action against medical accidents

EXPERTS NEWSLETTER

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This is the second of our newsletters aimed at keeping the medico legal expert witness up to date with developments in this fast moving area of law.

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The importance of the expert witness cannot be overstated. This is particularly true in clinical negligence litigation where invariably the medical expert will be called upon to identify the standard of care the patient was entitled to expect. If lawyers consider that there has been a breach of the duty of care then they may need to consider additional medical expert evidence on causation. That is, they will be trying to establish what injury, if any, has been caused by the breach of duty as well as what the prognosis

While this all seems fairly straightforward on paper, this can be a lot harder to apply in practice. At the centre of all of this is the client – an ordinary member of the public who is often bewildered by their own injury and/or loss and who perhaps find it difficult to trust "professionals". The relationship between instructing solicitor, the expert/s, and then latterly with counsel if the matter progresses, is key to any client's case and to managing their expectations; it is crucial that they operate as a team.

Again, in practice the team element is frequently lost. Breakdown in communication can occur for many reasons, particularly if an expert changes his or her opinion of a case. Opinions can change for a number of reasons; the fact that the expert has been poorly instructed on the issues at the outset is just one example.

Equally, an expert's further reading of the medical records may bring to their attention something they ought to have seen but missed first time round – an expensive mistake for the claimant's solicitor and their client!

AvMA will be running a seminar at **Exchange Chambers in Liverpool on 24th January 2018** to look at some of these issues. The seminar is aimed at both the legal profession and medical experts and will be an opportunity to interact and network in a friendly and open atmosphere. The event is competitively priced at £75 plus VAT and places are limited; for details of the course content please view the link here:

In preparation for the forthcoming Expert/lawyer seminars this year's expert questionnaire focuses on the problems experts commonly experience with solicitors and lawyers. We have kept the ques-

tionnaire short. We have also deliberately posed the questions in a way that requires you to simply select the response that best reflects your experience; there is room at the end of the questionnaire for you to elaborate on any or all of the issues raised and any others which we have not included but which you consider to be relevant. The questionnaire is online and can be found here. Please complete it by **31st December 2017**.

The Medico Legal Market

The Discount Rate

Since my First Newsletter earlier this year in February, there have been a number of changes: the revised discount rate became effective from 20th March. The rate has moved from 2.5% to -0.75%. So, why does a change in the discount rate make a difference? The short answer to that is, damages for personal injuries, including clinical negligence claims, are calculated to put the injured person back in the position they would have been had the negligence not occurred. Awards of damages are not calculated to enable an injured person to become financially better off, quite the contrary.

Identifying the appropriate award of damages requires detailed calculations and appropriate expert evidence to identify the exact loss to the claimant. First, the relevant categories or heads of damage must be identified. This will include losses such as: loss of earnings, additional care costs, and the cost of necessary equipment or adaptations to property. The losses may also include the cost of additional heating for those patients who have restricted mobility and/or are housebound as a result of their injuries; these are just a few examples of the type of issues to be taken into account.

The losses have to be considered within the context of losses incurred to date (past losses) as well as current and likely future losses. Quantum experts will be asked to report on the costs likely to be incurred by the individual claimant. Those reports are instrumental in identifying and quantifying the pertinent losses so the annual cost or multiplicand can be identified.

The multiplicand then has to be multiplied by the number of years the claimant will be affected by the loss (the multiplier). However the court has to consider the effect of inflation and that the cost of services and such like will not remain static. They will increase over time. At the same time, the court must avoid over compensating the claimant and must treat claimants as ordinary prudent investors. If the judge simply calculated the award by looking at the multiplier and the multiplicand without applying a discount rate, the result would be that the claimant could benefit from the interest that would accrue on the resulting lump sum; this would put the claimant in a better position than they would otherwise have been.

To avoid the claimant having a financial benefit from any award of interest, a discount rate is applied. The discount rate is expected to take into account the likely effect of future inflation on the award. The higher the discount rate the lower the overall damages awarded, conversely the lower the discount rate, the higher the award of damages. Identifying the correct discount rate is not an exact science and the rate does need to change from time to time to reflect changes in the financial market.

In 2001 the discount rate was based on three-year average yields from the government's Indexed

Linked Gilt Stock (ILGS). In 2001 it was recognised that the ILGS yields were low, however it was also thought that there was a reasonable prospect of a return to higher interest rates in the foreseeable future. That of course did not happen – in fact, in recent years we have seen a period of some of the lowest interest rates ever. Allied with that, care costs have risen at a greater rate than the Retail Prices Index (RPI). The combination of low interest rates and higher care costs has meant that in fact, claimants have been under compensated; the recent change in the discount rate is intended to address this imbalance.

Periodical Payment Orders (PPO)

The NHS as a public body is able to provide reasonable security for claimants in the future and consequently is in a position to offer PPO's to claimants as part of their settlement package. Most claimants elect to receive sums for care, equipment and other future losses by way of a PPO.

A PPO means that the NHS can pay costs such as care and equipment annually, rather than in one lump sum. This approach helps the NHS stagger the lump sum payments that would otherwise be required, it also gives the claimant greater security. One of the benefits of a PPO is that they are payable for the duration of the claimant's life. If a claimant exceeds their projected life expectancy the payments will continue, if their life expectancy is less than expected then the NHS stop paying those sums at the time of death. Furthermore, PPO's will increase in line with actual inflation.

Organisations such as the Medical Protection Society (MPS) or Medical Defence union (MDU) are not able to offer reasonable security in the future and are therefore unable to offer PPOs.

Safe Space

On 21st April 2017 the government published its response to the consultation on "**Providing a "safe space" in healthcare safety investigations**". The consultation sought views on the aim to create a balanced 'safe space' whereby staff would feel confident that the law would prevent the disclosure of information they provided to a safety investigation. At the same time the consultation suggested that patients and families would be reassured that, as a result of the safety investigation, they would learn the facts of their or their loved ones' care and what could be done to improve the safety of that care.

More than 1/3 of consultation responses were opposed to safe space altogether. 60% of respondents were in favour of creating a safe space. The response recognised that it will take time for HSIB to build trust. It also confirmed that safe space would not be rolled out to local investigations at this stage although this was likely to be revisited: ***"In time…at the point where the principles of safe space have been tested and trusted …we will consider extending the adoption of safe space to investigations undertaken by and on behalf of …NHS funded care"*** (p11, para 2.9)

It was noted that: *"There was general recognition that the standard of some investigations in the NHS was poor".* Additionally, that ***"Patients and staff alike did not yet trust the NHS locally to use it properly or fairly – patients saw it as a way to avoid accountability, while staff saw it as a potential way for their employers to force self-incrimination"***

The Health Service Safety Investigation (HSSIB) Bill

HSSIB came into being in April 2017. The HSSIB Bill was published 14th September. The Bill confirms that HSSIB has the function of investigating "qualifying incidents" which occur during NHS Services. A qualifying incident is one which has implications for patient safety.

HSSIB's function is to address risks to the safety of patients by improving systems practices within the NHS. However, the bill also makes clear that individual trusts will be able to apply to HSSIB to become accredited by them.

According to sections 20 and 21 of the Bill, accreditation will enable a trust to carry out both external and internal investigations. Under the draft Section 28, there is a prohibition on HSSIB or accredited trusts disclosing things held by it in connection with investigations to any person including any information or documents. There may be an exception to this where there has been the commission of an offence in which case HSSIB "may" disclose information to the police. In cases of misconduct disclosure to the regulatory body "may" occur. Note: there is no mandatory duty to disclose, even in relation to the police or regulatory bodies.

HSSIB and/or the accredited Trust carrying out the investigation must publish a report on the outcome of the investigations. The report "may" include information about any information or document to which the prohibition applies. There will be no right to the disclosure of documents although disclosure may be obtained with an order from the High Court. The Bill suggests that the High Court should only make such an order where it can be shown that disclosure is necessary in the interests of justice and where the interests of justice outweigh any adverse impact on future investigations.

AvMA is concerned that, if the Bill were to be passed in its current form, without amendment, then it will provide a gateway to effectively introducing a safe space into local investigation before HSSIB has demonstrated that patients and staff trust that the investigations will be conducted properly and fairly. There are insufficient safeguards to allay patients' fears that this is simply a way of trusts avoiding accountability. From the perspective of the staff it does not offer any protection from employers recriminations and/or reprisals. There is a very real risk that this Bill would simply countermand the considerable steps that have been made towards making the health service more open, honest and accountable; it would be directly contrary to the duty of candour.

DH Consultation on fixed Recoverable Costs (FRC)

This consultation closed in May of this year. It is clear that the object of these proposals is to save money and in principle that is something AvMA supports. However, it is crucially important that any cost savings are not made at the expense of access to justice. The proposals in the May consultation include:

- Costs payable to claimant solicitors should be fixed, regardless of the complexity of the case or any issues on defendant conduct.

- £1,200 maximum spend on expert fees. That is, all expert fees, not each expert instructed!
- Fixed costs should apply to clinical negligence cases up to £25,000 in the first instance, rising beyond that in due course.

The DH has yet to publish their response to the consultation. AvMA has concerns that these proposals will simply shunt the actual costs of litigation onto the claimant. Unless all the experts involved in a case are able to produce reports and play their part in the litigation for a sum not exceeding a total of £1,200, then it would appear inevitable that anything in excess of this figure will have to be deducted from any award of damages the claimant may receive. In a low value claim, it is easy to see how this approach could wipe out a client's award of damage.

Further, it is unclear who is going to fund the initial expert report. After the event insurance is likely to disappear. If that happens then either the solicitor pays the expert's fee or the client does. It is unlikely that funding the initial expert report will be economically viable for solicitors. Equally, many potential claimants will struggle to find even £1,000 to contribute towards the cost of obtaining independent expert evidence. The result will be that valid, but low value clinical negligence claims will not be brought. This will result in a loss of access to justice and a loss of accountability and learning for the NHS and other care providers; this would be a retrograde step.

Lord Justice Jackson's Review of Litigation Costs

You are likely to be aware that Lord Justice Jackson (Jackson) is the architect of fixed recoverable costs and cost budgeting. His original paper on costs in civil litigation was published in 2010; however he recently undertook a review which was published earlier this year on 31st July. The focus of the Jackson review was to develop FRC for low value cases, however it is notable that to date he has been unable to produce a satisfactory grid of fixed costs for clinical negligence claims that provides proper remuneration to lawyers and experts undertaking this work whilst allowing access to justice.

Jackson's view is that the only way to avoid runaway litigation costs is to either (i) Introduce a scheme of FRC so parties can refer to a costs grid to identify their exposure to costs in advance or (ii) Impose a binding budget for individual cases at an early stage.

He recognises that CN cases are often complex, of low financial value but of huge concern to the individuals on both sides. He notes that controlling litigation costs whilst ensuring proper remuneration for lawyers is a vital part of promoting access to justice. If the costs are too high, people cannot afford lawyers. If the costs are too low, lawyers won't do the work.

Jackson has concluded his supplementary report by recommending that the Civil Justice Council (CJC) and Department of Health (DH) should set up a working party with claimant and defendant representatives to develop a bespoke process for handling clinical negligence claims. The process should initially be for clinical negligence cases up to £25,000 and should devise a grid of fixed recoverable costs (FRC) for such cases. We understand that ministers have recently approved the principle of a working party although the terms of reference and detail are yet to be confirmed.

Rapid Resolution & Redress (RRR)

RRR is a potential alternative scheme to litigation for severe birth injuries. This consultation closed on 26th May and the government's response is awaited. AvMA welcomes the notion of such a scheme and some of its aims are laudable, notably:

- A reduction in the number of severe, avoidable birth injuries by encouraging a learning culture, improving the experience of families and clinicians when harm has occurred and making more effective use of NHS resources;
- An emphasis on understanding the reasons why the harm occurred with a focus on system level failures rather than attributing blame to an individual.
- Ensuring eligible incidences are thoroughly investigated within 90 days of a case being considered eligible for investigation.
- Once eligibility is established, a compensation package should be made available to provide for the current and future needs of the injured individual.

According to the proposals, the compensation package is likely to comprise of 3 main elements:

i) An early upfront payment:

ii) Periodical payments and

iii) A lump sum award.

The early up front payment will be in the range of £50,000 to £100,000 and would be issued when the child attains four years of age. This sum is intended to ***"support families with any upfront costs acquired, to take care of their child, such as adaptations to accommodation"*** (para 4.17).

It is maintained that the average total value of compensation would be "***around 90% of the average current court award"*** (para 4.24).

As far as the provision of services such as care are concerned there is little detail on this other than a suggestion that care would be offered at rates considerably less than those currently allowed by the courts. A top up sum would be allowed to help purchase something akin to local authority care.

The cost of care and adaptation to property is a key component of the calculation of damages to be paid to a child that has suffered injury at birth as a result of negligence. The care costs are identified with reference to the cost of private care; in turn, the private care costs reflect the actual market rate payable for care services and therefore the actual costs of care. It is well known that local authorities have difficulty in recruiting suitable carers; part of the reason for this is that they are often unable to pay the market rate. Local authorities have insufficient numbers of carers and inconsistent staffing levels; even if a top up were to be offered it is difficult to see how this would operate in practice.

There are also concerns about the level of award offered for accommodation. The cost of accommodation will vary according to the child's actual needs, where they live and how much adaptation

is required. I would suggest that the majority of alternative accommodation or adaptation to property costs will far exceed the £50,000 - £100,000 being suggested.

The real answer to reducing the cost of brain injured babies is to reduce the number of babies injured.

Non recoverability of ATE Premiums

There has been no news on the proposal to remove the recoverability of ATE premiums in clinical negligence claims. This proposal first reared its head in September 2015. It is important that this consultation is aired as soon as possible to enable claimant clinical negligence lawyers to have the full picture of the commercial landscape they are operating in.

Why does the recovery of ATE premiums affect experts? If ATE premiums cease to be recoverable in clinical negligence claims many firms will find it difficult, if not impossible, to carry the risk of funding expert reports. If firms are unable to assist with funding the experts' reports, it will fall to the individual claimants to fund these investigations. In the days before conditional fee agreements (CFA) claimants who were not eligible for legal aid were expected to fund their own investigations. Many valid claims were unable to proceed because the costs of investigations were outside the reach of ordinary people. The loss of recoverability of ATE premiums could herald the return of those pre CFA days.

National Audit Office (NAO) Report 2017

The NAO brief was to examine whether the Department of Health (DH) and the NHS LA (now NHS Resolution (NHSR)) understand what is causing the increase in clinical negligence costs. It also evaluated their efforts to manage and reduce the costs associated with clinical negligence claims. Additionally they explored the NHSR's contribution to helping trusts to reduce the number of negligence claims they receive by sharing learning about past incidents and by encouraging wider forms of redress for affected patients.

The NAO report was published in September 2017 and says that some of the biggest factors contributing to the rising costs of CN are largely outside the control of the health system. They cite:

- ⇒ Developments in the legal market place
- ⇒ Increasing level of damages awarded for high value claims
- ⇒ Changes to the discount rate

The NAO say the increase in legal costs is mainly due to a large number of low to medium value claims.

However whilst it notes that the NHS's proposed or current actions to address rising costs are:

- ⇒ A safety and learning team to engage with trusts on patient safety issues

- ⇒ A programme to improve maternity care
- ⇒ Repudiating claims without merit
- ⇒ Use of ADR
- ⇒ Settling more cases before court proceedings

It does not ask why so many of those initiatives are so recent. It does not challenge why it is that NHSR is taking longer to resolve cases – according to the NAO report, in 2011 the average time taken to resolve a claim was 300 days. In 2016/17 that had increased to 426 days. The report notes that every extra day taken to resolve a claim costs an average of £40. An extra 126 days settlement therefore costs £5,040 per case. The report did not examine the NHS approach to SIR or complaints – areas that are known to be very weak and it didn't look at the missed opportunities to settle cases early on.

Public Accounts Committee

The Public Accounts Committee (PAC) met on Monday 16th October to discuss the NAO's report with key stakeholders including Richard Heaton of the Ministry of Justice and Helen Vernon, CEO National Health Service Resolution (NHSR). They were particularly keen to explore the practical, day to day impact of rising costs on the NHS and to better understand the way in which NHSR, DH and MoJ are working together to tackle those costs while providing a quick and efficient service for claimants.

PAC noted that the cost of clinical negligence claims to the NHS was £1.6billion in 2016–17. This is quadruple the figure for 2006–07.

Essentially, Sir Chris Wormald on behalf of the NHS explained that in their view there were two key underlying phenomena to these cost increases. First, the increase in life expectancy for people with severe disabilities has had a knock on effect on the cost of lifetime damages. The second reason proffered was an expansion in the number of much smaller cases. According to Sir Chris Wormald these increases are not related to changes in NHS, they are due to changes in the legal market.

According to evidence given before the PAC, the NHS have taken steps to extract the learning from claims and share those with the NHS trusts. They say they are controlling the volume of claims coming through.

However, the PAC did demand a better understanding of why these changes had not been introduced earlier on to save costs going forward. The PAC is also clearly concerned that the NHS failure to conduct early investigations was one of the causes of increased costs. In response, the NHSR maintained that they embrace early resolution from letter of claim stage; the NHSR expressed concern that mediation was difficult to get off the ground because of resistance from claimant lawyers.

Report on ADR and Civil Justice – October 2017

It is difficult to know what the real problem with mediation is; claimant lawyers argue that mediation is not routinely offered. Further, the Civil Justice Council (CJC) in their report published in October 2017 "ADR and Civil Justice" (ADR or Alternative Dispute Resolution includes mediation) noted that ADR has to adapt to fit the sums in issue.

The CJC report noted that ADR must not be disproportionately expensive or time consuming to the value or importance of the case. The report also highlights that a group of senior, experienced mediators identified that only about 1 % of their cases involved clinical negligence claims. The findings also suggested that those experienced mediators estimated that 90% of their referrals came from parties which had agreed to the process, rather than outside nomination.

A leading provider of ADR services noted that their experience and the experience of others was ***"… mediation is used well and widely in high value cases that are safely inside the High Court scale"***. One conclusion that might be drawn from this is that it is more difficult to reconcile the cost of mediation and other ADR processes in low value cases. If that is correct, then it may suggest that the NHSR mediation scheme requires adaptation.

One thing is clear, more does need to be done to stem the number of clinical negligence claims that are being made and settled. Perhaps examining the issues that give rise to claims in the first place, then addressing those issues is the best place to start.

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