SUBMISSIONS AND EVIDENCE TO LORD JUSTICE JACKSON'S REVIEW OF FIXED RECOVERABLE COSTS

RESPONSE DUE:

23rd January 2017

AvMA Submissions and Evidence to Jackson LJ Review of fixed recoverable costs (FRC)

Introduction

1. Action against Medical Accidents (AvMA) was established in 1982. It is the UK charity for patient safety and justice, specialising in advice and support for patients and their families affected by medical accidents. Since its inception AvMA has provided advice and support to over 100,000 people affected by medical accidents throughout the United Kingdom. AvMA's perspective comes very much from the experience and point of view of injured patients/families and the litigants themselves, but is informed by our unique relationships with specialist clinical negligence lawyers, medical experts, and the NHS, and also our knowledge and experience of how clinical negligence litigation works in practice.

2. AvMA offers specialist services to the public, free of charge across the United Kingdom. This includes a helpline and an individual casework service staffed by legal and medical professionals.

3. The pro bono inquest service was set up in September 2009 and launched in July 2010. The project aims to find representation for people who have been affected by the death of a loved one where the death occurred in a medical setting. Currently, the service provides advice and in some cases representation to in excess of 100 inquest cases per annum. Through our work, we have developed considerable expertise in providing assistance and representation to members of the public at inquests.

4. AvMA provides specialist support services for legal professionals through our Lawyers Resource Service including the recommendation of expert witnesses. We organise specialist training courses and conferences for health and legal professionals, advice agencies and members of the public.

5. AvMA operates a specialist accreditation scheme and assesses solicitors for eligibility to the panel based on their experience and expertise in clinical negligence. The AvMA panel has been running since the late 1980's and is the longest running clinical negligence accreditation scheme as well as being the first accreditation scheme of its kind. We reaccredit our panel solicitors after 5 years to ensure that they are maintaining standards, both the original application for accreditation and reaccreditation process require solicitors to submit case reports. As a result we have access to over 200 case reports annually.

6. The case reports ask for a number of pieces of key information, for example: when the solicitor first had contact with the client; when the letter of claim was

sent; when the letter of response was received; when proceedings were issued; when the case settled. The information is collected as a means of identifying how quickly a solicitor progresses claims. Where there is delay, the solicitor has the opportunity to explain reasons why delay occurred. The information not only enables us to assess a candidate but also provides us with a keen sense of the difficulties commonly encountered by Claimant solicitors in progressing cases.

AvMA's Response

7. AvMA has confined its responses to questions where we feel able to comment based on our experience and information available to us through our services and panel accreditations.

8. Our expertise and experience relates to clinical negligence issues. As a result AvMA's response to this review has been approached by considering how fixed recoverable costs (FRC) might impact specifically on clinical negligence claims.

Proposal to extend FRC to make the cost of going to court more certain.

9. Clinical negligence costs will not become more certain simply because a FRC regime is imposed.

10. Any proposal aimed at making costs more certain in clinical negligence should first be considered within the context of the factors that give rise to increases in legal costs in this area.

11. Identifying the factors which give rise to clinical negligence costs will inform whether FRC will, on its own reduce the cost of litigation in this area. It is also crucial to understanding how and why the introduction of FRC to this area of work risks being seriously detrimental to access to justice and will only encourage inequality between claimant and defendants.

12. AvMA has publically expressed the view that there needs to be proper consideration of these factors; we have suggested that this exercise should be undertaken in partnership with stakeholders such as ourselves, claimant and defendant lawyers, medical experts, the Department Health (DH) and the Ministry of Justice (MoJ). It is indeed unfortunate that this suggestion has not been taken up. In responding to this review we consider it important that some of those factors are identified, so that hopefully they will be addressed. Some of the factors are set out below in bold.

13. **A failure to adequately address the issues that give rise to negligence and breaches of duty**: In August 2013 the National Advisory Group on the safety of

Patients in England prepared a report entitled "A promise to learn – a commitment to act, Improving the safety of patients in England", the author of the report was Don Berwick and the report is often referred to as the Berwick Report. Don Berwick candidly identified the need to *"Place the quality and safety of patient care above all other aims for the NHS. (This, by the way, is your safest and best route to lower cost)"*.

14. We believe that in most cases there is ample opportunity to learn from mistakes and resolve clinical negligence claims before they reach the litigation stage. These opportunities are not being taken advantage of and used to their maximum potential to improve patient safety or to avoid litigation. Accordingly, if the costs awarded following successful litigation were to link directly to the failure to exploit those opportunities then there would be greater incentives for these processes to be thoroughly explored first, so as to avoid litigation. Examples of some of the available processes are highlighted below.

15. Serious incident reporting (SIR): NHS trusts are not doing enough to prevent negligence and unnecessary injuries occurring. This fact was echoed by the Care Quality Commission's (CQC) report on SIRs last year (link to their report below). The report states: ***"We saw a number of investigation reports…Many of them did not result in clear conclusions or recommendations that could be expected to reduce the likelihood of the incidents happening again."***

    http://www.cqc.org.uk/sites/default/files/20160608_learning_from_harm_briefing_paper.pdf

16. It is our experience that SIRs are often not called when they ought to be, families are not involved in the process and the report is not always shared voluntarily. If SIR reports are produced in an objective, open, honest and robust way they will identify failings which will in turn will limit the issues between the parties. This will also provide an opportunity to admit liability at an early stage; the legal costs of both parties will be cut considerably in most cases if quantum is the only issue. Low value claims in particular will become cheaper and more proportionate.

17. Complaints procedure: Defendants still do not appear to have a uniform way of analysing their complaints; if they did this would almost certainly help them to identify areas of concern which repeatedly arise. Instead, we continue to see response to complaint letters written in medical terms which are difficult for the public to understand. The response frequently fail to answer the questions raised and they often fail to take a broad objective view about the care provided to the complainant.

18. This approach leaves complainants with little choice but to either drop their concerns (which many do) or seek legal advice. The Clwyd/Hart report of October 2013:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/255615/NHS_complaints_accessible.pdf documented problems with the complaints process. That report quotes from Sir Robert Francis QC's report on the Public Inquiry into the Mid Staffordshire NHS Foundation Trust: "*A health service that does not listen to complaints is unlikely to reflect its patients' needs. One that does will be more likely to detect the early warning signs that something requires correction, to address such issues and to protect others from harmful treatment*." This illustrates the importance and weight that needs to be attached to the complaints procedure. Despite these reports, little or nothing appears to have been done to change the culture in NHS complaints processes.

19. Letter of claim and response: Although the Pre Action Protocol (PAP) for clinical disputes states (para 1.7) that sanctions may be imposed for failing to comply with the protocol, in practice this rarely happens. Greater emphasis needs to be put on the importance of imposing sanctions unless there are exceptional reasons not to, for example issuing proceedings to protect limitation.

20. Under PAP, the defendants upon receipt of a letter of claim have four months to investigate. Whilst there is an expectation that defendants will obtain independent medical expert evidence this does not appear to be routine. This may contribute to a deny, defend and delay culture which increases costs. The system may be improved if it were mandatory for the defendants to obtain independent expert evidence before preparing their letter of response, unless the parties agree it is not necessary.

21. When looking at the process around the letter of claim and response there should also be a requirement that all relevant documents should be disclosed in advance and within the same time limits that the medical records should be disclosed. Failure to disclose relevant documents at this time should result in a penalty unless there are exceptional reasons. One such reason might be that a SIR is in the process of being compiled in which case it should be incumbent on the defendants to prioritise the report and to disclose it within a mutually agreed time.

22. Concluded litigation: There is no formal process by which the outcome of litigation is fed back to the trust or hospital concerned; this makes it difficult for them to show that they understand the issues that gave rise to the negligent treatment. Equally it makes it difficult to identify whether they are able to demonstrate that changes have been made to prevent those incidents from recurring.

23. Identifying changes made: Whether it is following the preparation of a serious incident report, recognition of a valid complaint, or concluded litigation there is no mechanism by which the defendant is obliged to formally set out what they have done to address the failings in the system.

24. In our experience, clients are often driven to litigation because it is the only avenue open to them to obtain the truth, seek redress and ensure that the same thing does not happen to anyone else. The failings in the complaints process, serious incident reporting process and letter of claim stage result in widening the underlying mistrust that clients feel.

25. The current system would benefit if it introduced a mechanism by which a defendant is obliged to account for how they have addressed the failings identified. This would ensure that defendants could demonstrate to the public that notice has been taken of events, lessons have been learned and procedures put in place to minimise or eliminate the chances of the same issues happening again. If this results in a reduction in clinical negligence incidents then this will save costs. AvMA has already approached the NHS LA and Department of Health with a suggestion to use "Patient Safety letters" as one way to help ensure there is reflection and learning following litigation. An outline of the suggestion can be found here:

    https://www.avma.org.uk/?download_protected_attachment=Briefing-Patient-Safety.pdf

26. **Culture**: The nature of AvMA's accreditation process is such that we see an estimated 200 case reports per annum, these are cases which have settled in the preceding 18 months. We are aware that some cases appear to take an inordinately long period of time to settle. The longer a case runs the more expensive it becomes.

27. We have seen evidence of defendant organisations failing to give full and timely disclosure of all relevant documents at the outset so the case can be properly investigated.

28. We have seen examples of where the NHS LA have failed to settle cases at the earliest opportunity, for example claimants putting in early part 36 offers which are refused and unrealistic counter offers or no counter offer being made at all.

29. In some cases, such as elderly care claims, there is a sense that the claim is being dragged out to see whether this will make it uneconomical to run due to risks on proportionality.

30. We have seen evidence of cases which have been run to the last stages of the litigation process before settlement is reached; however the vast majority of costs have been incurred by then.

31. We frequently receive reports from claimant lawyers of defendant representatives attending settlement meetings, such as round table meetings, without having specific authority to settle cases – this causes unnecessary delay in settlement.

32. **Accreditation:** Following the introduction of the Legal Aid Sentencing, & Punishment of Offenders Act 2012 (LASPO) introduced in April 2013 many personal injury (PI) firms began undertaking clinical negligence work. This was to compensate for the loss of income these firms experienced following the introduction of FRC in low value PI claims.

33. Many of these new firms have little or no specialist knowledge of clinical negligence work and litigation; their screening procedures are poor and their ability to identify and weed out weak clinical negligence cases that do not have merit is limited. The result is that cases are being brought which would not otherwise be if they were in the hands of specialist solicitors.

34. The reduction in the availability of legal aid for clinical negligence claims has played a key part in encouraging this market. The Legal Aid Agency dictates that only firms with a legal aid franchise in clinical negligence can offer legal aid in this area of work. A legal aid clinical negligence franchise can only be obtained if there is a clinical negligence solicitor who is accredited by a recognised panel. However, as legal aid is now restricted to injuries occurring around the time of birth, any other injury will have to be conducted by some other means of funding, usually a conditional fee agreement (CFA).

35. AvMA is responsible for setting up the first accreditation scheme and has been accrediting clinical negligence practitioners for in excess of thirty years. Accreditation is considered necessary to help ensurer members of the public can find their way to lawyers who have experience and expertise in clinical negligence matters. We expect accredited lawyers to give independent and robust advice on whether a claim has prospects of success; it is in no-ones interest for unmeritorious claims to be brought, least of all an injured patient.

36. The effect of allowing non specialist lawyers into clinical negligence has been felt by both claimant lawyers and defendant groups, it has not helped the public who are now often encouraged to make a claim by aggressive media advertising. The NHS LA recognises this difficulty; the NHS Litigation Authority Report and accounts 2013/14, cited an 18% increase in the number of claims made in the preceding financial year. The NHS LA described this as *'an unprecedented increase in claims'*. The report also stated that *'… changes to the legal market, in particular changes to claimant's legal funding arrangements, had a significant impact on our work. For example, reduced fixed costs in motor personal injury claims have attracted a number of new entrants to the clinical negligence arena as one of the last remaining areas where claimant solicitors can charge an hourly rate, resulting in us having to deal with more than ever new claimant solicitors. We have also seen an increase in poorly investigated claims and claims where*

the care clearly was not negligent being brought by lawyers who do not specialise in clinical negligence work.'

37. In addition, The Legal Services Consumer Panel Report: Accreditation schemes – progress report (April 2014) noted that *'one important change since 2011, however, is that the Legal Aid Agency (LAA) no longer operates the Specialist Quality Mark or the Mediation Quality Mark. In the past some schemes required these as part of their entry or re-accreditation requirements, meaning that the LAA helped to set the standard for many consumers who used lawyers with an accreditation mark.'*

38. AvMA considers that there is a correlation between claims that lack merit being brought and inexperienced claimant lawyers.

39. The clinical negligence market would benefit from defendant lawyers and NHS LA claims handlers having equivalent accreditation processes. This would demonstrate that defendant organisations are ensuring that only practitioners with experience and expertise in clinical negligence work are managing clinical negligence claims.

40. An equivalent defendant accreditation scheme would help to ensure that some of the poor practices complained of by claimant lawyers are weeded out; those practices include a delay, deny, and defend culture, which significantly contribute to the increase in clinical negligence costs. Although the NHS LA maintains that they have Key Performance Indicators (KPI) for their defendant panel firms, they are unable to share those KPIs as they are commercially sensitive. We suggest that any defendant accreditation scheme is appropriate and transparent.

41. Any changes to clinical negligence work should ensure that accreditation of both parties is a key requirement.

The Types and areas of litigation in which FRC should be extended

42. The nature of clinical negligence work is such that we do not see that it is easily suited to a FRC regime. AvMA believes that a properly managed and implemented cost budgeting process is a fairer and more appropriate way of controlling clinical negligence costs than any FRC regime.

43. However, if FRC is to be introduced for clinical negligence claims we urge that the rates of remuneration paid are commercially viable. This will ensure that low value claims can continue to be brought.

44. Any FRC regime must recognise that the burden is on the claimant to prove their case. This requires claimant lawyers to investigate the case properly at the outset; unlike PI claims, negligence in clinical negligence claims can usually only be determined by involving requisite expert evidence. This necessarily means

that the claimant lawyer will incur costs in excess of those incurred by the defendants and this needs to be reflected in any FRC regime.

45. Most clinical negligence cases are run on a conditional fee agreement (CFA) arrangement. Accredited claimant clinical negligence lawyers recognise that there is no profit or benefit in running claims that are unlikely to succeed. These lawyers properly investigate and risk assess cases at the outset ensuring that only cases with apparent merit are pursued.

46. Solicitors should not be discouraged from properly risk assessing cases at the earliest opportunity although those investigations should be proportionate to the facts apparently in issue. The fact a claim is low value, does not make it less expensive to investigate therefore there is no value in allowing fixed pre issue costs. Fixed pre issue costs are likely to encourage less detailed investigation.

Should claimant costs and defendant costs be different?

47. Both claimant and defendant lawyers should be paid a fair rate for the work they do. The rate should be appropriate to ensure that there are sufficient incentives for cases to be properly investigated at the earliest possible opportunity.

48. AvMA has been able to obtain details of the rates paid to NHS LA defendant panel solicitors though a freedom of information act request. The rates can be found in the NHS LA legal framework agreement: https://www.avma.org.uk/?download_protected_attachment=Framework-Agreement.pdf

49. The framework agreement identifies that in claims valued up to £50,000 all work done including service of the defence will receive £2,000 plus VAT. The £2,000 payment includes the cost of all disbursements. Disbursements include counsel's fees and experts reports. All additional work following on from the defence up to conclusion (although not trial) is fixed at a total cap of £4,500 plus VAT inclusive of disbursements. Thereafter a partner or solicitor of 10 years post qualification experience, based in inner London will be paid £194/hour plus VAT.

50. To give the NHS LA hourly rate context, it could be compared with the Supreme Court Costs Office (SCCO) guideline hourly rate (GHR) of £409/hour plus VAT for someone of equivalent experience. It is worth noting that the GHR has not been increased since 2010.

51. One interpretation of these fixed payments may be that if the defendant firms can work for this rate, so too can the claimants. The other interpretation is that the rate is too low to incentivise defendant solicitors to investigate these claims properly at the outset.

52. When considering these rates it should also be born in mind that in most instances the cases will have been conducted by the NHS LA in house team before being transferred to panel solicitors, consequently some work will already have been done on the cases. The rates quoted above do not take into account the costs incurred by the NHS LA in house team or staff in individual NHS trusts.

53. Following AvMA's freedom of information act request, the NHS LA confirmed that the criteria for transferring cases from in-house NHS LA staff to panel solicitors is upon service of proceedings or "earlier if considered appropriate on an individual case". If that is correct then it suggests that the defendant firms will receive £2,000 for considering the information gathered by the NHS LA and arranging for a defence to be filed.

54. Given the fact that the NHS LA usually sends the letter of response, it is not clear whether they obtain independent medical expert reports or if this is left to the panel solicitor.

55. In the same freedom of information act request, AvMA asked the NHS LA to provide details of the hourly rates paid by the NHS LA to medico legal experts instructed by NHS LA panel solicitors. The NHS LA said they were unable to respond to this question owing to the way claims are recorded on their claims management systems. They advised that in order to provide this information they would have to "…individually review each claim" and to do that would incur a cost in excess of the appropriate limit.

56. AvMA is not in a position to comment on what an appropriate rate might be other than to say the rate payable to an experienced clinical negligence lawyer ought to be fair and reasonable.

57. AvMA does not seek to speak with authority on whether claimant and defendant lawyers should be paid the same rate other than to observe that experienced claimant lawyers do a considerable amount of work weeding out cases that don't have merit, ensuring these cases are not brought. This is an important exercise that saves both defendant organisations and the courts money.

58. For those cases that are brought, the burden is on the claimants to prove their case, this is a much more onerous position that the defendants. The claimant must show that there has been a breach of duty, that the breach resulted in injury; the loss needs to be quantified as general and if applicable special damages.

59. The claimant lawyers job is to drive the litigation. Claimant lawyers also have to be skilled at dealing with clients who are often very distraught whilst at the same time managing their expectations and obtaining relevant information from them; arguably this ought to be reflected in a more favourable pay structure for claimants.

60. It is relevant to note that experienced claimant clinical negligence lawyers know that most of their clinical negligence cases will be run on a CFA. Lawyers will only be paid for the work they do if the case is successful; this is a powerful incentive to ensure that only claims with merit are taken on. It does not make financial sense for a claimant lawyer to take on cases that are likely to be unsuccessful. The commercial impact of unsuccessful cases is such that claimant lawyers invest in rigorous screening procedures, it also drives claimant lawyers to be proactive with progressing cases and to regularly review the prospects of a case succeeding. There are sound business reasons for not pursuing cases that are unlikely to succeed. By contrast, defendant lawyers carry none of the risks that claimant lawyers do; they are paid regardless of whether the cases they have conducted are won or lost.

61. It may be that a more cost effective and favourable approach would be to reward parties for early settlement. Equally, cost penalties should be imposed for those parties that drive the litigation to trial particularly where no attempt has been made to resolve the case along the way.

The concept of proportionality

62. As matters stand, the Civil Procedure Rules determine that proportionality trumps reasonableness and necessity (CPR 44.3(2)(a)). This is a matter of considerable concern for claimant lawyers, particularly in light of the first instance decision of Master Gordon-Saker in the case of ***BNM v MGN Limited [2016] EWCA Civ 1537*** (appeal to be heard in October 2017). AvMA believes that if adverse conduct as identified from CPR 44(3)(5)(d) were to trump proportionality this would help to focus the parties minds on early settlement. By addressing conduct the courts will have the opportunity to influence culture.

63. There should be a greater emphasis on the need for early settlement in these cases. The courts should have greater regard to behaviours in the pre-action stage; it should become routine to ask questions such as: were the serious incident reporting requirements adhered to? Was the serious incident report independent and robust enough? Was it shared with the family and or legal representatives in a timely manner? If appropriate, ask did the parties place sufficient weight on the evidence given at the inquest? Was the complaints procedure followed in an objective and open manner and was the response to the client's complaint frank and honest? Was this a case which could and should have settled at the letter of claim and response stage? Where there are missed opportunities in the pre-action stage then the offending party should be penalised.

Accommodating disbursement costs within a FRC regime

64. Access to justice in this field of work will only be assured if claimants can access legal advice and the necessary experts. As referred to above, a key part of this is ensuring that rates of remuneration available to practitioners are reasonable. If the rates are not reasonable then specialists will not do the work and the public will at best receive a cut price service.

65. It is also critical that funding is available for disbursements. In AvMA's experience most claimants are unable to meet the high cost of independent medical expert reports even in the pre action stage.

66. In order to pursue a claim claimants frequently rely on After the Event insurance (ATE) to cover the cost of expert's fees. At the moment ATE premiums are recoverable in successful clinical negligence cases; however the Ministry of Justice has advised that it intends to consult on whether ATE premiums should continue to be recoverable. If recoverability is lost then this will make it much harder for claimants to cover the cost of experts reports, seek just compensation and recourse through the courts.

67. Where a case is considered to have good prospects of success, some law firms have covered the cost of a client's disbursements. However, following the changes introduced in April 2013, in particular the restriction on recovering success fees, many clinical negligence firms are struggling to cope; cash flow is a common problem and this makes it difficult for many firms to cover their client's disbursement costs.

68. If recoverability of ATE premiums is lost and firms are not able to cover the disbursement costs then not only will many smaller clinical negligence firms face difficult if not ruinous times but clients will be unable to access justice because they will not be able to meet the cost of obtaining independent medical evidence.

69. In August 2015, the Department Health (DH) published a pre consultation document on FRC in clinical negligence. That document raised the possibility of capping expert's fees in all reports obtained by claimants on liability, causation, quantum and condition and prognosis, but with no such cap for defendants.

70. The clinical negligence lawyer is totally reliant on the advice and opinions given by the medico legal experts, it is therefore critical that the expert is suitably experienced in his or her field of medicine so they can speak on the standards expected with authority.

71. It is equally important that medical experts are independent and impartial and do not hold a bias either for patients or medics. A clinical negligence claim stands or falls by the quality of the advice given by the expert.

72. Most medical experts give their medico-legal opinions whilst continuing in active medical practice, often full time. It stands to reason that if they are going to spend time on examining the standards of care employed and or looking at whether negligent treatment gave rise to injury there has to be sufficient incentives for them to undertake the work.

73. It must be remembered that not only do medico legal expert give up their time to write reports but they also put their own professional reputation on the line when they criticise another practitioner's work.

74. In 2015, AvMA met with the British Medical Association (BMA) to see whether there was any possibility that experts might be persuaded to reduce their fees. As we understand it, the GMC's view is that experts operate in an open market, if they are not paid sufficiently for their reports they will simply withdraw from the expert reporting market.

75. AvMA has undertaken its own review of experts fees to identify whether a cap on their fees would cause them to reduce their hourly rates. AvMA experts say they will not reduce their rates.

76. If experts fees are subject to a cap and experts do not reduce their fees then it will be left to the claimant to make up the difference between what is allowed by way of the capped expert fee and the commercial rate charged by the expert. This could be considerable and would have to be deducted from any award of damages recovered by the client.

77. Artificially depressing experts fees by putting a cap on them will not alter the market forces. Evidence of this can be found in the way the Legal Aid Agency has depressed the rates payable to experts in clinical negligence cases. The result has been that most good experts will not do legal aid work, however defendant organisations are not bound by the same restrictions and can and do pay what the market dictates. This creates an unequal playing field between claimant and defendant lawyers.

78. There must be a greater emphasis on the need for parity between parties, this means equal access and freedom to choose relevant experts. We have already referred to the fact that the DH pre consultation on FRC suggested a cap on experts fees for claimants. There was no equivalent suggestion for defendants despite the fact that the NHS LA deal with the vast majority of defendant claims and are funded by tax payer money.

79. There is a clear anomaly in allowing the NHS LA to pay a higher rate to their experts than the claimant can to their own experts specialising in the same field of medicine. The situation is particularly difficult to accept given that the claimant is the injured party and is responsible for proving whether they have suffered

injury as a result of a negligent act caused by an act or omission by someone working for an NHS Hospital. There is no logical reason why the NHS hospital should be in a better position than the Claimant.

80. Experienced claimant and defendant lawyers are often instructing experts in fields of specialism where there is limited availability. An experienced expert who has an established reputation in medico legal matters is more likely to give a robust view on the merits of a claim than someone who has little or no experience in the field. As such an opinion from an experienced medico legal expert is likely to be more cost effective as it reduces the chances of an unmeritorious case being brought and increases the chances of a swift conclusion to the case.

81. If claimants are unable to access medical expert evidence then they will be unable to bring valid claims. In turn, this will inevitably mean that the injured party has no access to justice. It will also mean that there is no accountability on the part of the care provider and this will encourage poor care and negligence to perpetuate and to go unchallenged.

82. The high cost of court fees, particularly the issue fee has also compounded the problems of funding clinical negligence disbursements. Court fees are a bar to accessing justice.

83. Counsel's fees have to be included in the current cost budgeting system, the courts are therefore able to check and approve these costs, which they do. If a bill is submitted by the successful party at the conclusion of the litigation and barristers fees are considered to be excessive then there is an opportunity to challenge this by way of detailed assessment.

84. Given that no two clinical negligence claims are the same is must be right that disbursements should be open to challenge in the event that the fees claimed in a particular case are considered excessive.

85. AvMA supports maintaining the current system for the assessment of costs and disbursement in this field of work, particularly given the reliance upon involving specialist, highly skilled individuals.

Risk to client damages

86. We have not seen any suggestion that the introduction of FRC would prevent firms from entering into a CFA with their client; we understand that FRC and CFAs are common place in PI litigation.

87. If a FRC regime were introduced for clinical negligence claims and assuming a CFA could offered in conjunction with any FRC cost regime then this is likely to have a severe impact on the claimant's damages.

88. The claimant would potentially be liable for several deductions from their damages. First, the lawyer's success fee would be deducted; a maximum of 25% of the total award subject to this being limited to general damages and past losses.

89. Secondly, where a CFA has been entered into, the claimant's lawyer will be able to recover the difference between what is being claimed on the hourly rate under the CFA and what is recoverable under the FRC regime. The difference will be deducted from the client's damages.

90. Should there be any shortfall in what can be recovered for disbursements then this too can be taken out of the client's damages.

91. As costs are not ring-fenced in the same way as success fees, clients may discover that despite being the successful party they will receive little or nothing from the litigation process. The lower the value of the claim the greater the likelihood that this will be the outcome.

92. This situation will not encourage defendants to settle claims any quicker. On the contrary, from a tactical point of view there would be every reason for a defendant to delay and incur as much cost as possible to effectively run the claimant out of the litigation process.

93. This situation offers no incentive for defendant lawyers to settle claims, or to settle claims for fair levels of compensation. In turn this is likely to have a disproportionate effect on the most vulnerable in society, such as the elderly and the bereaved whose claims are typically low value.

94. A FRC regime that does not encourage equal access to experts, and fair compensation does not offer access to justice for the client and cannot be supported by AvMA.

FRC - Threshold

95. For the reasons stated in this paper AvMA does not think that FRC are appropriate at any level in clinical negligence claims.

96. Although it might be seen as straight forward and tempting to hive off so called low value claims (this term often refers to claims worth no more than £20,000 - £25,000), for special costs treatment, this is a big mistake in our view.

97. So called low value claims are very important, in practice they typically include fatal accident claims (where there is no dependency), still birth claims, elderly care claims and some types of misdiagnosis of cancer cases. With a growing ageing population the treatment and care of elderly patients is a matter of public interest.

98. The cost of proving a so called low value claim can be as expensive as proving a high value claim; one example of this is still birth claims where the experts required on liability and causation can be similar to those required on a cerebral palsy claim, only the quantum recoverable is different.

99. The way in which a care provider handles their low value claims can be an indication of how well they are being managed. Post LASPO we have seen how claimant lawyers rigorous screening procedures and increased caution over proportionality issues has resulted in claimant lawyers becoming even more circumspect about the cases they take on. Many claimants with low value claims now struggle to get representation.

100. If claimants with low value claims are unable to get representation then poor practices within the NHS will go largely unchallenged and will continue; this is not in anyone's interests.

The need for a clear and timely introduction of any FRC regime

101. AvMA is mindful that the introduction of LASPO caused a rush of solicitors seeking to issue proceedings to secure the benefits of the old system. This encouraged lawyers to abandon rigorous screening in order take advantage of the more favourable system.

102. If a FRC regime is introduced it must ensure that there is ample opportunity for the new rules to be introduced in a reasonable and controlled way. This is necessary to ensure that claimant lawyers are able to advise their clients properly from the outset. It should also help to avoid a flood of cases being issued or managed in advance to avoid the implications of any new FRC regime.

Conclusions:

103. In a personal injury claim the issues on liability are often much more readily identifiable to a lawyer. Many of the issues giving rise to liability are set out in statute: the Road Traffic Act and the Occupiers Liability Act are just two pieces of legislation that make it possible for the lawyer to identify liability. Personal injury lawyers typically don't need independent medico legal expertise to identify whether there has been a breach of duty or not. This fact alone makes it more

feasible for low value personal injury cases to be streamlined, the same cannot be said of clinical negligence claims.

104. Although AvMA does not support the introduction of FRC for clinical negligence claims we do believe that there are ways to save costs in clinical negligence cases.

105. In the DH's pre consultation FRC (referred to above) it justified rolling out a consultation on FRC on the basis that: (i) There has been an increase in the number of reported incidents resulting in harm; (ii) The legal environment encourages claims and this in turn has increased the number of patients who claim as a proportion of incidents; (iii) an increase in the number of people bringing claims without merit (iv) The emergence of non-specialist lawyers leading to disproportionate and excessive claimant legal costs for lower value claims; (v) there has been an increase in damages over and above inflation for high value claims.

106. If the above justifications are valid, then the suggestions made in this response would adequately correct those difficulties without causing undue hardship to legitimate claimants. We strongly recommend that clinical negligence is excluded from FRC and that instead, the relevant stakeholders work together to address the issues identified, other real causes of unnecessary costs, and come up with solutions which reduce costs whilst preserving access to justice and promote learning to help prevent negligent incidents in the first place.

107. In relation to point (v) of the DH's justification we take the view that damages payable are determined by the nature of the injury sustained. It is the judges who take the lead in identifying the level of damages to be awarded; we believe they are much better placed to comment on the validity of the awards made than the DH whose priority is to reduce the costs expended by the NHS.

108. Savings can be made by placing greater onus on defendants to respond to failings in their care by demonstrating that changes have been made to address the causes of poor and or negligent treatment. As Don Berwick pointed out this will prevent mistakes and subsequent injuries from being repeated which in turn will stem the flow of negligence claims and save money.

109. Savings can also be made by addressing cultural issues, including defendant behaviour and bad practice in litigation – these are probably the biggest contributors to the unnecessary increase in clinical negligence costs. This goes hand in hand with putting greater emphasis on using the early opportunities to admit liability and settle claims before proceedings are issued.

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23rd January 2017