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The charity for patient safety and justice

Expert Newsletter

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Editorial

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Clinical negligence is very much in the spotlight at the moment. Hardly a day goes by when there isn't a media story featuring some aspect of medical care, whether good or bad. All this at a time when the NHS is facing unprecedented pressure from high public demand for services, be they maternity or Accident and Emergency as well as a reduction in the number of people who wish to go into and stay in the medical profession.

Scrutiny over how public funds are being spent, whilst justifiable, adds to the pressures; problems are exacerbated by a growing elderly population and insufficient social care. These are just some of the factors that are contributing to the difficulties being faced by the National Health Service; the complete picture is undoubtedly a complex one!

AvMA recognises the great skill and high level of service that most patients receive; our doctors are some of the most respected and able in the world. We share the national pride and high esteem in which the medical profession, in particular the NHS, is held. However, things can and do go wrong with healthcare. There may be many reasons for those errors; certainly systemic failings, which are often outside of a doctors control, can contribute to clinical failings.

It is important for both the doctor and the patient to know that where there have been failings, there are systems in place to help identify what the issue is and what is being done to address it. In some cases where things have gone wrong, the treatment is negligent; that is, it falls below the standard of care expected of the ordinary average clinician operating in that field (so GPs should be judged by the standard expected of the ordinary GP and orthopaedic surgeons should be judged by the standards of care expected of the ordinary, average, orthopaedic surgeon and so on). Where negligence has been identified and that negligent treatment gave rise to harm, compensation should be offered; where appropriate, fair compensation should be offered swiftly for any injury arising from negligent treatment.

AvMA believes that litigation should be a last resort. There are systems and processes which, if operated impartially, openly and honestly, should resolve many if not most cases without the need to issue court proceedings. Where Serious Incident Reports are prepared with the involvement of the patient and or the families at the outset, the terms of reference tend to be more comprehensive. Of equal importance is that the investigator is open minded and robust in their consideration of the facts and evidence, and that this is reflected in the report. The report should form very clear conclusions

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and help identify any changes required. The complaint process offers another opportunity to resolve problems at an early stage.

Unfortunately, the serious incident reporting and complaint avenues are not always managed in a way that enables issues to be resolved fairly or at all. The result is that many patients feel that they have no alternative but to seek redress from litigation – in our experience, no patient takes the litigation road without experiencing a great deal of stress and anxiety. We recognise that doctors, nurses and medics involved in litigation also experience stress and anxiety – there is no doubt, litigation is not for the faint hearted!

It is indeed a great pity that all too often the management of the SIR or equivalent process and complaints handling is such that it renders these processes as missed opportunities; it is this mismanagement that often results in patients and families going to a lawyer. However, where cases are referred to lawyers, AvMA believes it is vitally important that they are handled by lawyers who have experience and expertise in clinical negligence law. To help ensure this, during the mid 1980s AvMA set up an accreditation scheme; under the scheme we assess a lawyer's skills, if they are considered competent and able and satisfy our interview procedure, we will admit them to the AvMA Panel. Our panel members are reaccredited every five years and we are the longest running independent accreditation scheme.

AvMA's goal is to ensure that members of the public who believe they have suffered injury as a result of negligence have the best opportunity to prove their claim, alternatively understand what went wrong with their treatment. There can be little doubt that the expert medico legal witness has played a significant part in enabling the public to access justice where it is due. Many of our medico legal experts chose to be involved in this specialised area as it is, rightly, seen as a means by which leaders in their fields of medical practice can help to drive up standards. You may be interested in **this article which appeared in the *Guardian* on 24th January**, which reminds us of how far we have all come in improving standards of care and openness in health care.

I really hope you find this newsletter informative and welcome your feedback. I will of course endeavour to keep you updated on matters as they progress.

Best wishes

Lisa O'Dwyer
Director Medico-Legal Services

Medical expert database listing confirmation

One simple but important way of ensuring that we offer a high standard is by carrying out an annual check that expert's details are fully up to date. It is important that your information is current; especially your hourly rate and average turnaround time for preparing reports. We want to be confident that any expert we recommend is still interested in doing medico-legal work and willing to be recommended.

You will have been sent a copy of the **Medical Expert Database Listing Confirmation** form in recent correspondence but in case you have misplaced it, a **copy is available on the website**. ■

Fixed Recoverable Costs (FRC) consultation

You may remember from my previous correspondence that the DH first published a short pre-consultation on Fixed Recoverable Costs (FRC) in August 2015. At that time we were told that a full consultation was imminent. In fact the consultation has only just been published on 30th January 2017!

Pre Consultation on FRC – August 2015

To recap, the 2015 pre-consultation paper set out the main tenets of the DH proposals. At that time they were:

i) Solicitors costs will be awarded on a fixed fee basis relative to the value of the claim, rather than complexity.

ii) Claims with a value of up to £250,000 may be included in this regime.

iii) Expert fees to be capped at a maximum recoverable sum reflecting the likely number and cost of expert reports needed; the cap would apply to all reports, those on liability, causation, quantum and prognosis.

The key proposals in the recent 2017 FRC consultation paper are:

i) FRC to apply to claims valued between **£1,000 and £25,000** – fast track or multi track but not small claims track.

ii) The limits should apply to private healthcare providers as well the NHS LA.

iii) **Exemptions:** A number of exemptions are proposed: protected parties (children); where the number of experts reasonably required by both sides on issues of breach and causation exceeds a total of two per party; child fatalities (including still birth).

iv) **Payment of lawyers costs:** It has been suggested that this could be managed one of four ways. The four options are a **time analysis approach; staged flat fee arrangement** (costs would be fixed irrespective of the amount of time taken to settle the claim); **early admission of liability arrangement**: (flat fees used for claimant solicitors are reduced by a suggested 10% where the defendant admits liability); a **costs analysis approach**: This is based on the mean relationship between current costs and damages.

v) **Experts Fees:** The DH are consulting on capping expert fees so that a successful claimant will only be able to recover a maximum of £1,200 from defendants. We understand that £1,200 is meant to cover the cost of liability, causation, and condition and prognosis reports inclusive.

vi) **Single Joint Experts:** There is a suggestion that SJE could provide an opinion in **"broad terms"** on breach of duty and causation at an early stage.

The fact is that the courts already assess clinical negligence bills with regard to whether the costs incurred were proportionate to the matters in issue. Costs which were necessarily and reasonably incurred but which are disproportionate to the matters in issue may be disallowed. In addition the courts currently look at whether the costs are proportionate by having regard to a number of factors, including the complexity of the litigation and the conduct of the paying party.

Under the current system of assessing costs if the NHS LA and other defendant organisations believe that a claimant's bill is too high they can refer it to the court to be assessed by a costs judge. The NHS LA can and do exercise that right. AvMA takes the view that with complex cases such as medical negligence it is equitable that an independent judge, specialising in costs work can assess these cases taking into account the factors set out in the above paragraph. The current system works; it is not broken and it does not need fixing.

AvMA is concerned that if the proposals suggested are introduced they will do no more than shunt the costs of litigation on to the injured party. If an expert report is going to cost more than the cap will allow, the difference will have to be paid out of the claimant's damages. The FRC proposals do not prevent lawyers entering into a Conditional Fee Arrangement (CFA) with their client; under a CFA a lawyer is entitled to charge a commercial hourly rate. If the lawyer is only going to recover a fixed fee from a losing party then the difference between the commercial rate and the fixed fee will also have to come out of a client's damages.

Under a CFA the lawyer takes a risk, if he or she loses the case they don't get paid for the work they have done. To compensate for that risk, if the lawyer is successful they can recover up to 25% of a client's damages (limited to

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general damages (this is the award made for the injury, pain and suffering) and past losses).

It is not difficult to see that if the current proposals were introduced for claims up to £25,000 there is a very real risk that a claimant who has won their case may actually end up with no compensation at all after all the deductions have been made.

In the consultation paper, the DH are at pains to say that fixing the recoverability of costs will not limit the claimants entitlement to compensation or the overall damages awarded. What they fail to say is that if these proposals are adopted, whilst the claimant's entitlement to damages won't be eroded their ability to receive the amount they are awarded will be. This is a little like giving with one hand and taking with the other: it does not amount to access to justice and will only serve to prevent patients who have valid causes of action from bringing claims. It is disingenuous to call this access to justice. Certainly, a scheme of this nature may save money, it will also serve to ensure that injured patients are not compensated and that negligence will be covered up – there will be reduced or no accountability and that will not drive up standards or encourage learning.

AvMA is particularly disappointed that the consultation does not offer any concrete proposals for improving patient safety. AvMA has made a suggestion for improving patient safety and learning from litigation but this has not been taken up. **An outline of our proposals can be found here**.

We welcome your feedback on this suggestion. Please contact **norika@avma.org.uk**. ■

The pros and cons of single joint expert reports

At first blush, there is every reason to consider that single joint expert (SJE) reports are a good way forward. AvMA expects the experts on our database to be fair, balanced and objective. We don't want experts who see themselves as for the claimant or for the defendant, we want robust, impartial views to be offered following careful consideration of the records.

Many experts reason "I am objective and fair, my opinion on a matter would not alter simply because I was looking at the same set of facts but being instructed by a different side". AvMA would not argue with this logic and would, in fact, applaud this approach; an expert's duty is to the court, not to whichever party pays him or her.

However, an SJE is not the panacea to clinical negligence it might appear to be. There are several difficulties for SJEs; one of the most significant is the loss of legal privilege. Legal privilege is what gives an expert the ability to discuss freely the pros and cons of a case with the instructing lawyers. This is usually done in conference with counsel, but also by way of telephone discussion with the instructing solicitor. The loss of legal privilege will undermine the expert's ability to test difficult matters during discussions in conference. For example an SJE will not be able to attend conference with only one party's legal representatives being present – both will need to be there – there will be no ownership in the expert.

Other points for experts to think about is the fact that there is a very real risk that an SJE will effectively become the arbitrator or adjudicator in low value claims; their initial conclusion will be a key deciding factor as to whether the claimant can progress their claim or not.

The use of an SJE will also mean that the court will not see the full range of opinion available on the issue.

Further down the line, the use of an SJE may give rise to objections to the nominated expert being instructed and subsequent impasse. ■

After the event insurance (ATE) consultation

You may remember that previously I mentioned that there were two consultations pending, FRC and after the event (ATE) insurance. The ATE insurance consultation has not been published. You may ask, what is ATE insurance? Why is it important?

Most insurance products are payable in advance, you essentially gamble on whether an event will happen or not. If the event does happen, the insurance will pay out, providing you have paid the premiums due. If the event does not happen, you continue to pay your premiums and the insurance company benefits. Unlike the typical insurance scenario, ATE insurance is purchased in clinical negligence claims after the injurious, negligent event has occurred.

Up until April 2013, the usual rule on costs was that the losing party paid the successful party's reasonable costs. ATE insurance was introduced to cover a claimant's liability to pay the successful party's costs in circumstances where the claimant lost their action. ATE insurance protected a claimant from having to sell their home or use their savings in order to pay the defendant's costs bill. The premiums payable in ATE insurance were generally very high; however, if the claimant was successful, the losing party had to reimburse the ATE premiums as part of the claimant's costs.

April 2013, saw the introduction of Qualified One Way Costs Shifting (QOCS). This means that if a claimant loses their clinical negligence action, the defendants will not be able to recover their costs from the claimant. There are a couple of situations when a claimant might lose QOCS protection (for example, if it can be shown that the claimant has acted dishonestly) but in the scheme of things this is rare. As a result of QOCS, it is no longer necessary for a claimant to take out ATE insurance as the successful party to litigation will no longer come after them for their costs. The benefit of this to defendant organisations such as the NHS LA and others is that they do not have to pay the very high ATE insurance premiums. However, ATE insurance has retained a foothold in the clinical negligence market because it still offers cover for the cost of expert fees and other litigation risks such as the failure to beat a Part 36 offer. The premiums for these ATE products are lower than before; currently the premiums for this insurance are recoverable from the losing party but the Ministry of Justice (MoJ) is expected to consult on this.

If the situation arises where it is no longer possible to recover ATE premiums from the losing party, then it will be difficult for a claimant to bring a clinical negligence action because of the cost of expert reports. Legal aid is no longer available except in very limited circumstances; many firms are unable to cover the cost of expert reports and invariably individuals seeking to bring a clinical negligence claim rarely have anything approaching £3,000 to obtain liability and causation reports. ATE insurance offers different terms and products but it is possible to obtain insurance to cover the cost of expert reports in circumstances where the claimant's case does not proceed or is lost.

If the premiums payable on ATE insurance are no longer recoverable then many potential claimants will not be able to fund even initial investigations and valid claims will not get off the ground.

It should also be borne in mind that expert fees are not the only expense for claimants; the cost of the court fee to issue proceedings is now extremely high – 5% of the value of the claim over £10,000.

There is a very real risk that by removing the recoverability of ATE premiums, the government will simply ensure that patients will not be able to afford to bring claims, even claims under £25,000. ■

Lord Justice Jackson – review FRC

Lord Justice Jackson was the architect of the fixed recoverable costs regime. FRC has been introduced into some areas of law, such as personal injury (PI) where the ability to identify liability is often a great deal more straight forward than in clinical negligence claims. Jackson's first report on civil costs was published in 2010 and despite the fact that he recommended legal aid be retained, it has not been!

Many of the original proposals have already been introduced but Lord Justice Jackson is now carrying out a review of FRC to see how well they are working; the report is expected to be published this summer. AvMA submitted evidence to him and if you are interested in finding out more **our paper can be found on our website**. ■

National Audit Office (NAO) investigation

At the end of 2016 the NAO announced its intention to investigate whether the Department of Health and the NHS LA understand what is causing the increase in clinical negligence costs. This news was warmly welcomed by AvMA who had been contacted by the NAO before they made their decision.

The NAO will evaluate their efforts to manage and reduce the costs associated with clinical negligence claims. They will also assess the NHS LA's contribution to helping trusts to reduce the number of negligence claims they receive by sharing learning about past incidents and by encouraging wider forms of redress for affected patients.

The NAO are inviting relevant parties to provide evidence for their study, if you are interested you can email them on **enquiries@nao.gsi.gov.uk**, The NAO report is also due summer 2017. ■

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Safe space

Other potential change includes the introduction of the "safe space". Whilst AvMA supports the need for clinicians to come forward and speak openly about mistakes they have made or near misses, we challenge the notion that clinicians fail to come forward for fear of litigation. You can see our **response to the consultation on our website**. There are many reasons why clinicians do not come forward, including fear of professional embarrassment and repercussions from employers. We have invited your further comments on safe space in our **2016/17 questionnaire** and assure you that we will keep your identity confidential.

We appreciate the time you take in completing our questionnaire, which does provide valuable information and insight into clinical negligence practice from the expert's perspective. An anonymised spreadsheet of the responses received from the last questionnaire has been compiled and again, this is available for your perusal on **the experts page of the AvMA website**. Please do complete your questionnaire and return it to **norika@avma.org.uk** as it helps us improve our service to you. ■

Donation to AvMA

Some of my colleagues have already contacted you inviting you to make a donation. As an independent charity we do rely on the generosity of our supporters, I take this opportunity to thank you for your generous contribution.

Your donations go towards helping us meet the costs associated with providing our services to the public, free of charge. Those services include: a helpline service which is open five days a week and is staffed by professional volunteers (doctors and lawyers); a *pro bono* inquest service to provide support and representation to the bereaved who have lost a loved one in a health care setting and written help and advice for those cases that are too complex for the helpline but nonetheless require advice. It also contributes to our ability to continue our work on patient safety issues.

If you would like to make a donation but have mislaid the previous AvMA mail-outs, **a gift aid declaration form is on our website** under the "forms for experts" section. ■