Further supplementary written evidence submitted by Action Against Medical Accidents (NLR0075)

1. Important Context/Background

Action against Medical Accidents (AvMA) is a patients' charity working for better patient safety and justice when things do go wrong. Our role is to represent the interests of patients and harmed patients in particular, not the interests of lawyers. We do however enjoy a very good relationship with lawyers who specialise in clinical negligence and a good understanding of the environment in which they work. We also work with government departments; regulators; NHS bodies; and health professionals in pursuit of better patient safety and justice.

On 31st January 2022 the Department of Health and Social Care published a consultation on its proposals "Fixed recoverable costs in lower value Clinical Negligence claims". Although we commented on the concept briefly in our first submission, this submission provides further comment on the proposals now that they are known.

The Department first consulted on very similar proposals in 2017 and the proposals were rejected by the majority of respondents. Patients' organisations in particular, including AvMA; the Patients Association; and National Voices were strongly against the proposals.[1] This was on the basis that they would lead to a reduction in access to justice for injured patients/families; were inconsistent with a 'just culture' in healthcare; would lead to lost opportunities to learn from incidents and improve patient safety; and failed to deal with the root causes of high legal costs in clinical negligence.

In spite of this, the Government asked the Civil Justice Council (CJC) to develop proposals for fixed costs in clinical negligence cases. Despite requests to do so, Ministers refused to include exploration of the root causes of high costs and how to avoid them; alternatives to fixed costs; or the impact on patient safety; in the terms of reference for the CJC Working Party. The resultant report was flawed in many respects, not least in that it failed to include views that were inconsistent with or called into question the proposals and process leading to them.

The fact that it is the Department of Health and Social Care is running the current consultation is significant. Access to justice is not something that this department has expertise in or responsibility for - this is the domain of the Ministry of Justice. The Department of Health and Social Care has a huge conflict of interest in that it pays the bill ultimately for anything the NHS spends, including on clinical negligence litigation. One has to question the appropriateness of a department with a huge conflict of interest driving what is essentially another department's responsibility. This has also led to a lack of objectivity in the policy proposals and in the consultation itself.

2. What causes high legal costs in clinical negligence cases?

Anyone who reads the consultation document who is not familiar with how clinical negligence works could be forgiven for thinking that legal costs are high in lower value clinical negligence claims because claimant lawyers are being greedy and claiming more than they should. AvMA does not condone claims for excessive costs.

Where a party believes the claim for costs is excessive, solutions already exist. Typically, parties will try and negotiate this themselves, where that is not possible then the matter can be referred for "summary assessment". This is where a costs judge considers the papers and sets out what they

[1] https://www.avma.org.uk/wp-content/uploads/Letter-to-the-Editor.pdf

think is fair. If the parties remain unhappy with the outcome of the summary assessment process, they can go to a full oral hearing before the judge in a process known as "detailed assessment".

Costs judges assess claims on what is referred to as the "standard basis" this means that only costs which were reasonably and proportionately incurred are allowed. The process is rigorous so that even if costs were reasonably incurred, they will not be allowed if the judge considers the cost to be disproportionate to the value of the claim.

It is clear that a robust system for challenging costs already exists, introducing fixed recoverable costs into this complex area of work will simply prevent some injured patients and/or their families from accessing justice. AvMA made a Freedom of Information request to NHS Resolution about any successful challenges they have made about legal costs in claims with £25,000 damages or less, and they could provide us no evidence of this. This suggests that NHS Resolution does not find it necessary to use the summary assessment or detailed assessment procedures, either because they consider the bill of costs received to be fair and reasonable or because they have managed to negotiate fair and reasonable settlement of the bill without recourse to the courts.

To state the obvious, not only legal costs but the cost of damages (compensation) paid and, most importantly, the terrible human cost of clinical negligence cases will be avoided if the perfectly avoidable lapses in patient safety that lead to them are prevented. This is about healthcare providers learning lessons and tackling systemic problems that exist within their organisations. The CJC proposals for fixed recoverable costs in low value clinical negligence claims do not seek to address the need to learn from mistakes and to make sure the same incident does not repeat itself. As a member of the CJC working party AvMA offered suggestions on how healthcare providers could learn from litigation, but this gained little traction or interest from the DHSC.

If these incidents are well investigated at the outset, at the complaint and/or serious incident report and pre action protocol stage and the NHS is proactive in seeking to settle cases where it is at fault without litigation, legal costs associated with settling clinical negligence claims can usually be avoided almost entirely. Even when it comes to cases that are litigated, legal costs are only recoverable in 'successful' cases. If these cases are investigated properly and settled promptly the vast majority of legal costs are avoided. Only in cases where there is protracted defence of claims do the legal costs become very large. It is a fact that around 80% of cases where legal proceedings have been issued settle in favour of the claimant.[2] This means that there are huge opportunities to save money on the legal costs of clinical negligence if the NHS and its lawyers investigate and assess cases better and settle them earlier. The longer a claim runs on, the greater the costs incurred. The aim must be to settle valid cases early on.

In clinical negligence cases, the onus is on the claimant to prove negligence and causation. The claimant does not have free medical expert opinions at their disposal and the cases require significant investigation and other work to stand a chance. Almost all clinical negligence cases are now run on the so-called 'no-win no-fee' or 'conditional fee' arrangements. This is because the Government took almost all clinical negligence cases out of scope for Legal Aid, which the NHS Litigation Authority (now NHS Resolution) said was the most cost effective way of funding clinical negligence claimant costs. 'No-win no-fee' is necessarily more expensive as the claimant solicitors get nothing if they do not 'win' their case. However, defendant solicitors get paid for however long they spend on a case, win or lose.

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

3. What concerns us most about the Government's proposals?

It is already very difficult for injured patients/families to make a successful claim for clinical negligence. This is even more the case in lower value claims, as the courts already consider proportionality very seriously, and many law firms therefore decline to represent clients with lower value claims because it is hard to recover their costs and to make a profit. As referred to above, even though a claimant may reasonably incur costs, those costs will not be allowed if they are disproportionate to the overall value of the claim. Defendant lawyers, have no equivalent benchmark. We have seen a marked increase in people coming to us for help because they are finding it hard or impossible to find a solicitor to represent them. The imposition of fixed recoverable costs in the way proposed would make this problem much worse. Even if a solicitor is found who is prepared to take on a case, there will be a perverse incentive for defendants to try to price the claimant out by continuing to defend, in the knowledge that the claimant solicitor simply will not be able to continue as they would not be able to recover their costs.

Professor Fenn's paper: "Evaluating the proposed fixed costs for clinical negligence claims: An Independent Review" dated January 2017 and appended to the DHSC consultation on fixed costs in 2017 compared the current cost recovery process with the proposed fixed costs in the 2017 consultation. He observed that the ***"gap between the current revenues and the proposed fixed costs" would have to be raised from client's damages and referred to this as the "client charge".*** That gap remains under the CJC current proposals. At page 21 of that report Professor Fenn concludes "***Clearly, if there were to be no change to current behaviour and revenue requirements by claimant's solicitors, many of these claims would simply not be viable for claimants. In particular, those of low value (e.g. below £25,000) which were anticipated to require litigation would be unlikely to obtain representation"***

Also at page 21, Professor Fenn, states:" ***Given the uncertainties over the extent to which any of these possibilities develop, the impact of the fixed costs proposals on the number of claims brought against potentially negligent health care providers would be unpredictable. Any major reduction in the propensity of patients to identify negligence could of course have wider implications for patient safety."***

In effect, whether it is the Government's intention or not, the proposals would make access to justice impossible for many people injured through clinical negligence. This is unfair and has no place with regard to the NHS which is supposed to operate within a 'just culture'. In effect, the Government is asking the very patients that the NHS has injured to accept further sacrifices in order to save the NHS money. This will affect low income families worst. To them, £25,000 is a huge amount of money (in addition to the need to see accountability and learning, which is usually top of their priorities).

However, as well as reducing access to justice being unfair, there are other unintended consequences of these proposals. If the ability of patients/families to challenge initial defences and denials are reduced, some incidents will never even be recognised as patient safety incidents and opportunities to learn from them to improve patient safety will be lost. It is often the case that these claims are defended because the NHS actually does not understand that it has been negligent until the legal investigations bring them to that realisation. Most cases where legal proceedings are issued are defended and ultimately settle in favour of the claimant.

The scheme would likely see an increase in claims management companies and non specialist solicitors moving into this market to fill the void left by specialist solicitors who can no longer afford to. There would likely be an increase in litigants in person, as many will not be able to get legal representation. Both of these would cost the NHS and the courts more time and money. Currently, specialist clinical negligence solicitors help screen many potential claims because they are able to assess them. Where cases are taken on by specialist solicitors they tend to be better managed. Litigants in person tend to be less knowledgeable and consume much more of the defendants and the court's time.

One of the fundamental flaws in the fixed costs regime is the failure to recognise and understand that just because a clinical negligence claim is low value, does not mean it is not complex. One example is elderly care claims. These are often complex and therefore expensive to run because older people tend to have underlying co-morbidities which makes causation expensive and difficult to establish. It would be a huge and inexcusable loss to the individuals concerned if these cases could not find representation because of the fixed costs regime and/or the impact of the client charge. It would also be a loss of learning to the NHS and other healthcare providers to say nothing of the impact the loss of accountability would have to society.

The complex nature of clinical negligence claims is evident from the fact that very few clinical negligence claims issued by lawyers experienced in this work are issued in the fast track. They are issued in multitrack to reflect the complex nature of the cases. The fact that there are designated Masters in the High Court dealing primarily with clinical negligence work is another indicator of the complex nature of these cases.

It is of considerable concern that the current CJC proposals for a FRC scheme for clinical negligence pivots on the use of Early Neutral Evaluation (ENE). AvMA does not dispute that ENE may be an effective tool as part of party's alternative dispute resolution (ADR) considerations, the fact remains that there is at best, there is little experience of this process being used in clinical negligence litigation and our feedback from claimant clinical negligence lawyers suggests that most practitioners have no experience of it.

Referring again to Professor Fenn's report he says at page 8, paragraph 3.1 "Scope" that ***"By my calculations 64% of all clinical negligence claims have a value below £25,000"*** With that in mind it seems to us at the very least cavalier to be restructuring litigation to include new and largely untried processes which cannot demonstrate an improvement on the existing process or that it will save costs. Injuries arising from clinical negligence change lives, this "wild card" approach cannot be shown to be efficacious or appropriate and should not be suggested as an alternative without at the very least a pilot being run. Furthermore, there is no evidence that experienced evaluators can be found to work at the rates suggested in the consultation.

4. Are there better ways to reduce legal costs without damaging access to justice?

The answer is most definitely yes.

During the pandemic, AvMA, the Society of Clinical Injury Lawyers, and NHS Resolution worked on a clinical negligence protocol for handling claims during the pandemic. This has been shown to save considerable amounts of money and shows that when people get around the table and talk, solutions can be found. Unfortunately, the Government has rejected repeated requests by AvMA and others to engage meaningfully about the causes of high costs in clinical negligence and how to

reduce them. Instead, there has been a dogged determination simply to push ahead with these fixed costs proposals at any cost.

Obviously, doing more to prevent incidents of negligence by improving patient safety is the most effective way of avoiding legal costs (not to mention the human costs and compensation ('damages')). The Government could do more to invest in patient safety rather than compromise on access to justice. However, there is more that can be done about those cases that do slip through the net, to reduce legal costs. Below we make some suggestions but do not claim to have all the answers. We would prefer the opportunity to get around the table with all the stakeholders and develop solutions.

We suggest the following alternatives to imposing fixed recoverable costs:

a) Dramatically improve the quality of investigations

If the NHS investigated incidents well, and recognised when there have been errors or omissions that cause harm, it would learn lessons for patient safety as well as enable it to make earlier admissions of liability without legal proceedings being issued. This would save huge amounts of money wasted in legal costs by defending cases that should have been settled earlier. There will need to be investment in experienced and trained investigators but this would pay for itself many times over. NHS Resolution is trying a similar approach with its Early Notification Scheme. Although it is early days and the scheme could no doubt be improved, the logic is the same. NHS Resolution should be supported in developing a similar approach with all claims and time should be given for this to work rather than compromising access to justice.

This need for greater emphasis on early investigation appears to be recognised by the CJC in their recent work on "Review pre action protocols: Interim Report" dated November 2021.[3]

At page 4, of that report the key reforms canvassed include introducing a "good faith obligation" to try to resolve or narrow the dispute at pre action stage. It would help the parties to identify the issues they agree on and those they do not – this envisages earlier, efficient, and effective investigation of claims. Most importantly, the proposals envisage giving weight to the pre action protocol by expanding the powers of the court so penalties can be imposed on parties for noncompliance with the pre litigation stage.

b) Avoid or remove perverse incentives to defend cases for too long

There is a very strong incentive for claimant lawyers not to take on cases that are not meritorious and to drop claims if it is clear they will not win. They do not get paid any legal costs at all if they lose their case. However, defendant solicitors get paid win or lose. There should be strong incentives introduced to encourage a more robust assessment of cases early on and earlier settlement. Cases that have been defended and led to high legal costs being incurred should be thoroughly reviewed and where appropriate the defendant lawyers penalised. Consideration should also be given to bringing in accreditation for defendant lawyers. It is widely recognised that the accreditation of specialist claimant solicitors in clinical negligence pioneered by AvMA and replicated by the Law Society has greatly improved the quality of claimant representation.

c) Ensure learning from clinical negligence cases to improve patient safety

[3] https://www.judiciary.uk/wp-content/uploads/2021/11/CJC-PAP-Interim-Report.pdf

Although NHS Resolution has made a start in trying to learn more lessons from the cases it handles, there is still relatively little evidence that this is widespread and resulting in improvements. We continue to see the same kind of incidents being repeated again and again and leading to serious harm or death. We have repeatedly called for 'joining the loop' in clinical negligence cases. We tried hard to engage with the Department of Health and Social Care and defendant representatives to consider this on the Civil Justice Council working party on fixed costs, but failed. We have developed the concept of a 'patient safety letter' to be written following any clinical negligence claim by the health provider. This would set out what if anything had been learned from the incident and any action being taken to improve patient safety. It would be shared with the patient/family; commissioners; and regulators. We believe this would help focus minds on making sure some good comes from these incidents, so they are less likely to happen to somebody else. Just about every person who comes to our charity for help say that this is what they most want.

5. If a fixed-costs system is to be introduced, make it fairer

Whilst AvMA believes there are better and fairer ways of reducing legal costs and supporting patient safety whilst protecting access to justice, we are not opposed to fixed costs in any circumstances. It is the Department of Health and Social Care's proposals as set out in its consultation that are so concerning. If the Government does decide to introduce fixed-costs, then it needs to reconsider how that is done. Clearly, a vitally important factor is what figures the costs are fixed at. If the figure is too low it means that law firms will not be able or prepared to represent some clients as it would not be commercially viable, this diminishing access to justice. Also, if the only way that lawyers can make it affordable to represent clients with these cases is to require the client to pay out of their damages for some or all of the legal costs that can not be recovered from the defendant, then this is also denying access to justice. In some of these cases this would be a high proportion of the damages received. It would literally be the Department of Health and Social Care making the very people who the NHS has harmed subsidise the cost to the NHS by sacrificing a large amount of their compensation.

As explained above, so-called 'small claims' can be just as important to the injured party and just as complex as very large claims. The proposed cut down 'fixed costs' approach is not suitable for all cases. We are glad that the Department of Health are proposing some exclusions, but we would recommend that cases where the claimant lacks capacity be excluded. These cases require a lot of extra time and are usually dealing with people with disabilities and complex needs. Consideration should also be given to having an option to consider requests for exemption of individual cases from the fixed costs' regime where there are exceptional circumstances or it is in the public interest for the case to have full and proper attention.

AvMA represents the harmed patients and families, not the lawyers. We are not in a position ourselves to advise on what level of costs are needed to keep most of these cases commercially viable to take on. Clearly, claimant law firms themselves are better placed to advise on that. However, as can be seen by the consultation document the Department has simply looked at the figures thought necessary by 'defendant' organisations and the figures thought necessary by claimant solicitors who actually do the work, and chosen the lower figure proposed by defendants. This lacks objectivity or credibility. The people with experience of running law firms/teams representing claimants need to be listened to and respected. The very least that one might expect is a compromise.

Finally, as discussed above, the proposals in the consultation document are untried and untested. This includes Early Neutral Evaluation – the key way proposed to determine cases. The consequences of these changes are so far reaching that there really needs to be a pilot of them, and careful independent evaluation of them before they are introduced widely.

March 2022