (MNE) is not

streamlining the existing process. The proposals are not taking out unnecessary parts of the existing process, rather it is altering the existing process completely and transforming it into something completely new, unknown, untried, and untested. Mandatory Neutral Evaluation has been designed specifically for this fixed cost process.

The use of Early Neutral Evaluation (ENE) in clinical negligence claims is extremely rare, it is almost never used. Making the neutral evaluation process mandatory is unique to this process, it has not been used before. The proposal has not streamlined anything, it has created a completely new process by introducing both MNE and sequential exchange.

The consultation maintains that a streamlined process is designed to ***"facilitate a rapid exchange of evidence and to be fair to all parties"***. The consultation also states that the DHSC's proposals "***would represent an important contribution towards addressing the overall rise in clinical negligence costs"*** (page 7 consultation).

There is absolutely no evidence before either the CJC or the DHSC to identify what the causes of high costs are (see our response to question 1 above). The most effective way of reducing the cost of clinical negligence claims is to learn from mistakes by identifying and accepting what has gone wrong and then being committed to addressing the issues that gave rise to the negligence and injury in the first place. There has been no attempt to provide for that in this scheme. Instead what appears to be a cost saving scheme which prevents an injured party from accessing justice has been designed for the purpose of preventing claimants from exercising their basic right to access justice.

The cost savings in these proposals, if there are any, will come about because it will simply not be worth the claimant's while to bring a claim using this process, or it is impossible to proceed because of the lack of legal representation. The process is weighted against the injured party

<u>Sequential exchange expert evidence:</u>

Sequential exchange of expert evidence will not encourage a fair process. It will encourage:

(i) A process that forces the claimant to reveal their hand first and allow the defendants time to consider whether they will obtain their own expert evidence to continue to deny the claim.

(ii) The defendants to be dilatory: Rather than instruct their own expert and carry out their own investigation at early stage as they are expected to do now, defendants will simply wait for the claimant's expert evidence.

(iii) The defendant own expert will most probably be instructed to focus on replying and rebutting the claimant expert evidence rather than focusing on whether there was a breach of duty. This will create a loss of learning and a lost opportunity to facilitate change where needed.

(iv) Delays in early resolution and settlement. Defendants will become reactive to the claimant's expert report, there is no incentive for them to carry out their own early investigation.

(v) No incentive for accountability and no justification or rationale for why the defendants did not admit liability at an earlier stage. The legal process needs to put greater emphasis on parties to explain why cases have not settled at the first opportunity, that requires both sides to investigate early and well, including expert evidence.

(vi) A lack of accountability. Where the defendants have received the claimant's expert report, and they do admit liability they do not have to set out their rationale for denying the claim in the first instance. They do not have to demonstrate that lessons have been learned or that they investigated the claim early on.

(vii) Poor behaviours and existing culture problems that pervade healthcare organisations in the UK to perpetuate.

It cannot be said that the current system of simultaneous exchange of expert evidence contributes to high cost of claims. There is no justification for such a seismic shift away from simultaneous exchange of expert evidence and a move to a sequential exchange especially when a shift of this nature will have a negative impact for the reasons stated above.

The rapidity of available evidence comes from one party, the claimants. The proposals are creating a unilateral system where the defendant will only investigate the evidence once they have received the claimant's evidence. There is no "***rapid exchange of evidence***" and there is no fairness to all parties, only an advantage to the defendant.

It will encourage the defendants to be dilatory in their approach as they will not have to carry out any substantive investigations until they receive the claimant's evidence. This will simply exacerbate the existing delay and deny approach.

Mandatory Neutral Evaluation:

Mandatory neutral evaluation (MNE) might be an improvement to the process, but the fact is this is a complete unknown. Early Neutral Evaluation (ENE) has not been used much, MNE not at all in clinical negligence claims.

The consultation maintains at page 8, that "***The aim of our proposed FRC scheme is to enable more claims to be resolved more quickly, more proportionate cost and increase the proportion of claims that can be resolved before involving the courts".*** Again, there is no evidence to demonstrate that MNE can contribute to this aim. On the contrary, the fact that it has not been used or at best rarely used to resolve clinical negligence claims simply opens the door to satellite litigation and additional costs, which on its own casts doubt on the efficacy of this newly designed process.

An untried step

At the very least any new scheme proposing the use of something as radical as MNE should be piloted, monitored, reviewed, and independently evaluated at specific points which are identified at before the pilot commences and certainly before any FRC

regime is introduced. The DHSC propose "***monitoring and evaluation of the scheme in its first years of operation***". That is too nebulous, a new process of this nature must be reviewed for its effectiveness, efficacy, and efficiency at regular defined intervals. Furthermore, the monitoring and evaluation should be carried out by a body independent of Department Health and/or NHS Resolution to ensure robust and fair assessment of the scheme.

A pilot will hold many benefits including whether it is even plausible to suggest a fixed evaluator's fee for the work which will need to be done in a low value clinical negligence claim. It may also offer the opportunity to explore whether the evaluator can and should identify learning opportunities for defence organisations to focus on, reducing the likelihood of the same mistake being made again. It may also offer the opportunity for the Evaluator in appropriate circumstances to confirm that the treating healthcare professional did not act in a way which fell below the standards expected of them, thereby exonerating them from allegations of negligent care.

AvMA is mindful that by making MNE mandatory it removes the claimant's right to explore other means of alternative dispute resolution such as mediation which may be considered a more appropriate way of resolving the claim. NHS Resolution are now heralding mediation as an effective alternative to litigation. Unlike MNE, practitioners and claimants do have experience of this process, it should remain an option and possibly even an alternative to MNE.

It is noted that the consultation maintains there is precedent for the use of mandatory neutral evaluation in the family courts. It goes without saying that family law and clinical negligence are not comparative legal practices. It should also be noted that the use of neutral evaluation is not mandatory in family law cases. That is a very relevant detail as it demonstrates that both parties go to neutral evaluation voluntarily, that voluntary approach on its own shows a willingness by both parties for the process to succeed. That mutuality of approach and intent is likely to be at the core of why parties in family disputes can achieve resolution. Our discussions with an organisation called Independent Evaluation confirm this.: https://www.independentevaluation.org.uk/ . Independent Evaluation offer ADR including ENE, they observe that the fact two parties are willing to go to ENE or any form of Alternative Dispute Resolution is key to the process succeeding. Mandating the process of neutral evaluation is not likely to encourage the same mutuality of approach and intention to reach resolution. It is more likely to render MNE as no more than a new and additional step in the litigation process. That is likely to simply increase the costs.

See also our response to question 9 on MNE below

Court process

The evaluators decision will have a very serious bearing on the claimant's ability to have their papers referred for a "paper hearing" before a judge on what will replace the trial process.

Following receipt of the evaluator's opinion the claimant faces considerable risks in proceeding to a paper assessment/trial before a judge. The proposals state that for a claimant to be considered successful following a judge's assessment the judge will have to award damages which represent a 20% increase on the evaluator's opinion.

The nearest comparative process to this is the requirement to beat a Part 36 offer. Part 36 offers are an effective tool in the litigation armoury, in those cases the claimant need only beat the part 36 offer. It is difficult to see why it is necessary for a claimant to beat evaluators offer by 20% simply to secure their access to a judge's paper hearing.

The risk to the claimant is compounded by the fact that in the event they do proceed to trial a failure to beat the evaluators offer by 20% will also risk a 50% reduction in the fixed costs available to the claimants' lawyers. The net effect of this is that a claimant will also have to cover the reduction in fixed costs allowed out of their award of damages. Even if the claimant does exceed the evaluator's offer, they will be penalised for exercising their rights unless the claimant clears a 20% increase in the evaluators offer.

Given that for many people £25,000 is not considered a low value claim but rather a substantial sum of money, it is also the case that a 10% or 15% increase on an offer of say £10,000 equates to £1000/£1,500 that too is a substantial sum of money but nonetheless the claimant will be penalised for seeking it.

The other effect of this approach is that claimant lawyers will be forced to accept low awards of damages simply to avoid the risks of such severe penalties. That devalues damages and puts the claimant lawyer at risk of under settling the claim. That is not a fair process, neither is it one to be encouraged. This increases the existing risk that a claimant's damages will be severely reduced and possibly wiped out altogether.

In our view, these penalties are draconian, they do not represent an improved process. They do not represent improved cost savings they will not promote improvements to patient safety they will simply prevent claimants from bringing claims, the savings will come from this fact alone.

General comment on standard track process:

AvMA does not object to a speedier, more cost-effective process but the right to proper investigation and an effective process should not be thrown away on a new and untried process. It also demonstrates a fundamental lack of understanding as to why claimants bring claims. This is often driven by the need and wish to understand what happened by having a proper explanation. This is born out by the work done by Behavioural Insights Team at the request of NHS Resolution and published in August

2018: https://resolution.nhs.uk/wp-content/uploads/2018/10/Behavioural-insights-into-patient-motivation-to-make-a-claim-for-clinical-negligence.pdf

The ability to achieve an explanation is lost in this new process especially in cases where the defendants simply admit liability upon receipt of the claimant's Letter of Claim and accompanying documents. Claimants are entitled to an explanation in any event and compensation where there has been a breach of duty.

Question 5: Do you agree or disagree with the proposals for streamlined processes in the light track?

• Agree

• Disagree

• Don't know

Why?

Please refer to 'Chapter 8: Streamlined processes for standard track and light track claims', and Figures C and D of Annex C in the consultation document and give any reasons for your answer.

There is every reason why cases which have clear admissions of liability should be dealt with swiftly. The nature of a full admission of liability is such that the only issue between the parties should be settlement figure and resolution. The light track is unlikely to be attractive to parties unless they have agreed beforehand that liability has been admitted and that the case should enter the light track process.

To include cases into the light track where liability may be in dispute is to defeat the object of providing a process for cases that can and should be easily and quickly resolved. Any case where liability is in issue should be commenced in the standard track. If liability is agreed, then it can then be transferred down to the light track process. It does not work the other way around. Starting disputed claims in the standard track will act as point of focus for the defendants to carefully consider the evidence with a view to admitting liability if the case is straightforward and it is appropriate to do so.

As drafted the light track gives the defendant the option to dispute liability and/or quantum. The defendants have 21 days to respond, if they fail to respond then the claimant must wait 8 weeks from receipt of the Letter of Notification before the case can move to the standard track.

If the claimant commences in the light track and liability is subsequently disputed, then the claimant lawyer will not be paid for commencing in the light track. The claimant has all the risk and none of the incentive to use the light track under these proposals. For the light track to work the admission of liability must be clear from the outset and before the process has commenced.

If liability is admitted prior to entering the process, the stocktake provision to explore settlement at an early stage is sensible. Likewise, where the parties identify that C&P

evidence is required and this is obtained then a second stocktake opportunity to explore settlement after receipt of this evidence is also sensible.

MNE should be piloted before it is rolled out as a means of resolving disputes, failure to do so risks complicating the process and rendering it unworkable.

Question 6: What are your views on the evidentiary requirements applying to both standard and light track claims, that should be set out in the Civil Procedure Rules to support this FRC scheme?

Please refer to 'Chapter 8: Streamlined processes for standard track and light track claims', in the consultation document, with particular regard to stages ST(A), ST(B), (LT(A) and LT(B), when answering

Please see our response to question 4 above in particular our comments and concerns about sequential exchange of expert evidence, mandatory neutral evaluation and court process. Please also see our response to question 9 for concerns about mandatory neutral evaluation and the need for a pilot before any scheme is rolled out. See also our response to question 11 and proposals on sanctions

We refer to comments made on the light track at question 3 above and our view that there is no incentive for claimants to use the light track unless the defendant organisation makes a clear admission of liability at the outset.

It is clear from our responses to these questions that this FRC process is fundamentally flawed and not fit for purpose in that it does not encourage defendant organisations to investigate early and to admit liability on cases which deserve an early admission. There are no penalties for the defence organisations failure to make early admissions, there is no requirement for them to explain why admissions were not made early when they should have been and consequently why the claimant was put to proof and expense in proving their claim.

The scheme does not streamline the existing litigation process, instead it offers a completely new and untried process. The emphasis throughout is not on obtaining early access to justice as soon as reasonable and practicable but instead on saving costs at the claimant's expense and at the expense of providing justice to parties. Justice should be fair and accessible, this scheme is neither, instead it is weighted in favour of defence organisations and against injured claimants.

The scheme does not make any suggestions towards learning from litigation, even though claimant lawyers frequently come across the same negligent mistakes time and again when acting for different claimants who have been treated at different hospital. There is no interest or investment in patient safety and to that extent it is not only a missed opportunity, but it is also irresponsible.

The scheme shows no interest in identifying the true causes of high costs or addressing them. It does not seek to identify what is wrong with the current well established and developed process of litigation currently operating.

These proposals simply aim to parachute in a new, untried, untested, unpiloted scheme which serves only to save costs for those who are responsible for the harm

caused. The cost savings come from the claimant having to pay their lawyers for the shortfall out of the damages, or from claimants who are no longer able to bring a claim because they cannot secure representation. The scheme has been set up to ensure that the reputational risk to claimant lawyers is considerable such that if (as is likely) the award of damages is low, it is likely to wipe out or severely reduce any award of damages received.

The shortfall in the claimant lawyer's costs comes from the scheme being designed to short-change the claimant lawyer's for the costs properly incurred by them. This scheme is not about justice, fairness, rapid resolution it is quite simply about saving costs at any cost.

This process is reform for reform's sake, it is a vehicle for preventing claimants from accessing the justice to which they are entitled in order for the organisations which caused the harm or the Department of Health and Social Care to save money.

Question 7: Do you agree or disagree in principle that template letters and expert report model elements should be used as part of the streamlined processes in both the standard and light tracks?

• Agree

• Disagree

• Don't know

Why?

Please refer to the 'Template letters' section of 'Chapter 8' and to Annex B in the consultation document, giving any reasons for your answer, and providing any views or suggestions you may have for the format and content of the letter templates or expert reports

We think the template letters are useful but experienced clinical negligence practitioners will be used to doing this work and will doubtless have their own template letters that work for them.

We think it would be a mistake to mandate use of a prescribed form of letter.

It is our view that provided the Letter of claim, Letter of response, instructions to expert and so on contain the essential information that enable parties to elicit the key information and complete a stocktake this is sufficient.

We are also mindful that the longstanding and effective Pre Action Protocol for resolution of clinical disputes also suggests template letters but it is a matter for the individual practitioner whether to adopt them in exact format or not. To our knowledge, there has never been an issue with this approach.

No two clinical negligence claims are the same it seems sensible to allow lawyers the ability to decide whether to use the template letters or not. That approach works with

the pre action protocol, we think the same approach should be taken to the current proposed template letters

Question 8: Do you agree or disagree with the proposed fixed costs framework based on the CJC Working Group 'defendant group' costs proposals, including the suggested bolt-on cost for protected party claims?

• Agree

• Disagree

• Don't know

Why?

Please refer to 'Chapter 9: Fixed costs' and Tables 1 to 3 in the consultation document and give any reasons for your answer.

AvMA does not undertake litigation and claimant lawyers are the best people to comment on the viability of the fees. However, the lack of objectivity about this is quite incredible and adds to the perception of this scheme in reality just being a crude cost cutting exercise at the expense of injured patients' access to justice. How can the DHSC justify just going with the lowest figure possible, even though that is proposed by defendant law firms who do not understand the business realities of representing claimants? From the conversations we have had with our own claimant lawyer members and with associations like SCIL, most firms will not be able to represent claimants at those rates and even if they do and win, will need to take money from client's damages to make their involvement viable. This could wipe out much of if not all injured patients' damages even if they were able to find a lawyer to represent them.

Although there are some safeguards in that cases requiring more than two expert reports on liability fall outside of the scheme this does ignore the complexity involved in managing cases where lawyers are acting for claimants who do or may lack capacity. Please see also our response to question 1 above and question 10 below.

The suggestion that these complexities could be overcome by offering lawyers acting for claimants who lack capacity an additional "bolt on cost" of £650.00 seems to us unrealistic and only serves to increase the risk that this group of people will find it difficult to secure legal representation.

Part 21.10 CPR requires that where a claim is made by or on behalf of a protected party or child that settlement requires approval of the court. The cost of counsel providing the necessary advice on quantum for the court approval and solicitors being able to instruct counsel appropriately for £650 seems unlikely. This is especially true when considering that the £650 will also have to cover the cost of either counsel or solicitor attending court to secure the court approval of the settlement.

The Guideline Hourly Rates updated in October 2021: https://www.gov.uk/guidance/solicitors-guideline-hourly-rates#full-publication-update-history, demonstrate that the courts are allowing a 4 year PQE lawyer National 2 region £218 per hour. This further suggests that a bolt on fee totalling £650 is highly unlikely

to cover the cost of acting for someone where capacity is an issue. Therefore, the consequence of offering what appears to us to be paltry remuneration is that lawyers will simply refuse to take cases involving protected parties leaving people who fall within the category without representation.

Question 9: Do you agree or disagree with the proposed arrangements for mandatory neutral evaluation, including the costs framework for evaluations and how these are funded?

• Agree

• Disagree

• Don't know

Why?

Please refer to 'Chapter 10: Mandatory neutral evaluation' in the consultation document and give any reasons for your answer

Please also see our comments on MNE in our response to question 4 above.

It is possible that neutral evaluation could have a place in a speedier and more cost-effective process but as explained, we have concerns about the lack of experience with neutral evaluation in clinical negligence claims. There are also concerns about making neutral evaluation mandatory which takes away the party's willingness to submit to an evaluator's findings. There are other concerns about the MNE proposals as set out below.

ATE provision and the cost to the claimant

It is not clear that insurers will provide ATE cover for MNE. Insurers have no experience of this process either. Given that the proposal is that each party bears the cost of MNE equally this is an important point.

Without ATE cover many claimants will not be able to afford their share of the cost of MNE which on the figures suggested by the consultation document would be either £1,000, £750 or £375. It is unlikely that many claimant clinical negligence firms would be able to cover the cost on behalf of their client and even if they can, why should they?

The standing of the evaluator

The lack of experience in using mandatory neutral evaluation in clinical negligence cases, means there is no benchmark or gauge for what makes a good evaluator. The quality of the evaluator needs to be assured and that assurance needs be built into the process from the start not after some identifiable point in the future – see our comments on the need for a pilot above.

The consultations proposal is for the evaluation to be carried out by an independent specialist barrister of a minimum level of experience. That barrister is to be selected from a pre agreed panel.

It is important to both the process and to the parties that the Evaluator should have gravitas, experience and are able to deliver a just result befitting of the evidence in the case. Our enquiries suggest that even at 5 years call, barristers have little or no experience of cross examination in court, or of multi-track trials, the evaluator should have far more than 5 years call.

It is AvMA's view that it is imperative that the minimum standards expected of the evaluator are clear from the outset. AvMA considers it crucial that before being accepted to the panel the evaluator must be able to demonstrate the following:

- A minimum number of years call during which the evaluator specialised in clinical negligence claims. We are mindful that Independent Evaluation an organisation which was set up in 2013 and has undertaken early neutral evaluation in clinical negligence claims does not offer Evaluators of any less than 15 years call. In the absence of any other evidence that would appear to be a solid benchmark.
- Sufficient experience of both claimant clinical negligence and defendant work.
- Experience of the neutral evaluation process
- Impartiality and independence
- Experience of sitting as a judge. Judicial experience is more likely to result in a fair and just outcome which is delivered with confidence
- In the event that the Evaluator does not have judicial experience the Evaluator should be expected and willingness to sign a statement or declaration of impartiality and independence at the end of their opinion evaluating their evidence and reasoning for their decision

Evaluator's ability to clarify expert evidence

Given the pivotal role that evaluators play in this scheme, the fact the evaluation is on paper only and the evaluator is generally not expected to clarify/ask questions of the experts even if they consider this necessary is also of grave concern. The proposals recognise this as a problem but state that an evaluator will only be able to seek clarification on cases which are the ***"most complex of claims"*** (p43). The proposals have yet to define what cases will fall into the "most complex" category.

The evaluators' ability to seek clarification from experts has been prevented on the grounds that to allow this would "***undermine the speed and cost effectiveness of MNE".*** The proposals sacrifice the evaluators' ability to get at the core issues on liability. To prevent the evaluator from seeking clarification on core issues such as liability and causation is to prevent them arriving at a just outcome. Independent Evaluation has confirmed that there are no restrictions on their evaluators seeking clarification from experts in order to arrive at the right outcome.

If the MNE aspect of this process is to stand any prospect of succeeding whilst providing a fair and timely outcome the evaluator must be able to seek clarification from the experts where required

Professional indemnity cover for evaluator

The evaluator should also bear professional responsibility for their opinion and have adequate insurance cover if a party brings an action against the evaluator. It should be remembered that evaluators do not hold judicial office and their existing professional indemnity cover is expected to be limited to cover for activities of a barrister. An evaluator is a different role.

Given that the claimant's ability to access the court turns on the evaluator's opinion, it can be seen how the evaluator's decision potentially thwarts a claimant's access to justice. Access to justice is a fundamental tenet of our English legal system, anything that impedes that must not be allowed on a whim or a hunch that this will provide sufficient sanctions to protect the defendant position. There must be a duty on the evaluator to perform the evaluation to a high standard, that requires there to be checks and balances throughout the entire process including evaluators. There should be clear ramifications for evaluators who fail to execute their duties properly.

See also our comments below on the court process and the interplay between the claimant's ability to access this and the evaluators' role.

Costs framework for MNE

The proposed costs for the evaluator appear unrealistic. AvMA has made enquiries of Independent Evaluation an organisation which does have some experience of evaluations in clinical negligence claims, although not with the NHS. They have specialist clinical negligence evaluators, none of whom have less than 15 years call, all are experienced barristers many also sit part time as judges, they acknowledge that the value of the claim can often have no bearing on the complexity of the issues involved. Low value does not equate with straightforward. The remuneration for evaluators as set out in the proposals is not realistic and is not workable.

The proposals recommend payment of £2,000 for the evaluator to report on liability and quantum; £1,500 for liability only and £750 for quantum only.

Focusing on the liability and quantum aspect that would appear to be very little remuneration for what is a difficult and time consuming job which holds a lot of responsibility particularly given the evaluators impact on the claimant's ability to proceed to a paper trial.

Our concern is that the evaluator will provide a standard commensurate to that paid for. While the proposals is not clear on the amount of work likely to be involved it is likely that a typical bundle would consist of most if not all of the following documents:

(i) **Pre issue evidence**: We would expect this to include any complaint correspondence, serious incident reports, pre action protocol letters. The DHSC proposals only exclude some deaths so it is reasonable to assume that documents generated as part of the coroner's inquest will also be included.

The information available from the coroner will likely vary depending on whether the family were represented or not, how long the inquest lasted, but could reasonably be expected to include a statement from the deceased's family, statements from treating healthcare professionals, any independent expert or experts appointed by the coroner as well as any expert reports which the defence organisation or family seek to rely on. It will also include the coroner's conclusion which in the case of an Article 2 inquest can be expected to be quite detailed as well as any correspondence passing on prevention future death reports (PFD) required by the coroner

(ii) A letter of claim and a letter of response

(iii) A collated, sorted and paginated bundle of medical records put together by the claimant lawyer

(iv) Two claimant expert reports on breach and causation and two defendant expert reports on breach and causation – a total of four reports. Any literature relied on by the experts in support of their opinion to be included

(v) Two witness statements on behalf of the claimant and two witness statements on behalf of the defendant – a total of four witness statements

(vi) Claimant's Condition and prognosis evidence

(vii) Details of the claimants' losses (this may be contained either in the Letter of Claim or in a schedule of loss) and the defendant's counter schedule of loss

(viii) There may be a claimant reply to the defendant's letter of response

(ix) There may be a joint stock take letter

In addition, there is no facility for the evaluator to seek clarification from experts, other than in "*the most complex of claims*". The evaluator is expected to prepare a written opinion clearly identifying the evidence relied upon when reaching their conclusion. That appears to us to be a lot of work for very little reward, it is difficult to see how a barrister of good reputation and standing would be prepared to undertake this work for that remuneration especially given the impact of their decision.

Question 10: Do you agree or disagree with the proposals on claims to be excluded from the FRC scheme and on the approach to protected party claims?

- **Agree**
- **Disagree**

• Don't know

Why?

Please refer to 'Chapter 11: Excluded claims' in the consultation document and give any reasons for your answer

Capacity

The issue of whether a claimant has capacity or not, is complex. Lawyers acting for elderly patients may find that even if the case does only require two reports on liability the patient lacks capacity or their capacity fluctuates. That fact alone requires the lawyer to act with caution. Lawyers need to be certain that their client can give clear instructions on bringing a claim. Lawyers are required to satisfy themselves whether a client has capacity to give instructions.

Equally, claimants with learning difficulties may require more time to give instructions, people should be helped to make their own decisions where possible and exercise their autonomy. Including this category of claimant into the scheme would not allow that.

There is no accessible data on the number of clinical negligence claims brought by people with learning difficulties. It may be relatively few clinical negligence claims were brought by people with learning difficulties compared to number of other people bringing claims. However, we can assume that people with learning difficulties are already likely to be underrepresented and disenfranchised.

The 2020 LeDeR report: https://www.england.nhs.uk/wp-content/uploads/2021/06/LeDeR-bristol-annual-report-2020.pdf Identified that ***"preventable medical causes of death in adults were 24% in 2018, 23% in 2019 and 24% in 2020. For children the proportion was 10% across the three years. Treatable medical causes of death in adults were 41% in 2018, 40% in 2019 and 39% in 2020. For children, the proportion overall proportion was 29%. Compared to the general population, people with learning disabilities were more than 3 times as likely to die from an avoidable medical cause of death (671 per 100,000 compared to 221 per 100,000 in the general population)."***

Work of this nature should not be undertaken by a junior lawyer, these cases require careful management and sensitivity, they take time. The complexity of claims involving claimants who lack capacity is such that these cases should fall outside of a FRC regime. Failure to exclude cases involving capacity will mean that lawyers will not be able to provide proper and adequate representation to some of the most vulnerable in society.

Children

Where children fall within the scheme the bolt on rate will need to be increased to ensure that lawyers take these cases without having to recover the shortfall from their client's damages and to ensure that children with lower value claims can and will be represented.

Fatalities

All fatal claims should be excluded.

There is no worse outcome than death. The seriousness of this outcome is such that they are not suited to a FRC regime. The fact that the claimant lawyer is representing a bereaved family or loved one means that these cases require a sensitive approach and that takes time. This fact alone means they are not suited to a FRC scheme.

NHS Resolution recognises that particular care must be taken with cases involving death and therefore bereavement. We refer again to the 2018 paper prepared by the Behavioural Insight Team into patient motivation for making a claim which identified how important compassion is to claimants. (Para 4.2.1).

Deaths of children: The proposals recognise sensitivities with stillbirths or neonatal death cases but the impact for a parent who has lost a child is no less because that child is not an infant. The loss of a 2-year-old or a 12 year old cannot be said to be any less traumatic. It cannot be said that a claimant lawyer has latitude to be any less compassionate when managing the family of a child who has died. There is no rational reason why stillbirths, neonatal deaths should be excluded but deaths of children should not be.

Death of the elderly: With a growing elderly population and with the complexities around adequacy of social care there are strong public interest reasons why elderly deaths should not be included in a regime which focuses on speed and cost savings. Accountability is important to the public.

Mental health related deaths: Just as accountability and transparency are important to the public in elderly care claims so too is the public keen to ensure that the current poor state of mental health services in the UK is kept in the public spotlight. Accountability is key.

Where death occurs at the hands of the state ie hospitals and mental health centres the need for proper investigation is particularly important. Often deaths are caused by failures and or inadequacy of community care staff to follow up the patients. Those inadequacies are often contributed to by lack of funding, staff recruitment and retention issues. These must not be swept under the carpet, often litigation is the only way people can hope to find answers to what went wrong. The impact of suicide on those left behind is devastating.

These cases are often complicated by the need to consider Human Rights issues. As with elderly care there are public interest reasons for not including this category of case into a fixed costs scheme. The need for answers, recognition of how vulnerable groups have been treated and let down by the State and the need for change is often a driving force in these cases.

Mental health care is recognised as being in a state of crisis not least due to underfunding. Families often experience difficulties in finding a lawyer to bring these claims, a fixed cost scheme is likely to compound that difficulty.

For the avoidance of any doubt about the state of mental health services we refer to the CQC's most recent review of children's mental health services dated 2018: https://www.cqc.org.uk/publications/themed-work/are-we-listening-review-children-young-peoples-mental-health-services.

That review noted that: ***"We saw examples of services with caring and dedicated individuals who put children and young people at the centre of what they do. But these people are often working long hours, with limited money and an increasing demand for their services to overcome barriers to providing high-quality care. This cannot be maintained in the long run…Things need to change at the top, so those working with children and young people have the support they need to be able to provide the best care."***

It has been recognised that the need for young people to access mental health services has increased since 2018, contributed to by the coronavirus pandemic and the impact of lockdown. Litigation has a part to play in identifying the continued need for change, the very fact that the CQC ***says "things need to change at the top"*** reflects the importance of ensuring that deaths involving those who take their own lives because of mental health issues should be able to seek answers.

The CQC also recognised a lack of attention being given to people with learning difficulties and or mental health problems who die: https://www.cqc.org.uk/news/stories/deaths-people-learning-disabilities-or-mental-health-problems-not-always-given-adequate

The CQC noted: "***We also found that the deaths of people with a learning disability or a mental illness do not consistently receive the attention they need."*** The report also quoted Professor Sir Mike Richards, Chief Inspector of Hospitals, said: "***Investigations into problems in care prior to a patient's death must improve for the benefit of families and, importantly, people receiving care in the future... This is a system-wide problem, which needs to become a national priority."***

There are important public policy reasons for ensuring that the factors contributing to deaths must be carefully considered. It is clear that investigations must be used to improve care in the future. Litigation is one means by which families can, in appropriate circumstances, investigate. Whether death of a young person or adult is caused by suicide or by other means it is clear the reasons for that death and any problems in the system must be identified. Where appropriate, government bodies must be held accountable for shortcomings. These cases are not compatible with a FRC regime.

Inquests: Families involved in healthcare inquests already find it extremely difficult to find representation at the inquest hearing. Legal aid is difficult to obtain and is only available in very limited circumstances, as a result families are often unrepresented. Large public bodies and private healthcare organisations do not suffer the same funding crisis and are invariably represented at the inquest.

Those families who do find representation at inquest are generally only able to do so because a claimant firm will offer representation under the terms of a Conditional Fee Agreement (CFA) arrangement. The CFA will only be offered to families who are willing and have good prospects of bringing a successful civil claim.

Where there is a successful civil claim, only the costs of the inquest that are relevant to the civil claim are recoverable. Currently the costs recovered are on the standard rate, not on a fixed cost rate.

Generally, families are often unable to secure representation for the inquest even where healthcare providers can. The inequalities experienced by families at healthcare (and other) inquests are well recognised. Unless all fatal claims are excluded from the FRC regime, families seeking representation at inquest will find it even more difficult to secure representation at inquest.

Question 11: Do you agree or disagree with the proposals on sanctions to be considered and implemented by changes to the Civil Procedure Rules?

• Agree

• Disagree

• Don't know

Why?

Please refer to 'Chapter 12: Sanctions to encourage adherence to the scheme' in the consultation document and give any reasons for your answer

With reference to the light track: We have already set out that the only criteria for light track cases should be an admission of liability. The light track should be for cases where liability is admitted and the only issue preventing resolution is quantum. If this is not the case, we see no incentive for a claimant to proceed in the light track and hang around for 8 weeks only to realise the defendants are not going to admit liability and that the Claimant now needs to commence in the standard track anyway.

It is also noted that there is no provision for the claimant to be paid for that 8 week phase and therefore this reduces the incentive to start in the light track unless there is a clear admission of liability.

From time to time we do see admissions of liability where subsequently there is an attempt to row back from the admission. For example, breach is partially admitted but that part of the breach did not cause injury therefore the claim cannot proceed. Or, that further evidence has come to light which has cast doubt on the admission. In both of those situations not only should the claim fall outside of the FRC regime altogether, but it should also attract a financial penalty for poor defendant conduct.

With reference to the standard track: We consider a failure by the defendants to meet with the time limits imposed for a fulsome letter of response (6 months) otherwise the claimant's claim falls outside of the FRC regime to be an effective sanction.

It is crucial that the date from which the six months begins to run should be clear and unequivocal. We consider this to the date on the letter of claim.

We do have concerns that there will be attempts to raise arguments about this time limit. For example, we consider that providing the claimant has served a detailed letter of claim and accompanying documents (noting our views on unilateral service of claimant expert evidence) that should be sufficient. One can well envisage a situation where due to a change in the claimant's condition the schedule of loss might need amending. For example, because the claimant's condition improves or deteriorates unexpectedly.

If the schedule of loss needs to be amended to reflect this change in the claimant's circumstances, it needs to be clear that the amendment does not alter the substantive date for effective service of Letter of Claim. There should be no scope for the defendant to argue that constitutes an amendment to the core documents and therefore extends the time limit by which the letter of response is due.

The only time there may be an argument on this is if the changes made by the claimant go to the core issues to be investigated on breach and causation. From time to time it may be that a sudden and unexpected deterioration in the claimant's condition means the value of the claim increases in excess of £25,000 in which case it should fall outside of FRC.

We have serious concerns about the draconian nature of the sanctions suggested for a claimant seeking to access justice from a court following receipt of an evaluator's opinion which they do not agree with. Please see our comments on this under question 4 on proposals for the streamlined process where we have a subheading "Court Process".

Question 12: Do you agree or disagree that the proposals on FRC should apply to claims where the FRC letter of claim (or FRC claim notification letter) was submitted on or after the implementation date of the scheme?

• Agree

• Disagree

• Don't know

Why?

Please refer to 'Chapter 13: Implementing the FRC scheme' in the consultation document and give any reasons for your answer

We consider the best approach is for any FRC regime which is introduced being applicable only to cases where the Letter of Claim was written **after** FRC implementation date. This is about managing the client's expectations.

It is important for claimants to know and understand what they can expect both from the process and from their lawyers at the outset. Claimants find the litigation process complicated at the best of times, even explaining the legal test for clinical negligence can be difficult for some to comprehend. For example clients who are

told that the standard of care they received fell below an acceptable level and was negligent can often find it hard to understand that they cannot bring a claim because they have not suffered an injury as a consequence of that negligence.

Similarly, it is difficult for claimant lawyers to explain how costs work to a client. The case of *Belsner v Cam Legal Services Ltd* [2020] EWHC 2755 (QB) currently before the Court of Appeal illustrates this well.

For a system to be fair and accessible it needs to be understandable. Should a FRC regime be implemented, that is the time to explain to a claimant how the system works and what they can expect.

Question 13: Do you agree or disagree that the £25,000 upper limit for scheme claims should be reviewed post-implementation, and at regular intervals thereafter, specifically to take account of the effects of claims inflation?

• Agree

• Disagree

• Don't know

Why?

Please refer to 'Chapter 14: Reviewing the upper limit for claims' in the consultation document and give any reasons for your answer

We believe, if the scheme does go ahead, extreme caution needs to be applied to any increase in the upper limit for claims to fall under FRC because of the access to justice issues and the fact that doing so would be likely to bring in more complex claims which are not suited to such a process.

It is not unreasonable to review periodically to take account of inflation, but the costs recoverable should also be reviewed to take that into account.

Most importantly, for all the reasons we have pointed out, if the scheme were to go ahead, there should be a pilot first and an independent evaluation of inter alia, the effect on access to justice and whether the scheme as a whole is having the desired effect. There should then be periodic reviews.

We refer to the comments we made on the review process at question 4 "Mandatory Neutral Evaluation – an untried step"

The fixed costs proposals are seriously flawed because:

(i) They have been introduced without time being taken to explore the factors that give rise to high costs. The opportunity to address those factors has therefore been lost.

(ii) This is a new process, there is no evidence this is an improved process. The current litigation process is a tried, tested and effective process where excessive costs can be curbed and checked through the summary assessment and detailed assessment processes. In addition to the assessment process there is also clear guidance on costs being

proportionate such that even if costs are necessarily incurred they will not be allowed if they are disproportionate to the value of the claim

(iii) The way this process is designed will thwart the claimant's access to justice. Any cost savings (if there are any) will come from this, not from the design of this scheme. The effect on injured patients' access to justice is a very serious issue that needs careful, regular monitoring and independent oversight.

(iv) This scheme is being promoted by the Department Health and Social Care who are also responsible for the funding of the NHS, and for the cost of litigation and recompensing patients/families harmed through clinical negligence.. It is in their interests that they reduce the payment of damages to claimants whether by ensuring that claimant damages are used to supplement reasonable payment due to their lawyers, which would otherwise be paid by the NHS and other healthcare defence organisations or by preventing those victims from bringing claims in the first instance

(v) The proposals will ensure that it is difficult for claimants to bring claims valued at £25,000 or less. The risk to claimant lawyers of not being properly paid for the work they need to do is considerable. There is a real risk that only clear-cut cases where the negligence is so obvious you would expect early resolution will be taken on and likely to find representation. There will be a swathe of cases where the prospects of success are better than 50% but lawyers will not be able to take these. This needs to be kept under careful review

(vi) There are so many new steps (sequential exchange, mandatory neutral evaluation; restricted access to the courts for paper hearings only; severe penalties for claimants exercising their right to a fair hearing) that it is imperative this is kept under clear review on pre determined dates with a clear plan on how that review will be monitored and conducted.

(vii) There needs to be a careful review of how this scheme if implemented is affecting the value of claimant's damages after deductions have been made to make up the difference between the commercial rate the claimant solicitor must charge to stay in business and the amount they can recover under the fixed costs scheme.

(viii) It needs to be understood that fixing the costs in clinical negligence claims will not in itself bring the costs down. It simply pushes the cost on to the victim and claimant who has to pay the difference out of their damages.

(ix) There appears to be an assumption that the figure of "25,000 is considered to be low value. That is not the case. £25,000 is a considerable sum of money particularly to someone who has been injured and who as a consequence has been unable to pay their rent or mortgage because they have been too unwell to work. That assumption should be challenged at the review stage

The review needs to be carried out to ensure the above is monitored. Monitoring claims inflation is an insignificant reason for a review. This is a new and untried process as we have pointed out in this response there are clear difficulties in applying this process to low value claims. Those difficulties need to be monitored

and evaluated; they will not go away on their own. Extending the financial threshold to cases of more than £25,000 will only mean the flaws in this process will be extended to a wider group of claims.

The failures that currently exist in this scheme, such as accountability the failure to learn, the failure to resolve claims early, the failure to improve patient safety, the failure to promote access to justice and a fair and reasonable process will simply be extended so the same problems affect a wider group of claims.

Question 14: What are your views on how the proposals in this consultation might impact businesses involved in handling and processing lower value clinical negligence claims?

Please refer to 'Chapter 15: Impact on businesses, including small and micro businesses' in the consultation document, when answering

AvMA is not well positioned to answer this question given that we do not represent claimant law firms, only the interests of harmed patients. However, over the years we have witnessed many changes to the clinical negligence market and have observed their effect on claimant clinical negligence firms, including the loss of legal aid for clinical negligence, considerable increases in court issue fees, proportionality to mention but a few. All of these issues have caused the specialist clinical negligence market to shrink.

The process is full of unknowns.

The risks to people affected by clinical negligence are considerable especially as the ability to recover only the fixed costs proposed, does not of itself mean that claimant lawyers will restrict their charges to the level of fixed costs. Claimant lawyers will continue to charge a commercial rate. The difference between the fixed fee allowed and the commercial rate charged will be payable by the claimant out of their award of damages.

There is no ring fencing or capping of lawyers costs deduction from client damages. The only cap in existence relates to the success fee which can be charged by the solicitor when entering a CFA. The client's damages are going to be severely curtailed.

Claimant lawyers will only get paid on cases they win. They will have to take fewer low value claims ensuring those cases they do take on will have considerable prospects of success, probably more than 60%.

Claimant lawyers will not want to take complex cases which are difficult to run under a FRC scheme. In a low value claim the likely outcome is that even if the lawyer can be successful on the claim, they will have to deduct considerable sums of money from client damages. That will cause problems with the solicitor client relationship. It will mean firms will run considerable reputational risks in running these cases. Firms increase the likelihood of clients being dissatisfied with the outcome and either using the firms' complaints process and/or referring the matter to the SRA – both processes mean the solicitor will not be paid but will have to spend a lot of time dealing with this dissatisfaction.

The net result is that many of these cases will not be taken on because it won't be commercially viable for claimant solicitors to take low value claims under this fixed cst regime. There will be a swathe of potential claimants who will be unable to access justice. As explained above, even if cases are taken on and are successful, the claimant will almost certainly have to meet the shortfall in recoverable costs out of their damages.

For firms that do a lot of low value work, there is a reasonable expectation that under this scheme they will be forced to withdraw from the clinical negligence market altogether or face bankruptcy. That will impact on employees of those firms and may increase unemployment in the UK

Currently, mainly specialist law firms (those accredited by AvMA or the law Society) sift through hundreds of potential claims each day and risk assess the prospects of success providing advice to the potential claimant on why their case is unlikely to succeed. The vast majority of these potential claims (90%? CHECK SCIL) are assessed as unlikely to succeed and are not taken on.

That risk assessment process has a value to the NHS, there is a cost involved in taking time to risk assess a case and a cost associated with advising the potential claimant. Currently, that cost is absorbed by mainly by specialist claimant lawyers – the cost is hidden from the NHS, but it nonetheless exists. Specialist claimant lawyers understandably usually more expensive than non-specialist 'personal injury' lawyers. Feedback from our members suggests that many will be unable to operate under a FRC scheme as currently proposed. In our experience (and this is also borne out by NHS Resolution) non-specialist lawyers are less likely to screen out unmeritorious cases and run cases less efficiently. Even if they do screen out cases, this will lead to an increase in the number of litigants in person. Without the claimant's risk assessment process which effectively acts as a filter for claims against the NHS, the NHS will have to pick up that cost themselves. When potential claims come before the NHS case handler or NHS Resolution panel member, they will have to find time to assess it, the cost will fall back on the NHS.

The net effect of the FRC proposals as regards legal representation are likely to be that:

- Most specialist lawyers are forced out of the market for lower value claims
- Non specialist lawyers are more likely to be involved, if a claimant can get representation at all
- There will be a marked increase in litigants in person
- There will be huge consequential costs for the NHS and the courts which are likely to outweigh the perceived efficiency savings

Question 15: What are your views on how the proposals in this consultation might differentially or disproportionately impact small and micro businesses such as:

• law firms

• other small or micro businesses involved in supporting the handling or processing of lower value clinical negligence claims?

Please refer to 'Chapter 15: Impact on businesses, including small and micro businesses' in the consultation document, when answering.

Please see our response to question 14 above, otherwise we do not feel it appropriate for us to answer this question for reasons stated.

Question 16: What are your views on how the proposals in this consultation might impact:

• people with protected characteristics as defined under the Equality Act 2010

• health disparities or

• vulnerable groups?

Please refer to 'Chapter 16: Equalities impact' in the consultation document and the accompanying 'Equalities Impact Assessment', when answering

The protected characteristics under the Equalities Act are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

It is surprising to note that the Department of Health and Social Care considers the proposals "***unlikely to have a direct negative impact on any group"***

Disability: We refer to our comments on capacity and the evidence quoted from the LeDeR report in response to question 10 above. That report suggests that people with learning disabilities are three times more likely to die from an avoidable medical cause of death than the general population. It is likely to follow that injuries as a result of medical accidents are also proportionally much greater.

Likewise, people experiencing mental health issues are less likely to find representation than those without. A fixed cost regime does not accommodate the complexities associated with these groups which are already marginalised finding representation and then the additional time required to take instructions and represent them.

Low-income groups: women who have had children are more likely to be working part time or not at all and will therefore disproportionality fall within this scheme as it is equally likely that as a result of their earnings their claim will be assessed at £25,000 or less. Black and Ethnic Minority groups are disproportionately represented in low-income groups, so would be disproportionately affected. Likewise elderly people who are in receipt of a pension and those with a disability are more likely to be unemployed or low earnings.

We note that even the consultation document acknowledges that the Department's opinion is that the proposals are "unlikely" to have a negative impact on any group, and that is based on "assumptions". We respectfully suggest that given the radical, untested and controversial nature of these proposals and their potential impact, a far

more thorough analysis is needed. None of the analysis we have seen addresses the core question- “will these proposals negatively impact access to justice for harmed patients?”. Based not only on our analysis, but that of every single organisation we know of representing patients and harmed patients, it would. It might be argued that everyone negatively affected by these proposals will be impacted equally, but it seems clear to us that people with protected characteristics will be disproportionately affected. The consultation also asks for comments on the impact on ‘vulnerable groups” We would argue that anyone seriously affected by clinical negligence, especially those who lose a loved one due to negligence, is ‘vulnerable’

This of course begs the question should the proposals go ahead at all. At the very least, if the Government does intend to press ahead with the proposals there needs to be a more thorough analysis first and piloting of the scheme evaluated for the impact on access to justice generally, and on people with protected characteristics in particular.

FRC could be seen as having a disproportionate impact on those already disadvantaged for example there is a much higher risk of stillbirth in women facing multiple disadvantage. And the correlation more generally between disadvantage and patient safety https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-018-0828-7 People who have no financial safety net. This is against a backdrop of health inequalities more generally. https://www.kingsfund.org.uk/publications/what-are-health-inequalities - has some very stark stats. https://www.bmj.com/content/376/bmj-2021-067090.

More specifically, the International Journal for Equity in Health: https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-018-0828-7 demonstrates:

- (page 6) that “…*ethnic minorities have higher odds of experiencing harm and adverse consequences due to errors in the testing process (ordering, implementing, and performing the test, reporting results to the clinician, notifying the patient of the results and following up) compared to white patients”*
- It also finds (page 6) that “…*women have a lower likelihood of receiving proper and timely diagnosis respectively of cancer and coronary heart disease, compared to men”*
- Page 7 that “*they suggest that some vulnerable social groups are more likely to experience adverse patient safety events.”*
- Page 7 that “*this systematic review shows some examples of inappropriate care with patients presenting the same conditions, as a result of gender, ethnicity or socioeconomic disparities.”*
- Page 8 reports that “*Blacks are less likely to be detected with pressure ulcers because of darkly pigmented skin and a study [39] carried out in London reports that Bangladeshi patients are more likely to present non-classic symptoms of acute myocardial infarction pain compared to Whites, making the initial diagnosis more difficult”*

Given that the prevalence of shortcomings in medical care found in this paper affect women and ethnic minority groups more than any other it must follow that any attempt to restrict access to justice will disproportionately affect these protected groups more than any other. It cannot therefore be said that these proposals are "***unlikely to have a direct negative impact on any group"***

The proposals also state that "***There should be no direct effect of the FRC scheme on the amount of damages people receive in compensation".*** That comment is plainly misleading if not disingenuous. No analysis is presented to support this assertion, and it flies in the face of what the Department is being told by lawyers who specialise in this field, and organisations who work with patients and people affected by clinical negligence. As explained above fixed costs do not bring the cost of litigation down. It simply reduces the amount which the organisation responsible for the negligence (whether that is NHS or another defence organisation) has to pay to cover the actual and real costs of litigating. It does not alter the actual costs payable. The shortfall is payable by the claimant out of their award of damages, so it clearly does affect the amount of damages people can receive in compensation.

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