Department of Health

Introducing Fixed Recoverable Costs in Lower Value Clinical Negligence Claims

A response by the Association of Personal Injury Lawyers
27 April 2017

The Association of Personal Injury Lawyers (APIL) is a not-for-profit organisation with a 25-year history of working to help injured people gain access to justice they need and deserve. We have around 3,700 members, committed to supporting the association's aims and all of whom sign up to APIL's code of conduct and consumer charter. Membership comprises mostly solicitors, along with barristers, legal executives and academics.

APIL has a long history of liaison with other stakeholders, consumer representatives, Governments and devolved assemblies across the UK with a view to achieving the association's aims, which are:

- To promote full and just compensation for all types of personal injury;
- To promote and develop expertise in the practice of personal injury law;
- To promote wider redress for personal injury in the legal system;
- To campaign for improvements in personal injury law;
- To promote safety and alert the public to hazards wherever they arise;
- To provide a communication network for members.

Any enquiries in respect of this response should be addressed, in the first instance, to:

Helen Blundell, Legal Services Manager
APIL
3 Alder Court, Rennie Hogg Road, Nottingham, NG2 1RX
Tel:0115 958 0585; Fax: 0115 958 0885
helen.blundell@apil.org.uk

Executive summary

Cornerstones of the civil justice system

- It is essential that we maintain individual human rights and prevent injury where possible through social responsibility. We must never forget that for the injured person, this may well be the worst thing that has ever happened to them.
- Whilst efficiency of process is important, we must not lose sight of the fact that the injured person is at the heart of the compensation system. The law of England and Wales is in place to protect those who have been needlessly injured through no fault of their own.
- It is noteworthy here that the Department of Health seeks to advance its own cause, as wrong-doer, changing the way in which the injured person can succeed and the costs they can recover, in a way that would not be acceptable in criminal law.

Patient safety

- Despite the Department of Health's claim that it is committed to improving patient safety and reducing harm, the number of patients harmed in NHS care continues to rise. Incidents have increased by 53 per cent since 2010, suggesting no progress in reducing harm.
- In 2015 an average of 27 incidents resulting in death or severe harm were reported every day, suggesting that the DoH is failing to address the real reason for increased expenditure - the lack of patient safety.
- APIL recognises that improvements can be made to improve the process of obtaining compensation for those harmed but at the same time, prevention must become a higher priority for DoH.

The falling cost of claims and 'the LASPO effect'

- Analysis of data provided by the NHSLA shows the average cost of a successful clinical negligence claim has fallen by 7 per cent since 2013/14.
- The total cost of closed clinical negligence claims has also fallen by £22.25 million since 2013/14. This is in spite of increasing court fees, VAT and insurance premium tax (IPT).
- By allowing for the effects of the changes brought in by the Legal Aid, Sentencing and Punishment of Offenders (LASPO) Act 2013, the costs and expenses paid out by the NHSLA will now automatically start to reduce by around a third. This means that the NHSLA will already save one third of the sums it pays out, by doing nothing at all.

- In claims worth less than £25,000 those savings add up to an impressive 30.8 per cent of the sums currently paid out by the NHSLA in costs and disbursements on pre-LASPO claims.

Effect of the Government's court fees policy on the NHSLA's 'rising costs'

- Court fees are likely to affect a substantial number of clinical negligence claims brought against the NHSLA. In 2015/16, 5,845 clinical negligence claims which resulted in a compensation award were closed or settled by the NHS LA. Proceedings were issued in 2,685 (46%) of these claims. For a claim valued £25,000, the court fee payable upon issuing the claim has increased from £610 to £1,250, an increase of 104.9%, since March 2015.

Is the cost of claims really increasing?

- The cost of clinical negligence claims being closed by the NHSLA has been falling. In 2013/14, the average cost of these claims was £132,667. By 2015/16, the average cost had dropped to £123,883 – a fall of 7% compared to claims closed in 2013/14.
- The total cost of successful clinical negligence claims closed by the NHSLA has also fallen by £22.25 million since 2013/14 – from £740.15 million in 2013/14 to £717.90 million in 2015/16.
- Despite the misleading perceptions of increased claims costs perpetuated by the NHSLA, we accept that more can be done to improve the current process. Speedier resolution of cases will benefit the injured person.

Introducing Fixed Recoverable Costs

- On the basis that the fixed recoverable costs (FRC) being proposed are to be layered on top of existing processes, we oppose the imposition of mandatory FRC.
- A fixed, predictable claims process should be created first, then fixed costs for following that process can be properly calculated, saving both time and money for all those involved in the transaction.
- Imposing FRC on to the existing procedures which govern the conduct of clinical negligence claims will merely create additional and entirely predictable problems for the NHSLA, private health care providers and their insurers, as well as claimant representatives.
- If the DoH is determined to introduce fixed recoverable costs for claims valued at £25,000 or less, then it must also introduce a streamlined, predictable claims process so that the reduced costs match the reduced fees payable, along with

penalties and consequences for poor behaviour and additional incentives to promote early settlement.

There are also other incentives which can be employed to reduce costs

- These include rigorous enforcement by the NHS of the duty of candour; ensuring healthcare providers meet the current Never-Event reporting obligations; the NHSLA should abide by the *Pre-Action Protocol for the Resolution of Clinical Disputes* (the 'clinical negligence pre-action protocol')[1]; faster and better disclosure of medical records; reducing the number of patient incidents, through the implementation of additional learning and safety procedures.

Fixed Recoverable Costs Ranges

- If the DoH is determined to impose FRC, then our aim is to put forward reasonable views and suggestions as we recognise that should fixed fees be imposed, they should be as fair and equitable as possible and relate to all parties involved in these claims, not just claimants.
- Any fees imposed must be sufficient to ensure that injured people are still able to obtain advice and representation from a firm of solicitors. If this is not the case and fees are set too low, other middlemen such as claims management companies will emerge in the market.
- We are grateful that the DoH appears to have taken note of APIL's position outlined in its pre-consultation response: that there is at least the semblance of a rationale for restricting FRC to claims valued at no more than £25,000, because there are other schemes already in existence which have the same limit.
- Yet the consultation proposes that the fixed costs should apply to both fast track and multi-track cases. This is both unviable and manifestly unfair. If the claim process remains unfixed for cases valued up to £25,000 (and thereby continues to rely upon the CPR), then imposing a FRC scheme which applies to cases valued up to £25,000 irrespective of the track to which they are allocated is completely implausible.
- There are additional issues which will also have to be addressed such as reasonable expectation: at what point will the value of the claim be assessed for the FRC to apply? Later 're-valuation' of the claim: clinical negligence claims can suffer from 're-valuation' at a later stage due to the interplay of the claimant's pre-existing

[1] Pre-Action Protocol for the Resolution of Clinical Disputes: https://www.justice.gov.uk/courts/procedure-rules/civil/protocol/prot_rcd

illness and the uncertainty, at the outset, as to the recognised risks of certain surgical or medical procedures.

Implementation

- As will be evident, the association opposes the implementation of fixed fees for clinical negligence claims, for the many reasons set out in our response. However, if the DoH is determined to impose FRC, then option two – implementation to apply to claims where the adverse incident occurs after implementation date - would be preferable, although in our view a better and alternative option would be to use the date of the letter of notification as the implementation date trigger.
- We have grave reservations about the undefined transitional period contained in option one (paragraph 3.13 of the consultation). The suggestion that a transitional period could be used as a back door to including claims already excluded from the reforms is unethical and manifestly unjust.

Fixed Recoverable Costs Rates

- In our view, the rates in all of the options proposed would deter claimants from bringing valid claims.
- We are also concerned about the discriminatory effect that loss of earnings claims can have on the level of costs payable under the proposed options.

Expert Witness Costs

- APIL does not agree with this cap. Contrary to indications given by the DoH, the cap proposed in this consultation was not arrived at after consultation with the BMA, and is likely to be as unacceptable to experts as it is to legal practitioners.
- The elephant in the room in this consultation is the cost of an expert report.
- We know from experience with Legal Aid rates that imposing set expert rates can mean that experts are pulled out of the market and are simply not prepared to do the work for the set reduced fees.
- In these low value claims, is it really necessary to have a CPR compliant report which automatically pushes up the cost?
- Any proposal relating to expert fees must ensure that there remains a viable ATE market.

Single Joint Expert

- There are a number of difficulties with a SJE in clinical negligence claims: not least that many claimants use their proposed expert to ‘screen’ potential claims before

they progress. If the claim proceeds, the expert will be instructed to report: this process weeds out around 80 per cent of potentially new cases, saving claimants from bringing hopeless claims, and saving time and costs for the defendant who does not then have to defend numerous hopeless claims.

Early Exchange of Evidence

- Early exchange of evidence is a potentially cost effective way in which claims can be either settled or dismissed at an earlier stage than is the case in the current claims environment.
- In order to be cost effective, we question whether, if this is to be introduced by means of a rule change, the report needs to be CPR compliant. Early exchange of a short form (CPR non-compliant report) may well assist in identifying the relevant issues on causation or liability and could reduce the amount of time and expense spent on a claim.

Draft Protocol and Rules

- **Trial costs:** The consultation assumes that Fast Track trial costs are suitable for both Fast Track and Multi Track cases. This assumption is wrong. The courts invariably allocate even low value clinical negligence claims to the multi-track. Because of the additional expert evidence, the longer than one day trial lengths and additional oral evidence, we simply cannot see any justification why multi track trials should be included within the fast track fixed trial costs as proposed.
- **Multiple claimants:** multi-party claims (claimant or defendant) should be excluded from a FRC scheme.
- **Exit points:** if there has been no admission of liability (breach and causation) by the time provided for service of letter of response by the NHSLA/other healthcare provider, then the claim should be able to exit the fixed costs scheme. We see no reason why the defendant should be able to simultaneously contest the claim and deny the claimant additional costs to defend the claim.
- For a FRC scheme to work, there should also be a streamlined, predictable claims process for these claims. As with the existing pre-action protocols for low value road traffic, employers' liability and public liability claims (the 'RTA, EL and PL pre-action protocols'),[2] this process must have strict time limits, with failure to comply at key

[2] Pre-Action Protocol for Low Value Personal Injury Claims in Road Traffic Accidents from 31 July 2013 https://www.justice.gov.uk/courts/procedure-rules/civil/protocol/pre-action-protocol-for-low-value-personal-injury-claims-in-road-traffic-accidents-31-july-2013

points leading to the expulsion of the claim from the FRC scheme and back into the general costs rules for other excluded claims.

- **Other exemptions:** in addition to the exemptions listed in the consultation, there are a number of others which ought to be added to that list including: disputed liability; child fatalities; child claims generally; other protected parties; other fatalities; where there are more than two experts for *either* party; short life expectancy claims and Any claim including an allegation of a breach of the Human Rights Act 1998.

Behavioural change

- There are other levers which can be employed to encourage less adversarial behaviour on the part of all parties involved. These are vital if any fixed costs regime is to be considered a workable solution: the current proposals make little attempt to curb behaviours on the part of the NHSLA.
- These include: encouraging admissions of liability; a predictable claims process; enforcement of the duty of candour; abiding by the clinical negligence pre-action protocol; early admissions or a fixed costs penalty; better use of Part 36 offers; faster and better disclosure of medical records; accreditation of lawyers; compliance with and enforcement of statutory obligations relating to 'never-events' reporting; better use of alternative dispute resolution (ADR); the need for a culture change; the need to learn from mistakes; the need to adapt and evolve to improve patient safety.

Interim applications

- The use of interim applications should not be restricted (which is our interpretation of 'controlled'), particularly if other controls on behaviour by both parties are not created and implemented.
- Interim applications are used to drive the claim forward and enforce behaviour and compliance with timetables and rules.
- Removal or constriction of the use of interim applications would encourage a lack of compliance or co-operation between the parties.

APIL's opening comments

Cornerstones of the civil justice system

1. It is essential that we maintain individual human rights and prevent injury where possible through social responsibility. Negligent actions will happen and when this occurs we must have a system that provides access to care, rehabilitation and full redress to ensure, as far as possible, that the injured person is put back into the position that they were in before the negligence occurred.

2. APIL believes that the foundations of our civil justice system should be

   - Right to bodily integrity;
   - Access to justice for all in our society;
   - Protection of those who have been injured by the negligence of others;
   - Tortfeasor/polluter pays;
   - Full care and redress for the injured party;
   - Speedy and fair resolution;
   - Public confidence in the civil justice system;
   - Proportionality to issues and not damages.

3. The particular qualities of personal injury and clinical negligence law must be kept at the forefront of any considerations for reform in this area.

4. Clinical negligence claims law is unlike any other. The defendant is either an emanation of the State or is insured and defendants are able to use their enormous resources to defend claims. The claimant is an individual, who in the majority of cases was already sick before the negligence occurred. There is a David and Goliath struggle between the injured person and the State and/or insurers.

5. Personal injury law is one of a limited number of areas of law (defamation and discrimination being the other two) where personal integrity is at issue. Whilst efficiency of process is important, we must not lose sight of the fact that the injured person is at the heart of the compensation system. The law of England and Wales is in place to protect those who have been needlessly injured through no fault of their own.

6. We must never forget that for the injured person, this may well be the worst thing that has ever happened to them. It is essential that those injured should not be treated as commodities or commercial transactions. The aims of the Department of Health are at

odds with this. It is absolutely committed to reducing this debate to an issue about cost and process with little or no consideration about delivering access to justice for injured people. It has a professional duty and responsibility to the Treasury, and other medical defence organisations have obligations to their shareholders or mutual funds, while claimant lawyers have a professional duty to act in the best interests of their clients[3]. The defendants' over-riding duty to either the Treasury or their shareholders/funds explains their ceaseless efforts to inhibit the right of injured people to obtain full and proper redress through effective legal representation.

7. It is often overlooked that an injured person can only succeed in recovering damages and costs from a wrong-doer if they can establish that another person or organisation has been at fault. It is noteworthy here that the Department of Health seeks to advance its own cause, as wrong-doer, changing the way in which the injured person can succeed and the costs they can recover, in a way that would not be acceptable in criminal law. It is akin to a criminal defendant attempting to change the sentences which can be imposed for the crimes he or she has committed. It is fundamentally wrong to suggest that there should be an even-handed approach to the interests of the victim and the "interests" of the defendant.

Working for Injured people

8. We have said above that clinical negligence claims law is unlike any other. The same can be said of the relationship between a specialist personal injury lawyer and an injured person. The relationship is involved and complex. Not only will a lawyer advise and guide the claimant through the process of bringing claim, by providing advice on prospects of success, rehabilitation and quantification of the claim, but they also often provide much needed emotional support to the injured person at a time when their life has been turned upside down and the future can seem uncertain. There is far more to the relationship than a simple business transaction and it is this element of the relationship that sets it apart from any other. Clinical negligence lawyers do not consider their clients to be commodities and we believe that others should not consider them as such either.

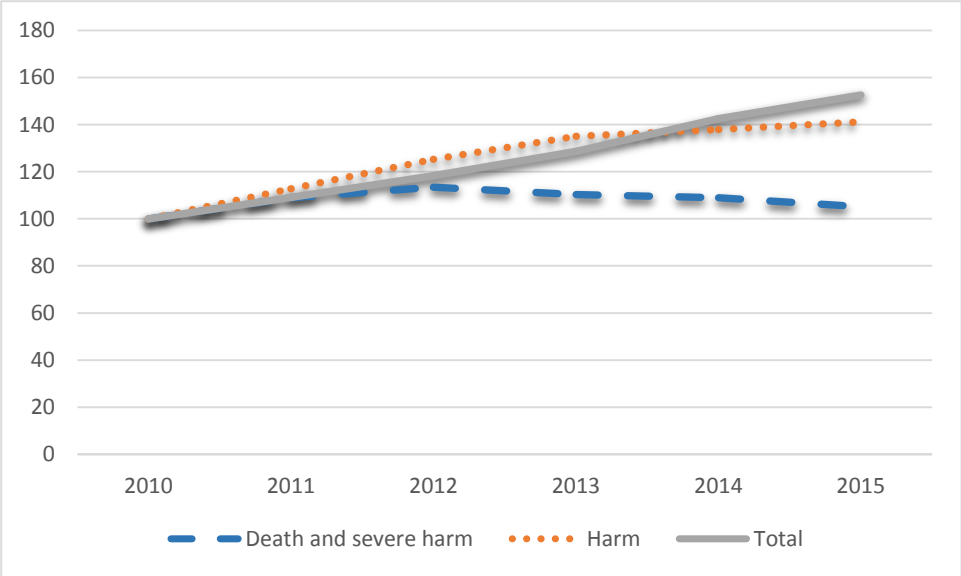
[3] Rule 1.04 Solicitors' code of conduct.

Patient safety

9. It is worrying that despite the Department of Health's claim that it is committed to improving patient safety and reducing harm, the number of patients harmed in NHS care continues to rise. Incidents have increased by 53 per cent since 2010, suggesting no progress in reducing harm. In 2015 an average of 27 incidents resulting in death or severe harm were reported every day, suggesting that the DoH is failing to address the real reason for increased expenditure - the lack of patient safety.

Fig 1.

Reported patient safety incidents, England (base=2010)



NHS data shows that 10,149 incidents resulting in death or severe harm were reported in 2015, equating to an average of 27 every day. This represents a 5% increase on the number recorded in 2010.

The number of incidents resulting in any degree of harm has also risen. 492,719 such incidents were reported in 2015 - an average of 1,350 every day.

Source: NHS Improvement, NHS National Patient Safety Agency (see appendix, table 1)

10. The NHS has argued that this increase in reported patient safety incidents reflects increased reporting rather than an actual increase in such incidents. This argument is not credible.

11. Since April 2010 NHS trusts in England have been mandated to report all serious patient safety incidents to the Care Quality Commission (CQC), with trusts asked to report all incidents resulting in death or severe harm to the National Reporting and Learning System (NRLS). The NRLS, in turn, reports these incidents to the CQC on behalf of the Trust.

12. Changes in the number of reported patient safety incidents resulting in death or severe harm should therefore reflect the changing number of such incidents in the NHS. If reports about these incidents increase, this is likely to reflect an increase in such incidents, rather than merely an increased incidence of reporting.

13. It is therefore concerning that the number of such reports has increased since 2010. In 2015, 10,149 patient safety incidents resulting in death or severe harm were reported, equating to an average of 27 every day. This was five per cent higher than the number recorded in 2010.

14. The extent of the increase in reported incidents resulting in any degree of harm is also concerning – since 2010 there has been a 41 per cent increase in such reports. While improved reporting practices may have partly contributed to this significant increase, it certainly cannot be ruled out that some of this increase is the result of an increased number of incidents.

15. Indeed, there has now been a focus on improving reporting practices for a number of years, yet the number of reported incidents has still continued to rise year on year. Furthermore, APIL is not aware of any independent research which would substantiate claims that the significant increase in reported incidents is wholly, or even primarily, the result of improved reporting practices.

16. Of the 492,719 patient safety incidents resulting in harm which were reported during 2015, only two per cent resulted in claims against the NHS.

17. APIL recognises that improvements can be made to improve the process of obtaining compensation for those harmed but at the same time, prevention must become a higher priority for DoH.

The falling cost of claims

18. Defendants such as NHS Litigation Authority ('the NHSLA') (NHSLA has now changed its name to NHS Resolution, but we will refer to it in this paper as NHSLA throughout, as we will refer to figures supplied in the past by the NHSLA as well as future conduct and costs which will apply to NHS Resolution) continue to argue that they are paying out too much in legal costs. Analysis of data provided by the NHSLA shows the average cost of a successful clinical negligence claim has fallen by 7 per cent since 2013/14. The total cost

of closed clinical negligence claims has also fallen by £22.25 million since 2013/14. This is in spite of increasing court fees, VAT and insurance premium tax (IPT).

The cost of claims – the 'LASPO effect'

19. By allowing for the effects of the changes brought in by the Legal Aid, Sentencing and Punishment of Offenders (LASPO) Act 2013, the costs and expenses paid out by the NHSLA will now automatically start to reduce by around a third. This means that the NHSLA will *already* save one third of the sums it pays out, by doing nothing at all.

20. In claims worth less than £25,000 those savings add up to an impressive 30.8 per cent of the sums currently paid out by the NHSLA in costs and disbursements on pre-LASPO claims.

21. Because clinical negligence cases typically take several years to resolve, the data currently available to the NHSLA does not reflect these substantial cost savings that have recently been introduced by LASPO.

22. According to the data APIL has collected from claimant practitioners, nearly half of the 'legal costs' paid by the NHSLA to claimant lawyers can be accounted for by success fees, ATE premia, court fees, VAT and experts' fees.

23. Since April 2013 both a large proportion of the ATE premium and all of the success fee have been paid by the claimant out of damages rather than by the NHSLA when it loses a claim. For this reason, the sums which the NHSLA says it pays to claimants give a misleading picture[4]. In fig.2 below we have looked at some of our members' claims and adjusted the figures to show a **pre- and post LASPO** picture, removing the historical bias. The final columns and summary row below clearly indicate the automatic savings of 30.8 percent from which the NHSLA will already benefit, in relation to all claims which have started since April 2013.

[4] The NHSLA publishes annual data, but it is not possible to ascertain from the data as currently compiled to accurately differentiate between legal costs incurred and the court fees, expert report fees, after-the-event (ATE) insurance premiums (for pre April 2013 claims) and VAT which have also been paid to the injured person's legal representatives, the court service and experts.

Fig 2

PRE and Post LASPO: Successful cases settled 12 months to 31st March 2013, showing spend expressed as percentage of average damages for claims valued at <£25,000

	Solicitor Costs	Success Fee	Barrister Fees	Barrister Success Fees	Medical expert fees	Other Disbs	ATE Insurance Premium	VAT Solicitors charges and Disbs	IPT on ATE Premium	Total Legal Costs Inc Tax
Pre LASPO	72%	41%	7%	4%	15%	33%	23%	24%	1%	220%
Post LASPO	72%	0%	7%	0%	15%	33%	10%	15%	1%	152%

Post LASPO - effect -30.8%↓

24. Using these percentages, it is possible to calculate the NHSLA's savings.

25. In 2015/16 alone, the NHSLA is likely to have saved £41 million on clinical negligence claims as a result of the LASPO reforms:
    - In 2015/16, the NHSLA closed or settled 3,503 'post-LASPO' clinical negligence claims. The claimant legal costs associated with these claims amounted to £95.97 million.
    - Assuming a 30 per cent drop in legal costs on post-LASPO cases, these claims would have cost the NHSLA £137.1 million in claimant legal fees, had it not been for the introduction of the LASPO reforms.
    - This equates to: £137.1 million – £95.97 million = saving of £41 million.

26. Going forward, the percentage of claims closed and/or settled by the NHSLA which commenced after the introduction of the LASPO reforms is likely to increase, as more historical cases are settled. This means that the impact of LASPO on claimant legal costs is likely to become more pronounced in future years.

27. The figures used to calculate this estimate also highlight the distorting effect that pre-LASPO cases have on the NHSLA's legal costs figures. In 2015/16, the NHSLA closed or settled 5,845 clinical negligence claims, and spent £325 million on the claimant legal costs associated with these claims. However, the vast majority (70 per cent) of this spend (£229.43 million) related to 'pre-LASPO' cases. This means that the claimant legal cost figures published by the NHSLA still largely reflect pre-LASPO practices.

28. On the basis that our data indicates that claimant legal costs on post-LASPO cases are 30 per cent lower, then the NHSLA would have spent £160.6 million on the pre-LASPO

claims it closed and/or settled in 2015/16, had these claims been run under the post-LASPO regime.

29. This means that if all cases closed or settled by the NHS LA in 2015/16 had been run under the post-LASPO regime, it is likely that the NHSLA would have spent £68.83 million less than the £325 million it actually spent on cases closed/ settled in 2015/16.

Effect of the Government's court fees policy on the NHSLA's 'rising costs'

30. The NHSLA's figures on claimant legal costs, to which the consultation documents refer, includes all fees paid by the NHSLA to claimant solicitors, including disbursements such as court fees.

31. This means that the substantial increase in court fees, introduced in March 2015 will have played an important role in explaining why claimant legal costs, as reported by the NHSLA, have risen. Indeed, in some cases court fees will have increased by over 600%[5].

32. For a claim valued £25,000, the court fee payable upon issuing the claim has increased from £610 to £1,250, an increase of 104.9%, since March 2015.

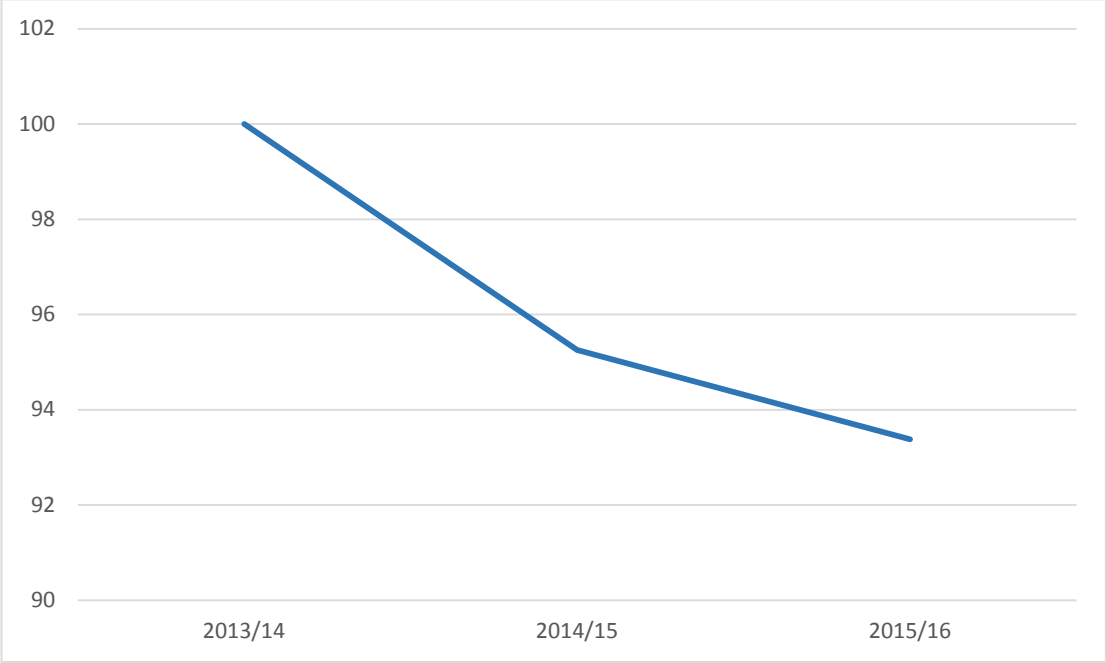
33. Court fees are likely to affect a substantial number of clinical negligence claims brought against the NHSLA. In 2015/16, 5,845 clinical negligence claims which resulted in a compensation award were closed or settled by the NHS LA. Proceedings were issued in 2,685 (46%) of these claims[6].

[5] Law Society, *Increases in court fees will impact access to justice*, July 2015, accessed at http://www.lawsociety.org.uk/news/press-releases/increases-in-court-fees-will-impact-access-to-justice-july-2015/. See table 2 of the appendix.
[6] NHSLA freedom of information responses

Is the cost of claims really increasing?

Average cost of closed clinical negligence claims with damages paid, excludes claims settled as a PPO (base=2013/14)

The average cost of a clinical negligence claim closed by the NHSLA has fallen by 7% since the introduction of the LASPO reforms in 2013/14.



34. An analysis of freedom of information response provided by the NHSLA shows that the cost of clinical negligence claims being closed by the NHSLA has been falling[7]. In 2013/14, the NHS LA closed 5,579 clinical negligence claims which resulted in an award of damages – the average cost of these claims was £132,667. By 2015/16, the number of clinical negligence claims closed by the NHS LA had risen to 5,795, with the average cost dropping to £123,883 – a fall of 7% compared to claims closed in 2013/14. These figures cover NHS LA spend on damages, defendant (i.e. NHS LA) legal costs, and claimant legal costs.
35. The total cost of successful clinical negligence claims closed by the NHSLA has also fallen by £22.25 million since 2013/14 – from £740.15 million in 2013/14 to £717.90 million in 2015/16.

36. Despite the misleading perceptions of increased claims costs perpetuated by the NHSLA, we accept that more can be done to improve the current process. Speedier resolution of cases will benefit the injured person. Cases are often vigorously contested only to be

[7] See table 3 of the appendix

settled days before trial, despite the fact that defendants have the ability to risk assess a case far more accurately than a claimant lawyer. Once a claim is notified either because the medical notes have been requested or the Trust is notified of a claim, the defendants have all the information available to them to conduct an early and thorough examination of the evidence.

37. The delay caused by vigorously contesting claims until late in the process also delays the ability for the NHS to learn from the negligence. In its strategy document, "Delivering fair resolution and learning from harm – our strategy to 2022" NHS Resolution admits that this is an issue[8] and that it needs to reduce the time lag between settling claims and learning from them.

38. It is APIL's view that procedures need to be improved which in turn will achieve cost savings and efficiencies in process. But they must not be so Draconian that specialist lawyers are no longer able to conduct these claims. We are disappointed that reforms proposed do not focus more heavily on patient safety and fixing the process, rather than simply slashing claimant costs.

39. If we get these reforms right there could be real benefits for the injured person, reduce the incidence of negligence and in turn create cost savings for the defendant.

Question 1: Introducing Fixed Recoverable Costs

Do you agree that Fixed Recoverable Costs for lower value clinical negligence claims should be introduced on a mandatory basis?

If not, what are your objections?

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

40. On the basis that the FRC being proposed are to be layered on top of existing processes, we oppose the imposition of mandatory FRC. A fixed, predictable claims process should be created first, then fixed costs for following that process can be properly calculated, saving both time and money for all those involved in the transaction.

[8] http://www.nhsla.com/CurrentActivity/Documents/NHS%20Resolution%20-%20Our%20strategy%20to%202022%20-%20FINAL.pdf

41. Imposing FRC on to the existing procedures which govern the conduct of clinical negligence claims will merely create additional and entirely predictable problems for the NHSLA, private health care providers and their insurers, as well as claimant representatives:
    - Inexperienced practitioners entering the market;
    - Cost cutting on the initial claims scrutiny, leading to increasing numbers of claims lodged, many of which would previously have been filtered out by the claimant's sifting processes;
    - Increasing numbers of litigants in person as more law firms turn away uneconomic low value claims;
    - Claims management companies entering the market where specialised solicitors are no longer available, leading to an increase in substandard claims and a lack of specialist knowledge as to how to conduct these claims leading to extra work for defendants;
    - Reduction in numbers of experts willing to be instructed at a reduced rate, leading to delays while experts' reports are sourced elsewhere. (See paragraphs 83-85 below).

42. We know from our Welsh practitioner members that the fixed cost Welsh NHS Redress scheme operating in that jurisdiction since 2011 has not evolved as anticipated by the Welsh Assembly. The scheme was designed to both reduce the work involved in clinical negligence claims and reduce the costs generated by the lawyers involved. It has done neither. However, the individual Health Boards' staff have received insufficient training and/or are under resourced. As a result, Welsh claimant practitioners report that many cases have to leave the scheme, usually due to severe delays in the NHS response and its gross undervaluation of claims.

43. We also know that simply because recoverable costs are fixed, this does not reduce the amount of work which is necessary to deal with claims. The Welsh NHS Redress scheme has a far more defined set of rules designed to reduce the work involved thereby reducing the cost involved. Despite the process defined in the Welsh scheme, additional work is almost always necessary: our members in Wales report that they will often write off more than half the value of the work they have done for the client despite having implemented efficiencies within their firms.

44. The effect of this is that in order to deal with claimants in the future under the proposed FRCs, practitioners will recruit less qualified practitioners in order to cut the costs of conducting a claim. The NHSLA will find that it is dealing with less experienced

practitioners and we predict that there will be a substantial increase in the numbers of litigants in person, as other firms turn away these low value claims. It is doubtful that any money will be saved if the claim process remains largely unchanged.

45. As it is, the proposals offer very little for injured people. There is little incentive for defendants to settle early. Quite the opposite: without controls on behaviour the defendant will be allowed to stall and the claimant's advisors will be 'outspent'. There is virtually no incentive for the defendant to make an early admission or to settle pre-proceedings.

46. In our view, if the DoH is determined to introduce fixed recoverable costs for claims valued at £25,000 or less, then it must also introduce a streamlined, predictable claims process for these claims so that the reduced costs match the reduced fees payable, along with penalties and consequences for poor behaviour and additional incentives to promote early settlement.

47. APIL discussed a low value FRC scheme with the NHSLA in 2011-13: a low value scheme aimed at claims valued at £25,000 or less was drafted and APIL costed out the fixed costs for that scheme. In the scheme we identified various aspects which would both save costs and streamline the claims processes involved so that the costs and the processes more accurately and proportionately reflected the value and complexity of such claims.[9]

48. In our view, there is a way to create a good low value FRC scheme and there are also alternative incentives which can encourage early settlement and good behaviour, saving costs for the NHSLA. They include:

Key characteristics of a good low value FRC scheme

49. The key characteristics of a workable low value FRC scheme are:

    a. A streamlined, predictable claims process:

       Without controls on the process (as is the case in the other FRC schemes for RTAs, employers' liability and public liability claims), the work which both sides (but particularly the claimant side) are expected to do will not be streamlined, and claimants in particular will be 'outspent' by the defendant NHSLA/private medical insurers who will continue to use the existing CPR to delay settlement of the claim;

[9] The scheme, with APIL's costings as calculated in 2013, can be downloaded here: http://www.apil.org.uk/files/NHSLA-Clin-Neg-Scheme-08-02-13-Costed.zip

A predictable claims process offers improvements for injured people: there are tighter controls over timeframes as the incentives for settlement are greater: failure to keep to timescales leads to the claim leaving the FRCs process, leaving defendants liable to pay costs in full if the claim succeeds;

b. Fixed recoverable costs (FRC) should only apply where the defendant admits liability in full in the letter of response**:**

Failure to admit liability in the letter of response or for the defendant to fail to keep to timescales would propel the claim back into the appropriate track, subject to costs budgeting, proportionality and, eventually, Lord Justice Jackson's fixed costs proposals for all civil litigation. We do not see why a defendant who refuses to accept liability and who is either found liable by a court, or who admits liability late in the claim process (when attempts by the claimant to prove liability have run up substantial costs), should benefit from a fixed costs regime;

We know from data available on the RTA, EL and PL protocols[10] that admissions are now made sooner and the risk of 'falling out' of the protocol procedure does influence behaviour.

c. A properly costed bottom-up fixed costs allied to a streamlined, predictable claims process;

d. Early referral of claims by NHS Trusts to the NHSLA to control defendant behaviour and costs;

e. If expert fees are to be fixed, then they should be fixed for both sides: claimant and defendant;

f. Abbreviated expert reports (which are not necessarily CPR compliant) served by both sides in the clinical negligence pre-action protocol stage to identify the issues, short-cut disputes and thereby save costs in the longer term;

[10] http://www.claimsportal.org.uk/en/about/executive-dashboard/

g. Early *mutual exchange* of abbreviated expert reports (within a defined scheme) to encourage earlier settlement rather than early claimant exchange;

h. Agreed chronologies to save time in the expert reporting stages;

i. Require accreditation of practitioners on both sides of the claims process to ensure quality and competence;

j. Excluded claims categories:

In addition to claims where liability is in dispute, claims involving the following criteria should be excluded from the fixed costs proposals: multiple claimants or defendants; child fatalities, other protected parties, other fatalities, more than two experts (one breach expert report and one causation report) reasonably required by either party, claimants with a short life expectancy and claims including an allegation of breach of the Human Rights Act 1998.

Additional/alternative incentives to reduce costs

50. There are other incentives which can also be employed:

a. Rigorous enforcement by the NHS of the duty of candour:

Members report that in some Trusts where the duty of candour is being complied with, there has been a positive change in culture, a greater openness and willingness to admit when things have gone wrong. Proper enforcement of the duty of candour should ensure that where negligence claims are pursued, the defendant trust is more willing to engage, to resolve the case in an efficient manner. It also leads to learning, rather than blame and should help to prevent mistakes from being repeated;

b. Ensuring healthcare providers meet the current Never-Event reporting obligations:

A Parliamentary and Health Service Ombudsman report in 2015[11] found that more than a third of NHS investigations into allegations of avoidable harm or avoidable

[11] https://www.ombudsman.org.uk/news-and-blog/news/ombudsman-finds-variation-quality-nhs-investigations-complaints-avoidable-death

death were inadequate and failed to identify when something had gone wrong. Over one-third of NHS investigations were not good enough to identify if something had gone wrong. Of the 150 cases, 28 of them should have been investigated by the NHS as a Serious Untoward Incident (SUI). Of those 28 cases, 71% had a complaint that did not trigger an SUI investigation. This encourages systemic learning from mistakes, a reduction in future negligence claims and aids an earlier investigate which assists both the claimant and defendant in any subsequent claim.

c. **The NHSLA should abide by the clinical negligence pre-action protocol:**

In the current clinical negligence pre-action protocol the *letter of notification* is designed to speed up the investigations process and give defendants the opportunity to make earlier admissions, thereby saving costs. Our practitioner members find that in reality, most English Trusts simply reply to a letter of notification stating that they will not investigate the claim until a letter of claim is sent (which is much later on in the claims process when more costs have been incurred). Without this control on behaviour the defendant is allowed to stall and the claimant's advisors are forced to continue to incur costs. There is no incentive for the defendant to make an early admission or to settle pre-proceedings;

d. **Faster and better disclosure of medical records.**

More resources should be made available to improve procedures for storing, retrieving and supplying medical records to the claimant's legal representatives. The Data Protection Act 1998 provides that requests for access to records should be met within 40 days. However, government guidance for healthcare organisations suggests that they should aim to respond within 21 days. In reality, the time taken by NHS bodies to supply medical records varies and is nearly always longer than 40 days. If there is a failure to supply the records, the only remedy is to go to court – a time consuming process which is unnecessary, avoidable, and creates both delay and expense.

Furthermore, when the medical records are delivered to claimants and their representatives, they are invariably chaotic, unsorted and unpagninated. Claimant solicitors are forced to employ medically trained assistants (often nurses) to go through all the records (often running to many lever arch files), sorting, ordering and paginating them, before any sense can be made of them and before they can be sent to the medical experts.

e. **Reduce the number of patient incidents, through the implementation of additional learning and safety procedures:** neither of which appear in the DoH's proposals.

Question 2: Fixed Recoverable Costs Ranges

Do you agree that Fixed Recoverable Costs should apply in clinical negligence claims:

- **Option A: above £1,000 and up to £25,000 (preferred)**
- **Option B: Another proposal**

Please explain why.

51. First, we assume that because the Ministry of Justice has recently indicated[12] that it intends to increase the small claims limit for these types of claim from £1,000 to £2,000, 'Option A' ought in reality to be stated as 'above £2,000 and up to £25,000.'

52. As will be evident from our response to question one, the association opposes the implementation of fixed fees for clinical negligence claims, for the many reasons set out in our response above and below.

53. However, if the DoH is determined to impose FRC, then our aim is to put forward reasonable views and suggestions as we recognise that should fixed fees be imposed, they should be as fair and equitable as possible and relate to all parties involved in these claims, not just claimants. Any fees imposed must be sufficient to ensure that injured people are still able to obtain advice and representation from a firm of solicitors. If this is not the case and fees are set too low, other middlemen such as claims management companies will emerge in the market.

[12] See paragraph 113: *Part 1 of the Government Response to: Reforming the Soft Tissue Injury ('whiplash') Claims Process - A consultation on arrangements concerning personal injury claims in England and Wales,* February 2017: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/593431/part-1-response-to-reforming-soft-tissue-injury-claims.pdf

54. In order to deal with claimants in the future under the proposed FRCs, practitioners will recruit less qualified practitioners in order to cut the costs of conducting a claim. The NHSLA will find that it is dealing with less experienced practitioners and we predict that there will be a substantial increase in the numbers of litigants in person, as other firms turn away these low value claims. It is doubtful that any money will be saved if the claims process remains largely unchanged and FRC are simply imposed upon it.

55. In these circumstances, we are grateful that the DoH appears to have taken note of APIL's position outlined in its pre-consultation response: that there is at least the semblance of a rationale for restricting FRC to claims valued at no more than £25,000, because there are other schemes already in existence which have the same limit: it is the fast track civil claims limit and it limits the effect of fixed costs to those injuries most likely to resolve within 12 months of the incident. However this current proposal remains unworkable. It is naïve to treat clinical negligence claims in the same way as low value (<£25,000) RTA, employer's liability (EL) and public liability (PL) claims, as if they were fast track cases. The majority of clinical negligence cases which are valued at £25,000 or less do not fit the fast track criteria (set out below) and are invariably assigned to the Multi Track.

56. Yet the consultation proposes that the fixed costs should apply to both fast track and multi-track cases. This is both unviable and manifestly unfair. If the claim process remains unfixed for cases valued up to £25,000 (and thereby continues to rely upon the CPR), then imposing a FRC scheme which applies to cases valued up to £25,000 irrespective of the track to which they are allocated is completely implausible:
    - Cases allocated to the fast track are those where a trial is likely to last no longer that one day
    - Oral evidence in the fast track is limited to one expert per party in any given field of expertise and to a maximum of two medical disciplines.
    - Financial value is only one consideration for allocation to a particular track.
    - Multi-track cases, by their very nature, involve claims where there is complexity of facts and significant oral evidence which in turn means that there is additional work which is necessary, not optional.

57. A majority of clinical negligence claims valued at £25,000 or less do not fit these criteria where breach and causation remain in dispute: they are usually assigned to the Multi Track and the trials invariably last for more than one day.

58. There are additional issues which will also have to be addressed:

a. Reasonable expectation: at what point will the value of the claim be assessed for the FRC to apply?

In line with the Court of Appeal's decision in *Qader v Esure*[13], that point ought to be settled at the outset, when the claim is first intimated. The burden should be placed upon the defendant to show that it was unreasonable, at the outset, for the claimant to have valued the claim at more than the £25,000 limit.

This is already the way in which entry to the low value RTA, EL and PL low value pre-action protocols operates: the claimant is permitted to evidence what he or she reasonably believed the value of the claim to be at the time it entered the pre-action protocol process. There is some satellite litigation on the point, but not to an onerous extent. The alternative approach risks a retrospective 're-valuation' of the claim at the point of settlement, which is linked to the second point, below.

b. Later 're-valuation' of the claim

It is worthwhile to remember that in almost all cases, the claimant is already ill before the injury-causing clinical negligence which forms the subject of the claim. For this reason, among others, clinical negligence claims can suffer from 're-valuation' at a later stage due to the interplay of the claimant's pre-existing illness and the uncertainty, at the outset, as to the recognised risks of certain surgical or medical procedures. For this reason, as indicated above, it is vital that it is the reasonable expectation of the value of the claim at the outset which is the trigger for deciding whether the claim fits within any fixed costs for claims worth £25,000 or less.

For example, there may be a very reasonable expectation that a claim is worth £50,000, but it eventually settles on the basis of 50 per cent because of material contribution to causation. For instance, the value may reduce in some oncology cases because it becomes apparent that while the negligence has made a difference to the nature of the treatment involved (usually more invasive and/or disfiguring) it has not affected the claimant's life expectancy. See **case study C** in the appendix for a good example of this issue.

c. There is no evidence in this consultation paper that the claims process will be pruned to reduce the amount of work necessary for these types of claims. If FRCs are to be

[13] [2016] EWCA Civ 1109

applied, they should overlay a fixed claims process to streamline the work conducted on these types of claims.

d. APIL's clinical negligence working group created a low value clinical negligence scheme which it proposed to the NHSLA in 2013 ('the NHSLA Scheme'). This scheme set out a streamlined claims process which identified where efficiencies could be implemented, to save time and costs for all parties concerned. We recommend that the FRCs should be allied to processes similar to those contained in the APIL/AvMA low value NHSLA Scheme[14].

Question 3: Implementation

Which option for implementation do you agree with:

e. Option 1: all cases in which the letter of claim is sent on or after the proposed implementation date.
f. Option 2: all adverse incidents after the date of implementation.
g. Another proposal.

Please explain why.

59. As will be evident, the association opposes the implementation of fixed fees for clinical negligence claims, for the many reasons set out in our response above and below. However, if the DoH is determined to impose FRC, then **option two** – implementation to apply to claims where the adverse incident occurs after implementation date - would be preferable, although see our comments in paragraph 63, by way of qualification if option two is not preferred by the DoH.

60. The virtues of option two are simplicity and certainty with less scope for disputes between solicitor and client, as well as *inter partes*. This option would allow all parties: claimant, defendant and their representatives, the necessary time to change their working practices, would not interfere with existing solicitor-client retainers (agreements as to how the case will be funded and conducted, the likely costs implications and so on) and would remove the necessity for transitional arrangements.

[14] The scheme can be downloaded here: http://www.apil.org.uk/files/NHSLA-Clin-Neg-Scheme-08-02-13-Costed.zip

61. The typical clinical negligence letter of claim is sent quite a while after the client's initial instruction: there is work which needs to be done between the date of first instruction and the letter of notification in order to properly investigate whether there is a valid claim. For this reason, the proposed implementation date would inevitably affect claims being taken on now under a completely different business model where clients have already been advised on their costs options.

62. For example: a client consults lawyers for the first time at April 2017 for a potential claim. His clinical negligence lawyers are unlikely to have received all the medical notes from the various hospitals/GP and obtained the necessary expert evidence before August 2017 (unless it is a very straightforward case). As a result they will not be ready to send a letter of claim before that date. The client will have already signed a conditional fee agreement which is contractually binding which will have to be honoured. The client will have thought he had agreed the extent of any sums which may be deducted from his damages, but those sums will prove to much more under the new proposed fixed costs.

63. A better and alternative option, in our view, would be to use the date of the **letter of notification** as the implementation date trigger. This letter is sent by the claimant representative much earlier in the claims process than the letter of claim. Implementation at this stage would reduce the 'implementation lag' which the DoH foresees with option two, while enabling solicitors to ensure that the client understands how the claim will be funded and conducted under a fixed costs regime before all the work necessary to bring the claim has been done.

64. We have grave reservations about the undefined transitional period contained in **option one** (paragraph 3.13 of the consultation). The suggestion that a transitional period could be used as a back door to including claims already excluded from the reforms is unethical and manifestly unjust. It will create a peak of claim numbers where claimants are placed under duress by these reforms to conclude their claims before they are ready to do so, risking under-settlement.

65. Option one would only be acceptable if it was implemented with a reasonable time-frame without the kind of back-door inclusion referred to in 3.13. Where there is an existing conditional fee agreement (funding agreement) for example, that must prevail, in our view. We would propose a solution similar to that applied to the implementation of LASPO: (where CPR 48.1 confirmed that the CPR rules and practice directions relating to funding arrangements (Conditional Fee Agreements, Collective Conditional Fee Agreements and After-The-Event Insurance policies) in force before 1 April 2013 (the LASPO

implementation date) would continue to apply to funding arrangements entered before the implementation date).

Question 4: Fixed Recoverable Costs Rates
Looking at the approach (not the level of fixed recoverable costs), do you prefer:

- **Option 1: Staged Flat Fee Arrangement**
- **Option 2: Staged Flat Fee Arrangement plus % of damages awarded: do you agree with the percentage of damages?**
- **Option 3: Staged Flat Fee Arrangement plus % of damages awarded: do you agree with the percentage of damages?**
- **Option 4: Cost Analysis Approach: do you agree with the percentage of damages and/or the percentage for early resolution?**
- **Option 5: Another Proposal**

Please explain why

66. We note that at 4.3 of the consultation the DoH acknowledges 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 these low value cases, but in our view, the rates in all of the options proposed would deter claimants from bringing valid claims.

67. We are also concerned about the discriminatory effect that loss of earnings claims can have on the level of costs payable under the proposed options. This effect should not be forgotten when looking at the value of clinical negligence claims. Fixed fees based on the value of the claim/percentage of damages awarded, will disadvantage those who earn less. A claim for loss of earnings will have a noticeable effect on the final value of the claim, which in turn will affect the resources which the law firm employs in order to conduct that claim. Low earners, the sick or retired will have lower value claims: law firms will inevitably use lower qualified practitioners on the lower value claims which will affect the nature of the advice which these individuals receive.

68. While the association opposes the implementation of fixed fees for clinical negligence claims, for the many reasons set out in our response above and below, if the DoH is determined to impose FRC, then none of the options are preferred, but we do have views on them which may assist the consultation.

69. We understand that these figures are illustrative only[15]. On that basis:

70. **Option 1:** if this option is to contain realistic headings which relate to the reality of running a clinical negligence claim, and can be properly costed using the published Guideline Hourly Rates. We are able to assist the Department do this. If properly costed at each level, then the defendant would pay more the longer the claim goes on (assuming it is resolved in the claimant's favour), which would actively encourage earlier settlement.

71. **Option four**: if the main policy aim of the consultation is to save money, then we believe that there needs to be a change in behaviour to facilitate that. Option four, the costs analysis approach, attempts to encourage a move towards earlier settlement since it becomes increasingly cost inefficient for defendants to continue to either deny liability or to avoid early exchange of expert evidence (which encourages early settlement/discontinuance to continue to run a claim towards trial).

72. However, this option is flawed. The defendant should not set the claimant's rates of pay. The conflict of interest renders the figures under consideration entirely suspect.

73. Furthermore, the claims process must include a fixed workflow so that costs can then be calculated using a bottom up approach to costs: establishing the necessary and reasonable hours to carry out the process, the appropriate fee earner levels for the tasks in hand and hourly rates likely to be the preferred starting point to establish fixed cost figures. Fixing costs onto the existing Civil Procedure Rules and practice direction will mean that defendants will still be able to 'drive the claim' forcing the claimant to do work which drives up costs: It is essential that the fixed costs are not too low for the claimant, particularly as this consultation suggests that the defendant's costs do not need to be fixed or capped.

74. The estimates of the necessary and reasonable time required for these clinical negligence cases are simply incorrect, if claimants must continue to use the current CPR and clinical negligence pre-action protocol. Our own estimates of the time taken at various stages are very different - even if we choose instead to base calculations on the time analysis conducted by APIL's clinical negligence working group for the low value clinical negligence scheme (which had a fixed process and was therefore more streamlined than the proposals under consideration here) proposed to the NHSLA in 2013[16].

[15] Based on the presentation given by DoH officials at the AvMA panel meeting on 9 March 2017.
[16] See the times and costings attached to the scheme here: http://www.apil.org.uk/files/NHSLA-Clin-Neg-Scheme-08-02-13-Costed.zip

75. We have examined the preliminary activity identified in Data Pack E[17]. After the screening process (removed from the tables below) we compared the work we believed was necessary in the low value NHSLA 2013 scheme (which has a fixed process) to that which the DoH suggests is necessary in a fixed-costs–no-fixed-process scheme. The differences are stark:

Preliminary investigations (Table 4D)

APIL's calculations		**Consultation calculations[18]**	
Activity	**Time spent**	**Activity**	**Time spent**
Engagement/fact finding See client/telephone client.	1 hour 30 minutes	Review of claim by senior solicitor/partner May require additional call for information	10 mins
Further telephone call/meeting to confirm instructions, and explain nature of process and obtain witness statement dealing with liability issues.	1 hour 30 minutes	Allocated to Solicitor and call to client Discuss claim with client Dictate attendance note	30 mins
Checks - KYC 1. Money laundering 2. ID check 3. Conflict of Interest 4. Fraud check 5. Bankruptcy check	12 minutes	No time allocated for KYC activities	0
Client care letter/Letter on process 1. Prepare letter on client care/ process / witness statement 2. Prepare letter of advice on special damages.	24 minutes	Upload key fields to CMS from attendance note Generate client care letter with brief summary of claim	15 mins
Prepare application for records Obtain client's signature on application for records	30 mins	Generate client documents Authority for records CRU information CFA/DBA Funding questionnaire / BTE/Union	0 mins
Drafting 1. Prepare formal attendance note – long form 2. Prepare witness statement	18 minutes 1 hour	Receive a call to discuss funding/CFA/client care documents Review returned client care documents	30 mins 3 mins
Total times spent	**5 hours 24 mins**		**1 hour 28 mins**

[17] Consultation documents: Annex E: data pack
[18] Consultation documents: Annex E: data pack

Question 5: Expert Witness Costs

Do you agree that there should be a maximum cap of £1,200 applied to recoverable expert fees for both defendant and claimant lawyers?

Please explain why?

76. APIL does not agree with this cap. On 9 March 2017, APIL was informed by the Policy Manager Acute Care and Quality at the DoH that the Department had consulted with the British Medical Association about the expert witness costs within this consultation. APIL has since carried out a Freedom of Information (FoI) request to identify any documentation relating to meetings, discussions, or contacts between the Department of Health and British Medical Association, relating to this consultation in general, or in relation to the setting of expert fees in connection with this consultation. The FoI revealed that there was no record of any meeting or discussion with the BMA. Contrary to indications given by the Department, the cap proposed in this consultation was not arrived at after consultation with the BMA, and is likely to be as unacceptable to experts as it is to legal practitioners.

77. The elephant in the room in this consultation is the cost of an expert report. We conducted analysis of clinical negligence claims where the solicitors' costs, expert report fees, success fees and VAT were separated out.

78. In the analysis of 184 successful clinical negligence claims worth £25,000 or less, we found that:
    - Expert fees amounted to 15% of the value of those claims.
    - An analysis of expert fees based on when they are incurred found that expert fees can be assumed to increase by between 60% and 70% if the claim goes to trial.

79. Avoiding trial by making early admissions automatically eliminates substantial expenditure on expert fees. This is, we submit, a far more effective means of reducing the level of expert fees than an arbitrary value cap.

80. Our research also shows that by the time the claim settles, defendants have usually spent as much and sometimes more than claimants on expert fees. Any cost-cutting restrictions must be even-handed. It cannot be right to allow a defendant to outspend the claimant on more experienced (expensive) experts to 'trump' the claimant's report.

81. If a cap is to be imposed, it must:

- Apply to both claimant and defendant, and
- Be set at a realistic level

82. In these circumstances, a cap might be effective. In any event, avoiding trial by making early admissions is a far more effective means of reducing the level of expert fees than an arbitrary value cap.

83. We know from experience with Legal Aid rates that imposing set expert rates can mean that experts are pulled out of the market and are simply not prepared to do the work for the set reduced fees.

84. A survey of APIL's working group of specialist clinical negligence practitioners revealed that many senior experts refuse to work at the Legal Aid Authority prescribed expert rates. One expert asked, "do they want indifferent opinions?" while another said that he limited his exposure to legally aided cases, ensuring that he only ever did two such claims at any one time.

85. In January 2015 a senior consultant wrote to one of our clinical negligence specialists. He declined to agree to the legal aid rates. He commented:

> "The consequence of the LA A's policy is that the well-tried experts who are experienced in dealing with these cases up to and including court appearances will choose to work for the NHSLA who will pay in some cases £200 per hour.
>
> On the other hand *[others on legal aid]* will have to make do with relatively inexperienced and untried experts. Experts like myself with many years of experience in cerebral palsy cases, including complex reviews of evidence, joint expert meetings and court appearances, will simply decline claimant instructions ...
>
> I believe there should be parity between experts and disciplines, whether instructed by claimant or defence."

86. Other questions relating to expert reports and fees must also be addressed by the Department of Health:

a. In these low value claims, is it really necessary to have a CPR compliant report which automatically pushes up the cost? Organisations such as TMLEP[19] offer a reporting service which assumes it is not necessary for a report to be CPR compliant at the early stage of a claim. It offers:
    i. A review of the claim with the medical records. This is a paper based stage: and the ensuing report is NOT CPR compliant. The records are sent to the correct consultant specialty who reviews them for breach of duty and causation. A view is given on whether the allegations are supported by the records for a fixed fee of £550 plus VAT. This report is sufficient to allow a letter of claim to be drafted by the solicitors and if needs be, it can be converted to a CPR compliant report at a later stage, for an additional cost.
    ii. If there is a need for the CPR report which is intended for disclosure, this stage costs and additional £225 per hour, not exceeding a total cost of £1,750 plus VAT.
b. Based on these costings, and assuming the early exchange of evidence would not be required to be CPR compliant, the minimum amount for any capped expert fee ought to be £2,300 (net) per expert report.[20]

87. Any proposal relating to expert fees must ensure that there remains a viable ATE market. Unrecoverable disbursements such as expert fees are a big issue for ATE insurers. Who meets that cost, particularly in lost cases? At the moment, the ATE insurer picks up the cost, but this consultation is silent on the issue of recoverability of the ATE premium. In clinical negligence claims, ATE insurance cover is vital – as we have said elsewhere it is axiomatic that an expert report will be required before it is clear (and in order to ascertain) whether there has been a breach of duty. For this reason, clinical negligence claims were exempted in part from the blanket withdrawal of recoverability for such premiums when the provision was implemented in LASPO[21].

[19] http://www.tmlep.com/
[20] We asked one member of our working group who specialises in low value clinical negligence claims to have a look at her recently settled files. She had obtained seven expert reports in four recently settled claims. The cost ranged from £800 + VAT to £2,000 + VAT. While this is a very small sample, it is taken from cases run by an experienced practitioner who already deals with these types of claims. These were CPR compliant reports and suggest that the fee suggested in our response above is more realistic than the consultation's proposed cap. It also shows that two experts are usually still required for these types of claim: a global cap of the kind suggested in this consultation would actively restrict the claimant's ability to obtain more than one report in many cases.
[21] Inserted into s.58C Courts and Legal Services Act 1990.

Question 6: Single Joint Expert

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. Should there be a presumption of a single joint expert and, if so, how would this operate?
Please explain why.

88. In APIL's NHSLA scheme, we proposed the use of a single joint expert (SJE), but only on the basis that the instructions were drafted by the claimant, approved/amended by the defendant, the report sent to both parties by the expert, paid for by the defendant and in any event, the defendant would only be bound by the report for the purposes of the scheme and not otherwise and it would not be disclosable, should the claim go as far as issued proceedings. We doubt these conditions will apply to any proposal now being considered by this consultation.

89. There are, in any event, a number of difficulties with a SJE in clinical negligence claims: not least that many claimants use their proposed expert to 'screen' potential claims, free of charge, before they progress. This is done on that basis that if the claim proceeds, the expert will be instructed to report. This process weeds out around 80 per cent of potentially new cases, saving claimants from bringing hopeless claims, saving the claimant solicitor from pursing claims which are likely to fail and saving time and costs for the defendant (who does not have to defend numerous hopeless claims) which would otherwise be intimated.

90. In addition to losing the benefits of screening cases, using a SJE can also mean a tendency for each side to be mistrustful of candidates put forward by the other. There can also be a reluctance for the claimant to involve a representative from the Trust in any medical examination. If the case proceeds to trial it can limit the courts opportunity to see the full range of opinion that may legitimately exist. Further, there is the danger that the court may be exposed to bias or prejudice on the part of a single expert – while the SJE may be impartial as between the parties, the same may not be true of bias towards a certain school of thought. There is no opportunity for the parties to be afforded the opportunity to test expert evidence in conference.

Question 7: Early Exchange of Evidence

Do you agree with the concept of an early exchange of evidence?

If no, do you have any other ideas to encourage parties to come to an early conclusion about breach of duty and causation?

Please explain why.

91. Early exchange of evidence is a potentially cost effective way in which claims can be either settled or dismissed at an earlier stage than is the case in the current claims environment. In order to be cost effective, we question whether, if this is to be introduced by means of a rule change, the report needs to be CPR compliant. As noted elsewhere (see paragraphs 49 f & g, 86 and 92), early exchange of a short form (CPR non-compliant report) may well assist in identifying the relevant issues on causation or liability and could reduce the amount of time and expense spent on a claim. See case study inserted below:

Case study: Early disclosure of evidence aids early settlement: Miss Y
Contraceptive implant incorrectly inserted *

Letter of notification sent – due to complaint being admitted but then no further response from healthcare provider;

Two experts reports obtained;

Letter of claim sent – Letter of response admits liability;

Claim then issued protectively;

Defendant served with photos (from the condition and prognosis report) and a schedule on a without prejudice basis;

Claimant offer to settle: £15,000;

Discussion between the parties ensued;

Defendant offer £9,000 to settle which was accepted.

* Case summary based on actual claim details provided by practitioner with 20 years' experience of working on medical negligence claims.

92. We also note that Table 9 (page 30 of the consultation) is far too complicated for a streamlined process and fails to provide for *early* exchange of evidence at all: by the time it appears at stage four, a lot of work has already been done by the claimant's

representative. In our view, the early, non-CPR complaint report ought to be served as soon as possible. Additionally, stage four only provides for service by the claimant of expert evidence – 'exchange' suggests that the defendant ought, at this stage at least have a report it can serve upon the claimant – early exchange only works if an 'exchange' actually takes place

Question 8: Draft Protocol and Rules

Do you agree with the proposals in relation to:

Trial Costs (paragraph 5.6)
Multiple Claimants
Exit points
Technical Exemptions (paragraph 6.9)
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)
Child Fatalities (paragraph 6.12)
Interim Applications
London Weighting
Please Explain Why

Trial costs

93. The consultation assumes that Fast Track trial costs are suitable for both Fast Track and Multi Track cases. This assumption is wrong.

94. Fast track trials are trials which are limited to one day in duration, where oral evidence (as opposed to written reports) is only required from one expert per party (such as claimant and defendant), where there is expert evidence (this can include the written evidence) in two or fewer fields of expertise. There are very few clinical negligence claims, even those valued at £25,000 or less, which fit these criteria. Because of this, the courts invariably allocate even low value clinical negligence claims to the multi-track.

95. Multi-track cases are claims which require:
    - oral evidence at trial from more than one expert per party,
    - expert evidence in more than two fields;
    - a trial which is likely to run for more than one day.

96. Because of the additional expert evidence, the longer than one day trial lengths and additional oral evidence, we simply cannot see any justification why multi track trials should be included within the fast track fixed trial costs as proposed.

97. Additionally, trial costs based on the value of a claim (and so ignoring its allocated court track) miss the point: if a clinical negligence claim has reached trial, it will inevitably involve complex aspects which will require similar amounts of work, regardless of value.

98. As for the Fast Track trial costs which are proposed in this consultation: even for cases which qualify for the Fast Track[22], the costs are lower than those which are currently payable for RTA, EL and PL claims.

99. Standard personal injury claim fixed advocacy costs[23] are also currently higher than those proposed in this consultation: the advocacy fee for a clinical negligence trial would, on the figures in this consultation, be lower than the sums currently awarded for a less complex trial for a road traffic accident claim.

100. For example a clinical negligence trial valued at £15,500 has a trial fee of £1,650. A claim of the same value arising out of a road traffic accident which goes to a fast-track trial would qualify for a fee of £1,705. Furthermore, if the court decides that a road traffic accident claim merits an allocation to the multi-track, then the trial fees are not fixed at all: this is in line with the November 2016 Court of Appeal decision in *Qader v Esure Ltd and Khan v McGee* [2016] EWCA Civ 1109, which is good law (and about to be enshrined in the Civil Procedure (Amendment) Rules 2017, Statutory Instruments 2017 No. 95 (L. 1), note 8(1), effective 6 April 2017).

101. Clinical negligence claims costs should be higher than standard fast track costs currently in force, should only apply to one-day trials and the decision in *Qader* should apply as it does for other fixed cost regimes.

Multiple claimants

102. In our view multi-party claims (claimant or defendant) should be excluded from a FRC scheme. The additional complexities introduced by multiple parties would render these claims impossible to run on the FRC being proposed by this consultation.

[22] See CPR 26.6(4) - it provides that a fast track claim is valued at no more than £25,000, the trial is likely to last for no longer than one day; and oral expert evidence at trial will be limited to one expert per party in relation to any expert field, expert evidence in a total of no more than two fields.
[23] CPR 45.29

Exit points

103. In our view, if there has been no admission of liability (breach and causation) by the time provided for service of letter of response by the NHSLA/other healthcare provider, then the claim should be able to exit the fixed costs scheme. We see no reason why the defendant should be able to simultaneously contest the claim and deny the claimant additional costs to defend the claim. The existing RTA, EL and PL low value pre-action protocols and the Welsh Redress scheme all exclude claims where liability is denied. This is a strong incentive to admit liability early in appropriate claims, to encourage the defendant to benefit from the FRCs regime – early ejection from the FRCS for denying liability concentrates the defendant's mind on this issue at an early stage and not, as is often the case now, at a point not long before the claim is listed for trial when substantial costs and delays have been incurred.[24]

104. Similarly, as we have described above (see paragraphs 40, 46, 58 c and d, 105 a and 106 b) for a FRC scheme to work, there should also be a streamlined, predictable claims process for these claims. As with the existing RTA, EL and PL low value pre-action protocols, this process must have strict time limits, with failure to comply at key points (response to the claimant's protocol letter of notification; failure to respond to offer to settle within a set period, for example) leading to the expulsion of the claim from the FRC scheme and back into the general costs rules for other excluded claims. See for example paragraphs 5.3-5.5 and related paragraphs 6.11 and 7.34 in the current pre-action protocol for low value personal injury (employers' liability and public liability) claims: https://www.justice.gov.uk/courts/procedure-rules/civil/protocol/pre-action-protocol-for-low-value-personal-injury-employers-liability-and-public-liability-claims

Other exemptions

105. In addition to the exemptions listed in the consultation, there are a number of others which ought to be added to that list:

    a. **Disputed liability:** If liability is disputed by the defendant, then the defendant has control and can force the claimant to run up costs (by refusing to co-operate, causing delays and so on) to make out the claim, making it unviable to run the claim on a low-level fixed costs basis. This is particularly the case if the claims process

[24] See case study B in appendix

does not contain fixed time limits or processes which enable the claim to move forward, forcing the claimant's intervention to move it along.

In all of the other low value fixed costs regimes (the low value RTA, PL and EL protocols), the processes which govern the way in which the claims are conducted are also fixed. Liability disputed claims automatically fall out of these other regimes precisely because (a) they cost more to defend that the fixed costs allow and (b) the defendant who denies liability must also take the risk that he will be penalised in costs if the claim is won despite the defendant's denial of liability.

FRC should only apply where the defendant admits liability in full in the letter of response. Complexity in medical negligence claims does not necessarily reflect the value of that claim. In contrast to RTA and PL claims for example, even establishing liability will turn upon expert evidence in virtually all cases. Clinical negligence cases are not the same as fast track EL claims – it is axiomatic that there must be expert evidence: expert evidence is required to ascertain even the factual evidence in dispute, something which is almost never required in other types of personal injury claim.

Furthermore, complexity is usually compounded by defendant behaviour. We propose that FRC should only apply where the defendant admits liability in full (both breach of duty and that this caused the injury).

We do not see why a defendant who refuses to accept liability and who is either found liable by a court, or who admits liability late in the claim process (when attempts by the claimant to prove liability have run up substantial costs), should benefit from a fixed costs regime.

b. **Child fatalities:** the consultation asks for views. We agree that dealing with these claims is particularly emotive and the sums available by way of damages are comparatively low due to the rules on bereavement damages. Because the law restricts the sums payable for a child bereavement to £12,980 (additional damages can be awarded for losses incurred such as funeral expenses, and to financially dependent family members) these cases involve large amounts of medical notes, grieving parents and very small sums available to claim. At a time in their lives when the worst thing that could ever happen to anyone – the loss of a child – has just

happened, it is right that such claims should be fully investigated and compensated, subject to the usual rules on proportionality, despite the legal expense.

But we take the view that it is not only child fatalities which should be excluded from the scheme.

c. **Child claims generally,** many of the issues which add to the costs of child claims are created by the CPR requirement that all settlements on behalf of children must be approved by the courts.[25] This additional layer of cost is necessary to protect the child claimant from parents or guardians who may decide to apply the sums elsewhere, and to protect trustees and legal advisors. It is not unknown for defendant insurers in the commercial sector (including RTA insurers) to pressure legal representatives into signing a parental indemnity instead of seeking court approval. While this is ostensibly cheaper in the short term for all concerned, it can (and does) prove costly for both the child and legal representative:

- It is not possible to enforce a settlement of a case which is settled by parental indemnity and;
- It increases the risk that the damages will go astray;
- Parents who do not want to seek the court's approval should be considered as a risk. It is not unknown for child claimants to turn up at a solicitor's office several years after the claim has settled to ask 'where are my damages?' only to discover that their parents spent the money on a 'family holiday' several years ago.

d. **Other protected parties**: children are not the only class of individuals who are similarly protected by the courts. Other protected parties also need the court's approval of their damages awards. This includes adults who lack capacity to conduct legal proceedings (and this includes pre-litigation steps such as those under discussion in this consultation)[26]. In the *Dunhill v Burgin*[27] appeal, the Court found that the policy underlying the CPR was clear: that children and protected parties require and deserve protection. The mainstay of that protection is both the appointment of a *Litigation Friend* (a person who can conduct the claim/proceedings on the claimant's behalf – not to be confused with a *McKenzie Friend*) at the

[25] CPR part 21
[26] See Dunhill v Burgin [2014] UKSC 1
[27] Dunhill v Burgin [2014] UKSC 1

appropriate time and the court's approval of any award: both of which add a layer of cost and complexity to what may otherwise have been a more straightforward claim;

e. **Other fatalities:** fatal claims have additional layers of work and responsibility which must be dealt with and which make them unsuitable for the same FRCs which are to be applied to 'living' claims.

   Claimants who die will usually be subject to an inquest. As there are issues of negligence and liability at stake, the deceased's family is in need of representation at that point before the claim for negligence can be advanced.

   Once the claim begins, the estate becomes the claimant (or becomes the claimant mid-claim because the claimant has died at that point), which also adds cost and administrative requirements to the claim.

   Inquest costs need to continue to be recoverable (as a normal part of the claim as they are now) so that the family can incur them, in the knowledge that they can subsequently be recovered should the negligence claim prove successful;

f. **More than two experts – either party**: the proposal is currently that there should be an exemption for claims where the number of experts reasonably required by both sides… exceeds a total of two per party. We can envisage situations where the defendant will unreasonably insist that only one expert each is necessary, depriving the claimant of the additional evidence he or she needs to prove the claim in order to keep the claim within the FRCs. In order to remove this potential abuse of the rule, we suggest that there should be an exemption for claims where the number of experts reasonably required by ***either side***… exceeds a total of two.

g. **Short life expectancy claims:** even if unrelated to the alleged negligence, these claims involve the most vulnerable claimants and they should be treated in a similar way to protected parties.

h. **Human Rights Act:** Any claim including an allegation of a breach of the Human Rights Act 1998.

Question 9: Behavioural Change

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.

106. There are other levers which can be employed to encourage less adversarial behaviour on the part of all parties involved. In our view, these are vital if any fixed costs regime is to be considered a workable solution: the current proposals make little attempt to curb behaviours on the part of the NHSLA, for example, which not only increase the amount of time it takes to settle claims, but actively drives up the claimant's costs in the meantime.

a. **Admitting liability:** complexity is usually compounded by defendant behaviour, which is why we propose that fixed costs should only apply where the defendant admits liability in full (both breach of duty and that this caused the injury). We do not see why a defendant who refuses to accept liability and who is either found liable by a court, or who admits liability late in the claim process (when attempts by the claimant to prove liability have run up substantial costs), should benefit from a fixed costs regime.

b. **Predictable claims process**: this is a basic requirement for these claims so that the reduced costs incurred by practitioners match the reduced fees payable, along with additional incentives to promote early settlement;

c. Duty of candour: Claimant's legal costs only arise in winning cases where there has been negligence by the healthcare provider. From then on, the main drivers and control of how the claim progresses are in the hands of the NHSLA, the NHS Trusts and the private medical insurers. It is important that the NHS rigorously enforces the new duty of candour. We believe that by doing so, an increasing number of claims will be investigated with the benefit of clear admissions of breach of duty from the NHS Trust from the outset: this will reduce expert costs, allowing the claim to focus on causation only in many cases.

An admission under the Health and Social Care Regulations is a notification that a safety incident occurred that may have resulted in death/injury – it confers no legal liability. This is important because our members report that where the Duty of Candour is upheld that there is greater openness between the healthcare provider and the patient. A focus on encouraging implementation of the Duty of Candour should improve transparency and easier access to information from the Trusts.

d. **Protocol:** The NHSLA and medical insurers should also ensure that that they abide by the clinical negligence pre-action protocol. Our practitioners tell us that this does not always happen at present. In the latest version of the protocol the innovation of the letter of notification is designed to speed up the investigations process and give defendants the opportunity to make earlier admissions, thereby saving costs. The impact of it is only now beginning to filter through into costs savings, but there is a great potential for significant costs savings where defendants choose to investigate cases at an earlier stage and make earlier admissions.

e. **Early admissions or risk a fixed costs penalty:** The problem for claimant lawyers is that the medical defendants' representatives (NHSLA, MDU, MPS) quite often will not make early admissions and the claim drags on for years as the claimant runs up costs and instructs experts to prove that the medic was negligent. As the defendants (particularly the NHSLA) have access to experts who can provide an opinion in-house, it must know that it is liable much earlier than its later admissions would suggest. See case study A in our appendix for an example of a seriously injured patient whose claim lasted five years until the NHSLA finally made a reasonable offer to settle. In our view, the costs matrix in the consultation will not adequately encourage earlier settlement as envisaged: the far stronger risk of losing the benefit of fixed costs in total would, in our view, concentrate the defendants' minds.

f. **Better use of part 36 offers**: Defendants such as the NHSLA ought to make better use of Part 36 offers.[28] A well-judged Part 36 offer will apply pressure on a claimant to settle a claim. APIL's claimant practitioners say that they rarely have to consider a realistic Part 36 offer from the NHSLA – if they did, earlier settlement, saving time and costs could become more commonplace. A good Part 36 offer requires the defendant to consider the claim in detail at an early stage, something which we have noted elsewhere does not seem to occur when the NHSLA represents the defendant. See

[28] Civil Procedure Rules Part 36: offers to settle. https://www.justice.gov.uk/courts/procedure-rules/civil/rules/part36

Case Study D in the appendix for an example of a claim where a well-judged defendant Part 36 offer could have resolved the claim much earlier. Part 36 offers also provide another driver towards good behaviour. See the comments of Sir Geoffrey Vos in OMV Petrom SA v Glencore International AG[29] in which he noted that the penalties contained in CPR Part 36 are not only designed to compensate the successful party, but can also include a penal element aimed at a party's misconduct. He said "*in my judgment, the objective of the rule has always been, in large measure, to encourage good practice."*[30]

g. **Faster and better disclosure of medical records.** More resources should be made available to improve procedures for storing, retrieving and supplying medical records to the claimant's legal representatives. The Data Protection Act 1998 provides that requests for access to records should be met within 40 days. However, government guidance for healthcare organisations suggests that they should aim to respond within 21 days. In reality, the time taken by NHS bodies to supply medical records varies and is nearly always longer than 40 days. If there is a failure to supply the records, the only remedy is to go to court – a time consuming process which is unnecessary, avoidable, and creates both delay and expense.

   Furthermore, when the medical records are delivered to claimants and their representatives, they are invariably chaotic, unsorted and unpagninated. Claimant solicitors are forced to employ medically trained assistants (often nurses) to go through all the records (often running to many lever arch files), sorting, ordering and paginating them, before any sense can be made of them and before they can be sent to the medical experts.

h. **Accreditation.** The Legal Aid system had an in-built quality control hurdle which had to be passed in medical negligence cases: lawyers were required to be accredited. Accreditation is a safeguard: to join a specialist panel (such as those run by AvMA, APIL, or Law Society) the lawyer must be experienced in dealing with particular cases and be good at their job. By way of another example, accreditation is a model adopted by MedCo to improve the quality of medical reporting in low value whiplash cases.

   Accreditation is not anti-competitive: it is a standard to which all can aspire. We recommend that accreditation becomes mandatory for medical negligence lawyers undertaking these cases. Insisting on accreditation, or employing strategies to nudge

[29] [2017] EWCA Civ 195
[30] Ibid at paragraph 32.

practitioners towards accreditation will deter the inexperienced solicitor and encourage the specialist.

This will save money for the NHS and NHSLA in the long run. Lack of specialisation combined with a sharp downward pressure on legal fees will inevitably lead to additional costs being incurred by the NHSLA as a result of having to deal with incompetent or inexperienced claimant legal representatives.

i. **Compliance with and enforcement of statutory obligations relating to 'never-events' reporting.** Failing to report a 'never event' may mean that the hospital is in breach of its NHS Standard Contract. Failing to report a 'never event' may also mean that the CQC requirements are breached (CQC (Registration) Regulations 2009[31]). However, according to the NHS England framework, 'failure' only means that NHS Commissioners should take appropriate action including 'remedial action'. In our view, the sanctions contained in the CQC regulations go beyond forcing the organisation to take remedial action. Regulation 25 of these regulations states that: "(1) A contravention of, or failure to comply with, any of the provisions of Regulations 12 and 14 to 20 shall be an offence. (2) A person guilty of an offence under paragraph (1) is liable, on summary conviction, to a fine…" There is both a criminal offence as well as the potential for an action for breach of statutory duty.

j. **Alternative dispute resolution (ADR):** Although the NHSLA has introduced a mediation scheme, the feedback from APIL's practitioners is that the NHSLA has been reluctant in the past to use it to full effect. A classic case where mediation would be effective would be that of a claim by an older person (so there is a shorter life expectancy and lower or no future loss of earnings), who has a number of co-morbidities. But in most cases, formal mediation can prove as expensive and time consuming as going to trial. Informal ADR, such as joint settlement meetings, round-table expert meetings and so on are much more effective. An article published in APIL's publication PI Focus on this subject, written by a clinical negligence specialist, provides and insight into these techniques can be found in the appendix, page 55.

[31] Regulation 11 states that "A registered person must, insofar as they are applicable, comply with the requirements specified in Regulations 12 to 20 in relation to any regulated activity in respect of which they are registered." Regulation 16 covers the circumstances in which the CQC must be notified of the death of a service user and Regulation 18, the circumstances in which the CQC must be notified of other incidents, including injuries.

k. **The need for a culture change:** For an example of the culture change required within the NHS, obstetrics claims (i.e. maternity cerebral palsy/ brain damage) provide an instructive case in point. Obstetric-related injuries represent 41 per cent of the value of clinical negligence claims received in 2014/15 by specialty[32]. As such, obstetrics represent an area where additional learning and safety would make a huge difference to the NHS litigation bill. Yet the NHS still receives broadly around 200 maternity cerebral palsy/brain damage claims a year and this hasn't changed since 2006/07.

l. **The need to learn from mistakes:** We know that it currently takes up to eleven (11) years for the outcome of a child's birth negligence claim to be fed back to health care professionals so that they can learn from the circumstances of that claim. APIL has offered to work with the NHSLA to share patient stories to help with learning. There is great merit in doing that and we urge the DoH to encourage the NHSLA to run a pilot programme;

m. **The need to adapt and evolve:** An example of a programme which has successfully improved patient safety and transformed the costs of avoidable medical mistakes, can be found in the 'Michigan Model': In late 2001 and early 2002, the University of Michigan Health System (UMHS) changed the way the health system responded to patient injuries, applying what has become known as the Michigan Model and has since been described as an early disclosure and offer (D&O) program.

The program demonstrated that the D&O approach has successfully cut the costs associated with liability claims by creating the safest possible environment for patients. Moving away from a 'circle the wagons' model where the traditional 'deny and defend' modus was in operation, the model resulted in fewer claims, fewer lawsuits, and lower liability costs.

Researchers reviewing the programme found that the rate of new claims at UMHS decreased from approximately seven per 100,000 patients to fewer than five. The rate of lawsuits declined from 2.13 suits per 100,000 patients per month, to roughly 0. 75. The median time from claim to resolution dropped from 1.36 to 0.95 years. Cost rates due to total liability, patient compensation and legal fees also decreased. Because UMHS generally refuses to settle what appear to be non-meritorious claims, patient compensation is now a direct indicator of substandard care in UMHS and a powerful motivator for increased safety and adherence to standards of care.

[32] *NHSLA Annual report 2014-15*: Figure 22, page 20.

Interim applications

107. The Government considers that both the use and cost of interim applications should be controlled, and seeks views as to how that is best achieved.

108. The use of interim applications should not be restricted (which is our interpretation of 'controlled'), particularly if other controls on behaviour by both parties are not created and implemented. Interim applications are used to drive the claim forward and enforce behaviour and compliance with timetables and rules. Removal or constriction of the use of interim applications would encourage a lack of compliance or co-operation between the parties.

109. Interim applications are vital in clinical negligence claims, often pre-action, to force the NHS and other healthcare providers to disclose the claimant's medical records. It is usual for the NHS to fail to meet the 40 day limit for disclosure set by the Data Protection Act 1998.

110. Defendants also use interim applications to apply for extensions of time when they cannot meet timetables set by the court, or to ask the court to force claimants to comply with timescales set by the court.

111. Similarly, claimants use interim applications to apply to the court for interim payments of damages where the defendant Trust has refused to make payments voluntarily.

112. Of course, if a fixed-cost-fixed-process regime was implemented, interim applications would not be so important to the claims process, because there would be fixed timescales within the process, and failure to adhere to them would automatically lead to penalties in costs or ejection from the fixed costs regime.

Appendix

Table 1

Reported Patient Safety Incidents, England (NHS Improvement, NHS National Patient Safety Agency)

	No Harm	Low	Moderate	Severe	Death	Severe and death total	Total
2010	790,856	270,114	69,154	6,783	2,867	9,650	1,139,774
2011	849,658	304,200	79,059	7,656	2,858	10,514	1,243,431
2012	912,136	340,105	86,009	7,390	3,562	10,952	1,349,202
2013	996,318	372,899	87,800	6,737	3,913	10,650	1,467,667
2014	1,143,658	388,840	81,791	6,792	3,726	10,518	1,624,807
2015	1,246,639	416,816	65,754	6,169	3,980	10,149	1,739,358

Table 2

Changes in fee thresholds for money claims in UK civil courts from March 2015, Law Society analysis

Claim range		Pre-March 2015 fee	March 2015 fee
£10,001	£15,000	£455	5 per cent (£500 -£750)
£15,001	£50,000	£610	5 per cent (£750 - £2,500)
£50,001	£100,000	£910	5 per cent (£2,500 - £5,000)
£100,001	£150,000	£1,115	5 per cent (£5,000 - £7,500)
£150,001	£200,000	£1,315	5 per cent (£7,500 - £10,000)
£200,001	£250,000	£1,515	£10,000
£250,001	£300,000	£1,720	£10,000
£300,001+		£1,920	£10,000

Table 3

Cost of successful clinical negligence claims closed by the NHS LA (excludes claims settled as PPOs), APIL analysis based on NHSLA Freedom of Information responses

	2012/13	2013/14	2014/15	2015/16
Number of closed claims	5,510	5,579	5,776	5,795
Claimant legal costs (£)	205,318,784	233,635,918	249,447,226	278,846,972
Average claimant legal costs (£)	37,263	41,878	43,187	48,119
Defence legal costs (£)	49,370,504	51,307,708	50,443,467	54,197,327
Average defendant legal costs (£)	8,960	9,197	8,733	9,352
Damages (£)	463,990,056	455,206,657	430,018,161	384,856,760
Average damages (£)	84,209	81,593	74,449	66,412
Total cost of closed claims(£)	718,679,344	740,150,283	729,908,854	717,901,059
Average cost of closed claims (£)	130,432	132,667	126,369	123,883

Case Study A

This study is taken from a case report first published on APIL's website and in PI Focus, APIL's membership publication.

Mr H v Bradford Teaching Hospitals NHS Trust

- **Denial of liability delaying settlement for five years**

The 54 year old claimant, Mr H, had a history of intermittent attacks of gout which would leave him bedridden. He attended the defendant NHS Trust on 1 September 2008 with a swollen, erythematous, hot left ankle. He had been vomiting and had diarrhoea. He was in septic shock, clammy and pale with hypotension and in renal failure with impaired liver function tests and very high C-Reactive Protein in the blood. The claimant was presumed to be suffering from cellulitis in the left ankle, and also an allergic reaction to his gout medication.

The correct diagnosis of septic arthritis in the left ankle joint was negligently not considered, notwithstanding that it fitted with all the claimant's symptoms and despite blood culture results which were inconsistent with cellulitis, but entirely consistent with septic arthritis.

The correct diagnosis and treatment only began on 14 September and, coming so late, was ineffective. Ultimately Mr H was advised that he would have to undergo a below the knee amputation of the left leg. But before the amputation could take place, Mr H was re-admitted, a chest x-ray showing pleural effusions: the ankle infection had now colonised his spine and lungs.

Mr H's amputation took place, and as a result of the secondary infection, he developed sever kyphosis of the spine.

Effects of the negligent treatment: Mr H became confined to a wheelchair. He cannot even walk short distances with crutches. He suffers from severe back pain and phantom pain in the missing limb. He suffers symptoms of fibromyalgia including fatigue and pain in various parts of his body. He takes extensive analgesia.

Previously independent (and with no dependants of his own) with his own business, he now requires assistance with all aspects of daily living. These care needs could not be satisfactorily met by Local Authority provision. He was unable to continue running his successful consultancy business.

While the NHSLA admitted that there was a negligent failure to make a diagnosis of septic arthritis, it denied that, but for the negligence, the seeding of the spine with infection and all that followed from that would have been avoided. The NHSLA asserted that Mr H's spine and lungs would have been seeded with infection in any event; that he would have been left with the severe curvature of the spine in any event, which would naturally affect his ability to ambulate, care for himself and work for a living.

Proceedings were issued.

The NHSLA continued to defend the claim until September 2013, five years after the patient had been injured by the NHS's negligence.

On 7 October 2013 the NHSLA finally made an offer to settle the claim which was accepted the following day.

Case study B

The Welsh Redress Scheme

Ms H and the Cardiff & Vale University Health Board

- **Liability denial – claim left redress scheme**
- **Additional costs due to denial of liability**

This case related to a lady who suffered a four-day delay in diagnosis and treatment for her fractured neck. The Health Board denied qualifying liability and refused the claimant solicitor's suggestion to jointly instruct a liability expert under the Redress scheme.

As a consequence, a conditional fee agreement with ATE insurance was entered into and an expert's liability report was obtained. The claimant made a Part 36 Offer to the Health Board, paraphrasing the negligence identified in the earlier liability report. After four months, the Health Board accepted the offer.

If this case had settled under the Redress Scheme, the NHS could have paid £1,920 costs (fixed fee of £1,600 plus VAT). Instead they paid £11,775.90 to her solicitors for legal costs and expert fees incurred.

Case Study C

This study is taken from a case report first published on APIL's website and in PI Focus, APIL's membership publication.

J v P Hospital NHS Trust

- **Delayed diagnosis of breast cancer.**
- **Example of 'revaluation' following expert evidence**

The claimant attended the defendant NHS Trust's breast clinic. She was referred by her GP after finding a lump in her left breast. She was referred for an ultra sound and advised that there were no features of cancer, but that there was a lump which could represent leakage from the claimant's breast implants. She requested a further consultation and expressed her concerns that the lump was cancerous. He advised against a fine needle aspiration of the lump because of its proximity to her breast implant, but arranged an MRI scan. The MRI report concluded that there were no features to suggest a prosthetic leak and advised a repeat ultrasound. The repeat ultrasound report identified a simple cyst. No follow up was arranged.

Fourteen months later she was seen again at the clinic having been referred back by her GP. She had noticed more lumpiness and tenderness. Three lumps were found. An urgent ultrasound scan identified several cysts. Although she was reassured, this time a fine needle aspiration from the enlarged lymph node was taken and the results were reported as "carcinoma cells present in a background of lymphoid cells." A mammogram confirmed breast carcinoma.

Delay
There had been a 14 month delay in diagnosing the carcinoma. The parties' experts agreed that that there had been ineffective multi-disciplinary working by the breast clinic, which resulted in the surgeons taking no effective action to diagnose a new breast lump in a 44 year old woman. They also agreed that further imaging investigation should have been offered with a view to confirming or excluding the diagnosis of malignancy. Further consideration by the multi-disciplinary team and consideration of guided needle biopsy should also have been done.

Causation
The claimant stated that if the correct diagnosis had been made at the time of the first consultations, she would have chosen breast conserving surgery (wide local excision). But due to the 14 month delay, she opted to undergo a double mastectomy in July 2001 which she felt, at that stage, was the safer option.

Expert evidence indicated that regardless of the delay, she would have had radiotherapy and a course of adjuvant chemotherapy, together with Tamoxifen. Additionally, expert evidence suggested that the time needed to recover from the more conservative treatment would have been the same as the time taken by the claimant to recover from the double mastectomy.

Due to the limitation date, protective proceedings were issued. A defence was filed, which admitted the delay in diagnosis of carcinoma, but disputed causation. The defendants argued that the claimant could have still undergone conservation surgery or left mastectomy only.

Quantum
A number of heads of claim were initially advanced in relation to past loss of earnings, future loss of earnings and care, but once the expert evidence made it clear that the period of time required for recovery from conservation surgery, radiotherapy and chemotherapy would have been the same as the time it took the claimant to recover from the double mastectomy, radiotherapy and chemotherapy, a more modest claim in relation to travel, therapy, household expenses and

specialist clothing was made, reducing the value of this aspect of the claim by £25,000. Various Part 36 offers were made, with the claim eventually settling for £25,000.

Case Study D

This study is taken from a case summary supplied by an APIL member with 20 years' experience of working as a medical negligence claimant lawyer.

Mr P

- **Delayed diagnosis of tendon damage**
- **Example of where a well-judged part 36 offer could have resolved the claim earlier**

Supportive evidence of the negligence was obtained by the claimant's representative, who then served a letter of claim upon the defendant health care provider.

The letter of response admitted liability.

The claimant obtained condition and prognosis evidence.

The claim was issued protectively, to avoid limitation issues after which the claimant made an offer to settle and served the condition and prognosis report, along with a schedule of loss on a without prejudice basis.

The defendant did not agree the claimant's valuation.

At this stage there was £25,000 between the parties (claimant had offered £35,000 and the defendant valued the claim at £10,000).

The clamant made an offer to settle of £30,000, but the defendant would not increase its offer.

As a result, the claimant's representatives served the particulars of claim and supporting documents upon the defendant and the case was transferred by the NHSLA to external solicitors, Browne Jacobson.

The defendant's solicitors made an offer to settle of £20,000 without having to serve a defence.

This offer was accepted and the claim settled for £20,000.

The additional costs of litigation, instructing Browne Jacobson and the associated delays could all have been avoided had the NHSLA made a well-judged part 36 offer at the time it only offered £10,000.

Alternative dispute resolution methods in clinical negligence: a recent personal experience

Dr Jock Mackenzie is a clinical negligence partner at **Leigh Day & Co** solicitors. He describes some of the different ways in which to resolve clinical negligence claims and the factors to consider when deciding which to use.

Personal injury practitioners are only too well aware of the need to use alternative dispute resolution (ADR) to settle claims and there has been clear impetus for personal injury claims to settle by some form of ADR from many quarters over the last few years, as part of an increasing drive to reduce the number of cases that reach trial. This includes clinical negligence claims and Master Ungley's standard clinical negligence order for directions encourages this. Such ADR includes mediation, round-table meetings and traditional negotiation, with or without formal part 36 offers from either or both parties. There are, of course, pros and cons to all of these means of resolution to a case, and much has been written about these (and mediation in particular) over the last few years.

My own personal experience of settling clinical negligence cases is neatly encapsulated in my last five concluded cases, all of which have involved different methods of ADR at various different stages in the cases, and it has been interesting observing the effects of each of the mechanisms in the different cases. The experience has highlighted some of the pros and cons of the various methods.

One of the cases was settled by traditional negotiation between the parties' solicitors, precipitated by a part 36 offer following the exchange of liability expert evidence. A second case was settled at a round-table meeting, also after the exchange of liability expert evidence, but following service of a schedule of loss. Another case was settled at a similar meeting, though between the issue and service of proceedings (which had been issued protectively). A fourth case was mediated successfully, mediation taking place after liability expert meetings and service of a schedule of loss. However, the final case was also mediated after experts' meetings, mediation unfortunately failing, so it proceeded to trial, at which the claimant was ultimately successful.

Negotiation

The first case was concluded by traditional negotiation between the parties' solicitors, in this case the negotiation occurring shortly after the exchange of expert evidence but precipitated by a formal part 36 offer and payment in from the two defendants.

Of all five cases, this was the least expensive method of conclusion and the least stressful for the claimant. The claim, though complex medically, was only of modest value. The claimant was keen not to be too personally involved in the negotiation and preferred the process to be carried out via the solicitors. It is possible that negotiation between the parties' lawyers as a settlement method may not appear to a claimant to be involving them 'in person' in the negotiation process (something which could be achieved in a few hours at a round-table meeting or mediation), even if, as is the case in my experience with most clinical negligence cases, it will be necessary at some stage during this negotiation process to have a conference with counsel before the claimant can be advised properly and is able to reach a firm conclusion.

However, a negotiation process between solicitors can afford a claimant more time to deliberate upon any offer and can allow the claimant to distance themselves from the defendant should they so wish (and possibly be a little more objective in their decision-making).

In addition, this form of negotiation also means that the claimant and defendant (or their representatives) do not have a face-to-face meeting, which in some cases, particularly where there may be acrimony or the case is especially sensitive because of its nature, can be a good thing. Furthermore, in this particular case, as the claimant lived abroad and there were two defendants, it would have made a round-table meeting or mediation more difficult to arrange, and probably more expensive than otherwise.

So it is not surprising that this case settled in this way, given the claimant's wishes, the fact that there were two defendants, and that the claim was of modest value.

Notwithstanding the effectiveness of traditional negotiation, not all cases can or are suitable to be disposed of by such a method and there are many good reasons for considering a round-table meeting or mediation.

Around the table

Two of the five cases settled after round-table meetings: one before the service of proceedings and one after the exchange of expert evidence and service of schedules of loss. Present at the meetings were the claimant, their solicitor and counsel, and the defendant's solicitor (or legal representative). In the case which settled early in proceedings, there was also present the clinician who was head of the relevant department at the defendant hospital and a representative from the NHS Litigation Authority was on the telephone: at the other meeting, a hospital legal representative and an NHS Litigation Authority representative were present.

In both cases, which were complex cases of moderate value, the process was relatively quick and effective, each case reaching a settlement within a few hours. This has not always been my experience, but in those cases where settlement has not been achieved at the meeting, it has always been achieved soon after.

The attitude of the claimants in each case was similar: neither was especially keen to be too personally involved in the negotiation, having found the litigation process thus far upsetting and difficult. It was for this reason that an early round table meeting was convened in one of the cases to see if early settlement could be reached. In the other case, the defendant hospitals' representative (representing both hospital defendants) was pushing for a round-table meeting rather than mediation and the process was initiated by the defendants, so the claimant was happy to

acquiesce.

While a round-table meeting is a similar process to that of mediation, in these cases it was less formal: with less formal documentation, less formal preparation and the absence of an independent third party arbitrator contributing to this reduced formality. This was an important factor in both of these cases and a positive expressed at the time by each of the claimants, particularly as the less formal nature of the process seemed to be reflected in production of a less stressful environment for the claimants. However, as with mediation, the process still afforded the claimants an opportunity to have their say directly to the defendants' representatives, as well as giving the defendants' representatives an opportunity to apologise and/or explain matters from their perspective to the claimant clearly and unambiguously: something which lawyers may complicate and an adversarial trial may be ill-equipped to do. This was clearly shown in the early settlement case in which the clinician present was at pains to explain what had happened and to apologise.

In both cases the process was less expensive than mediation would have been: costs saved including the costs of the mediator, preparation of the formal documentation and the overall length of the process. The speed of the resolution process for the claimant in one of the cases, however, made it somewhat overwhelming.

Mediation

The two remaining cases were mediated: one successfully and one unsuccessfully. Both were complex for their own reasons, the successful case being a moderate to high value case and the unsuccessful one being high value. In these two cases mediation was a more formal, time-consuming and expensive process than the two other methods of settlement mentioned earlier. It was also apparent that in these two cases it was necessary to have reached a particular point in the proceedings before the parties deemed mediation to be of any real value. Most likely this will be when a sufficient degree of information has been exchanged between the parties to enable each side to weigh up the pros and cons of their own and the other side's case; and this seems most likely to be after the exchange of expert evidence or after experts' meetings. Indeed, in the successful case, mediation was delayed from the originally ordered default date by agreement because the parties were not ready. This should maximise the possibility of settlement. It does mean, however, that it is most likely that much of the litigation process has been carried out before a clinical negligence case is amenable to mediation, although every case will of course vary according to its own circumstances.

The claimants pushed for mediation in both cases. In the successful case, one of the key driving factors was the opportunity for the claimant to have a 'day in court'. Both a round-table meeting and mediation could have afforded the claimant this possibility, while being considerably less stressful, emotionally draining and quicker than a trial, though it was felt that with the presence of an independent arbitrator, mediation was more likely to mirror the day in court than a round-table meeting. Indeed, the very active involvement of the client in the settlement negotiations meant that the outcome was very satisfactory, perhaps a little more than expected.

However, a potential significant disadvantage of mediation which may be perceived by a claimant is whether the defendant will take it seriously or whether it will simply pay lip-service to the process to avoid falling foul of the potential costs penalties. In an unsuccessfully mediated case, given its lack of success, one can perhaps forgive the claimant for reaching this conclusion. However, it seems that it is most likely that the failure of mediation reflects genuine disagreement between the parties rather than anything else. The failure of mediation does not mean the failure of settlement: it may be that the process will have sparked enough dialogue between the parties for a subsequent settlement to follow via traditional negotiation.

Notwithstanding the above, if all else has failed, then the default position is that of trial. There is little doubt that a clinical negligence trial is likely to be a stressful and emotionally troubling experience for a claimant, and it can be technically overwhelming, risky and therefore potentially very costly. But if it is successful, the claimant may be afforded a degree of closure to the case and the formal recognition of fault: the latter being something without prejudice settlement usually fails to achieve.

These cases show that there are many factors which may influence the outcome of any given case: they will, of course, vary from case to case and no two cases will be identical. In my experience, the most important factors seem to be the nature of the case and its inherent idiosyncrasies; the relationship between the parties (including the respective legal teams); and the degree of damages and costs involved. While it is important and a necessary part of the process of modern clinical negligence litigation to consider ADR in all cases, one of the skills required in a claimant solicitor is the ability to appreciate the needs of the claimant and to determine which mechanism is the one that will achieve those needs the most effectively yet realistically. ■