FORMAL RESPONSE TO
CONSULTATION ON

‘A New Focus for civil Legal Aid’

Introduction

Action against Medical Accidents (AvMA) was originally established in 1982. It is the UK charity specialising in advice and support for patients and their families affected by medical accidents. Since its inception AvMA has provided advice and support to over 100,000 people affected by medical accidents, and succeeded in bringing about major changes to the way that the legal system deals with clinical negligence cases and in moving patient safety higher up the agenda. The legal reforms of Lord Woolf in the clinical negligence field and the creation of agencies such as the National Patient Safety Agency and the Healthcare Commission have followed after years of campaigning by AvMA.

AvMA is proud of the key role it has played in making clinical negligence a specialism within legal practice. It continues to accredit solicitors for its specialist panel (without membership of AvMA's or the Law Society Panel a law firm is not entitled to a clinical negligence franchise) and promotes good practice through comprehensive services to claimant solicitors.

Given AvMA's direct experience of clinical negligence, the focus of our response will be seen from this perspective. Whilst we accept that many of our comments may apply equally to other areas we wish to confine our comments to clinical negligence which falls within our own knowledge and expertise. We have benefited from constructive informal discussions with the LSC and Department for Constitutional Affairs in developing our response, and from discussion with other patients / consumer organisations and specialist clinical negligence solicitors. It was also informed by a survey we conducted with members of AvMA's Lawyers' Service.

Our response comprises two sections:

- An overview
- Detailed comments and answers to questions for consultation which have implications for clinical negligence

Overview

The key question AvMA poses and addresses concerning the proposals is this: Is access to justice for the victim of a medical accident likely to be helped or hindered if the reforms proposed are implemented? AvMA has real concerns about any potential erosion of the rights of a person injured as a consequence of

clinical negligence to receive appropriate compensation. Our conclusion is that the proposals as they stand would inevitably damage access to justice in the field of clinical negligence. We provide explanations as to why this would be the case, and where we can, make constructive suggestions of alternative approaches.

AvMA is particularly concerned about the following proposals which we feel would damage access to justice:

- the proposed changes to eligibility for legal aid
- the proposal to require clinical negligence cases to rely on conditional fee agreements (CFA's or 'no-win no-fee') beyond the investigative stage

AvMA firmly believes that consideration should be given to improving access to justice in the field of clinical negligence rather than restricting it yet further. The LSC's own analysis shows that legal aid is used efficiently and responsibly in the field of clinical negligence. It is now well established that it is a myth that there is anything resembling a 'compensation culture' amongst patients and their families. Quite the contrary as the LSC points out, the number of legal aid certificates has been reducing, and net legal aid payments in relation to clinical negligence claims represent only 5% of the total cost to public funds. The latest figures from the NHS Litigation Authority, for 2003-2004, record a 20% reduction in the number of claims made compared with the previous year. All this is in the context of official estimates of medical errors in English hospitals alone approaching 1 million a year while only just over 6,000 clinical negligence claims are made. AvMA's own experience of directly helping thousands of medical accident victims each year is that people turn to the law only very reluctantly – usually as a last resort to get to the truth about what happened, or because it is the only route open to them to get the compensation they need to lead a reasonable standard of life after being injured.

This is not to suggest that recourse to the law should be the first or only means of seeking redress. AvMA shares the same belief as the LSC that legal action alone can not provide the explanations, apologies and assurances which people want. We also believe that it is in people's best interests to explore more user-friendly approaches to dispute resolution than litigation. We repeat suggestions made following earlier joint work with the LSC, CEDR and NHSLA for developing and improving the use of mediation. In our response to the chief medical officer's report '*Making Amends'* we made clear that we see positive potential for an approach such as an NHS Redress Scheme to provide an integrated approach to investigating medical accidents and offering compensation without recourse to litigation, provided there are a number of crucial safeguards. However, with the potential Redress Scheme still no more than a proposal and with the current NHS Complaints Procedure still excluding those who are explicitly seeking compensation, it is not appropriate at this stage to make any assumptions about what will be available or create extra barriers for people by forcing them to go through inappropriate procedures.

Lastly, whilst we appreciate the financial pressure on the legal aid budget, we have deep concerns about the likely impact on the NHS budget of the proposals. Whilst there would be a modest saving to the legal aid budget, the likely consequence of an increased reliance on Conditional Fee Agreements (CFAs – 'no win, no fee') to pursue clinical negligence claims would be to significantly increase the cost to the NHS. Moreover, we are very concerned that this proposal would result in non-specialist solicitors 'having a go' at clinical negligence claims. This would result in inappropriate litigation and in claimants with worthy claims losing out or being short-changed. It would undo much of the good work that AvMA and the LSC have done in making clinical negligence legal practice a specialist field. It would also leave access to justice to the vagaries of a particularly volatile and unpredictable commercial insurance industry and lead some people to resort to undertaking uninsured litigation. It is worthy of note that some of the most successful firms in the field of clinical negligence who are represented on AvMA's specialist panel and who could undoubtedly benefit commercially from the proposed move to more use of CFA's, recognise that this would be to the overall detriment of access to justice.

Questions for Consultation: detailed comments and answers

Question 1: Does the funding code strike the right balance between funding early advice and contested litigation? How far should reforms go to refocus CLS funding toward early resolution and away from litigation?

As stated above AvMA welcomes the view that public funding be employed for alternative mechanisms of redress other than litigation. However, it has not been customary for solicitors to assist clients in alternative mechanisms because the funding has not been there to do so. Hence we found from our survey that solicitors were reporting that whilst they encourage clients to make a complaint to an NHS Trust as a pre-requisite to consider whether investigation is merited, in practice most clients have to navigate their way through the system alone (unless, of course, assisted by AvMA or ICAS. So far as ICAS is concerned it is, of course in the early stages of its development and does not have within its remit or capability the task of dealing with issues of clinical or legal complexity). Some solicitors are prepared to act on a pro bono basis but work is unlikely to be extensive. The result is that an opportunity for early admissions/ settlement of claims may be missed. Although legal help is available, in practice most solicitors do not avail themselves of it because of the cumbersome administration involved at very unprofitable rates. This aspect is discussed in further detail below (Question 3).

Hence, our concern is that if a balance is to be found, assistance for claimants must be adequately and effectively financially resourced. The proposed NHS Redress Scheme might reduce the amount of litigation if it works properly.

However, the point needs to emphasised here and elsewhere, that the scheme does not exist as yet and the proposed details remain under-described. Regardless, (and we return to this later on) it will be necessary to dedicate a significant amount of public funding budget to fund independent legal advice to participants in any potential NHS Redress Scheme or similar approaches. Thus, any “savings” are much more likely to benefit the Department of Health than the LSC.

AvMA also believes it is wrong to conflate the expense of litigation with the incentive for claimant solicitors to prosecute claims. This is to ignore the fact that resolving clinical disputes is a two-way process. We are made continually aware of cases where the defence do not concede that a mistake in treatment or management decisions was made until very late in the day. Responses to complaints are frequently less than candid and honest. Therefore, whilst we support alternative ways to resolve clinical negligence disputes as and when appropriate, it must be understood that in order to achieve resolution complainants/claimants need to be supported throughout the process. They must have access to specialist advice and there needs to be realistic and appropriate funding to support it.

Many solicitors currently undertake filtering work on a pro-bono basis. Some do complaints and inquests pro bono. It is felt that this free work is not recognised by the LSC and will be lost if the proposed changes lead to a significant shift to non panel solicitors representing clients.

Question 3: Given the current serious pressure on the CLS budget and the need to live within budget, are there other areas, not covered in this consultation, where savings could be made?

We recognise the pressure on the CLS budget. However, for the reasons stated above we find it iniquitous that largely because of the huge cost of funding criminal and asylum cases, potential claimants in clinical negligence cases should find access to justice even harder to achieve. Clinical negligence is an area where there is strong evidence that there is a very small amount of litigation (and reducing), given the scale of medical errors acknowledged by the Department of Health. The official estimate of medical errors is nearly 1 million per annum, yet only a little in excess of 6,000 people make claims. The LSC acknowledges that there is no evidence of poor practice, and there is not a substantial amount of savings that can be achieved from the proposals relating to clinical negligence. Furthermore, we find it remarkable that some of the proposals (see section on CFAs), whilst they may save the CLS budget a modest amount, would end up costing another government department (in this case the Department of Health) and the State as a whole, considerably more.

Financial eligibility

a) Income

Question 4: Is it appropriate to concentrate savings on the upper eligibility limit for legal representation? Should the upper limit for legal help and representation be aligned? What forms of safeguard should be introduced to protect the most vulnerable clients?

There is a logic to bringing the upper income limits for legal help and for legal representation into alignment. However, a decision to reduce the upper limit for representation to the current limit for the legal help scheme will simply exclude more people from the Legal Aid scheme. AvMA's prime concern is to protect access to justice for those people affected by medical accidents and would argue that if there is to be a change then the legal help limit should be raised to the legal representation limit.

b) Capital

Question 5 What forms of safeguard or exemption should apply if the £100,000 equity disregard is abolished? Should the £100,000 mortgage cap be retained?

We are worried about the proposal to abolish the existing rules whereby the first £100,000 of equity in an applicant's home is disregarded. Based on current house price figures, in the south- east in particular, many perhaps most homeowners would be disenfranchised by this change.

There are practical problems arising out of these changes but more importantly there are ethical if not socio-economic considerations. If the property concerned is the claimant's home it is not an asset that can be or should be used to fund litigation. Those profoundly injured following a medical accident seek financial redress to obtain the vital care and services they need to recover the quality of life that can only ever approximate the one with they have been deprived through another's fault. To ask a person who happens to be a house-owner to risk their family's home by taking out a loan to fund the costs of a legal investigation places them in an invidious and reprehensible position. Ought, as a matter of policy the government to encourage debt? Is the LSC ignoring the fact that most applicants

for legal aid have low incomes in the first place so that it would be difficult if not impossible to obtain finance by way of a loan on the property, at least from a reputable lender that may not charge punitive interest?

In addition the practical constraints in no longer applying the equity disregard have also not been thought through sufficiently. Solicitors will now be vested with the responsibility of calculating the equity taking into account a valuation of the property. Who is responsible for undertaking the valuation itself? The vagaries of the property market also appear to have been ignored so that any hike in prices in any one year may move a legally aided applicant outside scope with consequent revocation of the certificate. If the claim is cut short for this reason who is the winner? Everyone loses, including the LSC: it loses the opportunity to recover the costs in the event that the case might have proceeded to a successful conclusion (through litigation or ADR post investigation). There will be additional administrative costs which would be better used in helping the client.

Finally, there are points in the document that we would welcome further clarification upon. At paragraph 2.10 the question is asked about whether the mortgage disregard should be retained at all. If it is not retained and the fact that one has a mortgage is ignored for the purpose of calculating your capital this would mean that you would be treated as having capital even with no equity in a property. However, more confusingly, the question asked at the end of this section is whether the mortgage cap be retained. If the cap went but the disregard retained then this would increase the number of people eligible. Another more obscure point concerns the capital disregard for pensioners. Under the new proposals for pensioners will this be in addition to the equity disregard or instead of it? That is, will pensioners who are homeowners be worse off under these proposals? Should this be the case then access to justice will further be reduced in respect of the elderly and could well comprise the subject of legal challenge.

Exemptions

If the £100,000 equity disregard were abolished, there would need to be many safeguards to prevent some of the most vulnerable people being affected. Disability or incapacity due to a medical accident, which is the subject of a claim, should be one area for exemption. People on a low income will need to be protected. The vagaries of the property market will have a disproportionate effect in some areas of the country. The proposed changes are likely to aggravate these differences and lead to unexpected and unintended consequences. The proposal has the potential to make access to legal aid practically non-existent to homeowners living in London and the South East, and probably throughout England and Wales. Further work should be carried out by the LSC to assess the impact of these changes before they are made.

We note that some exemptions are proposed to the inclusion of equity in calculation of an applicant's capital targeted to those on the lowest incomes, particularly pensioners and the disabled. How will disability be defined? AvMA advocates that all applicants that have been injured due to clinical accidents ought automatically to be exempt from the inclusion of equity in the calculation, whether the accident occurred in the hands of the state or otherwise.

Discouraging unnecessary publicly funded litigation

Question 18
Should the criteria be amended to require more cases to proceed through the NHS complaints system before litigation is considered (compared to the current approach which applies only to cases under £10,000) if so from what date?

Question 19
What are the categories of clinical negligence case or circumstances in which referral to the complaints system might be inappropriate? Should a different approach be applied in Wales?

We believe that it would be premature to amend the code to force claimants to go through the NHS Complaints Procedure first. Specialists in clinical negligence are more than able to identify when it would be in the client's best interests to use the complaints procedure first, and often this is the course taken – especially when AvMA advise clients. However, the current complaints system is not geared towards identifying the issues that directly inform decisions about the merits of a compensation claim. In fact, the procedure specifically excludes such matters and concentrates solely on seeking to resolve dissatisfaction. If a complainant signals his/her intention to seek compensation they can even have the shutters brought down on their complaints investigation. Even under the recent reforms, NHS complaints can take a long time to complete, and AvMA are aware of some cases that have fallen outside limitation because of delays due to the NHS Complaints Procedure being completed. Huge investment in staff and training may be necessary to enable the NHS investigate complaints more thoroughly and speedily, and to deal with the extra complaints the proposal might result in. If a claimant and their specialist adviser are sure that the best course of action is to proceed to litigation, then to force people back to the complaints procedure will be perceived as yet another obstacle being put in the path of accessing justice. It would have the effect of wearing some people down to the point where they cannot cope with the prolonged stress of starting all over again with what is a completely different procedure.

If the decision is taken to require people to use the NHS complaints procedure before qualifying for legal aid, we would suggest that the limitation period must be extended. However, we also recognise that the effect of delays can be detrimental to the defence as well as the claimant. If limitation periods are

extended there may be difficulties with formulating a defence or a claim if witnesses cannot be traced or memories fail. There may be problems in locating key documents. Circumstances when it would not be appropriate to require people to have used the complaints procedure include:

- where both sides agree it would make more sense to deal with the issue through the legal route
- where the NHS has brought an end to the complaints procedure because of the complainant's intention to take legal action
- where the complaints procedure can be demonstrated to have taken an unreasonable length of time
- where the NHS can be seen to have been less than fully honest about the incident already, or where reasonable doubts exist about the objectivity with which the NHS will be able to investigate itself
- where there is danger of getting close to or exceeding the limitation period (unless, of course, limitation is extended whilst the process is going on).

The NHS Redress Scheme

Our concerns were aired in our response to Making Amends in relation to the chief medical officer's proposals for a Redress Scheme without any guarantee of appropriate independent specialist advice for the claimant. As we have indicated before, the nature of such a scheme is so under-described and un-formulated that we do not see how the LSC can be in a position to base any proposed reform to public funding given the unknown. Therefore, we are somewhat concerned to note that if and when a redress scheme is established for claims against the NHS the LSC propose amending the funding code to ensure that cases do not proceed to litigation that could be more appropriately dealt with by Redress. We would have no objection to this in principle provided there are some important safeguards, such as a fully (publicly) funded specialist scheme is available to advise the claimant as to the appropriateness of entering the scheme or not, and to represent and support them through it. This would include advice about the quantum of any offer made. This is particularly pertinent in relation to the severely neurologically impaired. Other factors such as the independence of medical expert opinions used to determine whether people meet the criteria, need to be clarified before it can be determined to what extent any such scheme is sufficiently robust to be seen as an alternative which the LSC should require people to use before qualifying for legal aid. Even if this does become the case, there should be an objective consideration of any subsequent application for legal aid, which takes on board that the investigation has not been fully independent or as robust as would be the case in litigation. The 'findings' of such a scheme should not be accepted as necessarily valid or correct.

We also understand that the NHSLA proposes to introduce a fast track small claims scheme soon although the workings of the scheme have yet to be finalised. Our experience of the RESOLVE pilot scheme previously was that

even in cases where it was clear that the case could not be pursued the medical reports were often opaque to the client, thereby not satisfying the client's need for a full investigation. While, we are fully cognisant of, as well as sympathetic to, the need to balance the cost to the public purse with monetary value for the client, we are concerned to ensure that victims of medical accidents get the redress which they deserve. We are anxious that applicants, otherwise financially eligible for legal aid, are not excluded from legal aid simply because they did not qualify for compensation under a future NHS Redress or NHSLA scheme following an investigation that may well have fallen short in some way.

Role of ADR and mediation

Question 20: How can the commission encourage the wider use of non-family mediation and other forms of ADR? In what circumstances should the commission require mediation to be pursued? What further steps could be taken to promote more mediation of clinical negligence disputes?

Very few clinical negligence cases are ever contested at trial. Most firms settle cases following round the table discussions with their opponents. The courts already have the power to ensure that ADR is considered and take into account any unreasonable refusal to enter into ADR in making decisions about costs. The LSC's own data suggests that a further safeguard might be to require an offer of mediation or negotiation to be made in letters of claim and provide the LSC with copies of this and of the response before being awarded further funding for a case.

AvMA is an advocate of alternative dispute resolution (ADR) where appropriate. However, AvMA remains concerned that so many cases still settle too late on in the process. Mediation cannot work if the claimant does not have enough information to assess the strength and value of the claim. For this reason many mediations do not happen or when they do, happen too late in the process to have a significant impact on costs given how close the parties are to trial at that stage.

AvMA recommends that a "cooling off" period is timetabled at the time of the CMC to follow exchange of expert reports and possibly after expert meeting to allow parties to take stock and consider their position with a neutral prior to trial. A realistic amount of time should lapse between exchange and trial to allow for any slippages in the timetable.

While mediation may be effective in circumstances prior to exchange of medical evidence (e.g. breach of duty or liability conceded) AvMA is opposed to the idea of compulsion implicit in the paper. We are disappointed by the lack of progress in the joint AvMA / CEDR / NHSLA project originally funded by the LSC. The

project envisaged the provision of training for all stakeholders who might be involved in mediation in clinical negligence cases. We remain committed to the exercise and hope that the LSC and/or Department of Health now recognise that it ought now to finally attract the support it needs. Another part of the same project would provide clinical negligence-specific training and accreditation for mediators. The wider availability of true specialists would both improve confidence on the part of people who might use mediation, and should also help make the costs of mediation, which are currently very high, more competitive. As stated before, despite widespread support for the project we are disappointed that it has not been pursued beyond the feasibility study funded by the LSC and despite the intentions of the Department of Health referred to in Making Amends[1].

Until such training takes place we remain guarded about a process that might well be effective and fair but appropriate safeguards need to be in place prior to whole-scale endorsement of mediation. Furthermore, the benefits of mediation are anecdotal as opposed to scientific and evidence-based. The LSC's own figures do not support the claims made for it.[2] Moreover, it takes more than the claimant to reasonably accede to or decline mediation. The LSC's own data[3] reveals that in most cases mediation did not occur because the offer to mediate was declined by the defence.

If, as the LSC proposes, certificates are limited to pursuing ADR we are worried about otherwise perfectly meritorious claims being abandoned because the defence tactically refuse ADR knowing that funding will be withdrawn (as, we are informed, is currently the case).

A Pre Process Review

One of the ideas emanating from the AvMA/NHSLA/CEDR project (funded by the LSC) was the idea of a pre-process review (PPR). We felt this was key if mediation was to gain support. The idea is to help parties choose between the options of litigation, adjudicatory ADR (to include expert determination outside the court), non-adjudicatory ADR (eg mediation) or negotiation and settlement. The establishment of new procedures would be based upon a "gatekeeper" concept in which a neutral provides a preliminary assessment of the case. Cases that required extensive preparation could be identified, and help given to make the process as focused, economic and fair as possible. Those that could be addressed more quickly and simply, eg by invoking the small claims scheme, redress scheme, mediation (or a combination of the two) could be identified and directed toward the appropriate process. Each case would be considered on an individual and non-binding basis. The categorisation of the case would indicate whether the case could be dealt with speedily with minimal expert reports at low

[1] Ibid, page 96, para23-24
[2] Colin Stutt in his paper to the AvMA annual conference July 2004.
[3] ibid

cost to assess the merits of the claim or whether more preparation and advice was indicated. While the process would be non-binding it might have costs consequences if ignored. However, a neutral could also advise that further investigation into an issue was warranted before a final decision could be made.

One potential benefit of such a process so far as the LSC is concerned is that any recommendation made by the neutral could be referred to the LSC providing it with an objective assessment that might, in turn, be determinative of the appropriate funding stream. For the claimant part, if a neutral advises that further investigative work up is needed, then this will assist in any application for additional public funding. The concept of a PPR has not, for lack of funding, been fully worked up yet but initial soundings from the advisory group to the project suggested there was scope for further development and AvMA would welcome the opportunity to discuss or collaborate further with the LSC/ DCA and or the DoH in the near future.

Conditional Fee Agreements

Question 21
In what additional categories of case and in what circumstances should funding be refused on the grounds that a case appears to be suitable for a conditional fee agreement? To what extent should the viability of funding be linked to the availability of insurance in support of a CFA?

On this aspect of the consultation paper AvMA has particular concerns. We are opposed to any expansion of the use of CFAs in funding these cases given the complexities and problems that such agreements engender. In particular we oppose the idea that CFAs can replace public funding without the benefit of independently commissioned research into the area. It is not at all apparent why the LSC should seek to reduce access to Legal Aid to clinical negligence claimants. As we demonstrate elsewhere in this response, there is far less take up of clinical negligence cases than one would expect, given the official estimates of the number of serious errors in the NHS. The proposal is also puzzling given that most commentators agree that because of the high costs involved in CFAs which attract success fees and often require huge insurance premiums, this would mean that a modest saving in the CLS budget would be translated into a much larger drain on the NHS Litigation Authority. The NHSLA itself is not keen on the idea of further expansion of CFAs. No research has been completed on the cost implications, or how CFAs have worked in clinical negligence thus far.

Some of the problems regarding CFAs are already well known. The fact that CFAs contain complicated provisions for defining success, paying expenses, terminating agreements early, high premiums etc has been well-rehearsed

elsewhere. However, AvMA has additional and specific concerns. The core of AvMA's work has been the education and provision of specialist lawyers in the field of clinical negligence. The LSC acknowledge that the role of specialist lawyers has contributed to the increase in quality of services by franchisees. AvMA invests a substantial amount of its resources into the monitoring of and administration of our panel. Further changes in improving the panel are afloat. Therefore, we are depressed by the notion that what we have long worked toward is likely to be set back by years if non-panel member firms undertake this work with their inadequate experience and training. Such a move will be to the detriment of the defence (in having to deal with prolonged, possibly unmeritorious claims) but claimants are likely to suffer in particular. In Making Amends reference was made to the fact that:

"Defendants as well as claimants can use conditional fee arrangements and they are therefore available to the NHSLA's solicitors as a means of running those cases it believes have a serious defence."[4]

Since there is nothing in section 2 of the Access to Justice Act 1999 precluding the defence from recovering a success fee or premium, should the defence (including the Medical Defence Organisations) utilise these financial arrangements, AvMA forsee all sorts of undesirable consequences, not least the prospect of premium costs hitting the roof.

We have concerns about the number of potential claimants contacting solicitors for the first time who are being turned away at preliminary "screening" sessions. There is a lack of research into who has been turned down for CFA: We do not know whether lawyers with a financial interest in the outcome are being over cautious, turning down otherwise deserving cases. This information is crucial if CFA work is to replace public funding. Solicitors will have to undertake their own internal (business) risk assessment as to the volume of work that can be funded on this basis. Whilst CFAs may have a role to play in increasing access to justice, caution must be exercised in expanding that role. All but two of the respondents to the AvMA survey indicated that a higher prospect of success (at least 60%, but some indicated 70-80%) is demanded for a CFA than for public funding before a solicitor firm will agree to take the case on a CFA basis, even following investigation. We already note from our own risk assessment work that we undertake that ATE providers apply different eligibility criteria than the LSC. This will lead to the inevitable "cherry picking" of cases that AvMA has long been concerned about. Those cases where the prospects are more finely balanced may not be pursued and this causes AvMA huge concerns since very often the catastrophic injury cases can be very evenly balanced, relying as they do very often on factual evidence in dispute. The fall-out could be very high indeed since clinical negligence cases are not straightforward: They are not your average "slip and trip."

[4] Ibid, page 71, para 57

Our own experience of risk assessment shows us that many cases where ATE cover is sought relate to very serious injuries where the stakes to the client, both personal and financial, are very high indeed. This emphasises the fact that the needs of clients need to be very carefully safeguarded as they are very vulnerable. How many of these potential claims are mistakenly being turned down at screening stage (in some cases screening involves no more than a telephone interview) because solicitors conducting CFAs apply differing criteria for success? How will a client know this?

Linked to the provision of access to justice is the seeming disparity in the insurance products that some solicitors have access to. Many survey respondents indicated that they were confused and lacked confidence about their knowledge of the products on offer. Some indicated that they had negotiated contracts with specific suppliers that "tied" them to a product. Our discussions with providers suggested that that this sort of arrangement may be of benefit to some individual claimants but conceded that it might be less so for others, yet solicitors will be constrained if they do not supply the volume of cases that gives them access to the product. Larger firms or those dealing with a greater volume of cases may be able to negotiate more favourable deals with insurance providers than others. Larger firms have dedicated advisors looking into financial arrangements that might benefit both the client and the firm. We have concerns that the smaller or medium sized firm undertaking clinical negligence work may meet problems of liquidity in the funding of disbursements etc. Several firms repeatedly apply for insurance and are declined while others are continually accepted (or some even have "delegated authority" entitling them to insure those cases that the conducting solicitor deems suitable without independent assessment by the insurer). This suggests that there are two tiers of CFA agreements that litigants are being denied equal access to. There are "hidden" costs to most CFA agreements: Interest on loans is not recoverable from defendants when the case is conducted on a CFA. Many claimants may not really understand this recoupment from damages in the context of a "no win no fee" agreement. Another recurring problem is that of obtaining "top-up" cover when the amount of cover insured for needs to be extended. Some clients may be exposed to the risk of being under-insured but lulled into a false sense of security by having a policy. This is a very worrying trend, particularly as some solicitors under-insure in the first place, under-estimating the costs. The consumer may be being badly served.

The insurance market is volatile and uncertain. We would anticipate that as some companies take "hits", they will either go out or withdraw from business or escalate the costs of premiums. If there are fewer companies willing to take on clinical negligence claims, there will be fewer providers and higher costs. There is no guarantee that insurance for CFAs will remain a viable option in the future. Respondents to our survey highlighted incidents of claims being made against insurers in respect of unsuccessful cases and not being paid out for reasons varying from the insurer going out of business to the insurer attempting to void

the policy and involvement of the insurance ombudsman. The regulation of the insurance sector needs to be looked at.

AvMA has anxieties about the number of cases that are being conducted on CFAs not backed up by insurance and the fear that this trend may be increasing with the problems in obtaining insurance cover in difficult cases or due to expense of the premium. The NHSLA as well as solicitors representing the medical defence organisations (MDOs) have indicated that in a situation where a claimant loses at trial and was not insured in respect of costs the defence would pursue the claimant personally for costs.

As a matter of public policy, the potential for conflict that may arise between client and solicitor cannot be under-played. Many responded to our survey stating just how uncomfortable they felt with the conflicts that CFA agreements posed and how the defence frequently exploited the potential for conflict. We learn of many cases in which the defendant agrees to settle on a basis otherwise attractive to the claimant but inclusive of costs leading to last minute adjustments to the success fee thereby placing the lawyer in the invidious and ethically abhorrent position where the lawyer is the bar to an otherwise acceptable settlement. We believe that the presence of a CFA might provide an incentive to the NHS/MDOs to contest the borderline cases more aggressively as costs are recoverable if the defendants win. Conversely, the stakes are higher if the defence lose as it will be required to repay costly premiums and success fees.

It is also particularly noteworthy that some of the most successful clinical negligence solicitors on AvMA's specialist panel, who would benefit financially from such an arrangement, are adamant that it would work against the interests of many potential claimants who would no longer be able to access justice. Access to justice for clinical negligence victims would become dependent on the vagaries of the commercial insurance industry.

For the above reasons, we believe the proposal is contrary to the principle of access and that it should be reconsidered. However, if there is a policy decision to follow this proposal, we very strongly support the suggestion that it should be piloted first and that Legal Aid be guaranteed for at least the investigative stage of clinical negligence cases but, in any event, to exclude cases where the client is under a legal disability. We recommend that it would also be necessary to fund ongoing disbursements.

Cost protection

Question 25
Should cost protection be reduced for non-family cases? If so what should the extent of liability be and are there categories of case or circumstances which should receive special attention?

We find this proposal particularly objectionable especially in the context of clinical negligence. If a clinical negligence case is being brought in good faith, following legal advice from a specialist solicitor supported by independent expert evidence, why should someone who can ill afford the cost be penalised because the case is not successful or has to be withdrawn? There is no evidence of a compensation culture or exploitation of the system that merits the idea of a cost contribution. Some clients will already be making monthly contributions toward legal aid. How will the LSC seek to recoup the cost contribution in circumstances where it may be as little as £5 per month? Will the administrative costs justify such a proposal? A claimants own financial resources militate against making the claimant liable for costs given that the threshold for legal aid eligibility is so low the claimant is unlikely to be able to afford to make payment in the event of an adverse costs order. Also, interlocutory applications to the court are more frequently undertaken on the advice of lawyers and not at the client's own behest. In any case, the courts are already vested with this power to order a claimant to pay costs in the event that s/he is conducting litigation unreasonably.

The general cost benefit test and the cost benefit matrix

Question 26
Should the general cost benefit test in the code be strengthened to require proportionality between costs and damages in all categories where it currently applies?

Question 27
What cost benefit ratios should apply to clinical negligence cases in the funding code?

We do not agree with this proposal. It does not take into account the extra expense involved in pursuing clinical negligence cases. It also strikes us that changing the formula would work to the detriment of solicitors conducting cases in London or the South East where the hourly rate is much higher. However, all this is to ignore the fact that the expense in running clinical negligence claims does not stem from lawyers alone but the large amount expended on disbursements in these cases due to the costs of medical experts. While it would be tempting to suggest that the LSC place a cap on the hourly rates allowed for experts, this would only have the effect of stopping the best and most sought after experts from acting for claimants rather than the defence placing the latter at an unfair advantage. It would lead to a situation where cases worth less than

around £150,000 would not meet the cost benefit requirement, if one estimates the cost of a contested trial at around £40,000. Application of this rule would act as a driver to more cases being undertaken on CFAs-creating a ludicrous situation where costs would excessively outweigh damages. It also creates a perverse incentive for the defence to refuse mediation / ADR in legally aided cases as they will assume that legal aid will be limited to these processes alone.

Finally, we meet particular problems in our Advice and Information department in referring on fatal accident cases that many solicitors simply will not touch for the simple reason that the award of damages is likely to be "low" so that LSC funding will be refused. Our views with regard to the funding of fatal cases in particular are already known within the LSC. They have been documented in our response to the DCA consultation on *inquest funding* (www.avma.org.uk) Needless to say we feel immense disquiet at the prospect that meritorious claims of personal interest to the injured client but of public interest and concern also in the case of fatalities will not be pursued if a cost/benefit equation is simply and crudely applied.

Conclusion

We hope that our observations and comments will be seen as useful. AvMA is a strong advocate of public funding to promote access to justice and supports the aims and objectives of the LSC, with whom we enjoy a constructive relationship. Should there be any issues arising from this paper or otherwise that the LSC requires further clarification on, we would welcome the opportunity to develop or discuss them further.

Fiona Freedland
Legal Director
October 2004.