RESPONSE TO

DEPARTMENT OF HEALTH CONSULTATION:

INTRODUCING FIXED RECOVERABLE COSTS IN LOWER VALUE CLINICAL NEGLIGENCE CLAIMS

MAY 2017

About AvMA

Action against Medical Accidents (AvMA) is the UK charity for patient safety and justice. Established in 1982, AvMA provides specialist support and advice to people who have been affected by lapses in patient safety. AvMA works in partnership with government departments, health professionals, the NHS, regulatory bodies, lawyers and other patients' organisations to improve patient safety and the way injured patients and their families are treated following lapses in patient safety. AvMA also accredits specialist clinical negligence solicitors so that injured patients or their families have access to the best quality legal advice if they need it. Consequently, AvMA is uniquely well positioned to respond to this consultation from the perspective of the people who would be affected by the proposals.

Executive Summary of our response

We believe these proposals are premature, ill-informed, and pose a serious threat both to access to justice and to patient safety.

Premature and ill-informed

- The proposals are based on unreliable data.
- No account has been taken of the effect that the Legal Aid Sentencing and Punishment of Offenders Act (LASPO) is already having on costs and access to justice. The Ministry of Justice is reviewing this and is due to report in 2018.
- No account has been taken of key factors that contribute to higher costs in clinical negligence. In particular the Department of Health has not considered defendant behaviour or waited to hear what the National Audit Office review of the NHS Litigation Authority (NHSLA) has to say. This is expected in July 2017.
- Research by Master Campbell on behalf of AvMA casts further doubt on the reliability of the Department's assumptions (see Appendix).
- The proposals have been developed without any meaningful input from patients or claimant lawyers or their organisations. Nor has there been any analysis of alternative approaches to reducing costs, which we and other stakeholders have offered to help with.
- No assessment has been undertaken of the impact of these proposals on patient safety. Our response explains why this impact would be harmful.

Threat of access to justice

- The proposals would drive accredited specialist solicitors out of clinical negligence. NHSLA and other stakeholders agree that non-specialist claimant solicitors are more likely to bring non-meritorious, but time-consuming and costly claims.
- Based on our experience since LASPO, would-be claimants are already finding it more difficult or failing to find a solicitor to represent them at all. If the proposals were to go ahead, many more 'smaller' claims would not be financially feasible for solicitors to take on.
- Even if a claimant were to find a solicitor and manage to win their claim, they would inevitably be required to pay out a significant amount from their damages to meet legal costs which currently would be met by the negligent defendant.
- The kinds of cases worst affected by these proposals are those involving children or older people; all fatal cases; and cases involving people with mental capacity issues.
- Cases of 'low value' can be just as serious and complex as a 'high value' case.

Threat to patient safety

- Many patients and their families would no longer be able to challenge healthcare providers through the legal process when there have been inappropriate denials of mistakes or liability.
- This would mean a lost opportunity for healthcare providers and the NHS to learn lessons for patient safety from cases they had wrongly defended.
- If implemented, the proposals could inadvertently encourage a 'deny and defend' culture amongst healthcare providers rather than the desired 'open and fair' culture.

An alternative approach

AvMA recommends the Department of Health should engage with the relevant stakeholders including patients and families who have had to rely on clinical negligence litigation; specialist claimant and defendant lawyers; medical experts; and patients' organisations. This group should review all the real contributors to high legal costs with the benefit of the Ministry of Justice's review of LASPO and the National Audit Office's review of the NHSLA; explore the various options which could be used to reduce avoidable costs or avoid litigation altogether, and make recommendations.

Our response to the specific consultation questions

Question 1: Introducing Fixed Recoverable Costs	Yes	No
Do you agree that Fixed Recoverable Costs for lower value clinical negligence claims should be introduced on a mandatory basis?		x

If not, what are your objections?

AvMA has commissioned an independent report from Colin Campbell (CC), a former permanent Costs Judge at the Senior Courts Costs Office (SCCO) at the Royal Courts of Justice where he continues to sit as a deputy. CC has used his experience to comment on the methodologies set out by the DH in their proposals and their assessment of the market rate. It should be noted that CC is independent of AvMA, he has experience of assessing clinical negligence work as a result of his work at the SCCO. Full details of CC's experience and credentials are set out at paragraph 2 of the report which is attached at Appendix 1 to this response; where appropriate we have quoted from that report.

We believe that the proposals are premature, ill informed, and pose a threat both to access to justice and patient safety. Below we set out some of our reasons for this.

1. The effects of the last reforms (Legal Aid, Sentencing & Punishment of Offenders Act 2012 (LASPO)) which affected the funding of clinical negligence claims are just beginning to be realised. There is still a shortage of information on the full extent of the savings made as a result of the NHS LA no longer being liable to pay 100% success fees arising on pre April 2013 Conditional Fee Agreements (CFA) as well as the cost of After the Event (ATE) insurance premiums which reflected the risk of having to cover the defendant's cost of trial in circumstances where the claimant lost their case. Undoubtedly, significant savings will be made from the existing reforms and these must be properly analysed before embarking on yet more change to this highly specialised area of law.

2. The NHS LA has recently changed its name to NHS Resolve. This became effective in April 2017, the stated primary focus is to resolve concerns fairly. The intention is to ***"keep cases out of the courts wherever possible, minimise legal costs and deliver resolution in its broadest sense, which is about more than just money"***. This focus needs time to become established and to identify whether the approach is able to deliver what is required in real terms. If NHS Resolve does fulfil its aims then it would follow that admissions of liability will be made as early in the process as possible, cases will resolve and settle sooner and without the need for litigation; the inevitable result will be that costs will fall. NHS Resolve should be allowed to demonstrate that the public funds spent on its change of approach has been effective and is not simply a rebranding exercise; fixed costs should not be necessary.

3. There is no evidence that FRC in CN claims will reduce the level of costs paid out by the NHS LA and other defendant organisations without compromising access to justice. We believe that the proposals, if implemented, would inevitably have a serious negative impact on access to justice for people harmed as a result of clinical negligence. This view was shared by the equalities advisory group convened by the Department of Health (see answer to question 11) and indeed this risk was recognised by Professor Fenn, who says in his report: ***"(claims) of lower value (eg below £25,000) which were anticipated to require litigation would be unlikely to obtain representation"*** (p21). AvMA's own consultation with specialist clinical negligence solicitors accredited by us has told us that the vast majority, if not all of them, would be unable to represent clients with such claims under any of the options put forward in these proposals.

4. Even if would-be claimants were able to obtain representation it would be unlikely to be from an accredited specialist solicitor (which the Department and NHS Litigation agree would be a retrograde step), and if they 'won' they would inevitably lose a significant amount of the damages which should go to meet the actual needs that were identified that they have. This is because the proposals effectively shunt the cost of bringing claims from the defendant organisations onto the patient/client through deductions from their damages. The deductions will be made in the following ways:

   (i) 25% success fee on general damages and past losses

   (ii) Claimant lawyers will be able to act for clients on a Conditional Fee Agreement (CFA) alongside fixed costs; this may be unavoidable if solicitors are going to be able to continue to provide representation. The CFA will entitle the lawyer to charge a commercial rate for their work. The indemnity principle means that the lawyer will have to give credit for the level of costs they receive by way of fixed fees, the shortfall between the fixed fee rate and the CFA rate will be recouped from client's damages.

   (iii) The suggestion that medico-legal reports on liability, causation and condition and prognosis can reasonably be obtained for a total fee of £1,200 is not supported by any evidence we have seen or that experts would be able or prepared to produce complex reports of this nature where their professional integrity and that of their colleagues is on the line within those financial limits. Medico-legal experts will continue to charge a commercial rate for the work they do and the client will have to pay the difference between the expert's commercial rate and the rate allowed under the FRC regime.

   (iv) Other disbursements such as court fees are very high. Currently, some claimant firms and After the Event (ATE) insurance products will cover these costs. If, as was proposed in September 2015, the ability to recover ATE premiums from Defendant organisations is lost then assuming it is still viable for insurers to offer an ATE product, the client will be liable for the cost of the premium. This is a further sum which will have to be deducted from the client's damages.

It should be noted that if ATE products cease to exist in CN claims then it raises the question of who will cover the cost of obtaining the necessary expert report and other disbursements? Firms will not be able to cover these costs due to the level of expense involved, difficulties with cash flow and the risk of non-recovery of damages and therefore, the non-recovery of the costs of investigating the claim and the associated disbursements.

The reality is that most claimants will not be able to cover the investigation costs due to the expense; it will effectively herald a return to the 1990's and the situation that was common place before the introduction of CFAs. At that time the typical scenario was that if a client could not afford the cost of the disbursements and was not eligible for legal aid, the claim could not be brought. The effect of this will be that even where

patients do have a valid claim but their award of damages is likely to be low, the award will be so severely eroded by deductions necessary for bringing the litigation that it will not be worth their while bringing a claim.

These circumstances are likely to encourage an increase in Litigants in Person (LiPs) as this will be the only way open to many claimants to seek redress. This is to be avoided, not only will most claimants be at a loss to appreciate the legal test in this complicated area of law but it will also result in the courts becoming clogged up with LiPs. This will result in increased adjournments and court time being wasted which in itself carries a considerable cost. This outcome is supported by Master Campbell who says at paragraph 7.3 of his report: ***"…That will lead either to injured parties being unable to recover compensation where something has gone wrong with their care or to an increase in the number of litigants in person who lack legal training to bring claims at proportionate expense, leading to a climate that is even more adversarial than it is now"***

5. There is no evidence that the current post LASPO system of proportionality is not working. The quoted annual cost of clinical negligence litigation in England (£1.2-1.5Billion) takes into account costs incurred on cases that were pre LASPO and therefore the NHS was responsible for paying both 100% success fees and significantly higher ATE premiums. The changes introduced in 2013 through LASPO will yield considerable savings for the NHS, these savings will only be apparent about now as it takes roughly 3 -4 years for new cases being run under a new regime to go through the new costs assessment process. A great deal of time and training has been spent on refining the cost budgeting process, this needs to be properly analysed. The costs budgeting system allows judges to look at all of the relevant issues including parties conduct and the complexity of the issue when setting the costs. This is a crucial point as value and complexity are not synonymous and the proposal for a FRC low value scheme does not address this point sufficiently.

6. Although the FRC proposals offer refinements to the pre action stage, it does not address the costs that accrue once proceedings have to be issued. The cost of issuing proceedings and following the CPR is considerable, to save costs the system itself has to change. The only way a FRC scheme could work without compromising access to justice is if the fixed costs recoverable are reasonable commercial rates and liability is admitted. We do not believe that any of the methodologies proposed or the reference to guideline hourly rates in the way the consultation proposes to use them support the likelihood of the rates being appropriate to clinical negligence work.

   Master Campbell does not accept that the time analysis proposed by the DH in their consultation document reflects either a "***case of average complexity***" (p21, para 4.4 of Consultation paper) or that the time allowed is reasonable – see paragraphs 6.10 - 7.3 of Master Campbell's report for full details and his analysis.

   Accordingly, Master Campbell's analysis and rational opinion leads us to conclude that none of the methodologies proposed by the DH, their assessment of market's rates or their understanding of what is required to run a case of average complexity is supported by the evidence and if introduced, will not result in a reasonable commercial rate or sufficient time for a clinical negligence case to be run properly. As Master Campbell points out, ***"it would be professionally irresponsible***" for lawyers to run clinical negligence cases in the way proposed as it does not allow for the input of suitably experienced lawyers. Such an approach would inevitably lead to dissatisfied clients and referrals to the Solicitors Regulatory Authority (SRA).

   In short, lawyers will not be able to run clinical negligence cases properly under these proposals and so they will have no choice but to withdraw from this work, as Master Campbell points out at paragraph 7.3 of his report: ***"It follows that if any of the options are adopted using the rates proposed in the consultation paper, firms of solicitors will cease to undertake LVCN [low value clinical negligence claims]. That will lead either to injured parties being unable to recover compensation when***

something has gone wrong with their care or to an increase in the number of litigants in person who lack legal training to bring claims at proportionate expense, leading to a climate that is more adversarial than it is now."

Clearly, the proposals will result in members of the public being unrepresented and unable to bring clinical negligence claims; the proposals, if implemented will compromise access to justice. Those lawyers that do attempt to undertake clinical negligence work under any of the methodologies or rates proposed risk a professional negligence claim being brought against them and this will only serve to bring the legal profession into disrepute.

7. There is no evidence that artificially depressing expert rates will work, capping expert fees will only compromise the quality of the reports produced. The artificial depression of medical expert rates in legal aid cases demonstrates that experts simply withdraw from the work.

8. In the course of designing these proposals, little or no account has been taken of what is probably the biggest contribution to seemingly disproportionate costs, which is defendant behaviour. This is in spite of AvMA and others repeatedly requesting the Department to do so and offering to help identify the real causes of higher costs and find ways of reducing them. Invariably in cases with very high costs, the case has initially been defended and often continued to be defended, when a better internal investigation and analysis could have led to earlier recognition of failings and admission of liability. This would save massive amounts in avoidable costs.

   Given that the level of costs recoverable under a FRC regime has not been identified, only the methodologies, we take the view that currently the only circumstance in which a FRC scheme might work is in cases where the fees allowed are commercially viable and liability has been admitted.

   Again, we refer to Master Campbell's report where at paragraph 6.12 he sets out the factors which are taken into account when considering whether the amounts payable by the NHS LA are just; the factors include conduct. Master Campbell goes to far as to say that ***"…defendant conduct where there have been late admissions of liability or settlements immediately before trial are significant issues in this context"***

9. In addition to the courts already taking proportionality and validity of applications for costs seriously as discussed above, there is already an additional safety net in the form of the NHS Litigation Authority (NHSLA). The NHSLA quite reasonably challenges costs which are believed to be unreasonable and/or disproportionate. Indeed it celebrates its success in doing so in its annual report. Quite rightly it appears that it chooses not to challenge the vast majority of cases on costs because they are reasonable and proportionate. If there are more unreasonable or disproportionate claims for costs which are not being challenged, then perhaps there is a case for increasing the capacity of the NHSLA to do so rather than imposing fixed costs, with all the unintended consequences which come with that.

10. Just as importantly as all of the above, we believe an unintended consequence of the proposals would be to damage rather than improve patient safety. In cases that have incurred what appear to be disproportionate costs it is almost always the case that these have initially been defended. It is only through the work specialist claimant lawyers and appropriate expert evidence that defendants (the NHS and other health providers) have been brought to the realisation that they have been negligent. If claimants are not able to challenge initial denials through litigation then the NHS and other healthcare providers would not learn from those cases where they have not recognised their own failings initially and vital lessons for patient safety will be lost. If defendants know that a denial of liability is likely to result in a claimant being unable to obtain representation and challenge them, another unintended consequence would be likely to be the promotion of a deny and defend culture – quite the opposite of the 'open and fair' culture which the Department would like to encourage. It is worth noting that

Professor Fenn himself acknowledges the threat to patient safety of these proposals: ***"Any major reduction in the ability of patients to identify negligence could of course have wider implications for patient safety" (p21).***

A major flaw in this consultation has been the failure to independently and impartially examine the issues that give rise to increased legal costs; conduct of the parties is a considerable issue. We have consulted with our independent medical experts, many of whom work for both claimant and defendant bodies; in 2015 we asked our data base of experts, what Claimant and Defendant behaviours delay resolution of claims? Some of the responses we received were as follows:

- ***"Failure to disclose all facts, evidence is a tactic used by D"*** – GP/midwife/plastic surgeon/
- ***"Sometimes D lawyers try to delay by defending the indefensible until almost the trial date"*** – GP/O&G/dentist/midwifery/colorectalsurgeon/paedurology/A&E/gensurgery/urologist/oncology
- ***"increasingly C lawyers are becoming v sensitive as to what goes in or is removed from a report"*** – orthopaedic/gen surgeon/vasc surgeon/
- ***"D very slow to instruct experts so claims run on…"*** respiratory medicine/A&E/

It should be noted that the sentiments expressed in the quotes were echoed by a number of different experts; we have identified where this has occurred by referring to the range of specialists who have mirrored these concerns. It is important to note that the medical experts' experience corroborates that of Master Campbell who also refers to the late incidence of admission of liability or settlement.

The statutory duty of candour was only introduced into the NHS in November 2014. As expected it takes time for NHS staff to be trained in this duty and how and when it applies. The duty is only just beginning to become established and with improved openness and honesty, patients should in the future be receiving the information they need at a much earlier stage. Providing that information is being given to patients in the way expected, this should result in increased opportunities for earlier resolution of appropriate claims, thereby reducing costs. There should be proper analysis and consideration of how the duty of candour is operating before considering introducing further changes.

AvMA urges that a working party of stakeholders is put together to consider the issue of what factors give rise to the increase in costs in clinical negligence claims and come up with appropriate solutions / alternatives. Some of the costs are incidental to the litigation process such as medical expert fees - these are necessary for a claimant to prove their claim; the cost of issuing proceedings in court and taking out applications as well as VAT are all costs which are outside the control of the claimant and are therefore irreducible.

The symptom of high costs can only be properly addressed once the cause or causes has been established. A working party could identify what causes costs to increase and then look at the most effective way of resolving those causes. A working party could usefully draw on some of the alternatives already in existence or previously explored, such as an improved version of the Welsh NHS Redress scheme ('Putting Things Right'), provided for in the NHS Redress Act applying to both England and Wales but not implemented in England; revisiting the NHS LA clinical negligence pilot scheme discussed in 2011; reintroducing legal aid for clinical negligence claims and other options. We suggest that central to any new approach should be improvement to the way incidents are investigated; liability recognised and admitted early; and the information used to improve patient safety.

If you prefer a voluntary scheme instead, please explain how this would fulfil the same policy objectives as a mandatory scheme.

A voluntary scheme may be more feasible in circumstances where it is in both parties' interests to enter into the scheme freely. This will require that there are sufficient safeguards against poor conduct and that the fixed rates being offered are commercially viable. A voluntary approach will demonstrate a willingness by both parties to positively enter into discussions to identify the issues and award compensation without the need to involve the court process.

One of the strengths of the current proposal is the increased emphasis on the pre action stage; however there are considerable missed opportunities even with this. AvMA takes the view that there should be no need for most cases to be litigated if the defence organisations investigate the issues in a robust and independent manner – the statutory duty of candour requires that this should be happening. The investigation should take place at the earliest opportunity, invite the patient's views and be open and honest. There are usually two opportunities for this to happen: the serious incident report stage and then at the complaint stage. A common failing with the current system is that insufficient penalties are imposed on defendants where they fail to investigate properly; the result is that patients/claimants have no choice but to litigate. This needs to be addressed; if it were adequately dealt with it would act as a deterrent to any party operating a delay tactic. If conduct is addressed then parties will be more willing to enter into the FRC forum in return for a quick but fair resolution of claims and issues.

Question 2: Fixed Recoverable Costs Ranges

Do you agree that Fixed Recoverable Costs should apply in clinical negligence claims: We refer to the reasons why we consider these proposals inappropriate and premature in our response to question 1 above.	**Yes**	**No** **x**
Option A: above £1,000 and below £25,000 (preferred) **There is no evidence that FRC are necessary or that they will not severely compromise access to justice.**		**x**
Option B: Another proposal We have already stated that we support the formation of a working party to explore the factors giving rise to increased costs in clinical negligence claims and to look particularly at the issue of conduct. There needs to be greater understanding of why opportunities to resolve claims at the earliest stage are being missed. It stands to reason that if claims are resolved early on, it avoids the need for proceedings to be issued. Once proceedings are issued, the costs increase as parties need to comply with the Civil Procedure Rules (CPR). Early resolution will be possible when healthcare providers are better able to identify patient safety incidents, address them, share the changes made in the wake of recognising those failings and improve the system. Identifying the failings at the earliest opportunity maximises the chances of patient safety issues being addressed as soon as possible, thereby reducing the risks and failings perpetuating themselves. By reducing the number of incidents the incidence of negligence will fall, costs will also fall as there will be fewer claims and a reduced need to pay damages for negligent treatment – this is the most effective way to prevent claims and costs being incurred. Key to enabling claims to be avoided altogether or being resolved at the earliest stage and thereby reducing costs is to ensure that good quality, independent specialist advice and support is available to patients/families. We recommend that such a service be commissioned from suitable providers. Whilst such a service would link with providers of the independent NHS complaints advocacy services, it would need to be separate and much more specialist in working with people who have been harmed by lapses in patient safety. This is vital if patients/families are to be empowered in investigations and have access to advice to enable them to ask the right questions and to challenge inadequate explanations. Patients need to be recognised as the frontline monitors of our healthcare services and that if properly supported, can make a significant contribution to improving safety. It is our experience that patients often instinctively know that something has gone wrong with their treatment but they often lack the confidence and or ability to	**X**	

effectively express their concerns. Having access to specialist advice will help ensure that the relevant issues are identified and any failures in care brought to the attention of healthcare providers. This in turn will ensure that patients/families get a full and detailed explanation as well as allowing healthcare providers to take corrective action at an early stage.

An effective early investigation should also mean that any claims that are subsequently brought can then be quickly resolved.

In addition to providing specialist support, AvMA believes there are compelling reasons why the role of the Parliamentary Health Service Ombudsman (PHSO) should be extended to review an increased number of hospital complaints. The PHSO represents the second tier in the NHS complaints process however they also offer an independent and comparatively impartial view of the circumstances surrounding the complaint; often this is enough for members of the public to feel that their concerns have been taken seriously. It also offers an opportunity to identify failings that have been missed by the trust in their first response to a complaint. The PHSO is very familiar with the need to instruct independent experts and they already provide a type of quasi neutral evaluation service in that they can recommend that a trust pays the patient an award for a service failure.

There have been numerous independent reports criticising the quality of the NHS complaints process and in particular the fact that "***the current NHS processes for investigating and learning from untoward clinical incidents are complicated, take far too long and are preoccupied with blame or avoiding financial liability***" (Public Administration Select Committee 27.03.15).

On 13.12.16 the CQC published a report about the quality of NHS investigations into patient deaths and their failure to learn from deaths so action can be taken to improve care. The CQC review found that there was no consistent national framework in place to support the NHS in identifying whether the death was as a result of poor care. It noted that this resulted in lost opportunities for families to be involved in the investigations and families being left without clear answers as well as a failure for the trusts to take preventative action to prevent the same mistakes from happening again. This is very relevant, fatal accident cases that do not involve a dependency or nervous shock claim tend to be valued at less than £25,000; consequently getting this right will mean that this tranche of cases will have improved investigation and hopefully earlier resolution.

Quite clearly, trusts need to take their responsibilities to investigate incidents and/or complaints properly, there needs to be more training for staff on how to analyse the facts of the complaint, how to be objective, probative of the key issues and unafraid to challenge their own processes and staff to ensure that the conclusions reached are impartial, thorough and robust.

The opportunity to resolve potential claims early on is the key to cutting legal costs, particularly in lower value claims or even avoiding such claims altogether. However, this stage will continue to be ignored until such time as healthcare providers are able to demonstrate that they have mastered this skill. It has long been recognised that not enough emphasis is placed on the complaints and early incident investigation process and that there are real failings with these processes, despite this, little or nothing has been done to address this. AvMA considers that if suitable and sufficient incentives were in place there would be greater impetus and focus on this early stage. A powerful incentive might be a cost penalty for failing to carry out a proper investigation at the outset. Although the current pre action protocol (PAP) does state that the court may impose

sanctions for failing to comply with the current PAP, in practice it does not appear to routinely enforce this and this needs to be addressed. Again, this may be an area that a working party could look into in more detail.		

Please explain why

For the reasons stated above in the response to question 1, a FRC regime would only be appropriate for cases where liability was admitted. This is because those cases will be highly likely to succeed, the main issue being quantum. More generally, greater emphasis needs to be put on early resolution and this means a willingness to impose financial penalties for failing to operate a robust and independent system of investigation into incidents and complaints so they can be resolved without the need for recourse to the courts. Until penalties for poor conduct are introduced the system requires the claimant to prove their case and this is inescapably expensive.

Where the early opportunities to resolve claims are missed then the only alternative is for a claimant to revert to issuing proceedings, that is the case even under the current DH proposals. Once proceedings are issued the cost of litigation increases as the CPR need to be followed and there is an irreducible cost in this. The only real way to avoid this in low value claims is to change the litigation process by ensuring the earlier investigative stage is effective and can offer resolution.

The current proposals fail to acknowledge or encourage the use of experienced solicitors with expertise in this very specific area of law. An experienced and expert lawyer practising in clinical negligence can be identified by the fact they are accredited – The AvMA Panel accreditation was the first scheme of this kind and is the most established.

There are fundamental differences between personal injury claims and medical negligence claims, not least the fact that liability in clinical negligence is far from clear at the outset and relies on independent expert evidence. By contrast personal injury claims can often identify liability at an early stage by reference to existing statutes for example, Road Traffic Act, Occupiers Liability Act and so forth. Whilst there are similarities between personal injury work and clinical negligence work there are very significant differences which mean they cannot be treated in the same way. The NHS LA has previously identified the detrimental effect of having non-specialist lawyers enter the clinical negligence market place; they also see the importance of claimants having access to high quality legal representation. It is therefore crucial that the value that accredited lawyers bring is recognised and that their level of expertise is encouraged. There may also be merit in having a reciprocal accreditation scheme for defendant lawyers including those working as case handlers in the NHS LA. This will ensure that the skills required to handle clinical negligence cases exist and this will help encourage early resolution of cases.

The suggestion that there should be reciprocal claimant and defendant accreditation schemes could be explored in more detail if the suggestion of a working party were to be adopted.

Question 3: Implementation	Yes	No
Which option for implementation do you agree with:		
Option 1: all cases in which the letter of claim is sent on or after the proposed implementation date.		x
Option 2: all adverse incidents after the date of implementation.		x
Another proposal From the date the client first seeks legal advice.	x	

Please Explain Why

Part of the impetus for introducing a FRC scheme is to ensure that all parties know their likely liability to costs at the outset. If any FRC scheme is introduced at the time the letter of claim is sent then those clients who sought legal advice prior to the introduction of any new scheme will be disadvantaged by the change in costs recovery. Potentially clients may discover that a larger deduction from their damages will be made to make up the difference between the solicitor's contractual rate as set out on the CFA and the rate allowed under the FRC recovery. This may be a considerable difference, depending on what rates are introduced to any FRC scheme.

It is important that the system is fair to claimants; they are entitled to expect to be properly advised at the outset as to what their potential liability to costs will be. At the moment, any client seeking legal advice can only be told that there is a risk that the costs regime will change and if it does change, there is currently no way of telling what impact the change will have on the client's liability for costs and the deductions that may ultimately be made from damages. This puts those clients in a worse position than they would have been if FRC regime had not been introduced; it would be unfair and unjust. It would also create unnecessary conflict between the solicitor and the client and potentially give rise to an increase in the number of complaints being made.

Given that clinical negligence clients feel let down by one profession, every effort should be made to ensure that they do not then feel let down by another profession

Introducing Fixed Recoverable Costs in Lower Value Clinical Negligence Claims

Question 4: Fixed Recoverable Costs Rates		
Looking at the approach (not the level of fixed recoverable costs), do you prefer:	**Yes**	**No**
Please note that we do not agree with the rationale for the fixed costs proposals as they stand at all. The following comments are made in case the Department decides to press ahead with imposing these proposals against the advice of ourselves and other specialist stakeholders**.** We have no objection in principle to FRC or a staged flat fee proposal provided the fees offered are considered to be commercially viable enough that experienced clinical negligence		

lawyers are incentivised to undertake and or supervise the work and / or liability is admitted. Equally, it is important that the Claimant can retain the majority of their damages so that it remains viable for them to seek redress and access to justice. **Option 1: Staged Flat Fee Arrangement** We believe that the fees awarded should be high enough to encourage accredited lawyers to do this work; this is in the defendant's interests as well as the public's interest, the latter need to have their cases properly investigated and their expectations managed sensitively and sensibly. The former need to know that only cases with prima facie merits are being brought and that they have been properly risk assessed. The weakness with this model is that the basis of assessing the rate of remuneration is too low and not flexible enough to take into account relevant factors and the time allowed to undertake litigation tasks is woefully inadequate and will only expose lawyers working on this scheme to negligence claims. Consequently, there is no incentive for claimant lawyers to undertake this work, let alone ensure that injured patients are properly compensated. This view is supported by Master Campbell's where he says at paragraph 6.23 and 6.24 of his report: ***"…the DH recognises that lawyers will be deterred from taking on low value clinical negligence cases if remuneration is inadequate….[6.24]…it is my view that any implementation of option 1 will do just that"***		
Option 2: Staged Flat Fee Arrangement plus % of damages awarded: do you agree with the percentage of damages? We refer to the comments made in relation to option 1 above. We note that Master Campbell shares the view that Option 2 would not make any difference to lawyers; he considers that "the base figure is too low as the starting point" and the time allowed is insufficient – see paragraph 6.25 of Master Campbell's report.		
Option 3: Early Admission of Liability Arrangement: do you agree with the percentage of damages for early resolution? Under this proposal the D will get a reduction on C's costs regardless of when they admit liability, there is no incentive in this method for D to admit any earlier than is necessary. Under the proposals if the D admits liability in the pre issue stage the C will lose 10% of the fixed fee; C will lose 15% of their fixed fee if D admits liability at the post issue/ pre allocation stage. Given that C has no control over when D admits liability and given that the model suggests that D will be entitled to a reduction in C's fixed costs regardless of when the admission occurs there is no incentive for D to admit at all and no power for C to compel or encourage D to admit. The incentive is wrongly weighted; D should be admitting liability at the earliest opportunity. If the D has not properly investigated at the earliest opportunity then D should be liable to pay punitive costs. It would make more sense if the C were to receive a 10% increase in their fixed fee if the D choses to wait until pre issue stage to admit when they could and arguably should have done this at the complaint or SIR stage. This view is shared by Master Campbell who at paragraph 6.26 of his report says: ***"An outcome that pays a solicitor's firm less rather than more for its services, as envisaged in option 3 would not have any attraction either…"***		**x**
Option 4: Cost Analysis Approach: do you agree with the percentage of damages and/or the percentage for early resolution? We understand that the proposal for this option is based on the mean relationship between current costs and damages. Again this information is based on data provided by costs lawyers acting on behalf of the NHS LA. We repeat our previous concerns about the accuracy of this data and in particular the fact that it is unlikely that there is sufficient relevant post LASPO data available at this stage to enable any proper analysis of the mean relationship.		

This model also presumes that the introduction of FRC along these lines will result in further assumed efficiency savings and that costs could then be further decreased in line with those savings. Given the paucity of relevant data we are sceptical this model is workable in practice and to suggest that it will result in efficiency savings strikes us as being based on hypothetical assumptions rather than any hard, factual evidence. We refer to Master Campbell's report where at paragraph 6.27 he says: ***"There is insufficient material in the consultation paper to permit reasoned comment to be passed on option 4"***		
Option 5: Another Proposal		

Please explain why

There are some fundamental flaws running through options 1 – 3 inclusive, all of which are based on a time analysis approach. The first flaw is due to the way the time estimates have been arrived at. Details of how these time estimates have been arrived at are set out at Annex E (Data Pack) of the consultation. Section 1 of the Data Pack, states that the data used has been derived from all categories of clinical negligence operated by the NHS LA. This includes the existing liabilities scheme (ELS): This scheme cover clinical claims against the NHS where the incident took place before 1995; the ex – RHAs (EX-RHA) scheme which covers claims made against the former Regional Health Authorities (these were abolished in 1996) and the DH Clinical Liabilities scheme (DH-CL).

Information technology has made considerable advances and is now incorporated as a key part of any modern business, the older the case, the less likely the time estimates are going to be a true reflection of current day practice. Consequently, there is a very real risk that the data referred to include cases dealt with long before Legal Aid Sentencing & Punishment of Offenders Act 2012 (LASPO) was introduced and will include data that is no longer relevant. As such, the estimates identified do not provide an accurate assessment of the time being taken in current practice.

Further, the consultation advises that the time analysis was undertaken by a group of three solicitors, all allegedly with both claimant and defendant clinical negligence experience. The analysis was led by Adrian Jaggard; we understand that he runs a legal costs consultancy which maintains a data base of personal injury claims. However, according to the information set out in the CJC costs committee report of May 2014 this data does not include hours actually billed by firms (paragraph 4.10). It is not clear whether the data includes information relevant to clinical negligence claims or whether it is just personal injury. Adrian Jaggard is also understood to be managing director at a firm called Taylor Rose TTKW, the firm does not appear to deal with clinical negligence litigation. We have not identified the other two solicitors in the group and so the extent of their experience and expertise in clinical negligence litigation cannot be verified.

Lack of relevant information: It has proved very difficult for claimant firms to organise themselves to collect relevant post LASPO data; we understand that there is a paucity of this information currently available and this in itself suggests that the FRC proposals are premature. It is essential that the DH can consider evidence which truly reflects the current market place and time taken to complete tasks.

AvMA believes that to obtain a true picture of the current market costs the government should only look at post LASPO cases. The costs associated with these cases represents the climate which lawyers are currently operating in and how information technology has

progressed and been incorporated into everyday working life. Reference to pre LASPO cases will only skew the data on issues such as the time currently being spent on cases and market costs.

AvMA is concerned that the time allowed does not reflect the time actually required to properly assess claims. For example, the estimates identified in Annex E, Table 4F envisages that both GP and Hospital records will be reviewed by a grade C fee earner in 30 minutes. The Guideline Hourly Rates envisages a grade C fee earner as someone with less than 4 years post qualification experience. We have similar concerns in relation to the amount of time allowed for instructing a medical expert - 30 minutes has been allowed for this task to include summarising the facts and drafting questions on breach and causation. We would expect that a task such as this would typically include researching the condition, a review of the medical literature and text books such as Powers and Harris. We note that 20 minutes has been allowed to review a ten page expert report.

We refer to paragraph 6.21 of Master Campbell's report where he has analysed the time allowed for key tasks. It should be noted that where the DH has allowed 30 minutes for discussing the claim, Master Campbell says that "***It would be rare for the initial taking of instructions in a clinical negligence case to take under 2 to 3 hours. In other cases it would be more if, as often is the case, the client is under a disability, elderly, distressed or whose first language is not English"***

In relation to drafting a letter of claim, where the DH has allowed 40 minutes, Master Campbell opines that the details that are required for a Letter of Claim as set out in the Pre-action Protocol for the Resolution of Clinical Disputes could not be done professionally or in the client's best interests if it were undertaken in 40 minutes. Likewise, with the time proposed by the DH to review an expert's report; Master Campbell says that this would not allow a solicitor to ***"discharge his or their duty to his client without risking a claim in negligence were only 10 minutes to be spent on such an important task"***

Master Campbell also makes it clear that not only are the time estimates allowed inadequate and certainly do not reflect time required for a case of average complexity but it also undercharges the rates which would be recoverable on assessment as a minimum, at paragraph 6.15, he makes clear that in his opinion ***"…the analysis has not been prepared in a way which complies with the Rules of Court"***

At paragraph 6.16 Master Campbell says that the suggestion that a grade A fee earner would only be involved for 50 minutes is ***"unrealistic and inadequate even in a claim at the bottom end of a LVCN [low value clinical negligence] claim, which this case appears to be, and all the more so in a case of average complexity, as the consultation has suggested that it is".*** At paragraph 6.17 he continues: ***"It would be professionally irresponsible and potentially a matter a dissatisfied client might refer to the SRA were the grade A to be involved in such a case for just the 50 minutes suggested"***

We are mindful of the fact that if expert fees are to be capped then considerable skill and experience will be required to identify the relevant documents to be included in the instructions to the expert. This is not a job for junior staff alone and will require proper supervision from accredited and therefore experienced lawyers.

AvMA also notes that no credit has been given for the time taken by experienced clinical negligence lawyers in screening cases. It is in the interests of both the client and the NHS and defendant bodies that cases are properly screened to ensure that unmeritorious cases are weeded out at the earliest stage. The value of this process needs to be recognised and

rewarded; clearly this is a cost to claimant clinical negligence lawyers, it also costs the NHS and defendant organisations money to investigate unmeritorious claims.
AvMA notes that the consultation attempts to link the current market costs to the Guideline Hourly Rates (GHR). Again, we have concerns that this does not reflect the true status quo. First, the GHR is no more than a starting point for the assessment of summary costs; courts are not obliged to impose the limits set out. Secondly, the GHR has not been updated since April 2010, there have long been questions over the validity of these rates. Despite the CJC Cost Committee's best attempts to review these rates (culminating in their report to the Master of the Rolls dated May 2014) their recommendations were rejected due to concerns that the evidence relied upon was not sufficiently robust. Page 41 of the CJC report set out recommendations for a new hourly rate (Table 1), those recommendations included significant increases in some areas and reductions in others.

It is also relevant to note that at paragraph 6.6.3 of the report there was discussion about whether clinical negligence cases warranted their own GHR rate ***"due to the complexity, such as the lengthy preparatory process involving many hours of risk assessment and expert evidence"***. The committee concluded that the versatile nature of the GHR would enable each clinical negligence case to be assessed according to its own complex issues. The models proposed by the DH do not allow for any such versatility; we have some doubts over whether the GHR can properly reflect the market rate.

We draw your attention to Master Campbell's report where at paragraph 6.21 he says: ***"Whilst the tasks in question are broadly all those which are justifiably included in bills, the amount of time for undertaking them is unrealistic and inadequate…"***

At paragraph 5 of Master Campbell's report he sets out helpful background information on the GHR and in particular, paragraph 5.5 where he explains that the reason for leaving the GHR unchanged in 2014 was that Lord Dyson (then Master of Rolls) was concerned that ***"…the evidence on which its recommendations …[were] based is not a sufficiently strong foundation in which to adopt the rates proposed"*** he went on to say ***"It is imperative that sound and reliable evidence is obtained"***. Master Campbell makes the point that the inference is that ***"no such sound and reliable evidence is yet available in respect of the costs of running clinical negligence cases following the implementation of LASPO on 1 April 2013".*** If that is correct for GHR, it must follow that there is also insufficient evidence for the DH to draw any conclusions of the effect of LASPO changes in clinical negligence. This supports our own view that these proposals are premature and will only serve to prevent access to justice.

Question 5: Expert Witness Costs	**Yes**	**No**
Do you believe that there should be a maximum cap of £1,200 applied to recoverable expert fees for both defendant and claimant lawyers		X

Please explain why
In recent years AvMA has routinely engaged with the experts on the data base. We have found that the most effective way of doing this is to invite them to complete a questionnaire. In response to the DH's pre consultation proposals in 2015, our 2015/16 expert questionnaire focused on the medical professions reaction and response to the suggestion that their fees should be capped. The responses have

been captured in the following table – the responses relate to liability and causation experts only:

Questions Asked 2015	Yes	No	Don't know
Are you aware of FRC proposals?	46%	38%	16%
Are you aware of the proposal to cap expert fees?	44%	29%	27%
Would you reconsider your rate if a cap was introduced?	35%	45%	20%
Would you reduce your rate if it resulted in a deduction from client damages?	31.5%	50.5%	18%

In response to the question, "will a cap on expert's fees cause you to rethink your hourly rate?" some of the experts offered additional comments, these are set out below. Please note that these comments reflect the views of many experts who responded.

"I would think twice if the fee were significantly reduced"
"***it may not be cost effective to continue working"***
"I will only accept my hourly rate"
"I would have to see what the cap was set at"
"I don't think [this has] been adequately thought through"
"it is utterly unjust as those patients who have received poor care need redress…Why should justice be for the rich only"
"a lot of consultants will give up this type of work if their fees are severely capped. I certainly will"

In response to the question we posed - Do you think it is possible to fix a fee in cases less than £25,000 the response was as follows:-

Expert Response	How they answered	Comment
Yes	32%	The "yes" say with limited amounts of medical records and documentation
No	37%	The "No" say complexity has nothing to do with the value of the claim
Don't Know	31%	"The "don't knows" say they don't know how they could make this work

AvMA's meeting with the BMA and Expert Witness Institute (EWI)

In November 2015 AvMA met separately with both the BMA and the EWI to explore if there was any scope for influencing the cost of medical expert fees. Our invitation to the BMA and EWI was on the basis that we wanted to discuss the proposals on fixed fees

and capping of expert fees in clinical negligence claims. Specifically we wanted to know if there was any scope for discussing and identifying what a reasonable hourly rate or reasonable fixed fee for a medico-legal report might be and to open up dialogue between ourselves and the medical profession on this issue.
The BMA took the view that they could not get involved in identifying what a reasonable rate was, in their view this was down to market forces; a reasonable rate was whatever the market could bear.

The EWI's view was that you get what you pay for, if you pay £180 for a report, you will get £180 worth of work and the report will reflect that.

Both the BMA and the EWI's views resonate with the comments made by our experts in their questionnaires. Accordingly we do not support a maximum cap on expert fees; these are market forces that are outside the control of the claimant or claimant lawyer. Although the NHS LA maintain that they negotiate a rate with their experts, they are in a stronger bargaining position than claimant lawyers who are distinct commercial entities that compete against each other. To enforce a cap will only artificially depress the expert market, an example of this can be seen in the way the Legal Aid Agency artificially and unilaterally depressed expert fees in neurological injury claims; this has resulted in many experts refusing to do legal aid work. Imposing a cap will only force the cost of the report onto the claimant. It must be acknowledged that if the NHS LA are able to instruct medical experts at discounted rates as they say they do, and claimant solicitors are not then this in itself creates an inequality of arms. It will have the effect of the NHS LA having access to the best and most appropriate experts, while these will be out of the reach of the ordinary claimant.

In response to the suggestion that Defendant organisations should be subject to the same cap on expert fees we would comment that the defendants, especially the NHS LA will always be in a stronger position owing to their ability to provide the expert with bulk referrals. Additionally, given the way that QOCS operates it is difficult to see how and who will police whether the defendant organisations actually complied with the cap. In any event the claimant expert has more work to do in identifying the case by going through all of the medical records and relevant papers. By contrast the defendant expert need only respond to what is a focused report prepared by a claimant expert who has pared down the papers to the key documents and issues. The claimant medical expert will always therefore have more work to do than the defendant expert and this should be reflected in his or her remuneration.

Expert fees are high however this is something that a working party could look at in more detail to see if there are any effective ways of resolving this.

Question 6: Single Joint Expert	**Yes**	**No**
Expert fees could be reduced and the parties assisted in establishing an agreed position on liability by the instruction of single joint experts on breach of duty, causation, condition and prognosis or all three. Should there be a presumption of a single joint expert and, if so, how would this operate?		**x**
Please explain why We do not agree that there should be a presumption of a single joint expert on liability, causation and or condition and prognosis. The consultation paper suggests that a single		

joint expert (SJE) could provide an opinion at an early stage in "broad terms" but it is difficult to see how this would work in practice. By way of background, AvMA has an expert data base of in excess of 800 medico legal and quantum related experts. We require experts to be fair, balanced and objective and we don't approve of experts who see themselves as pro claimant or defendant; we want robust, impartial views to be offered following careful consideration of the records. We are very mindful that an expert's duty is to the court, not to whichever party pays him or her. However, a key problem with SJE 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 lawyer. 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 a SJE will not be able to attend conference with only one party's legal representatives being present – both will need to be there and this will create a number of potential difficulties with the client's legal privilege. In practical terms, there is a very real risk that a 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 a SJE will mean that the parties will not see the full range of opinion available on the issue/s in question. This is a very important consideration particularly given that the consultation intends that the opinion be given at an early stage, it may be that not all of the relevant papers are available or have been disclosed at an early stage. Additionally, if expert fee capping is introduced then the parties will also have to be selective about the papers that are forwarded to the expert for consideration – the expert will not have access to all of the papers as they do now. The fact that the SJE report is expected to be in general terms means that it is inappropriate for the purposes of full litigation and therefore inappropriate that the opinion of the SJE in those circumstances should identify whether the case can progress or not. A SJE report may be useful in cases where the expert is chosen from a list approved by both C and D lawyers, however this should be on the understanding that any concerns identified are treated as no more than an **indication** of how the case is likely to pan out – more along the lines of initial, neutral evaluation, rather than a deciding factor. That being the case, the SJE report would have little weight although it may help to narrow the issues, in light of that it is difficult to see that the cost of a SJE could be justified in these circumstances. It may be that a SJE report, could be used as impetus to elicit offers of settlement and in support of an early Pt 36 offer. Overall, if the purpose of the SJE report is to identify the key issues, as opposed to being used as a tool to resolve the claim then it may be of some use, but its limitations must be acknowledged. Further down the line, the use of SJE may give rise to objections to the nominated expert being instructed and subsequent impasse.		

Question 7: Early Exchange of Evidence	Yes	No
Do you agree with the concept of an early exchange of evidence?		**x**
If no, do you have any other ideas to encourage parties to come to an early conclusion about breach of duty and causation? AvMA believes that a thorough, robust and impartial implementation of serious incident report writing and complaint handling at the earliest opportunity including early disclosure of relevant documents would make a significant difference to identifying the core issues and speed up the process early on. As indicated previously, to help achieve this, patients need access to specialist advice to enable them to more effectively present their concerns and to challenge inadequate responses. A more effective investigation of patient safety incidents is likely to result in: (i) The core issues being more readily and earlier in the process (it should be noted that this will be contingent on the early and prompt disclosure of all relevant documents such as medical records, SIR etc.) . (ii) More focused complaints, where the complainant is able to set out the issues succinctly and coherently and the hospital is able to respond to them. (iii) Families and or patients being put at the centre of the reporting and investigative process (iv) Better quality investigations where the principles of the statutory duty of candour are observed and weaknesses provided by care givers are identified early on. (v) That the letters of response are equally focused, forthright and provide the patient/their families with the answers they are looking for. (vi) Greater involvement of patients and or their families in the investigations (vii) That both sides are able to identify at the earliest opportunity what the other is seeking to achieve by way of outcome		
Please Explain Why We can see that early exchange of expert evidence is likely to give rise to increased opportunities to settle early on. However, we need to be clear about the type of report that is being exchanged and how that exchange takes place. If the report is no more than a desk type report, obtained at limited cost then the report will reflect that, for example, if you pay £180 for a report, you will get £180 worth of work. The value of the claim does not reflect the complexity of the issues; any early reports must be thorough enough to consider the issues properly. Early exchange of expert reports raises concerns about what status those reports have, particularly if the claim is not resolved. If a claim does not settle in the pre-action protocol stage then it is highly likely that proceedings will then be issued; if that situation arises, how will those earlier expert reports be treated?		

AvMA are mindful of the proposed cap on expert fees, suggested at £1,200 for all reports including, liability, causation and condition and prognosis. In 2015 we asked our data base of experts whether they thought it was possible to provide these type of reports for a fixed fee – about one-third of our experts responded to our survey. When asked whether the expert would reconsider their rate in light of a cap, 45% said no and 20% said it would depend on the rate (at the time this survey was done the DH had not announced the level of the cap on experts fees). The majority 50.5% said they would not change their rate.

We refer to our comments and data from AvMA experts set out in response to your question 5, above.

We strongly oppose the suggestion that exchange should be sequential; any exchange of expert evidence should be simultaneous. Simultaneous exchange could occur after service of the Letter of Response but before issue of proceedings. This would ensure that the proposed defendant does not focus on responding to the proposed claimant's expert report but instead uses the opportunity to fully consider the contents of the Letter of Claim and take a robust and independent look at the treatment provided and form their own views on the standard of the treatment provided.

Question 8: Draft Protocol and Rules

Do you agree with the proposals in relation to	**Yes**	**No**
Trial Costs (paragraph 5.6) We agree that the trial costs should be paid in addition to any final stage fixed costs, however for the reasons referred to above we have concerns about the use of the Guideline Hourly Rates. The rates must be commercially viable for experienced lawyers. We would have thought that trial costs should be incurred once the brief has been sent to counsel. Briefs should only be sent once it becomes clear that the case is not likely to settle. If the case settles after the brief is delivered but before the trial has begun then counsel should be entitled to a fee for the work done; counsel needs to prepare for trial and it is not reasonable to suggest that this should and could be left to the last minute. Similarly, solicitors' costs for attending trial should be triggered at the point when the brief is prepared. Again, it is not feasible to suggest that the brief be delivered at the last minute. We have repeatedly made the point that a low value clinical negligence claim may still be a complex claim. The fact a case is going to trial is an indication that the issues are complex and this needs to be reflected in the cost recovery. If the D believes the case should not go to trial then it is always open to them to put in a properly calculated Part 36 offer which will protect them from not recovering their costs in the event the C loses at trial. It does in fact act as a further incentive and opportunity for		

settlement. If there is any argument as to the reasonableness or otherwise of solicitors instructing counsel when they did then it can be raised by the D at summary assessment stage. The rates set out at Table 8 appear very low to us however if accredited claimant lawyers indicate to the DH that they consider the rates to be commercially viable for them and counsel then we will defer to that view; AvMA's priority is to ensure that high quality specialist representation is available to claimants so they are able to enforce their rights of redress where necessary.		
Multiple Claimants The intention that FRC should apply to each potential claimant instructing the same legal representative does not appear to be controversial. However, we suggest that if the issues appear to give rise to a multiparty action that it should be open to the claimant lawyer to make an application for the case to come out of the FRC regime if they think this is appropriate. The costs of that application should be recoverable.		
Exit points We understand that the DH does not intend to define the "exceptional circumstances" which would result in recovery of costs greater than the sums allowed under FRC. It has been explained to us that the rationale behind this is to leave it open to the court to define exceptional circumstances. We think this is unhelpful and risks either costs being wasted on satellite litigation or the lack of definition making the extension of the fees allowed almost impossible to secure. The DH should say what it means, there is no reason why there cannot be greater clarity over the intention behind "exceptional circumstances", and failure to do so will risk the courts being overwhelmed by applications seeking an increase in costs. It will also result in the claimant bearing the costs which will no doubt be a further deduction from their damages. As we have explained, we think that fixed costs arrangement of the type described in the consultation might only work when liability had already been admitted. Furthermore there should be exit points in the event that the defendant does not adhere to the pre action protocol, or if the defendant refuses an offer to take part in mediation.		
Technical Exemptions (paragraph 6.9) We consider that the exemptions need to be broadened to include all protected parties, (those with mental capacity issues), and all fatal cases including stillbirths - not just children. These cases are of great personal and often public interest significance. Whilst often of low monetary value, these cases are usually complex and time consuming. Applying fixed costs to them would mean that these serious cases would be unlikely to be feasible for claimant solicitors to represent claimants in these serious cases.		
Where the number of experts reasonably required by both sides on issues of breach and causation exceeds a total of two per party. (paragraph 6.11) The consultation says that "the average number of expert reports in lower value claims is two…often the same expert". It is not clear how the DH assessed this however, AvMA has referred to its own experience of this by looking at the case reports submitted in		

support of reaccreditation for the AvMA panel – note, applicants need to be reaccredited every 5 years, part of this process requires the applicant to submit 5 reports from cases that have settled in the preceding 18 months. As part of this exercise, AvMA reviewed a total of 133 case reports, however only 9 of those cases related to claims valued at less than £25,000. This is indicative of the fact that more senior accredited solicitors are less likely to do lower value claims. 6 out of those 9 cases settled using a maximum of two experts. More generally 31 out of the 133 cases settled with a maximum of two experts, of those cases the highest settlement value was £1.5 million. It is difficult to derive any firm conclusions from this data but broadly we would suggest that a maximum of two experts for cases under £25,000 is likely to be a reasonable starting point.		
Child Fatalities (paragraph 6.12) **The consultation document is not clear as to whether stillbirths are included in their definition of child fatalities. We believe that it is vital that stillbirths are excluded from the fixed costs arrangements.** As stated above we also believe <u>all fatal incidents should be excluded from the fixed costs arrangements, if they go ahead.</u>. Fatal accidents are by their nature the most serious outcome particularly where they arise as a result of substandard medical practice. There is no logic in hiving off child fatalities alone. Further, the additional involvement of the coroner in such cases means that further opportunities to settle claims as well as patient safety lessons should be apparent after the coroner's investigation. The inquest process is a further complicating factor and is another reason why fatal cases should be excluded. There are many occasions when families need to be represented at inquest, there is a cost associated with this which a fixed recoverable costs regime cannot adequately address. By comparison the existing system is better able to adapt to ensure cost recovery in appropriate cases. Imposition of the fixed costs proposals as they currently stand would mean that many families who have lost loved ones as a result of lapses in patient safety would face coroners' inquests without representation, whilst the NHS and other healthcare providers spend a fortune on legal representation at inquests.		
Interim Applications There should be scope for interim applications to be made and the costs of those applications to be recoverable. The consultation accepts that the majority of clinical negligence applications will be referred to the multitrack as opposed to the fast track. That being the case, the standard directions used by designated clinical negligence Masters in the high court and which are commonly followed by the county court will be a starting point. It is common place for those directions to be varied and for parties to have to take out applications to vary the initial direction at later stages, for example, where an expert, despite their initial representation is unable to provide a report on time. Applications to extend time for service of the claim form and accompanying documents should also be recoverable; failure to allow these costs will result in firms refusing to consider complex, clinical negligence cases that are referred to them close to the		

limitation period. In our experience, it is not unusual to find that an injured party has no understanding of the limitation period and will often seek legal advice and or proceedings as a last resort; this can mean the claim is only considered close to expiry of the limitation period. However, this fact alone does not mean the potential claim is any less valid and interim applications of this type should not be seen as a high bar and act as a disincentive for valid claims to be investigated. We refer to paragraph 6.22 of Master Campbell's report where he comments ***"…Indeed, the figures presuppose that there are no interlocutory hearings of any nature. This is unrealistic and does not happen in practice"***		
London Weighting It is proposed that an additional 12.5% London weighting be added to FRC set out. AvMA is not in a position to comment whether 12.5% is the correct increment for London weighting and suggests that this is a specialist area; we note that the DH look to the CPR for their authority on this. AvMA certainly supports an increment for London weighting, there is unlikely to be any disagreement that rents and overheads in London are higher than other areas of the country.		
Please Explain Why See above comments		

Question 9: Behavioural Change	**Yes**	**No**
Are there any further incentives or mechanisms that could be included in the Civil Procedure Rules or Pre-Action Protocol to encourage less adversarial behaviours on the part of all parties involved in lower value clinical negligence claims, for example use of an Alternative Dispute Resolution process (ADR)? This would include both defendant and the claimant lawyers, defence organisations including NHS LA, the professionals and/or the organisation involved.		
Please explain why AvMA has made it clear throughout this response that we consider that not enough emphasis is being place on the early opportunities to resolve cases, in particular the need for more to be made of the complaints and SIR processes as well as improving defendant behaviour (the way that defendants handle clinical negligence claims). AvMA's pre consultation response to the DH's 2015 proposals made it very clear that in our view detailed consideration needs to be given to the reasons why the costs in clinical negligence claims are so high. AvMA believes that opportunities to admit liability and settle cases early on are being missed and called for proposals be put on hold to allow for		

"… **proper consideration of all of these issues…".** We repeat that call in this response, and again invite the DH and other relevant stakeholders to look at the factors that give rise to clinical negligence costs and how lessons can and should be learned.

We note that in the NHS LA Report and Accounts for 2014/15 they
"… identified the following potential drivers of the cost of claims:
1. An increase in the number of patients being treated by the NHS
2. An increase in the number of reported incidents. This may indicate an increasing and positive reporting culture and so is not necessarily reflective on an increase in incidents occurring.
3. An increase in the number of patients claiming compensation as a proportion of reported incidents
4. An increase in the number of patients who claim but who do not recover compensation
5. An increase in the number of lower value claims
6. Disproportionate claimant legal costs for lower value claims
7. Excessive claims for legal costs from some claimant firms
8. Rising lump sums and annual costs (usually for care), over and above inflation for high value claims."

We note that disproportionate and excessive claims for legal costs ranks only number 6 & 7 of this list of eight catalysts. It is also relevant that no further investigation into these assertions has been made. We would have thought that it is in the DH's interest to ensure these assertions are verified before introducing yet further sweeping reforms along the lines of FRC. The DH needs to be satisfied that any reforms along these lines are going to offer a solution to some of the alleged drivers of clinical negligence costs.

We suggest that there is a robust and independent review of some of the assertions listed as these may not be substantiated by the evidence. For example the suggestion that lump sums and annual cost of care are rising more quickly than inflation is not supported by the recent (27.02.2017) announcement of the adjustment to the discount rate (from 2.5% to -0.75%), the effect of which is to increase the lump sum awarded to the claimant. An adjustment to the discount rate was considered necessary to avoid under compensating the claimant.

Master Campbell's report makes it clear that ***"defendant conduct where there have been late admissions of liability or settlements immediately before trial are significant issues…"*** – see paragraph 6.12 of his report. This cannot be ignored, more must be done to examine why this is the case, or is perceived to be the case, particularly as the cost of such behaviours fall to the public purse.

April 2013 saw a raft of reforms introduced under Legal Aid Sentencing & Punishment Offenders Act 2012 (LASPO) which has severely reduced the availability of legal aid for clinical negligence claims as well as the costs recoverable from the losing party. The post LASPO review is not due until April 2018. We understand that the Justice Minister, Sir Oliver Heald told the Health Select Committee that it was intended to ***"look at how the act has been affected by litigation, the various reviews of legal aid done by bodies such as the National Audit Office and others. This will lead to an initial discussion to the extent to which changes to legal aid met their objectives…"*** He went on to say that ***'The memorandum and review will provide us with a robust evidence-based picture of the current legal aid landscape and how it's changed since LASPO.'***

No changes should be made to the current system until it can be shown that the change

is necessary and that the change will reduce the cost of claims not simply reduce access to justice. The National Audit Office (NAO) is currently studying whether the DH and the NHS LA understand what is causing the increase in clinical negligence costs, and will evaluate their efforts to manage and reduce the costs associated with clinical negligence claims. This is key information and should be considered properly before any further consideration be given to introducing yet another raft of reforms. The NAO report is due in July 2017.

Both the post LASPO review and the NAO report will provide critical evidence on how effective the current system is and whether it needs changing. If change is required these reports will provide much clearer indicators on what, where and how that change should be implemented to be most effective.

Although the DH consultation refers to the provision of ***"greater opportunities for early learning of lessons from harmful incidents to inform safer clinical practice"*** and that introducing FRC for lower value claims will ***"encourage openness, learning of lessons and early resolution for patients and trusts wherever possible"*** it fails to address how this increased and improved learning will come about. The consultation does not offer any concrete proposals on how improvements to the system can and will be made. The NAO study will also be looking at 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. Again, this is essential information and no changes should be introduced until it can be shown that they will elicit cost savings and that other improvements will be made to improve patient safety and learning more widely.

The fact that the NHS LA have acknowledged an increase in the number of reported incidents in their 2014/15 annual report should be properly investigated. The NHS is publically funded and is accountable to the public. It is in the public interest that the DH properly identifies whether the increase is due to a more positive reporting culture or due to a genuine increase in the number of adverse incidents.

If more were to be done to improve patient safety then it would follow that safer care would result in fewer incidence of negligence and therefore reduced costs. By way of illustrating this point, the NHS LA identifies that: ***"Whilst there has not been an increase in the number of claims brought for cerebral palsy in recent years, there has been an increase in the value. Such cases account for over a third of expenditure on claims within the year."*** The graph at Figure 9 of the 2014/15 report suggests that the converse is also true; there has not been a significant decline in the number of cases brought for cerebral palsy since about 2005. The common factors that give rise to cerebral palsy claims are readily identifiable from the NHS LA "Ten Years of Maternity Claims – An analysis of NHS Litigation Authority Data" dated October 2012 states that the ***"three most frequent categories of claim were those relating to management of labour (14.05%), caesarean section (13.24%) and cerebral palsy (10.65%). Two of these categories, namely cerebral palsy and management of labour, along with CTG interpretation, were also the most expensive and together accounted for 70% of the total value of all the maternity claims"***

There needs to be greater focus on reducing the expenditure on claims, the only way to do this is for there to be a proper investigation into the causes and for there to be an obligation to make improvements to prevent the same mistakes from being repeated. Any new system must make learning a key part of the process. In our view, trusts and hospitals must demonstrate how that learning has been incorporated and how the

changes have been effective. This should include incorporating learning from the coroner's courts.

A proper, independent review of the issues giving rise to clinical negligence costs should also consider suitable alternatives. We would urge that this includes careful consideration of models that have been used in other jurisdictions which have proven to be successful. AvMA would advocate particular consideration of "The University of Michigan's Early Disclosure and Offer Program". That programme notes that "***Most health systems view liability costs as simply a cost of doing business, and not a legitimate indication of the quality of their care***" the programme rejects that approach and sees settlements and court cases as ***"robust indicators of what UMHS is doing well, and where and how it continues to put patients at risk".*** The programme has ***"resulted in fewer claims, fewer lawsuits, and lower liability costs"*** much could be gained from learning from the Michigan approach.

Question 10: Evidence

Please provide any further data or evidence that you think would assist consideration of the proposal, particularly for other than NHS provision. In particular, we are interested to gather data from private, not for profit and mutual organisations delivering healthcare. Please identify your organisation in your response. We would be interested in hearing views on: the scale of expected savings if Fixed Recoverable Costs outlined is introduced; the expected growth in the number of claims received and settled over the next 10 years to help in modelling the impact of the proposals; any details on the number and size of legal firms involved in clinical negligence (primarily as claimant lawyers), any information on the likely administrative savings and set up costs due to introduction of Fixed Recoverable Costs. Please indicate whether your organisation would be willing to work with DH in providing more details on the impact for future IA analysis. This would be provided in confidence and anonymised in any future analysis.

Please provide evidence.

AvMA has appended Master Campbell's report dated 2nd May 2017 to its response.

Please see our comments to question 9 above and the evidence that will be available from the post LASPO review in April 2018 as well as the evidence and findings of the NAO in their report on the NHS LA due on 31.07.17. The need for change should be considered in light of the comments made in both of those reports and not before.

AvMA is prepared to work with the DH in finding a suitable solution to the rising costs of clinical negligence litigation but first the factors that give rise to those costs must be identified along with opportunities for preventing further, future incidence of negligence recurring.

Question 11: Equalities, Health Inequalities and Families

The Government has prepared an initial assessment of the impact of Fixed Recoverable Costs on equalities, health inequalities and families. This assessment will be updated as a result of the consultation. Please give your view on the impact of these proposals on: Age; Gender; Disability; Race; Religion or belief; Sexual orientation; Pregnancy and maternity; Carers; Health Inequalities and Families

Please provide evidence.

AvMA does not have further evidence to provide on this issue. However, our chief executive Peter Walsh was a member of the advisory group invited by the Department to comment on these issues. He points out that not all of the group's comments were reported in the analysis reported in the consultation document, and some that have been have been presented in a different way than they were in the version agreed by the group. The effect of this may be to give the reader a more confused and watered down picture than they would otherwise have had of the negative impact the group felt the proposals would have on certain groups. For the avoidance of any doubt the equalities advisory group specifically concluded:

> ***"The advisory group's view is that the increased challenges to Access to justice are likely to be disproportionately experienced by older people".***
>
> and
>
> ***"Stillbirth claims have been identified as one of the types of claims that fall into the lower value category which would be most likely to be adversely affected by access to justice problems depending on the FRC regime introduced because of the complexity of the cases. This will have a particular impact on mothers/women."***
>
> The group also commented on the inability to conduct a thorough analysis of impact on equalities due to the lack of detail in the Department's proposals.

APPENDIX 1

RESPONSE TO DEPARTMENT OF HEALTH CONSULTATION:

INTRODUCING FIXED RECOVERABLE COSTS IN LOWER VALUE CLINICAL NEGLIGENCE CLAIMS

MAY 2017

Comments on the Department of Health Consultation

"Introducing Fixed Recoverable Costs in Lower Value Clinical Negligence Claims"

Abbreviations

A*v*MA – Action *against* Medical Accidents

CJCC - Civil Justice Council Costs Committee

CPR – Civil Procedure Rules 1998 (as amended)

DH - Department of Health

FRC -Fixed Recoverable Costs

GHR - Guideline Hourly Expense Rates

LASPO - Legal Aid, Sentencing and Punishment of Offenders Act 2012

LVCN claims - Lower Value Clinical Negligence Claims

NHSLA -National Health Service Resolution

SCCO - Senior Courts Costs Office

SRA -Solicitors Regulation Authority

1. I have been asked by *AvMA* to comment on the Department of Health ("DH") consultation entitled "Introducing Fixed Recoverable Costs ("FRC") in Lower Value Clinical Negligence Claims".

2. My personal background is that I was a practising solicitor from 1983 to 1996 : between 1993 and 1996, I sat as a Deputy Costs Judge : from 1996 until 2015 I was a permanent Costs Judge at the Senior Courts Costs Office ("SCCO") at the Royal Courts of Justice where I still sit as a deputy. In these capacities, I have undertaken many assessments, both provisional and detailed, of bills in clinical negligence actions in which costs are payable by the losing party. The level of damages in those cases have fallen within the range £1,000 to £25,000 as well as those where the compensation has

been significantly higher. I am familiar with the arguments deployed in support of and in opposition to the level of costs sought in those types of claim. I have also sat as an assessor with Judges of the High Court in a number of costs appeals involving clinical negligence claims and the costs involved, including *McCarthy v Essex Rivers Hospital Authority NHS Trust* (Mackay J), *Blankley v Central Manchester and Manchester Childrens' Hospitals NHS Trust* (Phillips J) and *Manning v King's College Hospital NHS Trust* (Spencer J). Those cases self evidently have covered a wide range of clinical issues which have given rise to the negligence in question and the expense incurred in bringing them.

3. The materials provided for consideration include :-

- Table 5 referred to in the consultation paper (page 22) "Summary of time analysis: minutes required"
- Table 7 referred to in the consultation paper (page24) containing illustrative rates for current market costs relating to pre-issue, post issue, post allocation and post listing stages of clinical negligence litigation
- Confirmation that the costs quotation for each phase of litigation are cumulative by John Culkin Esq., DH
- Annex E consultation document prepared by the Clinical Negligence Policy Team
- NHS LA "Litigation Fact Sheet – basic information"
- CJCC Recommendations on GHR for 2014

4. Specific comments have been sought on the following:-

1. whether the time allowed for non-fatal clinical negligence claims valued at £1,000-£25,000 resonate with my own experience of such claims
2. whether the linking of market costs to the GHR reflects the amount currently allowed on detailed assessment in clinical negligence claims and are based on a sound application of the CPR.

5. Guideline Hourly Rates

5.1 Before addressing the questions, it is appropriate to explain what is meant by GHRs. Their genesis is to be found in the long established practice for payment of legal services under which the lay client is charged by reference to each hour of work undertaken by his or her lawyer.

5.2 Sir Rupert Jackson, the author of "Review of Civil Litigation Costs : Final report " published on 21 December 2009, has said of GHRs that "[it] must now be accepted that the level of GHR is a critical element in the civil justice system, because solicitors' profit costs account for a high percentage of total litigation costs…" and that "… The aim of the GHR should be to reflect market rates for the level of work being undertaken" and that " [these] , would be the rates which an intelligent purchaser with time to shop around for the best deal would negotiate".

5.3 From 2008 – 2012 responsibility for collating evidence and recommending the GHR was undertaken by the Advisory Committee on Civil Costs. The GHR which the committee published contained four grades of fee earner, respectively solicitors of over eight years qualified experience ("A"), solicitors and legal executives with over four years qualified experience ("B"), other qualified solicitors or legal executives ("C") and trainee solicitors, paralegals, or equivalent ("D").

5.4 The GHR were divided into three separate London areas together with other rates for major cities elsewhere and in the country. These have remained static since 2010. A report by the CJCC in 2014 , which gave recommendations for adjustments, was not accepted by the then Master of the Rolls, Lord Dyson and no review is ongoing, which might lead to the first increase in the GHR since 2010.

5.5 The reason for leaving the rates unchanged was that in Lord Dyson's view "….the evidence on which its recommendations …[were] based is not a sufficiently strong foundation in which to adopt the rates proposed" and that "It is imperative that sound and reliable evidence is obtained". Since rates have remained the same ever since, the inference to be drawn is that no such sound and reliable evidence is yet available in respect of the costs of running clinical negligence cases following the implementation of LASPO on 1 April 2013 ; this altered significantly the way in which claims could be funded under Conditional Fee Agreements from that date.

6. Comments on Question One

6.1 The issue for consideration is whether the time allowed in the tables at 4D -4L at Annex E of part B of Chapter 4 (pages 3-22) of the consultation document reflect the time required to assess claims properly. Put another way, it is to express a view about the time it should reasonably take to complete tasks in LVCN claims and about the hourly expense rates that it is reasonable for solicitors to charge.

6.2 In this context reference should be made to Annex E in full, but the following will suffice as a précis of the figures suggested.

- Tables 4D -4L inclusive (pages 13 – 21 Annex E) contain a "time analysis" for Non-fatal claims with damages above £1,000 and up to £25,000 written by a group of three solicitors excluding trial costs.
- The consultation paper states that the information provided is, or has been used to calculate, the FRC rates in Chapter 5 of the consultation document entitled "Claimant Funding"
- The time analysis was "…. Both bottom-up i.e. an assessment of what work was reasonable and proportionate for each step, and top-down using the data from costs lawyers who deal with many claims against the NHSLA referred to in relation to Tables 4A (litigated claims 2012/13 and 2013/14 and Profit costs of litigated claims by stage 2012/13 and 2013/14 respectively)".
- The claim use as an example, is said to be a "case of average complexity" (see consultation paper, paragraph 4.4 page 21).

6.3 The reference to the FRC rates in Chapter 5 is to the "Summary of Time Analysis : minutes required at Table 5" . This uses the GHRs to summarise the time spent by lawyers and advances £4,470 as being the total FRC payable for the work undertaken in Tables 4 C to 4 N in a lost case. (This material also appears as Table 4O).

6.4 The consultation paper then advances four options under consideration for setting FRC rates

- option one - staged, flat fee arrangement under which the recoverable amount would be fixed irrespective of settlement value, and would depend upon the stage at which the claim was settled
- option two - staged flat fee arrangement plus a percentage of damages under which there would be a lower fixed sum than under option one, but an additional amount would be calculated and paid as a percentage of the final damages awarded

- option three - a flat fee arrangement using the same rates as for option one, but reduced where liability is accepted within a defined period and settlement proposed
- option four - a cost analysis approach under which the same methodology for calculating FRC is used, but based upon the mean relationship between current costs and damages using data from costs lawyers who deal with many claims against the NHSLA.

Options 1,2 and 3 are based upon an estimation of legal time required to undertake LVCN claims under a streamlined proposal.

6.5 Option 4 would be based upon current market costs.

6.6 The time analysis presupposes that various grades of staff will undertake work on the case in question.

6.7 In levels of seniority downwards, these include Grade A,B,C and D staff, together with Administrative Support staff ("AC") not being legally trained or qualified. That work is subdivided into nine categories , with the time allowed for each task appearing below :-

- Preliminary Investigations AC 15 mins, C 103 mins
- Formal complaint to trust C 45 mins
- Liability investigations A 10 mins, C 245 mins, D 60 mins
- Liability negotiations (in event of denial) C 145 Mins
- Quantum investigations A 10 mins, C 229 mins
- Issue of proceedings A 5 mins, A 10 mins, C 269 mins
- Litigation tasks A 20 mins, C 512 mins, AC 10 mins
- Claim finalisation tasks C 19 mins
- Contingency – Additional Expert required C 181 mins

6.8 The totals for each fee earner, including contingencies is thus as follows :-

- AC 30 mins
- A 50 mins
- C 29 hours 8 mins
- D 60 mins
- **TOTAL Fee Earner time** 31 hours 28 minutes at a value of £4,470 plus VAT

6.9 These figures are stated to be the amount of time it would be reasonable and proportionate to take for each step in relation to the nine categories of work set out above.

6.10 In my opinion, the figures are seriously flawed. Before explaining why I consider this to be the case, it is important to make some preliminary points.

6.11 The FRC appears to presuppose that a "*One Hat Fits All"* approach is appropriate in LVCN claims. If that be so, it is one that is susceptible to many valid challenges.

6.12 In assessing reasonable, necessary and proportionate costs in such claims, there are a multitude of variables which bear upon the amount justly payable by the NHS LA in a lost case. In a non-exhaustive list, these will include:-

- whether the claimant is a protected party,
- whether there are problems with limitation,
- whether breach of duty and causation are in issue,
- whether there are part admissions, e.g. negligence is admitted, but causation is denied,
- whether the quantum of damages is straightforward or complex,
- whether medical evidence can be agreed
- whether realistic negotiations have taken place and Part 36 offers have been put forward which might affect the overall costs
- whether the conduct of any party has been such as to increase the level of costs reasonably incurred : defendant conduct where there have been late admissions of liability or settlements immediately before trial are significant issues in this context .

6.13 If any one (or more) of these factors is present in a potential claim, it will have an upwards influence on the level of costs which are likely to be incurred by both sides. However none of them appear to have been given any weight or consideration in Part B of chapter 4 of Annex E of the consultation document. On the contrary, the figures suggested bear no resemblance to the amount of legal time required at each stage "for a case of average complexity " : there is only one witness statement of one-page, one expert witness and one conference with counsel, with work on the pleadings all having been undertaken by the solicitors. This suggests that the claim appears to

be a case with little , if any, complexity. If it was, in truth, a case of average complexity, the figures need to be significantly higher.

6.14 The fallacy of the "*One Hat Fits All*" approach can be illustrated by a simple example : suppose claimant A and claimant B suffer injuries arising from similar but separate instances of clinical negligence, in respect of which the general damages will not exceed £20,000. Breach of duty and causation are denied, and both claims succeed. Claimant A is elderly and lives on a state pension : claimant B has a substantial income as a career sports player and is compelled to retire prematurely as a result of the injury. It is a statement of the obvious that the lawyers' task to establish breach of duty and causation will be the same in each case. However, because claimant A, has no earning capacity, special damages will be under £5,000 , whereas for claimant B, compensation will be very significant. If FRC were to apply, the solicitor for claimant A would receive far less in costs than the solicitor for claimant B solely because Claimant B was a high earner and claimant A was not, even though the amount of work needed to prove breach of duty and causation in each claim would be identical. A costs regime which can permit such an outcome (as FRC would), will deny justice to deserving claimants for whom solicitors will no longer be willing to act because the FRC will mean that the work can only be undertaken at a financial loss to the firm.

6.15 These preliminary points having been made, I turn to the specifics of the analysis. The first point to make is that for some items, less than six minutes has been allowed. Under paragraph 5.22(1) of the Practice Direction to CPR 47.5 , routine items will in general be allowed on a unit basis of six minutes each . It follows that by allocating as little as three minutes to each item, the Tables appearing in Part B have undercharged the amount which would be recoverable on assessment as a minimum. Another example of short-changing includes charging six minutes for a letter of substance of two pages written to the defendant enclosing damages proposals. In short, the analysis has not been prepared in a way which complies with the Rules of Court.

6.16 So far as fee earning work is concerned , as set out above, 50 minutes has been allowed for a grade A fee earner. This is unrealistic and inadequate, even in a claim at the bottom end of a LVCN claim, which this case appears to be, and all the more so in

a case of average complexity, as the consultation has suggested that it is.

6.17 In any sort of case, however big or small, some grade A input is required because the case needs to be vetted for suitability at the outset, thereafter for purposes of delegation to an appropriate fee earner and following that, at strategic stages in the litigation : for example, it cannot be reasonably expected that a grade C should advise on a Part 36 settlement offer without reference to a grade A. It would be professionally irresponsible and potentially a matter a dissatisfied client might refer to the SRA were the grade A to be involved in such a case for just the 50 minutes suggested.

6.18 So far as other fee earners are concerned, the analysis has proceeded on the basis that virtually all work will be done at grade C, with nothing at grade B, and under three hours for all other fee earners.

6.19 Whether or not the work is suitable to be undertaken at grade C is likely to be fact specific. In a claim in which breach of duty, causation and quantum are all in dispute, it is to be expected that the day-to-day case handler would be grade B or above, rather than grade C and below. The analysis makes no provision for this, even though it alludes to liability negotiations “in the event of denial”. Plainly, if the work needs to be done undertaken at above grade C, the FRC should be significantly higher.

6.20 With regard to time allowed for specific items, the figures advanced are risibly low, *a fortiori* , when matters such as funding and “obtain cheque for issue fee “ are not recoverable between the parties but have been included as if they were.

6.21 Whilst the tasks in question are broadly all those which are justifiably included in bills, the amount of time for undertaking them is unrealistic and inadequate. A few examples will suffice :-

- discussing claim with client - 30 minutes. It would be rare for the initial taking of instructions in a clinical negligence case to take under 2 to 3 hours. In other cases it would be more if, as often is the case, the client is under a disability, elderly, distressed or whose first language is not English.
- drafting letter of claim (6 pages) - 40 minutes. An examination of the Pre-action Protocol for the Resolution of Clinical Disputes sets out the extensive details which must be provided in the Letter of Claim. It could not be done professionally and nor would it serve

the client's best interests if this was to be undertaken in just 40 minutes

- instructing medical expert -30 minutes. The same point is made.
- Review expert's report (10 pages) - 10 minutes. One minute per page has been allowed : it is a statement of the obvious that a solicitor could not discharge his or her duty to his client without risking a claim in negligence were only 10 minutes to be spent on such an important task.

6.22 The analysis is also striking in what it leaves out.

- Although the consultation paper recognises that cases will be allocated to the multitrack, there is no provision for costs budgeting, either in the preparation of the budget or for attending before the judge at case or costs management conferences. Indeed, the figures presuppose that there are no interlocutory hearings of any nature. This is unrealistic and does not happen in practice.
- No allowance has been made for Advice on Evidence, inspection, mediation and advice on settlement under Part 36 save for 15 minutes in a letter to the client headed "explain quantum : explain the effect of CPR P36". The latter is particularly significant. The workings of Part 36 are complicated and have led to numerous appeals to the Court of Appeal. A claimant who fails to beat a Part 36 offer will be ordered to pay the NHS LA's costs from the last date on which the offer should have been accepted. In some cases this could result in the costs order wiping out the damages awarded. No basis has been advanced to support the view that such advice could be imparted in sufficient depth within 15 minutes : quite simply, it cannot.

6.23 So far as the options are concerned, the DH recognises that lawyers will be deterred from taking on low value clinical negligence cases if remuneration is inadequate and that accordingly, patients may not have the option of taking legal action where something has gone wrong with their care (see paragraph 4.3 of the consultation document (page 21)).

6.24 For the reasons given above, it is my view that any implementation of option 1 will do just that.

6.25 Would option 2 make a difference? I do not consider that it would. If a claim settled for £20,000, the additional amount would be £2,000

which would be inadequate recompense where, as here, the base figure is too low as the starting point. Of course, if the damages were £1,000, the extra amount would be just £100, less than one hour of the most junior fee earner's time.

6.26 An outcome that pays a solicitor's firm less rather than more for its services, as envisaged in option 3 would not have any attraction either. In short any of these options will deter lawyers from providing their services in LVCN claims and access to justice to needy patients will thereby be denied.

6.27 There is insufficient material in the consultation paper to permit reasoned comment to be passed on option 4.

7. Comments on Question Two

7.1 The analysis has been undertaken using the GHR without any uplift. No explanation has been provided why the factors set out in CPR 44.4 (3) have not been taken into account.

7.2 It is trite law that an enhancement to hourly rates is justified to reflect the factors set out in rule 44.4(5) , including the importance of the matter to the parties, the time spent on the case and any particular complexity (see *Kelly v Hayes PLC* [2015] 5 Costs LO 595 and *Group Seven v Nasir* [2016] 2 Costs LO 303 , in which rates significantly higher than the GHR were allowed). Whilst it is right that the GHR is taken as a starting point on an assessment of costs, they are just that, guidelines which are not binding. In clinical negligence, higher rates are *always* allowed, having regard to the CPR 44.4(3) factors which are applicable in varying degrees in every clinical negligence case. In addition, the court will consider other factors such as the extent to which breach of duty, causation and quantum are in issue. The straitjacket of FRC as set out in the analysis gives inadequate allowances for these considerations.

7.3 As I have mentioned above, the DH recognises that the level at which FRC rates are set will be key in ensuring that claimant lawyers can recover reasonable costs and are not deterred from taking on low value clinical negligence cases. Fixing rates at no more than GHR will do just that, all the more so when the rates in question have not been increased since 2010, even to adjust for inflation. Where solicitors remain willing to undertake LVCN claims, their emphasis will be on accepting only cases that are likely to succeed, with

claims that have merit, but are less straightforward, being rejected, leaving the prospective claimant without a remedy or compensation. It follows that if any of the options are adopted using the rates proposed in the consultation paper, firms of solicitors will cease to undertake LVCN claims. That will lead either to injured parties being unable to recover compensation where something has gone wrong with their care or to an increase in the number of litigants in person who lack legal training to bring claims at proportionate expense, leading to a climate that is even more adversarial than it is now.

8. Conclusions

8.1 FRC in LVCN claims will deny patients who have suffered personal injuries arising out of their care, access to justice save in the most straightforward cases because at the allowances proposed, it will be uneconomic for lawyers to take on their claims.

8.2 The GHR proposed are inadequate, do not reflect current practice at detailed assessment and fail to take into account or indeed, to apply CPR 44 .4(5) and relevant case law.

Colin Campbell

2 May 2017