RESPONSE TO

LEGAL AID: A SUSTAINABLE FUTURE

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Legal Aid: A Sustainable Future – A Response From Action Against Medical Accidents

About AvMA:

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 firm is not entitled to a clinical negligence franchise) and promotes good practice through comprehensive 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.

Our insight and experience is limited to the healthcare arena; clinical negligence in particular. Therefore there is much in the consultation paper dealing as it does predominantly with the criminal and family arena that we cannot respond to. Nevertheless, we have some observations that we would like to make confined to those areas that we do have experience of. Given these parameters, our comments comprise an overview of the consultation paper with some specific comments rather than a focused response to the consultation questions, the majority of which concern criminal or family legal aid.

Summary:

1. AvMA welcomes the opportunity to respond to the joint DCA/ LSC consultation published alongside Lord Carter's report. Broadly, AvMA felt there was much to commend in "Making Legal Rights a Reality" (that anticipated the outcome of Carter) and the stated objective in tackling social exclusion in particular.

2. Given our primary concern to ensure continued access to justice and quality legal services we worry about the creation of "advice deserts" given that clinical negligence is already restricted to specialist panel firms. Hence, we have reservations about the effect minimum income

requirements might have on firms undertaking clinical negligence work that the LSC may not have thought through sufficiently.

3. Whilst AvMA supports the LSC's aspirations of quality we have reservations as to whether this can be realistically achieved if standardising fee structures might well force firms to attempt to standardise services as well so that many firms develop factory style processes that we consider ill-suited to claims of this kind (arguably of any kind). Further, standardising fees means that tackling cases that already have inherent difficulties built into them are likely to be even less attractive to practitioners e.g dealing with clients with mental health problems. Diminishing revenue for undertaking clinical negligence work means that those firms doing this work will be less inclined to take on complex cases. Pressure on costs means that work on cases is likely to be devolved to more junior staff or para-legals. This is a trend that AvMA has noted already in some larger practices with senior experienced lawyers taking on a supervisory role, devolving cases to juniors with no single person "owning" the case and taking overall responsibility for tactics and strategy employed. Ultimately, if publicly funded clinical negligence work is not remunerative, lawyers will only take on more profitable CFA work. This will lead to cherry picking From a public policy point of view it makes little sense to curb the legal aid budget whilst leaving the department of Health to pick up the tab for costs incurred in undertaking the case on a CFA. Many clients will not have recourse to a lawyer and will have to rely on CLS Direct.

Dealing now with the main issues arising from the consultation document as it relates to clinical negligence we make our observations below.

Standard fees

Although the consultation refers to standardization in the context of legal help, the paper also makes reference to the LSC considering how to introduce standard or graduated fees in all the remaining areas "as soon as possible and certainly no later than 2010." (paragraph 2.29). As stated above we see great problems inherent in standard fees if transposed to clinical negligence claims. Solicitors are likely only to want to take on the simplest of cases. There will be little incentive to pursue cases where multiple claimants or defendants are likely to be involved.

Given that solicitors will have to make more use of legal help (hitherto not largely used in clinical negligence cases) in order to satisfy contractual requirements on Matter Starts as well as to meet minimum income requirements, it may not be clear to the practitioner taking the case on from the outset whether the case will

meet the threshold of an exceptional case. It is only if the cost on hourly rates would exceed four times the standard fee that the firm will be paid at the hourly rate. Unless practices know in advance whether complex claims are likely to come within the exception in advance then many clients with these claims will be disadvantaged.

In any event, we have noted standardization of fees encroaching upon the clinical negligence arena already. Many practitioners report consternation at time estimates in high cost schedules being reduced by LSC officers without real consultation with the practitioner involved in the case. We note the Special Cases Unit consultation on a template to be adopted in cerebral palsy cases. This appears to be fixed pricing through the back door. Whilst AvMA is fully cognizant of the financial constraints within which the LSC has to work, AvMA does not believe that any bench-marking attempts in relation to catastrophic injury cases is appropriate.

AvMA has also noted that despite assurances from the LSC that clinical negligence cases were to be ring-fenced from the imposition of fee capping in relation to experts, this has not always been the case. There have been reported instances of expert fees being reduced on case plans. We note from discussions with the LSC that this is a practice that is likely to be extended. Although we do not wish to rehearse arguments already presented in our extensive response to the consultation on expert fees, suffice it to say, that access to justice demands that clinical negligence claimants access resources available to the defence (who have no such financial constraints imposed upon them). The success of a claim is wholly reliant upon the expert who supports it. It cannot be right for the LSC to impose regulation of expert fees in respect of publicly funded claimants in an otherwise unregulated and competitive market thereby prejudicing the prospects for claimants. It does however indicate a need for the LSC to work with other organizations such as the Civil Justice Council/ BMA/ NHSLA.

High Cost Cases

We have registered concerns that even if a firm attains preferred supplier status delegated powers will not follow automatically. Even in high cost cases the LSC will still retain a range of decision making. Clinical negligence comprises the second largest area after public law dealt with by the Special Cases Unit. High value complex claims are likely to still retain administratively burdensome requirements. For example we note the draft guidance that is due to go out to consultation shortly concerning the recovery of disbursements/role of the statutory charge in relation to high cost cases. Practitioners want clear guidance that is both transparent and fair and works in the best interest of clients.

We have already noted a degree of volatility in the provision of clinical negligence services with mergers of some prominent firms and closure of clinical negligence

departments in others. The LSC has already stated elsewhere that: "We would in principle be interested in reducing the size of the Clinical Negligence panel based on the outcomes produced by existing panel firms." [1]However, there are significant benefits for clients in having a large and diverse range of suppliers of legal advice in the field of clinical negligence. Although it may be more efficient and therefore cost effective for the LSC to deal with a smaller number of large providers, biggest is not always best and clients could lose out. If the supplier base gets too small there are risks for the LSC that these firms could effectively form a cartel and pull out of clinical negligence altogether if their demands are not met. Therefore we are concerned about the practical effects of *preferred supplier* in reducing dramatically the number of firms providing a clinical negligence service. This could impact on access to local suppliers and on choice, but also on the ability of firms to develop specialist and innovative practice. In this connection, the following passage in Carter's report is pertinent:

64 "The improvements in quality have come at the price of reinforcing the tendency for firms and not for profit agencies to concentrate on particular sections of law, so there is now a declining number of family suppliers undertaking social welfare work. Furthermore, the increasing concentration of social welfare law services in not for profit agencies has further fragmented the delivery of civil law advice, despite the real improvements in access to benefits and debt advice that have arisen because of their involvement in civil legal aid. The fragmented delivery of services is a barrier to early resolution of problems and thus could be argued to be a barrier to the efficient interaction between civil and family advice and the rest of the civil and family justice systems. Such fragmentation ensures that clients' needs are not met efficiently.

Whilst we fully endorse the *concept* behind the delivery of seamless legal services we have reservations concerning the proposed models of delivery. Very little is stated either in Carter or in this consultation about the future of specialist areas like clinical negligence. Until surprisingly recently, clinical negligence work could be undertaken by any high street practitioner. S/he might take on a handful of these cases alongside his/her family/criminal/housing (etc) work. The 1990's saw the introduction of franchising and the development of specialist panels. It is readily acknowledged by the LSC that their suppliers in clinical negligence produce high quality work on the whole. What we do not want to return to is the days of the generalist practitioner, dabbling in many areas but attaining expertise in none of them. Nor do we wish to see advice/representation of the "lowest common denominator."

The Unified Contract-

Minimum Income Requirement

[1] Making Legal Rights a Reality-A consultation paper, July 2005,p.52, para 12.

The theory underpinning the idea of a minimum fund take of either £25,000 or £50,000 might, taken at face value, seem reasonable in some areas of work (leaving aside for the moment the important arguments about the impact minimum income requirements may have on black and ethnic minority practitioners and solicitors in rural areas) but is rather more complicated in the context of clinical negligence. Most panel members have to demonstrate a minimum number of clinical negligence cases in order to meet panel threshold therefore the income generated from clinical negligence cases seen ***as a whole*** are likely to be in excess of this. However, in practice, many clinical negligence firms have a mixed case load of private (CFA work on the whole) or before the event insurance work. In many firms clinical negligence work is undertaken alongside personal injury work (where no legal aid is available). Clinical negligence work may in fact be the only publicly funded work that many practices conducting clinical negligence cases undertake. Furthermore, many of the cases taken on may go on to achieve a successful outcome. This means that no claim on the fund is actually made. Accordingly, the minimum income threshold may not be achieved in relation to some panel firms.

The effect of the minimum income requirement in so far as it relates to clinical negligence could be one of the following:

- Either solicitors will be persuaded to take on less meritorious claims in order to make a claim on the fund (unlikely given the preferred supplier scheme with focus on outcome data), alternatively link with a "loss leading" department of law in order to meet this requirement (see below)

Or

- Be forced to give up publicly funded clinical negligence work and clinical negligence work altogether. If providers decide, through circumstances, to drop their legal aid work this is likely to impact on services for clients. A limited supply of specialist lawyers will mean that vulnerable victims of a medical accident will only will have recourse to the Community Legal services Direct. As presently constituted CLS Direct would not be able to provide clients with the specialist quality of advice needed (see below).

Either way this proposal does not appear to award or recognize success. It penalizes it. This would be a perverse outcome.

It is a mechanism for "dealing with fewer and larger suppliers to improve efficiency and to encourage the provision of holistic services with an emphasis on early resolution of legal problems."[2] Whilst AvMA endorses the principle of holistic services and has been actively encouraging its lawyer members, through, for example, distribution of our newsletter and conference training, to undertake and consider community care, education and public law cases in general, the

[2] Legal aid: a sustainable future. Page 24, para 5.16

LSC need to be cognizant of the realities and recognise the prevailing organisational structures within which clinical negligence practitioners operate. Many, especially in London, work in departments within predominantly commercial law firms. Setting up a social welfare department within such a firm may not be an option. These firms may give up clinical negligence altogether. Carter refers to "niche suppliers"[3] and recognises the importance of retaining them. We hope the LSC recognizes this also and will consider the potential impact the above-mentioned proposals could have on some of its highest performing clinical negligence providers.

The LSC intends that the unified contract marks a "shift from a contract that merely enabled providers to perform work to one where the LSC as purchaser, commissions specified work to be done." [4]This means that the LSC will require completion of a specified number of Matter Starts as well as volume of work and mixture of cases. As for the latter, this has been covered in some detail above. So far as matter starts are concerned, many clinical negligence practitioners do not as a general rule avail themselves of legal help. Many prefer to undertake this preliminary work free of charge. The effect of this stipulation will be to increase the cost to the LSC. Although AvMA would like to see more vulnerable clients having access to lawyers at an earlier stage we do not believe that this practical effect will be achieved. Solicitors are still likely to screen/assess potential clients' prospects of success before the first interview is arranged. In mandating the use of legal help advice for clinical negligence cases the LSC is only encouraging recovery of fees from the LSC that are currently provided for free.

AvMA welcomes the inclusion in the Unified Contract for providers to notify a client if they consider they may have been negligent, and, as a result, the client may have suffered damage. We assume that the LSC has sought advice from indemnity insurers about the legal indemnity implications of this.

Peer Review Score

AvMA does not believe that achieving a score of 3 ought to automatically disqualify a party from being offered a new unified contract. We are of course in favour of setting the threshold high. Nevertheless effort should be put into helping firms at level 3 or below achieve levels 1 and 2 rather than necessarily reducing the numbers of suppliers greatly. We were disappointed that the preferred supplier paper was so vague on detail as to how raising the threshold was actually to be achieved. We reiterate that we would be most willing to work with

[3] Carter, Page 66, para 109
[4] Legal aid a sustainable future,p.83,para 11.37

the LSC to develop courses/training for those aspiring both to achieve panel and/or preferred supplier status and with the potential so to achieve. We have always acknowledged that there is a tension between ensuring access whilst also ensuring provision of the best.

CLACS/CLANS and the NFP sector:
Interface Between Legal Aid Proposals And CLS Strategy

"Since the establishment of the CLS fund, legal aid funding is perceived by the advice sector to have played an important role in increasing the capacity of the not for profit advice sector to provide specialist legal advice to their clients. "[5]

AvMA has a great deal of experience of referring on to and working with private practice. After referral we continue to work with the solicitor and the client to deal with non-legal matters and to offer support to the client if requested.

AvMA recently submitted an application for a CLS Specialist quality mark (we have already reached the standard required for general help). This was done with a view to AvMA providing a more "holistic" service to clients. In particular, we have long been perturbed by the number of clients whose cases "do not find a home. For this reason the CLS concern to widen access to socially excluded members of the public chimes very well with our own strategy in placing AvMA in a position to assist with cases that cannot be dealt with by private practice. We believe that we could manage many cases under legal help. We would aim to resolve disputes where appropriate before issues become litigious. We have an excellent track record so far as our referral system is concerned and track referrals made to ensure clients do not drop out of the system.

How the CLAC/CLAN system could integrate the delivery of specialist legal advice such as clinical negligence would need to be explored further. Specialist organisations such as AvMA would be required to develop such a model.

[5] Carter, para 140

NHS Redress Scheme

Completion of the NHS Redress Bill is imminent. AvMA has been lobbying the government in relation to the provision of independent legal advice, funded by the State. It appears the DoH will not support the funding of independent legal advice other than the seeking of legal advice relating to quantum, and in some circumstances to jointly instruct an independent medical expert as part of the scheme's process. We note the CLS policy toward the future of clinical negligence cases and the presumption that litigation will not normally be funded until a redress route has been followed.[6] However the credibility of such a scheme depends on clients having faith in the process and confidence in the fairness of decisions being reached. We are keen to develop a role in advising and representing clients through the Redress scheme. We are aware that many firms will not be willing to undertake this "low value" work without adequate funding, a matter that causes AvMA concern. We suggest that the CLS has a direct interest in ensuring that participants in the NHS Redress Scheme are provided with adequate legal advice and representation.

Telephone Advice and CLS Direct

"Over time, civil and family legal aid is likely to be provided by fewer suppliers with larger contracts. However, there ought to be sufficient coverage to ensure appropriate access to quality legal services (including telephone advice), and maintaining a variety of suppliers in family law, social welfare law, and civil categories outside the 'core' social welfare areas of law. "(Carter)

The Legal Services Commission is expanding the CLS Direct telephone helpline and it is an important part of their CLS strategy. The Helpline is already an important part of meeting the need for legal advice. However, it is vitally important to ensure that as CLS Direct grows it is capable of providing a quality service. As Carter acknowledges phone services are an important gateway to advice for many people. Although CLS Direct may provide basic advice, such advice is not always consistent. It is not geared up to deal with specialist areas such as clinical negligence. AvMA has an established helpline service and would like to extend it as the help-line is so busy during its hours of operation. Our advisors, many who have both legal as well as medical qualifications, are able to identify problems and "triage" accordingly.

Due to the complexity of clinical claims and the lack of confidence in the NHS complaints procedure itself, we believe AvMA's role is key in assisting clients in their navigation toward the appropriate redress route to follow, whether it be a complaint to a regulatory body, an NHS trust, social welfare advice, support

[6] Making legal rights a reality, volume 1, appendix 1, page 12

networks or a legal claim. We know that if clients are ill-advised at this point they will feel more inclined to abort any attempt to seek justice. Accordingly, AvMA would be keen to expand its telephone advice service and would welcome further discussion with the LSC about ways in which this could be explored. However, any extension of this service would be subject to resourcing.

Conclusion

Whilst we are glad that clinical negligence continues to be recognised by the LSC to be a specialist area of law that warrants specialist advice. We are also aware that the paper ultimately amounts to a "stay of execution." As many of the proposals for other areas of legal work that will be phased in or otherwise will provide the model for clinical negligence to follow. Therefore, we would like to end our response with the view from Carter:

"**Civil justice**

185 Access to civil justice is one of the key components of a fair and decent society. It enables people to understand their civil rights and obligations, and if appropriate, enforce their rights in disputes." Wherever possible, disputes should be resolved without the need to resort to the courts, but where that is necessary, such disputes should be dealt with as expeditiously and effectively as possible by the courts**. ..**

Investigating a medical accident can provide solace and or financial recompense for an individual and his/her family if something goes wrong. Investigation also serves the public interest. The state has a vested interest in knowing where and when the standards of care fall short and getting to the root cause of the problem thereby preventing its recurrence. Reducing medical accidents reduces the financial burden on the state that goes beyond the provision of legal services because a medical accident takes a financial toll on health and social services as well.

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