RESPONSE TO

APIL CLINICAL NEGLIGENCE CLAIMS

AN EXAMINATION ON THE PROCEDURE

Introduction

AvMA's role is to support and advance the interests of patients who have been injured as a result of receiving medical treatment. It operates a Referral Panel to which solicitors with specialist expertise in pursuing clinical negligence claims on behalf of claimants belong, subject to passing stringent qualification tests. It runs high quality specialist training for those working in the field of clinical negligence claims. We also operate a helpline, Monday to Friday, which allows us to give advice us potential claimants and complainants. We also gather statistics from our helpline to gauge the impact on access to justice of changes in the law and gauge the need in the population for legal advice as to claims. One particular area where we have expertise is in advising clients on making a complaint using the NHS complaints procedure (or similar for private health providers). As part of this work we advise clients on their rights under the Data Protection Act to obtain copies of their medical records. We also have a database of expert witnesses, access to which is available to our solicitor and barrister members.

We therefore make the following comment on the **APIL clinical negligence claims an examination on the procedure** in respect of the issues that are relevant to the aims of AvMA and the interest of our clients.

SUCCESS FEES:

For discussion: Is there merit in establishing a framework for the operation of success fees in clinical negligence work

Although originally intended that success fees should be set at a level to reflect the solicitors overall risk to costs of conditional fee agreements public perception as presented in the media does not acknowledge this overall risk, with media attention focusing on high costs in individual cases. As solicitors increase their skills in screening and risk assessment an argument may be made for each case to be risk assessed and success fees set on a case by case basis or as the case progresses at the different stages of the case.

Unless independently verifiable data is made available on unsuccessful cases, where solicitors will receive no fees, defendants and the media will continue to focus on the successful cases where 100% success fees are claimed. This is misleading on two counts.

Firstly no account is taken on the overall risks to solicitors acting for clients for CFAs. Secondly there is little recognition that the actual percentage success fee recovered is often considerably less than 100%. Also many solicitors offer initial advice without charge when screening cases and before entering into a CFA, in effect providing advice pro bono; again there is little recognition of the work done.

An agreed framework for the operation of success fees including staged success fees would go some way to counter the media view. An agreed framework for fees would be clearer for claimants who often find a CFA costs regime difficult to understand. Provided such framework permits a proper assessment of risks we do not consider this would be a bar to access to justice. The application of staged success fees would still permit solicitors to take on high risk, lower value claims.

A fixed framework could also provide certainty for defendants and could help counter the premise that clinical negligence claimants are a drain on the National Health Service (this in itself is a deterrent to patients with a legitimate clinical negligence from bringing a claim).

Costly disputes over bills may be reduced and earlier admissions promoted. Firms already using staged fees (reflecting the practise of some After the Event Insurers) may be prepared to share information on how they work

We do not believe that such a scheme would bar to access to justice for the points already made above. We would be surprised if APIL members would not share information but this is a matter for APIL and its members.

We would not support fixed success fees related to track. We believe that a low success fee imposed on fast track cases (or small claims track) could be a major bar to access to justice. We would point out that though categorised as lower value claims, at the upper end of the fast track these sums represent a great deal of money to many claimants. Further the issues of liability and causation can be as complex as a high value case (as for example claims arising from a still birth or neonatal death where the issues are similar to those in cerebral palsy claims).

We would also make the point that Lord Justice Jackson's proposals that generals are increased to compensate for lack of recovery of success fees is illogical and unfair. The proposed increase in general damages would apply to claims with all forms of funding not just conditional fee agreement. Also as the defendant is paying costs and damages it saves little from the public purse (and if it were to recompense fully for the non recoverability of the success fee, would increase costs further). We are concerned that if success fees are taken from damages some clients will not be able to afford the care and treatment that they need as a consequence of the damage caused by their injury.

Funding

Discussion point: Is there merit in arguing for true one-way cost shifting for clinical negligence cases?

We support <u>true</u> one way cost shifting though not the proposal made in the final Jackson report. It has long been AvMA's policy that legal aid should be more widely available, a key feature of which is one way cost shifting. We do not believe that this would lead to an increase in frivolous claims. The claimant would remain responsible for the disbursement costs and the solicitors and barristers still at risk of receiving no fees at all. At the same time defendants would have the certainty that if they lose they will not be paying success fees. We believe that that the cost to the NHS would be less than at present and may be less given the relatively small number of cases that are successfully defended and costs awarded. Further we would challenge the NHSLA to prove otherwise. There must be no ambiguity about when (or if) a claimant becomes liable for defendant's costs.

While there has been some criticism of the level of ATE premiums (from Jackson and elsewhere) it must be recognised that the presence of both BTE and ATE insurance cover has increased access to justice for claimants of average means. We recognise that the introduction of true one way costs shifting could mean less business for ATE insurers but there will still be a need to insure the claimants' disbursements. If this model is run on

similar lines to the LSC model and includes disbursement funding and recoverability of ATE insurance premiums it would increase access to justice for those of modest means yet ineligible on financial grounds for public funding.

However the question must be asked whether the introduction of such a scheme would lead to withdrawal of public funding from clinical negligence altogether. Could a government argue that there is no need for public funding if the claimant would have access to justice and protection from adverse costs orders in a different way? If this were to happen it would impose a very great financial burden on firms who do a lot of catastrophic injury work where the costs of disbursements (presently funded by the LSC) are high and time scales long

A streamlined scheme for lower value clinical negligence claims

For discussion: Is there merit in promoting a speedy resolution scheme, similar to the one in Wales, in England?

There is merit in this proposal with some caveats. The scheme should only apply where the injury attracts a modest level of general damages. It should not apply where the injury is ongoing and where there is any uncertainty or where the claim for special damage is complex and includes a significant amount for future loss. These requirements roughly follow the same as those set out in the scheme for Wales.

Redress scheme

For discussion: Is there merit in promoting a redress scheme in England like the one consulted upon in Wales?

AvMA has been a supporter and promoter of NHS Redress and Speedy Resolution and was involved in every stage of the process leading up to the NHS Redress Act to ensure patients' interests were safeguarded. While the present framework for Redress is not perfect we support the basic principles for Redress. We believe that there are very real benefits to a claimant to have a complaint or claim dealt with quickly and fairly without the need for recourse for litigation but with the safeguard that the claimant has access to legal advice from the outset. It should be noted that the 'Putting Things Right' scheme in Wales has broader aims and objectives than Redress only. In particular it is intended the NHS in Wales consolidates the different investigatory processes, making sure the scheme is patient focused and a high priority is given to patient safety. As with the 'Speedy Resolution' scheme AvMA believes that the financial ceiling should not be set too high and that the

patient must receive support and advice including legal advice at an appropriate stage. It is of concern that the regulations and guidelines have yet to be finalised. At present access to legal advice is not guaranteed at the initial investigation stage. Also complex matters could be drawn into the scheme if the overall financial ceiling (which can include a care and treatment package) is set too high.

AvMA has responded in detail to consultations about NHS Redress in Wales, copies of our responses are available on our website

However, we fully support the need for independent expert opinion and advice from a solicitor who is a member of one of the specialist Clinical Negligence panels. We would not without further discussion support including members of the APIL accreditation scheme (senior litigator and above) while the scheme does not distinguish between those specialists in clinical negligence and personal injury. It is essential that there is a safeguard for children and adults without capacity that any settlement is with the court's approval. The claimant's right to leave the scheme and litigate should also be fully protected. This would include the right to seek further expert opinion and provision for the proper supervision of the limitation period during the redress process.

During the course of discussions leading up to the NHS Redress Act AvMA made proposals that there should be an alternative test of liability to apply to cases settled under the Act. We called this the avoidability test and believe it would go some way to redressing the imbalance between claimants and healthcare providers caused by the level of legal advice and expert opinion. Our proposal was that, subject to the claimant establishing that the damage was caused by healthcare treatment, the onus should be upon the defendant to establish that the injury was unavoidable; otherwise the claimant should recover damages under the scheme.

Multi track code pilot

For discussion: Is there merit in extending the Multi Track Code pilot to clinical negligence claims?

As an organisation that advises claimants with maximum severity injury we can see very considerable benefits to this practical approach that could lead to admissions of liability in 6 months of a claim being notified with a commitment to interim payments and funding a care regime from the outset.

150 However we are of the opinion that this time scale should be more flexible. It is rarely possible for a claimant to obtain several reports on liability and causation in 6 months. We are also concerned about the commitment to obtaining joint evidence on quantum or where sequential rather than simultaneous disclosure of evidence is the norm. We believe this puts the claimant at a disadvantage and leads to another level of compromise to the value of the claim.

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