FIXED RECOVERABLE COSTS IN LOWER VALUE CLINICAL NEGLIGENCE CLAIMS

REPORT OF

THE CIVIL JUSTICE COUNCIL

WORKING GROUP

OCTOBER 2019

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GLOSSARY

Bodies and organisations referred to in the report

APIL	Association of Personal Injury Lawyers
AvMA	Action against Medical Accidents
CPRC	Civil Procedure Rule Committee
DH	Department of Health (until January 2018)
DHSC	Department of Health and Social Care (from January 2018)
FOCIS	Forum of Complex Injury Solicitors
HMCTS	Her Majesty's Courts and Tribunals Service
MDDUS	Medical and Dental Defence Union of Scotland
MDO	Medical defence organisation
MDU	Medical Defence Union
MoJ	Ministry of Justice
MPS	Medical Protection Society
MRO	Medical reporting organisation
NHSLA	National Health Service Litigation Authority; renamed NHS Resolution in April 2017
NWSSP – L&RS	NHS Wales Shared Services Partnership – Legal & Risk Services, legal providers to NHS Wales
PAC	Public Accounts Committee
PIBA	Personal Injuries Bar Association
PNBA	Professional Negligence Bar Association
SCIL	Society of Clinical Injury Lawyers

Terms used in this report defined elsewhere

ADR	Alternative dispute resolution
ATE	After the event insurance - Insurance by one party against the risk of it having to pay its opponent's legal costs, where the insurance policy is taken out after the event giving rise to court proceedings. Post-LASPO, ATE insures the party's own disbursements and adverse costs
CMC	Case management conference
FDR	Financial dispute resolution - Family Court hearing to seek to promote settlement of money disputes in divorce
FRC	Fixed recoverable costs
LASPO	Legal Aid, Sentencing and Punishment of Offenders Act 2012
Never event	A preventable patient safety incident that should not occur if all proper procedures are followed.
PTR	Pre-trial review
SI report	Serious incident report

Terms defined by and used solely for this report

Claimant group	The representatives within the working group of claimant firms
Defendant group	The representatives within the working group of defendant interests

LT	Light track
MNE	Mandatory neutral evaluation
ST	Standard track
The parties	Claimant and defendant groups collectively

INTRODUCTION

The background to the CJC's work on clinical negligence claims demonstrates that the task set was a complex one. The Department of Health had already consulted on proposals for fixed recoverable costs. Sir Rupert Jackson had considered making recommendations in his 2017 report[1], but ultimately his only recommendation was that the CJC be engaged to consider process improvements and costs together.

We were fortunate to inherit work already done by the Law Society, which had set up a small group of specialist practitioners and had constructed a process flow which was the basis for many of the recommendations in this report.

The CJC put together a working group with both an inner "core" and a wider group of interested parties. At a very early stage it was obvious that the range of interests that needed to be represented was considerable: and as our terms of reference extended to experts, funding and patient safety, all those interests needed to be represented on the core group. In hindsight, the breadth of those terms of reference was very ambitious, and in the end, we have had to focus on the fundamentals of the claims handling process and legal costs.

As powers relating to health matters are devolved to the Welsh Government, we also had to grapple with the need to take account of diverging systems in England and Wales. NHS Wales has its own redress system: Putting Things Right, which already provides a mechanism for early resolution of low-value claims.

As will be clear from this report, the majority of the working group has been able to agree on some things, but not to conclude an agreement on the level of fixed recoverable costs. In the end the difference between the positions of the claimant and defendant groups on the level of costs is not a large one, reflecting the efforts on both sides to come up with realistic proposals and to do their best to narrow the gap. It is to be hoped that this report will form a meaningful basis for further consultation by the government.

The other point which will be clear from the report is that we have been given access to quantities of data. Professor Paul Fenn has provided a detailed analysis of his findings from this data, which has underpinned our work and appears as an appendix to this report.

I am very grateful to all members of the group for their constructive approach to this work and for having given so much time and expertise throughout our work since April 2018. I am also grateful for their patience: I am not a specialist in clinical negligence law or practice, and it is only through their input that I have been able to come up to speed quickly enough to chair this working group.

The process improvements outlined in this report, whilst not agreed by all, represent a broad consensus between many of the working group members on a better way of handling clinical negligence claims with a value of up to £25,000. The importance of such a consensus, even though not complete, cannot be underestimated. Inevitably the outcome is a compromise –

[1] *Review of Civil Litigation Costs: Supplemental Report - Fixed Recoverable Costs* – see chapter 1, paragraph 1.33 below

but one which I believe is in the best interests of all parties concerned in such difficult cases.

I should record that the dissenting views, which I have done my best to summarise in this report, are genuinely held and reflect real concerns on the part of those expressing them about the appropriate way forward. These are matters for DHSC to consider further when they consult on the recommendations in this report.

It is worth emphasising in any event that the support for these proposals on all sides is strictly on the basis that they are suitable for claims valued at up to £25,000 and no higher. Such streamlining of the claims process is proportionate when the sums at stake are modest, but should in no way be taken as a feasible option for larger value claims.

I would like to record my particular thanks to David Marshall, who as my Deputy Chair and on behalf of the Law Society once again provided sage advice and balance between claimant and defendant interests; and to Paul Fenn, who provided the important analysis of data willingly supplied from all sides and whose expertise in matters of fixed costs remains without equal. As members of Sir Rupert's panel of assessors, I suppose the three of us had some idea what we were letting ourselves in for!

Grateful thanks are also due to Philip Havers QC, who as mediator helped persuade the parties to table firm proposals on costs; to my researcher, Michael McCabe, who marshalled the material throughout our work and helped in drafting the final report; and to the Master of the Rolls, Bill Wood QC (as the CJC's ADR member) and the CJC Secretariat, for their advice and support throughout.

I have done my best to represent the views of the working party neutrally and fairly, although I have been an advocate of fixed costs for many years. The responsibility for any errors or misunderstandings in this report is mine alone.

Andrew Parker
Chair of the Clinical Negligence Working Group and CJC member

CHAPTER 1: BACKGROUND

Purpose of this chapter

1.01 This chapter examines the work that has been done to date to control costs of clinical negligence claims. It also looks at the changes to the field over the last decade, in particular the increase in claims and the rising costs.

1.02 Much of this chapter is based on an initial study commissioned by the CJC from Professor Rachael Mulheron, Professor of Tort Law and Civil Justice at Queen Mary University of London and a former CJC member. Her research provided helpful background material on the recent history of clinical negligence claims and related developments in government policy, as well as identifying several issues involving process. We are grateful to Professor Mulheron for her contribution.

Clinical negligence claims – what is covered

1.03 The term clinical negligence is not separately defined in the Civil Procedure Rules. The Pre-Action Protocol for the Resolution of Clinical Disputes also does not provide a definition as such, but sets out more clearly what types of claim are considered to be within its scope:

> 1.1 This Protocol is intended to apply to all claims against hospitals, GPs, dentists and other healthcare providers (both NHS and private) which involve an injury that is alleged to be the result of clinical negligence…
> 1.2 This Protocol is intended to be sufficiently broad-based and flexible to apply to all sectors of healthcare, both public and private. It also recognises that a claimant and a defendant, as patient and healthcare provider, may have an ongoing relationship.

1.04 The point is therefore well made that a broad range of claims is included.

1.05 During our discussions, the term was considered (without dispute) to extend to claims involving care (or want of care) in residential care homes; services provided by opticians and cosmetic clinics; and various kinds of therapy.

Brief chronology of reforms and reports covering modern clinical negligence claims

1.06 The following chronology is representative of the reforms to and reports covering modern clinical negligence claims but necessarily incomplete:

1998 - English and Wales Law Commission, *Liability for Psychiatric Illness* (Rep 249, 1998)

1999 - Access to Justice Act 1999 introduces recoverable success fees and ATE premiums; the Clinical Negligence Protocol is implemented alongside the Civil Procedure Rules

2000 - Government publishes *The NHS Plan, A plan for investment, a plan for reform*

2001 - National Audit Office, *Handling Clinical Negligence Claims in England* (May 2001)

2003 - Sir Liam Donaldson[2], *Making Amends: A Consultation Paper Setting Out Proposals for Reforming the Approach to Clinical Negligence in the NHS* (Jun 2003)

2006 - NHS Redress Act 2006[3]; Compensation Act 2006

2008 - NHS Redress (Wales) Measure 2008 (power of Welsh Ministers to make regulations in respect of NHS redress)

2009 - Lord Justice Jackson, *Review of Civil Litigation Costs: Preliminary Report* (May 2009); Lord Justice Jackson, *Review of Civil Litigation Costs: Final Report* (Dec 2009)

2011 - National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 and Welsh Government, Putting Things Right Guidance (2011, version 1)

2012 - LASPO: Part 2, in force from 1 April 2013, implements Lord Justice Jackson's recommendations from 2009

2013 - NHSLA, A Pilot Scheme for Managing Defined Categories of Clinical Negligence Claims (Feb 2013); Welsh Government, Putting Things Right (Nov 2013); extension of the original RTA protocol into protocols and rules covering personal injury claims up to £25,000 in value and implementation of fixed recoverable costs for all steps up to trial[4]

2014 - Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

2015 - Current version of Pre-Action Protocol for the Resolution of Clinical Disputes (Apr 2015); Health Service Ombudsman, *Report of the Parliamentary and Health Service Ombudsman* (Sep 2015); General Medical Council and the Council of Nursing and Midwifery, *Openness and Honesty When Things Go Wrong: The Professional Duty of Candour* (Jun 2015)

2016 - Lord Justice Jackson, 'Fixed Costs – The Time Has Come' (The IPA Annual Lecture, 28 Jan 2016)

2017 - DH, *Introducing Fixed Recoverable Costs in Lower Value Clinical Negligence Claims: Consultation Paper* (Jan 2017); Lord Justice Jackson, *Review of Civil Litigation Costs: Supplemental Report: Fixed Recoverable Costs* (Jul 2017); APIL, *Managing the Cost of Medical Negligence Claims: A Strategy for Improvement* (2017); National Audit Office, *Managing the Costs of Clinical Negligence in Trusts* (7 Sep 2017)

2018 - DHSC, *Consultation on Introducing Fixed Recoverable Costs in Lower Value Clinical Negligence Claims: Summary of Consultation Responses* (Feb 2018); Prof Paul Fenn, *Fixed Costs for Clinical Negligence Claims: A Cost Analysis Approach* (Feb 2018)

[2] Sir Liam Donaldson was then the Chief Medical Officer

[3] The NHS Redress Act has never been implemented in England

[4] The Pre-Action Protocol for Low Value Personal Injury in Road Traffic Accidents; The Pre-Action Protocol for Low Value Personal Injury (Employers' Liability and Public Liability) Claims; CPR 45 IIIA

Numbers of clinical negligence claims

1.07 The Compensation Recovery Unit (CRU) makes a record of all clinical negligence cases and settlements, though it does not differentiate between those cases valued at no more than £25,000 and those of higher value. In reading these statistics it is important to understand that the claims are recorded by the year in which the claim is registered with the CRU, rather than by year of underlying incident; and that settlements are likewise recorded in the year of settlement.

1.08 The numbers over the last several years are:

Table 1

Year	No of cases registered	No of recorded settlements	Recoveries made by CRU
2010/11	13,022	10,813	£11,355,691
2011/12	13,517	12,409	£13,851,502
2012/13	16,006	12,955	£14,756,268
2013/14	18,499	15,052	£12,959,074
2014/15	18,258	17,299	£14,043,706
2015/16	17,895	19,620	£15,628,754
2016/17	17,894	18,449	£18,127,873
2017/18	17,400	18,430	£18,466,405
2018/19	16,809	17,824	£17,612,000

1.09 To add context, the following table is from DH's 2017 consultation on fixed recoverable costs. It only covers claims against the NHS, and only for 2015/16, but it gives an indication of the percentage of claims with a value of no more than £25,000:

Table 2

Damages tranche	No of claims	% of total claims	% of claims settled for damages
Nil	4,983	46.2%	n/a
£1-1,000	184	1.7%	3.2%
£1,001-5,000	1,203	11.2%	20.8%
£5,000-25,000	2,272	21.1%	39.2%
Total	8,642	80.2%	63.2%

1.10 The claims resolved for nil damages (i.e. withdrawn, discontinued or determined in favour of the defendant) are not split by value claimed. Of those claims where damages are paid, over 60% of them are valued at no more than £25,000. It is reasonable to assume that a similar proportion of those nil damages cases would also have been claims for no more than £25,000.

Previous attempts at improvement

1.11 In July 2000 the Government published *The NHS Plan, A plan for investment, a plan for reform*, which committed the NHS to a 10-year process of reform. In particular, the NHS Plan

committed DH to looking at ways to improve the system for handling and responding to clinical negligence claims.

Resolve

1.12 A private firm, Resolve Services Ltd, was established by Litigation Protection Ltd in 2001. It implemented a pilot scheme in December 2001, and an assessment of its operation was undertaken by the John Posnett of York Health Economics Consortium in August 2002. The pilot was a joint initiative of DH, the NHSLA and AvMA, and was aimed at claims valued at less than £15,000. Features of the scheme included:

- Pre-agreed panel of claimant lawyers
- Claimant lawyers and medical experts preparing paperwork within strict time scales
- Maximum fee claimant lawyers could charge was £3,250
- Jointly instructed medical experts
- NHSLA evaluated claims based on those medical reports

1.13 The Resolve scheme handled 258 cases and was deemed successful both by Sir Liam Donaldson and Lord Justice Jackson. Posnett's report concluded that the scheme generated claims which claimant lawyers accepted would not have been made in the absence of the scheme.

1.14 In his 2003 report, *Making Amends*, Sir Liam Donaldson reviewed the options for a system of redress for those suffering loss or injury during treatment at NHS hospitals. His proposal was for some sort of NHS redress tribunal.

NHS Redress Act

1.15 In 2006, the NHS Redress Act was passed, giving statutory effect to some of Sir Liam's recommendations. The Act proposed a redress package where there was clinical negligence in a hospital. The redress package had to include: an offer of compensation, explanation, apology and a report of action to prevent similar occurrences. The redress package could include care or treatment. The package could be accepted, with a waiver of the right to sue, or rejected. The Act was, however, never brought into force in England.

2009 Jackson report

1.16 In his 2009 publication *Review of Civil Litigation Costs: Final Report*[5], Lord Justice Jackson concluded that there were seven reasons causing excessive costs in claims that ought to settle pre-issue. His report overall recommended the ending of recoverability for success fees and ATE premiums, as well as a range of other recommendations including the introduction of qualified one-way costs shifting for personal injury claims[6]. For clinical negligence claims in particular, he proposed a series of practical measures to tackle costs:

[5] https://www.judiciary.uk/wp-content/uploads/JCO/Documents/Reports/jackson-final-report-140110.pdf
[6] This term as defined includes clinical negligence claims.

- Insist that any letter of claim sent to an NHS trust be sent to NHSLA
- Increase the time for letter of response from 3 months to 4 months
- NHSLA should obtain independent expert evidence on liability and causation
- Incentivise defendant organisations to get to grips with the issues of the claim within the protocol period
- Create a means by which defendants can settle without admitting liability
- Ensure compliance with the protocol through effective penalties
- Claimants to cover up-front screening costs and recover costs if successful

1.17 Lord Justice Jackson also made recommendations as to controlling pre-issue costs in all clinical negligence claims through costs management. He proposed a pilot of pre-issue costs management, where claimants would have their costs limited to a threshold. The two threshold figures he proposed were £15,000 up to the date of the letter of claim, and a further £15,000 up to the start of proceedings. Claimants would have to apply to the court for the authority to exceed these figures.

1.18 He made clear that his proposal did not mean it would always be reasonable for claimants to incur costs of £30,000 before issue of proceedings. He noted that such expenditure would usually be unreasonable, although that would depend upon the circumstances of the case.

1.19 Lord Justice Jackson also recommended that regulations should be drawn up in order to implement the NHS Redress Act. He considered it detrimental that clinical negligence claims of whatever value had to be assigned to the multi-track, increasing litigation costs. He considered that any proposal to introduce a redress scheme for England and Wales:

> *'is a sensible one, which will facilitate the early and economic resolution of lower value clinical negligence claims in respect of hospital treatment'.*

APIL/AvMA scheme

1.20 In 2011 to 2013, APIL and AvMA worked with the NHSLA on a proposed fixed fee scheme for clinical negligence claims valued at £1,000 to £25,000. The scheme was scheduled to run for either six months or until 1,500 claims were entered into the scheme, whichever occurred first, at which time it was due to be reviewed. The scheme was voluntary, but there could be costs consequences if a claimant did not pursue an eligible claim through the scheme. The scheme was only intended to be open to accredited clinical negligence lawyers; and it was limited to claims against healthcare providers that were members of the Clinical Negligence Scheme for Trusts. The scheme included the following features:

- Claimants to use specified forms
- Disclosure limited to records believed to be relevant
- NHSLA to give liability response within 4 weeks (this was aspirational, not compulsory)
- Joint selection and single instruction of an expert on breach of duty and/or causation
- If the NHSLA indicated a willingness to negotiate a settlement together with an explanation as to why liability was neither admitted nor denied (e.g. causation difficulties), then the claim proceeded to the next stage, when additional disclosure

and a further expert report on condition and prognosis could be requested
- If the claim failed to settle and breach of duty had been admitted or an apportionment agreed, the claim proceeded to the last stage – arbitration; but if liability remained unresolved and the claim had not settled, the claim would exit the scheme
- Parties agreed that no deductions were to be made from client damages, thereby preserving client damages.[7]

Wales

1.21 Whilst the NHS Redress Act 2006 has never come into force in England, the Welsh Government used it to make the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011[8] in accordance with the NHS Redress (Wales) Measure 2008.

1.22 The Redress part of the regime applies to claims for compensation of up to £25,000. It is a voluntary scheme, in that it is intended to be an alternative route to the court process, through which those patients allegedly injured as a result of negligent treatment whilst receiving Welsh NHS care can receive compensation, as well as an explanation of what went wrong and an apology. It applies to all health boards and NHS trusts in Wales and general practitioners in Wales who have entered into arrangements with a Health Board for the provision of medical services and who have opted to be covered by the Health Board's indemnity arrangements. It does not apply to other primary care practitioners nor to independent providers.

1.23 The other aspect of the Welsh system is its Putting Things Right scheme, which is the overarching scheme in which Redress sits, and which seeks to create a culture change to one of openness and honesty. All concerns and complaints relating to any service, decision or care and treatment provided by a Welsh NHS Trust or a Health Board, including primary care, are investigated. If harm is alleged and the value is expected to be under £25,000, the Trust or Health Board must consider Redress.

1.24 If the Health Board or Trust consider that there is, or may be, a qualifying liability, it must produce an interim report which describes the investigation, and why there may be a qualifying liability, outlining the details of the available procedures that should be followed. The interim report should be sent to the patient (or the person who notified the concern) within 30 days, or within the 6 months period if extended.[9]

1.25 The decision by the Health Board or Trust to make an offer of redress or decline to make any offer must be given to the patient within 12 months of the date on which the

[7] This scheme pre-dates the implementation of LASPO, abolishing the recovery of success fees from the losing party and restricting recoverability of ATE premiums.
[8] Health matters were devolved to the Welsh government under the Government of Wales Act 1998. The making of the NHS (Wales) Measure 2008 authorised the setting up of the redress scheme in the 2011 Regulations.
[9] In his 2014 report *A Review of Concerns (Complaints) Handling in NHS Wales: Using the Gift of Complaints*, Keith Evans noted: '*In practice Health Boards and Trusts are routinely taking 6 months or more to respond to a complaint where the matter does not raise issues of liability – this is a breach of the regulations*'.

concern was notified. Any response by the patient to that offer must be made within 6 months.

1.26 Where the Health Board or Trust has accepted that there is or may be a qualifying liability, the patient is entitled to legal advice paid for by the Health Board or Trust. Legal advice should only be provided by recognised firms of solicitors with known expertise in clinical negligence and either accredited by the Law Society or a member of the AvMA Panel. Fixed fees apply for the provision of legal advice, which is available for:

- The joint instruction of clinical experts, including clarification of issues arising from their reports
- Considering any offer of Redress under Part 6 and agreeing settlement
- Responding to any refusal to make an offer

1.27 The patient may obtain joint causation evidence with the health body. All these provisions operate as a voluntary alternative to making a formal legal claim for damages. The Redress system is widely used in practice.

1.28 The £25,000 limit in respect of offers of redress/financial compensation includes incidents involving death, plus cases with a complex series of interventions. There are no exclusions for complexity.

2017 Department of Health consultation

1.29 In its consultation issued on 30 January 2017, *Introducing Fixed Recoverable Costs in Lower Value Clinical Negligence Claims*[10], DH proposed a scheme of fixed recoverable costs for lower value clinical negligence cases with a damages value of no more than £25,000. In the Ministerial Foreword, it was noted that:

> *'For claims under £25,000, claimant recoverable legal costs are on average 220% of damages awarded.'*

1.30 The consultation confirmed that the proposal to introduce FRC is a key strand of the Government's programme to improve patient care and patient experience, and the efficiency and cost-effectiveness of clinical negligence claims. DH asked for comments upon how to design and implement a scheme of FRC. The proposal was to develop a scheme whereby the amount of FRC would be based on a final settlement or judgment value. DH considered that the scheme should be mandatory, not voluntary; and that it should apply to claims of up to £25,000 which were allocated to either the fast track or multi-track, but not the small claims track[11].

1.31 Insofar as process was concerned, DH published an illustrative draft of the Civil

[10] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/586641/FRC_consultation.pdf

[11] The small claims track limit for personal injury claims is £1,000 for damages for pain, suffering and loss of amenity. Complex claims would be excluded from the small claims track; it is assumed that in practice, very few if any clinical negligence claims would fall within the small claims track.

Procedure Rules which would apply to its proposal, developed by the CPRC. The aim of the draft rules was to ensure that they were similar to those that operate for other personal injury FRC schemes. DH sought views on a number of key elements of the draft rules as part of its consultation. In its Summary of Consultation Responses, DH commented that:

> *'overall, there was little agreement from respondents on most of the eight constituent parts'.*

2017 Jackson report

1.32 In *Review of Civil Litigation Costs: Supplemental Report - Fixed Recoverable Costs*[12], published July 2017, Lord Justice Jackson recommended a general scheme of FRC for all fast track cases and a new 'intermediate track' for cases up to £100,000 in value and falling within certain constraints as to complexity, number of experts (limited to 2 per party) and with a trial estimate of no more than 3 days.

1.33 He noted that clinical negligence claims are too complex to be included in the fast track or in his costs proposals for the intermediate track. Instead, he recommended that DH and the CJC set up a working party with both claimant and defendant representatives to develop a bespoke process for handling clinical negligence claims up to £25,000. That bespoke process should have a grid of FRC attached.

1.34 Lord Justice Jackson's proposal took its lead from the work of the CJC in noise-induced hearing loss (NIHL) claims, where a similar exercise produced an agreement between practitioners on both sides as to process improvements and fixed costs (see the CJC's report, *Fixed Costs in Noise Induced Hearing Loss Claims: Final Report of the Civil Justice Council Working Party*[13]).

1.35 In DH's response to its consultation, it stated that it was considering all of Lord Justice Jackson's proposals and, in tandem, agreed that a working party should be established to develop a bespoke process for lower value clinical negligence claims and a costs matrix.

1.36 The MoJ has recently consulted on the wider recommendations and on the CJC's report into NIHL claims. The recommendations outside clinical negligence claims have been largely adopted, save that the government proposes to extend the fast track to incorporate 'intermediate cases', as an alternative to Lord Justice Jackson's recommendation of a bespoke track for case management of these cases.

2017 PAC report

1.37 In December, the PAC of the House of Commons published its report on the rising cost of clinical negligence claims[14]. The PAC reported that the annual cost (i.e. including damages

[12] https://www.judiciary.uk/wp-content/uploads/2017/07/fixed-recoverable-costs-supplemental-report-online-2-1.pdf
[13] https://www.judiciary.uk/wp-content/uploads/2017/09/fixed-costs-in-noise-induced-hearing-loss-claims-20170906.pdf
[14] https://publications.parliament.uk/pa/cm201719/cmselect/cmpubacc/397/397.pdf

and legal costs) of clinical negligence for trusts has quadrupled over the last decade — from £0.4 billion in 2006–07 to £1.6 billion in 2016–17, taking already scarce resources away from frontline services and patients. It was critical of government, described as 'disappointingly slow and complacent', in its response to this. The Committee made the following recommendations:

- DH and NHS Improvement should report back on how they have ensured that trusts prioritise resources on patients that are most at risk of harm from increasing waiting times in the NHS
- DH, the MoJ, and NHS Resolution must take urgent and coordinated action to address the rising costs of clinical negligence
- The Cabinet Office should consider including the "cost-shunting" impact of a policy when the impact assessment is produced and report back
- DH and NHS Resolution should work with trusts to identify and spread best practice in handling harmful incidents and complaints. This should include how trusts say sorry and support patients when things go wrong
- DH, NHS Improvement and NHS Resolution need to work with trusts to ensure that a consistent classification is used across incidents, complaints and claims data. They should use these data to provide insights into the reasons behind clinical negligence claims
- DH, the MoJ and NHS Resolution need to clarify why it is taking longer to resolve claims and report back on what actions they are taking to address this issue.

1.38 In October 2018, DHSC and the MoJ produced a response to the PAC[15] stating that they are committed to tackling the costs of these claims given that the NHS funds spent on them are not available for front-line care. They noted that whilst these are complex issues and there are no easy answers, they have been leading intensive work across government on this issue.

1.39 They also responded on the Committee's concern about the length of time required for resolution. Again, they noted that the issue is a complex one, but assured the PAC that NHS Resolution and HMCTS have been working to address issues around the time taken to resolve claims.

Conclusion

1.40 Two points stand out:

- there has been a concern that clinical negligence claims are too costly for some time;
- although many attempts have been made to deal with this issue, its causes are complex and any resolution difficult.

1.41 Where previous initiatives have been seen to have some effect, the working group has, where possible, incorporated some of the more successful elements into its own work.

[15] https://www.parliament.uk/documents/commons-committees/public-accounts/Correspondence/2015-20-Parliament/PAC%20-%20Clinical%20negligence%20and%20Cyber-attack%20on%20the%20NHS%20updates.pdf

CHAPTER 2: WORK UNDERTAKEN AND DATA COLLECTED

Purpose of chapter

2.01 The purpose of this chapter is to set out the methodology used by the working group and to summarise the work that was conducted. Professor Fenn's analysis of the data collected is included at appendix B.

Group membership

2.02 The working group attracted considerable interest, no doubt because of the previous consultation in this area by DH. A wider working group was set up to provide the broadest possible perspective available on lower value clinical negligence claims. The representatives came from a range of claimant solicitor firms (most representing interest groups) and defendant firms and bodies, plus the Bar and the judiciary. To engage with the maximum number of stakeholders whilst ensuring the best possible outcome, the working group was made up of 2 groups – the core group and the wider group.

2.03 The core group consisted of representatives of those organisations most affected by the working group's remit, listed below by firm and the organisation they represent:

Acumension – costs consultants providing services to NHS Resolution
AvMA
Bar Council – also representing the interests of PIBA and PNBA
Bolt Burdon Kemp – APIL
Browne Jacobson – NHS Resolution panel and Law Society
Clyde & Co – broker market
Expert Witness Institute – representing their interests and those of The Academy of Experts
Fletchers Solicitors – representing FOCIS
Hugh James – Welsh claimant experience
Irwin Mitchell – Law Society
Judiciary
Kennedys – NHS Resolution panel
Leigh Day – APIL
Medical Protection Society – representing the interests of MDOs generally
NHS Resolution
NWSSP – L&RS
RSA Insurance Group – representing the interests of specialist insurers
SCIL

2.04 The wider group consisted of the core group plus other stakeholders such as ATE providers, representatives of the Academy of Experts, the Forum of Insurance Lawyers and other interested practitioners. On occasion, some members of the wider group attended meetings of the core group.

2.05 As the core group's work progressed onto matters relating to experts, we also invited a representative from Premex, a large MRO with experience of providing services in lower value clinical negligence claims.

Meetings

2.06 The wider group met four times in 2018: 23 April, 12 July, 11 October and 4 December 2018. These meetings were a combination of reporting back from the work of the core group and presentations on issues of general interest. Those presentations included:

- summary from Professor Rachael Mulheron of her background study;
- DH and NHS Resolution on patient safety and learning from mistakes;
- Capsticks and Fletchers on their claims handling pilot.

2.07 Professor Fenn also gave presentations based on data provided to him: see further at 2.24 below.

2.08 The core group met ten times: in 2018 – 18 May, 5 June, 4 September, 26 September, 23 November, 12 December; in 2019 – 17 January, 1 February, 25 February and 11 March. The 2019 meetings, which focused on matters of process as well as costs, were all set up to prepare for the planned mediation on the level of fixed recoverable costs, which took place on 21 March 2019.

2.09 As will be apparent, the core group consisted mainly of claimant and defendant representatives. These each formed a group which met between meetings to make progress with aspects of the group's work. As we approached the mediation in early 2019, parts of the core group meetings involved the claimant group and the defendant group separating to make progress on specific tasks, as well as breakout meetings between selected representatives from each group to consider particular aspects of process.

2.10 On 21 March 2019, the working group engaged in a mediation with Philip Havers QC acting as mediator. The conduct of that mediation of course remains confidential to the parties who signed the mediation agreement.

2.11 Though it was felt that the working group made progress towards reaching consensus, ultimately this was not possible during the mediation itself. However, both claimant and defendant groups expressed a willingness to continue to explore possible solutions.

2.12 The result was that two members each from the parties met to continue discussions, with an understanding that they would continue to engage with and seek the agreement of their larger respective groups. This group of four made good progress, developing processes that were broadly agreed for both the standard track and the light track (see chapter 3) and outlining the proposals for neutral evaluation, which are considered at 4.18-4.66. They also came much closer to reaching an agreement on FRC than had been possible at the mediation.

2.13 Andrew Parker as Chair, David Marshall as Deputy Chair and Professor Fenn were in regular contact over the issues to be considered by the working group and met with the small group of four on 4 June 2019 to try and conclude matters.

2.14 The Chair also held separate meetings/calls with NHS Wales, to understand the Welsh Redress scheme; with AvMA, who were not able to attend the initial core group meeting; with ATE insurers, to consider issues relating to the cost of ATE; and with representatives of expert witness bodies and MROs, for a better understanding of the issues affecting use of experts and their fees. Apart from the AvMA meeting, detailed notes from all these meetings were made available to the core group, to assist with aspects of our work. Where relevant, later chapters of this report draw on those notes.

2.15 We are very grateful to the members of the working group for the considerable time they gave over an extended period. Whilst there was not always agreement, the members always engaged constructively and with the aim of improving the process for claimants, defendants and practitioners alike.

Engagement with government

2.16 Unusually, the CJC's involvement was commissioned jointly, by DH (now DHSC) and the MoJ. Both were invited to send observers to all group meetings, although it was agreed that they should not attend the mediation. DHSC, in particular, engaged in discussions at some of the core group meetings and made a presentation at one of the wider group meetings.

2.17 In view of the political interest in this work, DHSC requested regular updates on progress and were consulted on changes to the timetable of work.

2.18 It has always been made clear that following the completion of this report, the government would consult further on how to proceed. That is despite the extensive previous consultation by DH in 2017 (see 1.29-1.31). Those working group members who do not agree with the recommendations in this report should therefore have the opportunity to provide alternative views when that consultation takes place.

Terms of reference

2.19 The terms of reference are set out at appendix A.

2.20 The original plan for delivery of the CJC's report by September 2018 was always too ambitious; that timescale having been set well before it was possible for the CJC to start work and being driven at least in part by the need to respond to the PAC. Even by the time our work started, December 2018 appeared to be a more realistic target date.

2.21 The breadth of the terms of reference also gave rise to delay, in that this made it necessary to focus on areas other than attempting to agree fixed legal costs. It took until March 2019 for it to be possible to bring the parties to the table for a mediation on the level of costs, in that the process had to be sufficiently agreed by at least a core of people on both

sides for costs to be modelled. Indeed, even on the day of the mediation, we still had more than one process proposal on the table. To make progress on the day, we had asked the parties just to focus on one of those proposals, the defendant proposal: this was the process, although not agreed, which had been subject to the most discussion in core group meetings.

2.22 In the end we were only able to narrow the gap between the parties by focusing on legal costs and process alone and leaving the other issues on one side. As we explain in subsequent chapters, there were too many obstacles in the way of making any real progress on the use of experts; and with a Court of Appeal decision pending on ATE following an in-depth inquiry ordered by the court (see 6.56), there was no purpose in the CJC dwelling on this aspect.

2.23 We also had to move on from considering issues of learning and patient safety, save to reassure ourselves at the conclusion of our work that nothing in the recommendations we were making would have an adverse impact. We fully recognise the importance of this topic – chapter 7 in this report covers the issues in more detail – but the CJC, as an advisory body on matters relating to civil justice, can do little more than bring the relevant parties together and urge them to continue a constructive dialogue.

Professor Fenn's contributions

2.24 Professor Paul Fenn made a number of presentations to meeting of the core group and the wider group, using data supplied voluntarily from a number of sources. The slides from all his presentations were assembled into a single set for use by the parties at the mediation. He also spoke separately to the claimant group to assist them with analysis of the data and in considering their proposals for costs.

2.25 Professor Fenn has now written a summary report based on the presentations made, which appears at appendix B. This report includes some further tables produced alongside the discussions between the parties as referred to at 2.06 to 2.12 above, to compare the final proposals made by the parties on FRC and the suggested approach to resolving the gap between them as set out in appendix H.

2.26 Professor Fenn's work has helped us to make more progress than has been possible in previous attempts to address fixed costs for clinical negligence claims. All parties owe him a debt of thanks for the amount of time and effort he has devoted to helping the working group.

Conclusion

2.27 The working group, through its efforts, has brought an agreement on process and FRC close to fruition. In the time available, despite investigations which are summarised elsewhere in this report, we were not able to make any material progress on the level of experts' fees or on ATE premiums.

2.28 Professor Fenn's involvement has ensured that significant amounts of data have been collected and analysed, including on the use of experts and their fees. It is hoped that this

comparative wealth of data will provide sufficient material for the government to make firmer recommendations, for consultation purposes.

CHAPTER 3: PRE-ISSUE PROCESS

Purpose of this chapter

3.01 This chapter describes the process broadly agreed by the working group for low value clinical negligence claims. It lays out in detail the processes for both a standard track and a light track, covers the types of claim which are to be excluded and indicates the outstanding issues around process which the working group could not resolve.

3.02 The contents of this chapter (and indeed of the report as a whole) set out a concept, rather than formal procedural rules. It cannot therefore be expected that all details of the process or application of FRC have been fully ironed out. Those are matters to be left to the CPRC, once government has decided on the overall policy approach.

Overview

3.03 The pre-issue process occupied much of the time in working group discussions. Along with the need for fixed costs, it formed a core part of the working group's terms of reference.

3.04 At the outset of the CJC work, the existing work of a small group of practitioners, put together by the Law Society, was presented as a possible model for process improvements. The Law Society group had already discussed those proposals with a wider group of interested parties, which included AvMA and SCIL. We are extremely grateful to the Law Society group for sharing this with us and for allowing us to build on their previous work. The processes outlined in this chapter largely follow that possible model.

3.05 Despite this previous work, there was significant disagreement in the working group as to the best way forward. A minority of the claimant group, including SCIL who represent a significant number of firms, did not agree with the core concept of sequential exchange of expert evidence and have maintained that view throughout. However, the majority of the working group have broadly agreed with the recommendations set out in this chapter.

3.06 To avoid repetition of the point, we have recorded the recommendations but ask the reader to note that agreement to these is not unanimous. Where relevant, we have recorded the opposing views.

3.07 This was one of the points which prevented us from reaching an early agreement on matters relating to process. The other point was more fundamental: that until the discussions as to the level of fixed costs began in earnest, any consensus on the right process could only be provisional. The end product was always likely to be a compromise between the best process and the right level of FRC.

3.08 Although we were not able to reach complete agreement on the level of fixed costs, the pre-issue process now set out in this chapter and in particular the position on post-issue process outlined in chapter 4 reflect the refinement applied as the parties have narrowed the difference on the level of FRC.

3.09 A further point, on which the working group was unanimous, is that any recommendations in this report can only be viewed as suitable for claims with a value of no more than £25,000. That was ultimately the limit of DH's consultation and was a specific term of reference for the CJC. More importantly, the recommendations for process changes in this report can be justified by the need for a more proportionate approach to lower value claims, but different considerations apply in respect of higher value claims[16]. The recommendations are also led by data collected in respect of lower value claims only.

3.10 It would not have been possible to make the progress we have made, if there was any suggestion that our recommendations might in some way be applicable in the future to claims with a value above £25,000.

3.11 In the interests of brevity we have not recorded other process proposals made to the working group from time to time from any side. It seemed to us, as the discussions developed, that there was no consensus that any other proposal represented a significant improvement on the current process.

Existing process

3.12 The current Pre-action Protocol for the Resolution of Clinical Disputes sets out the procedure to be followed in clinical negligence claims of all values. It is built around a formal letter of claim and a formal letter of response, with a proposed template in each case. There is no requirement to serve expert evidence with either letter, although the claimant will usually have obtained expert evidence on breach and causation before submitting the letter of claim. Likewise, there is no requirement to serve witness evidence at this stage.

3.13 The protocol also allows for a letter of notification – an early warning of a claim. The use of such letters and the amount of information given in them is extremely variable, although some firms use them to good effect in cases where they consider there to be a claim which ought to be admitted without the need for expert evidence.

3.14 Annex A to the current protocol contains a flowchart which helpfully summarises the procedure. For ease of reference this is included at appendix J to this report.

3.15 Where a dispute has not been resolved after the letter of response, both sides should review their positions in a stocktake before the claimant issues proceedings. There is also a recommendation that where proceedings cannot be avoided, a chronology of events and case management directions should be agreed.

3.16 It is not clear how often this stocktake is used formally in practice. The Bar representative said that he had never seen a formal stocktake under the current pre-action protocol. The proposal below for a mandatory stocktake and discussion appears to go a good deal further.

3.17 Claims for clinical negligence once issued are nearly always allocated to the multi-

[16] The test of proportionality applies to all claims, but its application to higher value claims will necessarily be different.

track. Lord Justice Jackson (as he then was) found some evidence in 2017 of cases being allocated to the fast track, but the working group did not come across very many such cases in practice and we can only conclude that they would have been very straightforward claims.

3.18 In the vast majority of cases which proceed to litigation, there will be a dispute between experts on opposing sides. The exchange of experts' reports will typically take place following directions given at the case management conference, so at a late stage in proceedings. Discussion between experts is then the norm in cases which do not settle by that point.

A twin track approach

3.19 At an early stage in our work it was obvious that there were some cases which did not need expert evidence on breach and causation. Professor Fenn's data analysis shows in fact that up to 25% of cases settle pre-issue without requiring any expert evidence on either breach and causation or on condition and prognosis. This analysis is considered in more detail at 3.72-3.76 below.

3.20 There were other types of case in which the costs tended to be lower, whether or not expert evidence was required. Examples include claims involving cosmetic clinics, allegations in respect of care homes and dental claims. This is obviously a very broad generalisation about such types of claim, which can still vary in complexity, but there were relatively large numbers in the data sets for claims with a value of £25,000 or less.

3.21 This led to the development of proposals for a light track, in which the starting position is that no expert evidence is obtained in cases which are considered suitable for this procedure. The claim starts with a letter of notification, in a form more fully developed than the version in the current protocol. The defendant has a limited opportunity to confirm that the claim will be settled on a full liability basis, without the need for expert evidence on breach and causation to be obtained.

3.22 The standard track is therefore for claims where expert evidence on breach and causation is going to be required.

Standard and light tracks – summary points

- Process divided into standard track (ST) and light track (LT).
- LT to include cases where no expert evidence is required on breach and causation as previously. The defendant group say the LT should also extend to specific categories of claim, see 3.59 and 3.95 below.
- ST will involve sequential exchange of experts' reports on breach and causation and of witness statements, plus claimant's right of reply.
- At the end of pre-issue stages, there will be a mandatory neutral evaluation (MNE) in any case which has not settled.
- MNE will be carried out by a specialist barrister from an agreed panel.
- The outcome of MNE will not be binding on either party (see chapter 4).
- Even though the outcome is not binding, it is expected that MNE will remove the need

for proceedings in the vast majority of cases.

3.23 Detailed flowcharts are attached for LT and ST. These are for illustrative purposes only: there may still be some minor disagreement between the parties as to wordings.

Standard track

3.24 The ST process starts with the claimant's letter of claim, which is to be accompanied by:

- medical records – to be collated, sorted and paginated by the claimant (see further at 3.52);
- experts' reports on breach and causation (limited to 2 experts in different medical disciplines);
- witness statements (limited to 2 witnesses, statements in template form including a statement of truth);
- any separate report on condition and prognosis;
- details of losses, either in the letter or in a separate schedule if required;
- an offer.

3.25 The absence of a report on condition and prognosis does not invalidate the letter of claim, as long as the claimant is able to put forward an offer: see further at 3.51 below.

3.26 When the letter of claim is served it should also be forwarded to NHS Resolution on any NHS cases in England, NWSSP – L&RS in Wales, MDO or insurer (if known), depending on the defendant.

3.27 The defendant is to acknowledge letter of claim within 21 days. After that, the defendant must within a maximum of 6 months from service of the letter of claim choose one or more of the following options:

- Admit liability for the claim
- Accept claimant's offer
- Reject offer and make counter-offer
- Serve letter of response denying breach of duty and/or causation

3.28 The claimant group suggested that if the defendant provides an admission, they should also provide an apology to the claimant. We accept that this is a step which is important to the claimant and we would hope defendants would see the offer of an apology in such circumstances as good practice, but we question whether the formal pre-action process can go further than recommending that the defendant consider an apology.

3.29 If the defendant decides to serve a letter of response, it must be served within the 6-month period, include a reasoned denial and be accompanied by:

- Witness statements (limited to 2 witnesses, statements in template form including a statement of truth)

- Experts' reports on breach of duty and causation (limited to 2 experts of different medical disciplines)
- Counter-schedule of loss responding to claimant's valuation of general damages and heads of loss to be supported with a statement of truth. If claimant's special damages claim is modest this can be covered in the letter of response

3.30 The claimant has the right to reply to the letter of response within 6 weeks. This includes the right to obtain a further letter/report from their expert but also for the claimant themselves to respond where appropriate to the facts as presented with the letter of response. This may be the first occasion on which such factual information is made known to the claimant, so the right to reply with further evidence in response generally is an important safeguard.

3.31 A mandatory telephone discussion/stocktake is to take place within 4 weeks of the letter of response, unless the claimant provides a reply, in which event the deadline is 6 weeks from the date of the claimant reply. Further detail about the stocktake is considered below.

3.32 If the parties still cannot reach an agreement at the discussion/stocktake, the case then moves to MNE. The parties have 2 weeks to select a specialist clinical negligence barrister from the agreed panel. The evaluator will make an evaluation no more than 6 weeks later.

3.33 MNE is covered in detail in chapter 4.

The key issue – sequential exchange of experts' reports

3.34 Sequential exchange of experts' reports (and witness statements) was a core part of the proposals put forward by the Law Society group originally. It adopts the same working principle as was applied by the CJC on noise-induced hearing loss claims: that where the opinion of an expert is needed to establish liability, a report from that expert should be produced with the letter of claim.

3.35 Given its early inclusion, it is perhaps surprising that it remained a contentious issue throughout our work, up to and beyond the mediation.

3.36 Throughout, the defendant group were clear that this proposal was central to their position. They felt it enabled them to weed out claims which would otherwise be presented speculatively. It also placed them under real pressure to settle quickly and generally represented a culture change that was needed.

3.37 Some on the claimant side, particularly SCIL and AvMA, objected throughout to the proposed use of sequential exchange. Their primary concern was the possibility that requiring the claimant to submit their expert evidence before they see that of the defendant's expert will put them at a significant disadvantage. Claimants' reports would be prepared without sight of the factual evidence of the treating clinicians or the defendant's expert evidence. Instead, claimants' experts would have to rely solely on medical records and the claimant's

witness evidence, which can often be of limited value. There was also said to be a risk that the treating clinicians' evidence would be 'polluted' by seeing the claimant's case.

3.38 Additionally, SCIL raised the point that in the vast majority of these claims, settlement comes before any requirement for the claimant to serve factual or expert evidence on liability. Sequential exchange would, as a result, increase costs unnecessarily in their view.

3.39 Some on the claimant side supported the concept from the outset. They acknowledged that it was a departure from accepted practice and also accepted that it might put the claimant's expert at a disadvantage, although this could be addressed by safeguards around the ability of the claimant's expert to respond to matters raised in any report produced for the defendant.

3.40 Those representing the interests of experts pointed out the risks that sequential exchange might create a disincentive for what is already a limited pool of experts in clinical negligence cases.

3.41 There is no doubt that a culture change is required in the handling of lower value claims. Sequential exchange should discourage speculative claims – and speculative defences, as the defendant's obligation to serve their own expert's report with the letter of response is a key part of the recommendations. We have concluded that sequential exchange should be incorporated into these recommendations.

3.42 The proposal necessarily involves the sequential exchange of witness statements. The same considerations – and objections – broadly apply.

3.43 Throughout this report we have made it clear that the recommendations are only suitable for claims of lower value. This is nowhere more appropriate than in respect of sequential exchange: we see it as a proportionate answer to a disproportionate problem.

Safeguards for the claimant

3.44 The reservations about sequential exchange are genuinely held, and we take them seriously. It is clear that sequential exchange could put the claimant and their expert at something of a disadvantage, unless adequate safeguards are put in place. The purpose behind sequential exchange is to drive a change of culture, on both sides: in such circumstances care must be taken that the parties still have equality of arms and that sanctions are in place to ensure both sides adhere to the new process.

3.45 The main issue is that the defendant sees the claimant's evidence before even investigating the claim. We believe that this is addressed by the defendant only being able to defend the claim if they follow the same cards on the table discipline and within a strictly defined period. It is for instance common practice in industrial disease claims for the claimant to disclose medical evidence on causation and witness statements at an early stage in support of their case, irrespective of the value of the claim; and this usually works to narrow the issues.

3.46 There was a concern that the claimant's expert might be criticised at a later stage for not covering all relevant points, because at letter of claim stage they would not have seen the defendant's witness evidence. That risk is managed by giving the claimant alone a right of reply, including the ability to serve a supplementary report.

3.47 There was a proposal that the claimant's initial report and witness statements were to be served on a without prejudice basis, to allow them to be revisited at reply stage. We do not consider this to be necessary, as long as the context is understood and that no court, evaluator or defendant's expert seeks to criticise an expert or witness who adjusts their position to take account of facts not known to them at the time of their original report or statement. Acceptance of this point by all concerned is just part of the culture change required.

Evidence on quantum and settlement offers

3.48 At least in the standard track, this was another area of some disagreement. The defendant group wanted to see letters of claim with a detailed position on quantum and a formal offer of settlement from the claimant served with the letter. This they said would enable them to take an early view, particularly in the very low value cases, on whether the case really needed to be investigated further or could just be settled cheaply and easily.

3.49 Some on the claimant side on the other hand were concerned about the potential cost of investigating quantum before knowing the defendant's stance on liability. Equally many on the claimant side were very uncomfortable about the idea of making a formal offer to settle without quantum evidence available.

3.50 We consider in chapter 6 the need for expert evidence on quantum in all cases, noting that there is a core of cases within the data in which no expert evidence on liability or quantum was ever obtained; and that there is the possibility of seeking input on quantum from the breach and causation expert in liability disputed cases.

3.51 The recommendation is for claimants to set out information on quantum and to make offers; and the costs proposals on both sides reflect that. The claimant has the option of obtaining a report on condition and prognosis and serving that with the letter of claim, in support of the offer made. It is the making of the offer which will allow defendants to make a decision on early settlement.

Medical records

3.52 This was an early area of agreement. It is and remains the claimant's responsibility to obtain the medical records, both in the standard track and in the light track. Both sides also agreed it was for the claimant to organise the sorting of the records into a suitable order and production of a paginated bundle. We understand, particularly from speaking to those representing experts, that "clinical pagination" is very much preferred: that is, that the records are presented with notes grouped together by relevant team/speciality rather than the temptation to put everything in chronological order.

3.53 It was also agreed that in these lower value cases, all that would normally be required would be the records from the facility/facilities where the alleged negligent treatment took place and from the claimant's GP, plus records from any centre where follow-up treatment was provided. This would not prevent the expert from asking for further records, provided that such requests were kept to the necessary minimum.

3.54 There was some discussion of external services provided by certain companies for sorting medical records and providing access to stored versions electronically. In the environment of greater restrictions on use of personal data, especially special category data relating to health, such systems have clear advantages.

3.55 These services obviously come at an external cost. There was also agreement that the FRC for the solicitor should cover the cost of obtaining and sorting medical records, whether this is in fact carried out by the solicitors' practice themselves or outsourced.

3.56 Those representing the interests of experts were concerned that application of FRC to the cost of collating and paginating records might lead to a reduction in the quality of the bundles supplied, leading to extra work for the experts themselves. This will need to be monitored, but is not a reason in itself to exclude such work from FRC.

3.57 The defendant group welcomed the idea that the claimant would retain responsibility for obtaining and sorting the records. It was often easier and certainly quicker for the defendant's representative to obtain the sorted records from the claimant's solicitors.

Light track

3.58 The LT is a streamlined process for those claims where liability is unlikely to be in dispute. The working group agreed that the following types of claim are suitable for this track:

- Parties agree no expert evidence on liability required
- There is an admission of breach of duty (including but not limited to cases dealt with under the Welsh Putting Things Right/Redress scheme)
- There is a Never Event, as defined
- There is an SI Report, which identifies care below a reasonable standard of care (including investigations under the Welsh Putting Things Right/Redress scheme)

3.59 The defendant group also proposed the following category as suitable:

- There has been an inquest and the Coroner has determined either that care amounted to neglect or that death would not have occurred but for the identified neglect

3.60 The claimant group disagreed: they maintain that all fatal claims should be excluded from any FRC scheme. They argue that these cases are highly sensitive and by their very nature involve a greater amount of client care and therefore cost. The position on exclusion of fatal cases generally is dealt with at 3.87 below

3.61 A claim starts in the LT with the claimant sending the letter of notification, which is to be accompanied by:

- medical records – to be collated, sorted and paginated by the claimant
- an explanation of the basis for the case being in the LT and any associated documents (such as an SI report)
- details of losses and any accompanying evidence

3.62 The defendant is to acknowledge the letter of notification within 21 days. If, within 8 weeks, the defendant confirms the claim will be settled on a full liability basis, the claim continues in the LT; otherwise it moves into the ST to await a full letter of claim. Full liability in this context includes breach of duty and causation of the claimant's injuries: disputes on causation can be just as detailed and technical as issues on breach.

3.63 Within 4 weeks of the defendant's decision, if the claim remains in the LT, a mandatory telephone discussion/stocktake is held. If the parties fail to settle but decide that no further evidence is required, the case moves into MNE within 4 weeks. Alternatively, the parties may decide that further evidence is required.

3.64 The parties should decide the following within 2 weeks of the stocktake:

- whether a condition and prognosis report is required and if required agree a joint expert (limited to 1 expert). The default position is a paper only report, unless the expert indicates he/she needs to assess the claimant. Parties to agree an expert within 2 weeks of the stocktake discussion and to send instructions within 2 weeks of agreement
- whether the claimant needs to provide a witness statement setting out any continuing injuries for consideration by the expert; if required, to be provided within 4 weeks of the stocktake

3.65 The joint expert must indicate within 4 weeks of instruction if an assessment is required. If required, the joint expert has an additional 4 weeks to arrange an assessment and will provide the report within 2 weeks of the assessment. These time limits are aspirational: the expert should be asked to adhere to them, but this step is then outside the parties' control.

3.66 If the parties decide this further evidence is required, they have between 16 and 18 weeks (depending on whether the expert decides an assessment is needed) before a further telephone discussion with the aim of resolving the claim with the benefit of the joint evidence. After that, if the case is not settled, it enters the MNE stage.

3.67 If the parties still cannot reach an agreement at the discussion/stocktake, the case then moves to MNE. The parties have 2 weeks to select a specialist barrister from the agreed panel. The evaluator will make an evaluation no more than 6 weeks later.

The LT response: settle in full

3.68 One of the key aspects of the LT is the need for an early response from the defendant: the agreed period is 8 weeks from the letter of notification. There is a balance to be struck as to what response is required to keep the claim within the LT, which is essentially for cases where liability is not disputed. If liability is still in dispute at the 8 week point, the case comes out and goes into the ST process instead, with expert evidence and a full letter of claim.

3.69 The claimant needs to know that there is no need to prepare further on breach and causation. The defendant should ideally be making an admission, but in the limited period it may not be possible to get the necessary formal consent of the relevant clinicians or organisation to do so. The decision to settle the claim will in practice be made by the indemnifier.

3.70 The solution proposed by the defendant group is that they agree formally to pay reasonable compensation. This appears to cover the point, but only as long as it is clear that this represents compensation on a full liability basis, without any deduction for litigation risk or other factors. The trade-off for the claim staying in the lower cost LT is that the claimant gives up the opportunity to investigate liability issues at an early stage; the defendant must therefore concede any right to argue liability in return.

3.71 The point is made with some force by the claimant group that an admission of liability is important to the claimant. Whilst the procedure in the previous two paragraphs should speed up settlement of LT cases, defendants should acknowledge the need to provide a formal admission in such cases where they can, whether in the 8-week period provided for the response or as soon as possible after that.

Cases with no expert evidence

3.72 We comment further in chapter 6 on the anomaly that in around 25% of settled cases, no expert evidence was obtained at all on liability or quantum. This, as indicated, has led to the development of the LT concept.

3.73 The parties have engaged constructively in trying to identify the types of case that might be suitable for a “no expert” track, such as to fit with the 25% estimate, but have struggled to track them down. The identified categories, where in effect liability has been conceded by another route prior to presentation of the claim, are felt to represent a significantly lower percentage of cases.

3.74 There is the suggestion, which we consider below under “outstanding issues” at 3.94-3.98, that in certain types of case external experts are not engaged even on disputed cases and that both sides manage without needing to engage experts.

3.75 The proposed categories above include those cases where the parties agree no expert evidence on liability is required. On the face of it and despite support from all sides, this may seem an unlikely category to work in practice: the availability of higher costs if a case starts in the ST would seem to create an incentive for claimants’ practitioners neither to agree nor

seek agreement.

3.76 Having explored the point in some detail with the working group, we are satisfied on balance that it could work and that there is no better solution. It represents a kind of "you know it when you see it" test. There are also good reasons for the solicitor and the client to want to invite the defendant to make an admission or offer to pay full compensation at an early stage without incurring significant costs risk. It is just one aspect of these recommendations which will need to be monitored in practice following introduction.

Mandatory Stocktake and telephone discussion

3.77 This is another key requirement in both ST and LT. We expressed doubts above as to the effectiveness of the stocktake in the current protocol in practice. This proposal needs to be different. It will be a mandatory step. The parties are to explore the strengths and weaknesses of each other's position. Legal representatives are to have full authority to settle where liability is admitted.

3.78 The availability of MNE as the next step should not deter either side from seeking to resolve all or part of the claim. Even where liability cannot be agreed, it is expected that quantum should be capable of agreement.

3.79 We were told consistently that the majority of lower value clinical negligence claims settle before issue of proceedings; the data broadly supports this. We were also told that the defendant group in particular expect most cases to resolve before the stocktake is reached. With those assumptions, it is possible that use of the stocktake will be largely restricted to cases which may be more problematic: that should not lessen the commitment needed on both sides to use the stocktake as a means of resolving disputes.

3.80 If settlement cannot be achieved, the stocktake should still be used to seek to narrow issues on liability or quantum as necessary.

Limitation

3.81 A formal suspension to the limitation period is to be agreed on entry into the FRC scheme, unless the defendant raises limitation as an issue within 21 days of service of the letter of claim (letter of notification in LT). Limitation will then remain suspended until 8 weeks after exit from the FRC scheme.

3.82 This is a pragmatic approach to a scheme where costs need to remain proportionate to the issues at stake and where an issue as to limitation automatically takes the case out of the FRC scheme altogether. Whilst we recognise the concerns expressed by the courts as to the willingness of parties to agree to suspend the limitation period, this proposal was readily agreed by the parties for good practical reasons and formed a core part of the proposals from the Law Society group. As such we considered it appropriate for this to be supported.

Exclusions

3.83 This was in part another contentious area, although there was early agreement on most exclusions.

3.84 The working group agreed that not all lower value clinical negligence claims are suitable for this process. Exclusions are due primarily to the limitations of the FRC scheme, e.g. value (nothing over £25,000 can be considered); complexity, such as multi-defendant claims; or sensitivity, such as for stillbirth claims. The following table shows each side's list of excluded cases:

Table 3

Claimant	Defendant
Claims allocated to small claims track.	Claims allocated to small claims track
Claims valued above £25,000	Damages above £25,000
Claims where limitation has been raised as an issue and agreed by both parties	Limitation raised by defendant as an issue
Cases involving more than one defendant.	Genuine multiple defendants (where allegations against each defendant are different)
Cases involving more than one claimant.	
Cases involving more than 2 medical expert disciplines across all medical reporting	Claims requiring more than 2 experts
All fatal cases	Still birth and neonatal deaths
Protected parties – those lacking in capacity to stay out of FRC. Children to remain in the scheme with a 'bolt-on' for the additional work undertaken and Infant Approval Hearing	Protected parties to remain in with an additional fee.

3.85 In general, there was a great deal of agreement between the two sides as to what cases should be left out of the FRC scheme but, as the table shows, differences remain.

3.86 The strongest disagreements centred around inclusion/exclusion of:

- Fatal accident claims – cases in which the allegation is that the negligent act caused death;
- Claims involving secondary victims, i.e. psychiatric/psychological reaction by the claimant to injury sustained by another person;
- Protected party claimants – adult claimants who lack legal capacity and need to claim via a litigation friend.

3.87 The claimant group felt strongly that the sensitivity and additional work required for claims where it is alleged that the negligent treatment caused or contributed to death make them completely unsuitable for inclusion in a cost saving scheme. The defendant group in contrast considered that not all fatal claims should be excluded, especially in cases where there has been an adverse finding in respect of the treatment at an inquest. The defendant group accepted that any costs recoverable for representation at the inquest should be considered separately, outside the FRC scheme although no detail was provided as to how this might operate in practice.

3.88 The Chair indicated at an early stage in the work that he considered the default position should be that fatal claims should be outside the FRC scheme, subject to any agreement on particular types of cases suitable for inclusion. Some discussions took place between the parties, but no agreement was reached on any types of fatal case for inclusion.

3.89 The claimant group proposed a refinement on the position regarding claims for secondary victims. Where the primary victim's claim would fall within the FRC scheme, the secondary victim's claim should also be included (subject to any other exclusions e.g. as to value). Where the primary victim's claim would fall outside the FRC scheme, the secondary victim's claim would also be excluded. This proposal recognises that the secondary victim's claim cannot proceed without establishing liability to the primary victim.

3.90 The position in respect of secondary victims is also relevant to consideration of fatal claims: if those are excluded, any claims by secondary victims arising from the death of the primary victim would also be excluded.

3.91 The parties were able to come to an agreement regarding cases where the claimant is a child under the age of 18, which are generally to be included with the addition of a bolt-on fee sufficient to cover the need for additional work in such cases, including an infant approval hearing. They could not, however, agree on the inclusion or exclusion of other protected parties. This is largely because the need to assess legal capacity is more complex and may need to be revisited during the life of a case.

3.92 It should be noted that the restriction on the number of experts and other witnesses is not to prevent a greater number of witnesses being used in cases within this value band. It is in terms a limit to the complexity of cases kept within the FRC scheme: if the case requires more experts or witnesses, it comes out of the scheme.

3.93 Apart from those considered above, the remaining differences are not considered material. The limited data on types of expert per case suggests that in the set of cases requiring no more than 2 liability experts, 97% of claims had no more than 2 experts overall on all issues. A restriction of the scheme to cases involving no more than 2 expert disciplines across all medical reporting (i.e. breach, causation and condition and prognosis) is consistent with Lord Justice Jackson's 2017 recommendations for intermediate cases.

3.94 The government probably need to consider whether there is a sufficiently strong case in favour of including any of the disputed categories, in view of the arguments raised.

Inclusion of cases which the claimant group argue should be excluded may well have a material impact on the costs proposed.

Outstanding issues

Light cost cases

3.95 At a late stage the defendant group also proposed that cases involving certain types of liability issue should also start within the LT, in view of the level of costs involved in these even though the claims might not all involve an admission of liability or an agreement to pay the claim in full. These included:

(i) dental claims;
(ii) care home claims; and
(iii) cosmetic claims.

3.96 The claimant group did not accept that the LT was suitable for cases where liability is in dispute. They argued that the point of the LT is to filter out cases by virtue of liability being accepted, rather than by type of treatment provided. They also argued that if evidence on breach and causation is required in such cases, requiring them to start in the LT with a letter of notification would cause further delay and expense.

3.97 A further point has been made that inclusion of such cases in the LT could enable the defendant to deny liability and make a risk-based Part 36 offer, placing the claimant at a disadvantage compared to claimants proceeding under the ST and obtaining evidence on breach and causation before sending a letter of claim. This is a valid concern, although one which could be addressed by procedural rules if the proposal otherwise had merit.

3.98 These claims would have to be accommodated within the same fixed fee options (an alternative suggestion by the defendants as set out in their position statement of what would amount to a "light standard track" does not appear workable). The obvious option, if these proposals were accepted at all, would be for these cases to start in the LT with a suitable letter of notification, but to exit into the standard track if liability is not resolved or an offer of full compensation made within the initial 8-week period.

3.99 If the government wishes to consider this aspect further, then it should be included in any consultation for further comment by all sides. There are obvious advantages to limiting the LT to cases where liability is not disputed; but equally the recommendations in this report should not lead to costs increasing in some categories of case.

Template letters

3.100 Some work was attempted in earlier working group meetings on agreeing a template letter of claim, from which we would then develop a similar template for the letter of response and a letter of notification for the LT.

3.101 We have included at appendix K the latest version of letters we could find as

presented to the working group: a version of the letter of claim from each of the defendant and the claimant groups and a letter of response from the claimant group.

3.102 The claimants' version of the letter of claim is possibly more detailed and contains provisions requiring a response on issues of patient safety and learning. Other than that, there appears to be a large measure of agreement between the parties as to the content of the letter of claim. Both letters provide for initial disclosure of expert evidence and witness statements, suggesting that the claimant's version may not be completely agreed by the claimant group. Both provide for a reasonable level of detail on quantum.

3.103 The claimants' version also incorporates a section applicable to the LT, suitable for inclusion in a letter of notification. Although the defendants' version does not contain this, it again appears to represent a sensible starting point for the letter of notification. If nothing else it confirms the intention on both sides that the new letter of notification will be rather more detailed than is applicable under the current protocol.

3.104 The draft letter of response from the claimant side also contains provisions for a response on learning and patient safety. The defendant group have said throughout that this probably cannot be the focus of the response to the claim in the FRC scheme, as the response will tend to reflect the position of indemnifiers and not the named defendant. This may need to be considered further by indemnifiers and defendant bodies: the need for learning from incidents to prevent further harm to others is an important point for many claimants.

3.105 Given more time, we would expect it to be possible to agree templates for all three letters. It is obviously important that the final versions of letter of claim and letter of response mirror each other.

Conclusion

3.106 There is room for improvements to the process pre-issue, provided these are seen as purely limited to claims with a value of no more than £25,000 and subject to the exclusions listed.

3.107 The proposed scheme is built around:

a) a standard track and a light track;
b) exclusion of categories of case which are likely to be complex or sensitive;
c) the claimant retaining responsibility for obtaining and sorting the medical records, but limiting the records required;
d) sequential exchange of experts' reports and witness statements (ST), as long as appropriate safeguards are put in place;
e) a letter of claim (ST) which discloses the claimant's case and is accompanied by an offer to settle;
f) a letter of notification (LT) which contains more information on alleged liability and on quantum;
g) a letter of response which discloses the defendant's case and responds to the offer;
h) the claimant's right to reply;

i) a mandatory stocktake and discussion if the case cannot be settled after the reply.

3.108 These recommendations are broadly agreed, although not accepted by all in the claimant group. They reflect the balance between process improvement and costs control, which we recognised would need to be struck; and they form the basis for the costs proposals made by the parties, outlined in chapter 5.

3.109 There are a few outstanding issues on process, but these do not have a material impact on the overall process or on the costs proposals. The remaining issues on exclusions may have more of an impact if any of the categories not agreed are included in the FRC scheme.

3.110 The parties have made the point throughout that a change of culture is required on both sides in handling lower value claims. These changes are designed to drive the necessary culture change.

CHAPTER 4: PROCESS FOR CASES WHICH DO NOT SETTLE

Purpose of this chapter

4.01 The purpose of this chapter is to consider the possibility of improvements to the post-issue process, to highlight the costs associated with litigation and to put forward an alternative proposal of using neutral evaluation.

Work undertaken

4.02 Professor Fenn's data analysis shows that around 75% of claims settled without the need for proceedings. For those cases where proceedings were required, the costs of the litigation stages were naturally expensive. The data also suggested that a significant proportion of those cases which did litigate, settled before allocation to track.

4.03 As indicated above, the belief is that by encouraging early exchange of expert and other evidence pre-issue, the proportion of cases which settle pre-issue should be increased.

4.04 The points raised below on post-issue process were all discussed by the working group before the proposal for using neutral evaluation was raised. Where post-issue steps are considered below, they are not now the subject of any recommendations in this report and the detail is provided to explain the difficulties faced in agreeing a post-issue process and why there is support for neutral evaluation.

Front-loading

4.05 Against the positive effect that early exchange of evidence would have, there was a concern that by moving work on expert evidence into earlier stages of the case, the effect might be to front-load the work required, such that costs savings might not be realised. The claimant group suggested that the reports prepared for exchange would have to be in the form required for proceedings, that witness statements would also have to take the form that would be required before the court and that work on formulating the basis of the claim would be duplicated.

4.06 The defendant group in contrast argued that much of this front-loading already occurs and that costs would not therefore increase. They considered that witness statements would normally be taken in standard form irrespective of whether the case was likely to end in litigation.

4.07 The use of model forms for reports from experts and templates for letters of claim and response was seen as going some way to address these concerns.

Pleadings

4.08 The need for pleadings creates a further difficulty. As a means of streamlining the post-issue process, we considered whether the letter of claim could stand as particulars of claim and the letter of response as the defence. The claimant group argued that this would

create the obvious difficulty that counsel, who would nearly always be engaged to draft the particulars of claim, would instead have to be engaged to draft the letter of claim in view of its critical importance.

4.09 The data showed that at present, counsel is used in about half of all cases settled pre-issue. The comments from the claimant group suggested it was perhaps more usual to see counsel involved after the letter of response, than before the letter of claim.

4.10 As an alternative to this approach, the parties suggested that the mandatory stocktake could produce a list of issues and summarise the parties' positions on each of those issues. It was suggested that this list of issues could replace the need for pleadings. The Bar strongly opposed the suggestion that a simple list of issues could replace conventional pleadings. An alternative proposal which did find more support was that the parties produce what is effectively a Scott schedule, with columns for the claimant's allegations, the defendant's responses and the issues to be decided.

Other steps post-issue

4.11 The parties broadly agreed that with exchange of reports, witness statements and with disclosure of records taking place prior to issue, there was no obvious need for directions or for a CMC. With support from the judicial members of the working group, the parties agreed that it would be sensible for a PTR to take place, so that the court had an opportunity to consider whether directions were required and to deal with residual matters, such as the need for meetings between experts. The PTR would take place by video link or by telephone to avoid the cost of attendance.

4.12 Otherwise the parties agreed that with the focus on maximising the number of pre-issue settlements and with open exchange of evidence pre-issue, the only cases which were likely to result in proceedings being issued were those in which there was a genuine dispute and where the claim should proceed to trial as soon as practicable.

4.13 There was considerable discussion during the course of our work about the timing of meetings between experts. (In fact, these "meetings" tend to be telephone discussions.) At various stages in our work, there were proposals that these meetings should take place:

- pre-issue, but after mandatory stocktake
- post-issue but before CMC or PTR
- post-PTR and then only if directed by the court

4.14 Whilst there is an obvious benefit in such meetings taking place prior to the issue of proceedings, in case the meeting leads to resolution of the case, there was also a concern that this would result in additional front-loading and that it would not be of benefit in all cases.

4.15 As we approached the mediation on costs, the approach which appeared to find the most favour was that a meeting should take place pre-issue only if the parties agreed, but that in the absence of agreement the court would consider the position at the PTR.

Trial

4.16 Both parties considered there to be a need for specialist judges for clinical negligence trials, even in claims valued at under £25,000 (and perhaps more so in such lower value cases). The judicial members of the working group were receptive to this, although recognising that HMCTS would not necessarily be in favour of the concept. The need to list a case before a particular type of judge could delay setting a date for trial, especially where the availability of expert witnesses would also be an issue. It could also create an additional burden on those courts where the specialist judges would sit.

4.17 In any event it was recognised that with the expectation that fewer such cases would be proceeding to trial in any event, the availability of specialist judges in all locations where a trial might take place was likely to be impracticable.

The solution - neutral evaluation

4.18 Discussions at the mediation revealed a considerable gap between the parties as to the cost of cases proceeding beyond issue, as well as highlighting the concerns of the claimant group that changes to the pre-issue process would result in front-loading of costs, especially if cases then had to be prepared as if they could be issued. Following the mediation and with the support of the Chair, the parties considered whether there were other workable alternatives.

4.19 Although ADR was very much in the contemplation of the parties throughout, no formal ADR steps had been included in the process proposals at that point. The parties have however come up with a proposal for neutral evaluation which, although radical, is attractive as a means of resolving the complex issues outlined above.

The evaluation process

4.20 MNE is a bold and imaginative proposal and favoured by representatives of both sides. The expectation of all members of the working group is that the majority of cases will settle before the mandatory stocktake and discussion, which in effect marks the end of the pre-issue stages in either ST or LT. If the mandatory stocktake works effectively, it should lead to resolution of a further percentage of cases.

4.21 If the case is not resolved by the mandatory stocktake, it would then be referred for MNE. The full details of how this proposal would work still need to be ironed out, but the initial proposal is that evaluation would be carried out by a specialist barrister of a minimum level of experience selected from a pre-agreed panel. The claimant group suggest a minimum of 10 years' call, whereas the Bar favour a broader demonstration of sufficient competence and experience. The mechanics of setting up and agreeing a suitable panel of barristers (and allowing applications to join, etc.) need further consideration, but the parties drew on their own experience of being able to agree mediators in clinical negligence claims without much difficulty.

4.22 The evaluation would be a paper-based process. The evaluator would not have a role as mediator, but would be asked to produce a written opinion as to their assessment of the likely outcome on liability, quantum or both aspects as required. This evaluation would then be provided to the parties simultaneously.

4.23 It is expected that most evaluations will be on liability disputes only. The working group considered it rare for quantum not to be settled by negotiation and to be the reason for proceedings being issued.

4.24 The parties agree in principle that there should be no process improvement proposals or fixed fees beyond the neutral evaluation, which would take place after the agreed pre-issue stages. There has been debate about whether MNE should be binding on either or both parties; this is considered further below, with our conclusion and recommendation that it should not be binding on either party – but that willingness on either side to reject the evaluation and litigate should be controlled by meaningful sanctions.

4.25 There are several advantages to this approach, which should result in significant costs savings. These are considered below, as are the possible drawbacks of departing from the established court procedure.

A mandatory step

4.26 It is proposed that the neutral evaluation step will be mandatory in all cases which have not settled before or at the stocktake stage. This is an important point: a voluntary evaluation would not have the intended effects and would therefore negate the advantages set out below, both in terms of costs savings and process.

4.27 We believe that in this particular practice area, where claims valued at no more than £25,000 incur disproportionate costs because of their complexity (especially where proceedings are commenced or contemplated), imposing a requirement for an independent evaluation to take place is the right step to take.

4.28 The proposal is not without precedent in the court system generally, although formal ADR in civil procedure has to date remained a recommended step only. The FDR appointment in family proceedings is a step required under Part 9 of the Family Procedure Rules, albeit one which takes place during proceedings rather than pre-issue.[17] The judge hearing the FDR appointment takes what is in effect an evaluative role, in that the judge is permitted to indicate what the outcome might be if the case proceeded to a full hearing. We understand that this process works well in practice; although neither party is bound by the indication given at the FDR appointment and can proceed to a full hearing, in practice 75 to 80% of disputes settle at or very soon after the FDR hearing.

4.29 Lord Briggs (then Lord Justice Briggs) referred to similar conciliation schemes used in

[17] FPR 9.15(4) requires the court at the first appointment to make a direction for an FDR appointment, unless:
"(a) the first appointment or part of it has been treated as a FDR appointment and the FDR appointment has been effective; or
(b) there are exceptional reasons which make a referral to a FDR appointment inappropriate."

some courts for small claims in his final report on the Civil Courts Structure Review[18]. In the context of the Online Court and promoting effective use of ADR, he also noted the need to ensure that:

> *'…everything is done first to encourage would-be litigants to seek to settle their disputes before going to court.'*[19]

4.30 Although the recent report of the CJC's ADR Working Group[20] did not consider that ADR should be mandatory, that was particularly in the context of mediation. Having concluded that there should be "*earlier and more stringent encouragement of ADR in case management*", they stated:

> *'We would be extremely reluctant to propose mandatory mediation at this juncture…it is hard to see it being other than harmful for a blanket requirement, of one particular form of ADR, to be super-imposed.'*

4.31 In the case of using neutral evaluation in lower-value clinical negligence claims we can see a distinction to be drawn, especially as practitioners on both sides are broadly supportive. DHSC has previously proposed the use of single joint experts as a way of addressing the disproportionate costs of these cases. Elsewhere (6.27) we have concluded that the use of single joint experts would amount to a determination of the case and so is not appropriate, except for additional evidence on quantum on the LT when needed (see 6.31). However, an evaluation by a specialist barrister would have the advantage of providing an early and cost-effective assessment of the issues in dispute, but without necessarily determining the dispute should either party reject the assessment and decide to proceed to trial.

4.32 Although this may be a point on which the government should seek its own advice, we have reached the provisional conclusion that the imposition of an ADR step does not infringe either party's right to a hearing under Article 6 ECHR. That conclusion depends in large part on the outcome not being binding on either side, although the failure to accept the MNE outcome should have costs consequences if not beaten at trial.

Outcome not binding

4.33 If the evaluation step itself is to be mandatory, then we have concluded (for the reasons set out below) that the outcome from the evaluation cannot be binding on either party. We consider that this is an important safeguard in applying what would be an untested provision for mandatory ADR.

4.34 This issue was discussed with the small group. Although the defendant group at least would have preferred to see the parties bound by the outcome, subject to a limited right of

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[18] *Civil Courts Structure Review: Final Report* July 2016 https://www.judiciary.uk/wp-content/uploads/2016/07/civil-courts-structure-review-final-report-jul-16-final-1.pdf . See especially at 2.16 – 2.23

[19] Ibid at 6.72

[20] *ADR and Civil Justice* https://www.judiciary.uk/wp-content/uploads/2018/12/CJC-ADRWG-Report-FINAL-Dec-2018.pdf

appeal, the claimant group considered that this could infringe the rights of the claimant to a hearing under Article 6 ECHR. If the outcome cannot be binding on the claimant, the defendant group say that a liability evaluation at least cannot be binding on the defendant either: either the named defendant or an individual clinician would be facing allegations as to their professional competence and would therefore have equivalent rights.

4.35 A further point to be considered was that although we acknowledge that not all clinical negligence claims arise out of care or treatment provided by public bodies, it is correct to say that a significant proportion of them do so. We believe in any event that the rights of the claimant and of the clinicians involved mean that either side should have the right to proceed to a hearing if they do not agree with the outcome from the MNE; the involvement of a public body as the defendant/employer would make that conclusion even more likely.

Sanctions

4.36 Even if the outcome is not binding, there are practical ways in which parties could be encouraged to give serious consideration to the outcome before electing to proceed. In particular, a decision to reject an evaluation and proceed to trial could, and we believe should, be subject to cost consequences if the party rejecting the offer fails to obtain a more favourable outcome. We do not consider that such controls would in principle represent any breach of Article 6: in terms they are not that different from the operation of Part 36 and other rules on costs and sanctions for breach of the CPR.

4.37 The precise nature of any sanctions is probably a matter for the CPRC, but the following ideas were put forward by the parties for consideration:

- for evaluations on liability issues, the specialist barrister's evaluation could be shown to the judge at the conclusion of the trial on issues of costs;
- a quantum evaluation could be shown to the judge after they determine damages and takes effect in the same way as a Part 36 offer (a more extreme option could be that the party proceeding, which could be claimant or defendant, has to have "beaten" the offer by a pre-set margin, but this may be a step too far in a new process);
- any party deciding to reject the MNE and proceed to have some risk of paying costs if they lose;
- any trial would be to consider the evidence exchanged pre-issue as presented to the evaluator, together with such additional oral or written evidence as the court permits, not on different evidence.

4.38 The last point is particularly important. The MNE concept (and indeed the sequential exchange of evidence) works to control costs, as long as the parties cannot simply reject the outcome and then produce evidence from different experts or witnesses at a subsequent court hearing.

4.39 Any costs sanction on the claimant for not accepting an evaluation would need to be an exception to qualified one-way costs shifting. If such an exception were made, balance would require a defendant rejecting the evaluation to face more than just the costs of litigation as a sanction – perhaps a fixed 10% uplift in damages and costs, in the form

currently available under Part 36. A point is made fairly by the claimant group that any regime of sanctions must be even-handed, although the same point applies to the discussion of sanctions generally in 5.50-5.59 below.

Cost and who pays

4.40 There will be an additional stage of fixed recoverable costs payable to the claimant's solicitor if the case proceeds to MNE. There will also be a fee payable to the evaluator, at a level to be determined and likely to vary depending on whether evaluation is needed on liability only, quantum only or liability and quantum.

4.41 The fee for the evaluator needs to be set at a level which will allow the barrister to consider the evidence and to produce a written evaluation in sufficient detail for the parties to be able to see how the conclusions are arrived at. Whilst it need not be as comprehensive as a court judgment, the evaluator will need to record and analyse the relevant parts of the evidence and to give reasons for their conclusions.

4.42 A point was made by the representative of the Bar that the fee has to be set at a level which will attract barristers of appropriate seniority to carry out this work. As long as the fee reflects a reasonable fee for the work which needs to be done, we do not consider that any further incentive is needed: in practice we anticipate that individual barristers will see some benefit in being on the agreed panel and in being selected to carry out the MNE, for which their fees will be met in any event.

4.43 Proposals from the Bar and from defendants as to fees for the evaluator are considered at 5.44-5.46 below.

4.44 Responsibility for paying the evaluator's fee also needs to be considered. Although it is accepted that most referrals to MNE will be on liability, the step would also be available for disputes on quantum. In this situation, there needs to be some costs risk for the claimant in rejecting a settlement proposal and incurring the costs of a further step, both as to who pays the fee initially and whether the cost can be recovered following a favourable outcome.

4.45 There is a measure of agreement (with some objections) that the same approach should be taken as is usually applied for the fees of a mediator. This would involve the evaluator's fee being shared equally by the parties at the outset and being met by the defendant if the claimant succeeds. (In quantum cases "success" could be measured against the defendant's final offer.) This would operate to deter use of the MNE step in cases which could otherwise be disposed of earlier.

4.46 This approach would mean that the claimant would be at risk as to 50% of the fees for the MNE. In practice that cost is most likely to have to be covered by ATE. That aspect of the ATE premium would not be recoverable from the defendant. We acknowledge that there might be some effect on the cost of ATE overall, although savings in post-issue exposure to disbursements should offset this. In view of the relatively limited cost and the expectation that most cases should settle due to the early exchange and stocktake and without needing referral to MNE, we consider any effect on the cost of ATE to be manageable.

4.47 The government will need to be satisfied that the ATE market will provide cover and that the cost will not be a barrier to claimants proceeding to MNE. AvMA, SCIL and others also raise questions about the risk of further deduction from claimant damages because of the risk of additional ATE cost. Those are proper concerns but, where the cost of MNE should replace the risk of exposure to court fees and post-issue disbursements, we would be surprised if the cost of ATE would increase in an open, competitive market.

Effect on overall costs

4.48 The parties believe that there will be savings in pre-issue costs as a consequence. Certainly, it has been possible to narrow the gap between the costs proposals on each side as a result of this development, where previously it appeared that this might be difficult to achieve.

4.49 Although reports of experts and witness statements, as disclosed with the letter of claim or letter of response, will not need to be in a form ready for trial, they will need to be prepared thoroughly against the likelihood that they will be assessed in MNE. With an evaluation on paper, it is obviously very important that the evidence is suitable for such assessment, otherwise the evaluator may find it difficult to reach a view.

4.50 SCIL suggest that evidence will also need to be trial ready, in view of the claimant's right to proceed to trial (but with restrictions on further evidence). As stated above, the controls will need to be considered by the CPRC: a balance has to be struck between avoiding unnecessary costs pre-issue by permitting the parties to expand their initial evidence on the one hand and limiting the right to abandon current evidence and obtain new reports on the other.

4.51 We also repeat the caveat raised at 3.46 above that there should be no criticism of an expert or witness for any adjustment to their evidence to take account of facts not known to them at the time of the original evidence.

4.52 The process no longer provides for a discussion between experts, either pre- or post-issue. The cost of this step is therefore saved, although it does place more importance on the way in which both parties prepare for the mandatory stocktake and discussion.

4.53 Any difficulty in changing the approach to pleadings is resolved. There is no need for the letter of claim to be prepared as if it were a pleading; and at the same time there is no risk of duplication of time in pleading the case after comprehensive letters of claim and response.

4.54 The main saving will of course be in the costs of proceeding to litigation and trial. Although the data shows that some 75% of cases settle prior to issue of proceedings, the cost of litigation still represents a significant burden, not least because the losing defendant incurs both the claimant's costs and their own costs. This includes additional fees to experts and counsel as well as solicitors' costs on both sides. Overall this could represent the biggest saving of costs in these cases in practice.

Advantages and drawbacks of MNE

4.55 We set out below the obvious advantages and disadvantages in putting forward MNE as a means of avoiding the costs of post-issue process. Although this proposal has only been put forward by the parties at a relatively late stage in discussions, it has received considerable attention and we are satisfied on balance that it should form a central part of our recommendations.

4.56 MNE helps to address a number of the problems raised by the parties in making improvements to the pre-issue process, in terms of reducing the knock-on effect of preparing for litigation at the same time. It has the advantages that an assessment is made by a specialist independent barrister and that this is carried out without proceedings being required. It will speed up the process of resolving claims: a case within this scheme does not need to be prepared for litigation and the costs and delay of litigation are also avoided.

4.57 In terms of its ability to resolve costly disputes on liability, we believe it has a similar impact to the government's idea of using single joint experts, without the drawbacks of that concept as covered in 6.25-6.31.

4.58 We have made it clear throughout the report that the recommendations are specifically to address the disproportionate costs of lower value clinical negligence claims up to £25,000 in value and should not be taken as applicable to higher value claims. This is especially true of the proposal for MNE.

4.59 There is the risk that by reducing assessment of the issues on breach and causation to a paper evaluation, this does mean that the evidence is not probed further. There are numerous examples of where the evidence of a practitioner as to their usual practice has been undermined at trial; or where the opinion of an expert as to the existence of a responsible body of medical opinion has been negated. This is one reason why the overall right to an oral hearing needs to be preserved, albeit with controls.

4.60 AvMA raise the question as to whether the evaluator should be permitted to seek clarification from the parties' experts. There is a difficult balance to be struck, in a proposal which is intended to reduce costs and simplify the process. We would want to avoid routine enquiries back to experts, causing additional fees to be incurred, where the focus is for the evaluator to make a decision on the material already available from claim, response and stocktake. On the other hand, some cases may occasionally need further input before an evaluation can be given. This is just one of the details that still need to be resolved as to the rules applicable to such a process.

4.61 The availability of MNE for quantum as well as for breach and causation is also critical. Although we were told repeatedly by practitioners on both sides that cases rarely litigate on quantum, the process must not put pressure on claimants to accept offers which may be on the low side. An MNE process for quantum only avoids that.

4.62 Likewise the process for MNE must not be seen by claimants and their solicitors as an opportunity to recover more costs without penalty. We believe that this balance has already

been addressed, in the recommendations above as to who bears the cost of the MNE (and therefore the risk) at the outset.

Should MNE be piloted?

4.63 There have been calls within the working group for all these proposals to be piloted. The experience of voluntary pilots for FRC schemes (as opposed to new procedures generally) is that they tend not to work, for obvious reasons. A mandatory pilot would either have to be universal (and therefore the same as introducing the changes and monitoring outcomes) or be applied in some restrictive fashion to particular courts: not easy in a system where the claimant has the right to have their case heard in any court.

4.64 There is also the problem of delay. Even under this new process, cases will take many months to proceed from initial instruction of solicitors to conclusion. A pilot would risk putting back the planned change and introduction of FRC by some considerable time.

4.65 Some working group members are understandably cautious about the use of MNE and consider that it should be piloted. We have considered this call more seriously, but ultimately find it difficult to see how it could operate in practice. The proposal is for a pre-issue step; individual claims would have to be assigned to MNE at issue of court proceedings by some (probably random) form of allocation. The advantages of avoiding the cost of preparation for court would therefore be lost.

4.66 The legitimate reason for proposing a pilot is to determine whether the plans work effectively. That could be done in a better way by setting up in advance a proper system of monitoring outcomes and recording data on all cases, with a commitment to review say 3 years post-implementation[21]. The working group has benefited from the availability of data provided voluntarily by practitioners and their organisations, but there is no substitute for formal data collection and analysis.

<u>Other post-issue measures</u>

4.67 We have outlined some of the ideas provided by the parties above at 4.11-4.17, including a more streamlined process and specialist judges and some options as to the timing of discussions between experts. These do not necessarily address the difficult questions around pleadings and front-loading.

4.68 The costs proposals from the claimant and defendant groups set out in chapter 5 are predicated on the use of MNE as the primary solution for controlling post-issue costs. Although the use of MNE does not prevent the claimant from issuing proceedings, we concluded that no further work should be done on trying to improve the post-issue process for what should prove to be a very small number of intractable cases.

<u>Conclusions</u>

[21] A parallel can be drawn with the introduction of the Welsh Putting Things Right scheme in 2011, followed by assessment via the Evans report in 2014.

4.69 MNE is an attractive solution to some difficult problems. It is also a radical departure from existing mechanisms of resolving disputes; and it was proposed at a relatively late stage in our work.

4.70 If it works as intended, MNE would remove the need for changes to post-issue process and resolve some more difficult issues about pre-issue process, where we cannot offer alternative solutions.

4.71 There are obvious concerns about whether it would work effectively. Not all members of the claimant group agree with the proposal and the Bar also has some legitimate concerns about how it would work, both for them as evaluators and for the parties. It has been suggested that the proposal could be piloted, but it is difficult to see how this could work in practice.

4.72 Concerns have been raised as to whether MNE would be compliant with Article 6 ECHR. We believe this has been addressed by the outcome not being binding on either side, although we also recommend the use of sanctions to deter unnecessary or unreasonable litigation. On this point the government will need to seek its own advice in any event.

CHAPTER 5: FIXED RECOVERABLE COSTS

Purpose

5.01 The purpose of this chapter is to set out the proposals made by each side for fixed recoverable costs in their final position statements. It also addresses various costs-related issues raised during the working group's discussions.

Work Undertaken

5.02 The main purpose of the CJC work was to attempt to generate proposals for FRC for lower value clinical negligence claims. We entirely accept that the terms of reference were set broader than this relatively narrow construct, to include process improvements and other issues such as patient safety. However, the need for recommendations on costs was clear from the outset.

5.03 It is fair to say that it has proved difficult to focus the discussions on costs alone. Nearly all meetings of the working group, including those following the mediation, started with a dialogue about process.

5.04 Although the mediation was not successful, it did push both the claimant and defendant groups into tabling costs proposals and starting a dialogue over the appropriate level of fixed recoverable costs. To that end, we are grateful to the mediator, Philip Havers QC, for facilitating those very important first steps.

5.05 Without breaching the confidentiality which remains around the mediation, those discussions demonstrated the gulf between the parties and prompted something of a rethink. The final positions of the parties reflect a lot of hard work on all sides to narrow the gap between their respective positions, and all those involved deserve considerable credit for the efforts they have made.

5.06 One reason why process never left the table, even when costs were being discussed, was that it was always understood that the two would have to be tailored to each other. The costs had to account for the work required to be done. Process improvements which would only add to cost would have to be considered in that context. We always anticipated a final balancing act between process improvements and costs control, such that the process would need to be refined even at the end – and so it proved.

5.07 Professor Fenn has carried out a considerable amount of work in analysing the data presented to him during the life of this working group. He has also had discussions with each of the groups privately as to how to approach setting FRC, as well as regularly providing assistance to the Chair in understanding how to move forward. All those involved owe him a debt of thanks for his pivotal role.

The parties' final position statements

5.08 Despite the considerable progress made, no agreement has been reached save in respect of one minor step in the light track. The final position of the claimant group and of the defendant group are recorded in their position statements, at appendix C and appendix D respectively.

5.09 The purpose of these position statements was to enable us, with the agreement of the parties, to present their final positions on the level of FRC as arrived at in the mediation and subsequent discussions. Although we asked the parties to deal with certain other aspects relating to process, we did not call for position statements on all matters.

5.10 As well as the position statements of the parties, we requested a position statement from the Bar, to focus mainly on issues relating to the proposal for MNE. The contents of this have largely been considered in chapter 4 above, although we deal with fees for MNE at 5.42-5.49 below.

5.11 We also received position statements from SCIL and AvMA. These were not requested and do not limit themselves to issues of FRC. SCIL state that they remain opposed to FRC. AvMA, in a lengthy paper, indicate that they are not going to comment on the figures proposed for FRC in themselves, although they do address general concerns about the effect of any FRC regime on damages and access to specialist advice.

5.12 There is a risk that by including these additional position statements, we distort the original intention of requesting the statements from the parties. However, there is also the possibility that this report would not be considered complete without a record of the views of those who do not accept the proposals for FRC.

5.13 We have concluded that the SCIL position statement should be included in full, not least because it is short and because it does include some commentary on costs issues. The AvMA paper is a different matter. It is over twice as long as the claimants' overall position statement, it deals with a number of areas which were not the subject of any request for a position statement and in some areas, it overlaps with the views expressed by SCIL.

5.14 In the circumstances we have decided to edit the AvMA paper to limit it to specific sections dealing with areas which represent AvMA's real focus: protection of client damages, access to justice and patient safety. That is not to exclude AvMA's more general views, which can be covered in response to any DHSC consultation on the recommendations in this report.

5.15 As part of the closing discussions in June, the Chair floated the idea that a recommendation be made on behalf of the CJC as to where the appropriate middle ground might lie. This proposal received a degree of support but was not accepted by both sides. Following discussions with DHSC, it was felt that there could be some benefit in outlining a possible methodology for resolving the remaining disagreement between the parties, along with an indication of the possible result of using that methodology. This is set out in appendix H.

5.16 The final positions can be summarised as follows, all figures are exclusive of VAT and disbursements:

Table 4 - Standard Track

Stage	Description	Claimant	Defendant
1	All steps up to and including stocktake	£6,000 plus 40% of damages agreed	£5,500 plus 20% of damages agreed
2	From stocktake up to and including neutral evaluation	£2,000 in addition to stage 1	£500 in addition to stage 1

Table 5 - Light Track

Stage	Description	Claimant	Defendant
1	All steps up to 21 days after letter of response is due	£2,500 plus 25% of damages agreed	£1,000 plus 10% of damages agreed
2a	From 21 days after letter of response up to and including stocktake	£1,500 plus further 5% of damages agreed, in addition to stage 1	£500 in addition to stage 1
2b	From stocktake up to and including neutral evaluation	£500 in addition to stages 1 and 2a	£500 in addition to stages 1 and 2a

5.17 The use of a formula which includes a percentage of damages as part of the fixed fee is in line with other FRC structures in use or proposed. It is simply a representation of the overall fee in a way which is more proportionate to the damages at stake.

5.18 At a late stage the defendant group proposed a third table, representing certain types of case which could start in the LT but then move to the ST if liability is not accepted in full. They maintained that these types of case should attract lower fees because they tend to require lower fees now. Details are set out in the defendants' position statement.

5.19 The claimant group rejected this approach, arguing that if expert evidence on breach and causation is needed in a LT case, it needs to move to the ST and attract ST level costs. The point is not therefore agreed. In any event it would add to the complexity of what is supposed to be a simple system of FRC.

Issues raised by the parties

Alternative views

5.20 SCIL suggest that FRC at the level proposed (especially those from the defendant group) will drive lawyers out of the market and leave claimants either acting as litigants in person or in the hands of claims farmers or unregulated representatives. This is pure speculation and is difficult to follow: the level of costs proposed by the defendant group will generate at least £7,000 costs on average (see tables 19 and 20 in appendix B) and the claimant group's figures are higher. We feel justified in saying that with costs at this level, specialist firms are likely to stay in the market they already occupy.

5.21 AvMA raise related issues: that the proposed structure may drive lawyers only to take

on higher value claims, towards the upper end of the £25,000 value band; or only to take on cases which they are almost certain they will win. To a significant degree, the process proposals are designed to weed out cases with less merit, by requiring supporting expert evidence with the letter of claim. A lower percentage of damages as part of the FRC formula, as is proposed by the defendant group, may also help to retain incentives to pursue lower value but still meritorious claims.

5.22 AvMA's principal concern is that claimants will find themselves facing further deductions from damages, such that the claimant themselves will be dissuaded from taking action. This is a valid concern, although we do not accept that the effect would be to reduce severely or even wipe out damages altogether. The effect of the test of proportionality also needs to be considered, see below.

Proportionality

5.23 The defendant group raised the issue of proportionality at various points in the discussion about costs. They emphasised the importance of moving from a position set by reference only to data relating to current case settlements. They made the point that the approach to proportionality by the courts has been evolving, and that they expected it to be more restrictive in the future.

5.24 The position of the claimant group was based more on analysing the work which needed to be done in cases of this type. Whilst that had some relation to the value of the claim, the starting point was more that the work was necessary to pursue such claims.

5.25 The recent decision of the High Court in *Malmsten v Bohinc*[22] confirms that the test of proportionality is a separate check on costs, beyond that of reasonableness and necessity. To that extent, it is likely to represent a reduction from a simple assessment of all the steps that need to be taken. However, as the decision makes clear, this has to be put into the context of the complexity of the type of case involved.

5.26 Clinical negligence claims where liability is in dispute are by their nature inherently complex. They involve the use of expert evidence on liability, often on both sides. We question the extent to which the proportionality test will have a large impact on ST cases.

5.27 The position on LT cases may be a different matter. Where liability is resolved at an early stage, albeit with the difficult background of failed clinical treatment and therefore a greater need for client care, the proportionality test may have a greater impact in controlling costs by reference to the value of the claim.

5.28 The real problem with applying the proportionality test to the work of this group is that no one can say objectively what effect it would have. Some cross reference to other FRC regimes (in force or proposed) may provide clues, but we are wary of taking those comparisons too far.

5.29 AvMA raises concerns about the risk of further deduction from damages, see 5.11

[22] [2019] EWHC 1386

above. If AvMA is right on this point, extensive application of the proportionality test may have the same effect, without there being any obvious benchmark against which the claimant and their solicitor can judge the appropriate level of costs to be incurred. At least with FRC, the position is known in advance and solicitors can limit the work done to that which is necessary to pursue the claim, as opposed to a focus on maximising recoverable costs.

Front-loading

5.30 Some of the arguments as to the proposed new pre-issue process causing front-loading of costs are dealt with in chapter 3. It remained a significant part of the claimant group's argument that the new process would lead to greater front-loading of costs, with the result that the costs incurred up to the letter of claim stage would be higher than now.

5.31 As indicated in chapter 3, the defendant group argued that much of this front-loading takes place already and that there might be little difference in practice.

5.32 To some degree, the proposal of MNE is intended to address the need for additional front-loading, or at least the duplication of costs that might be caused by preparing a case for litigation.

Use of counsel

5.33 Use of counsel was another more contentious point. The claimant group argued that the involvement of counsel was a positive control on the presentation of claims. They considered that counsel's fees should simply be treated as a disbursement in the case.

5.34 The defendant group argued that in lower value cases, there had to be some restraint on the use of counsel and that, if their fees were allowed as a disbursement, this would mean that the solicitors would outsource much of the work to counsel that was intended to be covered by their own fees. They favoured a single FRC scheme, in which one figure was allowed to cover work done by solicitors and counsel.

5.35 The interests of the Bar were separately represented on the working group. A position paper from the Bar is included at appendix E, although the focus of this paper (at the request of the Chair) is more on the concept of MNE.

5.36 The Bar did their best to engage in a constructive and realistic way on issues which obviously relate to their fee income and to avoid a position of self-interest. They maintained throughout that the use of counsel, including in the pre-issue stages, can bring benefits and must not be disincentivised. They accepted the need for overall control, but favoured a system in which a certain element of the single figure was "ring-fenced" for counsel or advocate.

5.37 The ring-fencing approach was more applicable at an earlier stage of the costs negotiations and in view of the way those negotiations developed, we believe (and the Bar accept) that a ring-fenced element of the FRC is no longer appropriate. The Bar does however maintain that the involvement of counsel in lower value clinical negligence claims is necessary

and proportionate and should be recognised as part of the overall cost of such cases.

Experts' fees and ATE

5.38 The work on experts generally is covered in chapter 6. Although the working group's terms of reference extended to include the fees of experts and their funding, we were only able to make limited progress on a complex topic.

5.39 The fees of experts do represent a significant cost in disputed liability cases, but it is not clear to us from the limited work done that this is because of either excessive use of experts or excessive time spent by them. There was some evidence that a more disciplined approach to the way in which the expert was instructed, coupled with a model form of report or a checklist for instructions, might lead to more efficient working and fewer hours spent by the expert.

5.40 The data collected during consideration of the involvement of experts will hopefully assist in further analysis of the cost and ways by which it might be addressed: see chapter 6.

5.41 For the reasons set out in chapter 6, we have not taken matters any further on ATE premiums.

Fees for MNE

5.42 The solicitors' costs for this step are dealt with in tables 4 and 5 above.

5.43 The parties agree in principle that the evaluator's fees should be fixed, with separate fees for evaluations on liability only, on liability and quantum and on quantum only (although the parties expressed the view that quantum only evaluations should not be needed).

5.44 The Bar's position paper addresses the arguments as to the level of fees in some detail and makes the following proposals (exclusive of VAT):

(a) Liability and quantum: £2,000
(b) Liability only: £1,500
(c) Quantum only: £1,500

5.45 The defendant group proposed lower fees:

(a) Liability and quantum: £1,750
(b) Liability only: £1,250
(c) Quantum only: £750

5.46 The claimant group as a whole deferred to the position of the Bar, as best placed to consider the appropriate level of fee that should be payable.

5.47 With the exception of quantum only MNE, the differences between the Bar/claimants and the defendants are small. The Bar makes the point that the process is entirely new and

that practitioners will have to be attracted by the level of fee payable. We comment elsewhere on the latter point but we accept that the process is new and that a degree of caution is required to ensure the level of fee is set appropriately.

5.48 At first sight it is surprising that the fee required for an MNE on quantum should be the same as that for liability. We accept (as does the defendant group) that the fee required would be more than the difference between a liability and quantum MNE and one on liability only, but we would expect less work to be required on quantum than on liability.

5.49 Subject to that point the final decision, in the absence of agreement, rests with the government. A cautious view, i.e. to adopt the Bar's figures except for quantum only, might well be appropriate but with careful monitoring of take up and outcomes. The number of MNEs is expected to be small and on quantum especially so: if data shows frequent take up, that would need to be investigated further.

Sanctions

5.50 This topic has been raised on occasion during consideration of the proposals for pre-issue process. The point being made with some force by the claimant group is that the model hinges on the provision of a meaningful response by the defendant, accompanied by their expert report if liability is disputed, within a set timeframe. If that does not happen, it risks undermining the improvements to the process.

5.51 The claimants make the point in their position statement that sanctions are needed to help enforce the change of culture needed. This is accepted, although the nature of the sanctions has not been ironed out.

5.52 One option would clearly be for the time limit to be strictly enforced and for cases where defendants do not comply to be excluded from the fixed costs regime. The difficulty with any such model is that it creates a class of cases which will either not have fixed costs at all or will need a separate scale of FRC devised for them. There is already a twin track approach based on complexity, for which figures have been produced which are not yet agreed. It is not a practicable proposition to create a further option for non-compliant cases: the better option is to apply additional costs but retain the cases within the FRC scheme.

5.53 Professor Fenn made a related point in one of his presentations: that defendants may see escape from the FRC scheme as an opportunity in lower cost cases, to the detriment of claimants and their solicitors. This sort of avoidance behaviour also needs to be controlled.

5.54 Subject to those important points, it remains a central part of the proposed pre-issue scheme that the defendant's response is delivered in a reasonable time period and is a meaningful reply to the detailed allegations and expert evidence presented.

5.55 The claimant group maintain that cases where defendants do not comply should come out of FRC into standard costs. They maintain that no other sanction would be effective and point to the personal injury protocols in support of this, although these are not directly comparable and it has been found that such a mechanism can drive unacceptable behaviours,

especially if “escape” is into the space of unlimited hourly rate work.

5.56 The working group did discuss whether a financial penalty for late service of the letter of response would be appropriate, increasing by reference to the delay. This was in recognition of the point that delay will tend to generate additional costs. It was suggested that a sum could be payable to the claimant personally as well as or in place of a costs payment to the solicitor, although the parties could not agree on the appropriate level of payment in either case. There is broad acceptance, based on Professor’s Fenn’s analysis (see in particular section 4.2 and table 13 in appendix B), that delay in settlement will lead to increased legal costs.

5.57 The aim of any sanctions is to incentivise good behaviour and it is accepted that there need to be some changes to behaviour on both sides for reform to be effective. The two key points in the process are the letter of claim and the letter of response, only one of which is subject to a time limit. Other time limits do apply to both sides, but it is not immediately clear how these could be enforced by sanctions.

5.58 The focus has been entirely on sanctions against the risk of behaviour by defendants. We accept that such sanctions may be needed, but it is a fallacy that it is only the behaviour of defendants that needs to be controlled. Equally, it cannot realistically be argued that the penalty for claimants is for the case to remain in FRC. The FRC scheme is not designed to be a penalty at all, but an appropriate measure of control to keep costs in proportion to damages.

5.59 The need to ensure that the letter of claim is in proper form and accompanied by the necessary evidence is probably more a matter for procedural rules.

Learning and patient safety

5.60 The CJC’s terms of reference require us, when considering these proposals:

> *To have regard to how any improved process or scheme of FRC might affect issues of patient safety, including the way in which case outcomes are reported back to healthcare providers for learning purposes.*

5.61 This particular chapter focuses on the level of FRC. The claimant group, with some reservations, are satisfied that the proposals for FRC which they have put forward are sufficient to allow such claims to be brought when needed. The defendant group have similar goals, even though the costs they have proposed are lower: certainly no one is suggesting that meritorious claims should not be brought.

5.62 The linking of an element of the FRC formula to the level of compensation paid to the claimant ensures that both sides have in mind that the degree of harm suffered by the claimant has a direct effect on the level of costs. Not only is that consistent with other FRC schemes, it also reinforces the importance of the claimant in the process. We accept that it is an imprecise measure of the importance of the claim to the individual claimant, but in our view, it remains preferable to a simple lump sum for costs in all cases and the parties appear to accept this.

5.63 The overall effect of these proposals for costs and process should also be to speed up resolution of disputes.

5.64 We accept that these may be small gains, but we are satisfied that there is no adverse effect from these costs proposals. Other aspects of patient safety are considered elsewhere in the report, particularly in chapter 7.

Conclusions

5.65 In the absence of a concluded agreement, the proposals of the claimant and defendant groups for the level of FRC are summarised in tables 4 (ST) and 5 (LT) above. A further proposal for different FRC for certain cases starting in LT and then exiting into the ST was not accepted by the claimant group and is not included here.

5.66 Each proposal is structured as a base figure plus a percentage of damages: the FRC is represented by the overall figure, but this method provides an additional incentive for the solicitor to obtain the appropriate level of damages for the claimant.

5.67 Proposals from the Bar for fees to be paid to the evaluator for an MNE are set out in 5.44 above and are adopted by the claimant group. Alternative figures are proposed by the defendant group. Government will need to decide which fees to adopt: as the process is new, a cautious approach, i.e. to adopt the Bar's figures except for quantum only, might well be appropriate but with careful monitoring of take up and outcomes.

5.68 It was not possible to make meaningful progress on tackling the level of experts' fees or on ATE premiums.

5.69 The issue of sanctions for non-compliance with time limits needs to be considered further. Any scheme for sanctions should have as its focus that claims should remain within the FRC scheme, subject to an appropriate penalty.

CHAPTER 6: EXPERT EVIDENCE AND ATE

Purpose of this chapter

6.01 The purpose of this chapter is to set out the work and conclusions regarding the use of experts, the concept of sequential disclosure of experts' reports and the conclusions on the use of single joint experts. The chapter also touches on experts' fees and the use of ATE.

The current situation – experts on liability

6.02 Use of expert evidence on liability (breach and causation) in the majority of clinical negligence claims is vital. These cases involve issues of clinical judgment and where liability is not admitted at an early stage, expert evidence is necessary to achieve resolution.

6.03 At present, reasonable fees can be recovered for the cost of reports and other work reasonably required by expert witnesses. There is no standard fee scale for experts; these are set between the expert and the lawyer. We are told that due to anticipated recoverability and proportionality arguments, fees are often queried by claimants' solicitors at the point of initial approach and instruction, but that reductions are consistently refused by experts as they have no incentive to do expert work at a lower fee.

6.04 Some firms use MROs to obtain reports and to provide other services alongside the provision of reports. Obviously, there is a charge for such services, over and above the external cost to the MRO of the expert's fee for the report. We were able to examine data from one large MRO, which did suggest that in practice there was little difference between the fees charged overall by the MRO and the fees payable where firms obtained the report direct.

6.05 The reasons for this may not be simply down to the buying power of the larger MROs or the administration and credit control services that MROs may provide. The involvement of a commercial agency, used to handling medical records and providing instructions to experts in relatively standard form, suggests that there are some savings to be made from efficient engagement with experts. This was a theme which those representing the interests of experts also raised.

6.06 Defendant firms on the other hand say they are used to negotiating fees with experts and tend to pay lower fees than those charged to claimants. The overall buying power of panel firms representing NHS Resolution cannot be ruled out as a factor, although firms were clear that no "bulk" deals were being done. A more cogent reason may be that the defendant's expert is instructed with a benefit of seeing the claim and the detailed allegations, such that the role of the defendant's expert may be more focused.

6.07 SCIL also suggests that with experts being required to state the split between claimant and defendant work, this may be a factor in some experts accepting lower rates from defendants. They point to similar experience with members of the Bar, although we are not certain that the same considerations would necessarily apply for experts.

6.08 Experts' fees vary greatly depending on a number of factors. These include: the number of hours the expert spends reviewing the solicitor's instructions; the number of hours spent drafting the report; the hourly rate the expert charges (which generally depends on specialism, but may also vary within specialism); and the amount of time required of the expert after the report has been submitted (e.g. for supplementary reports, experts' meetings, attendance at conference with counsel or trial).

The current situation – experts on quantum

6.09 The need for expert evidence on quantum (condition and prognosis) was a topic of frequent discussion within the working group. Those discussions took place alongside the passage of Part 1 of the Civil Liability Act 2018, which introduces a ban on the making of what are known as "pre-medical offers", i.e. an early offer without sight of a medical report.

6.10 That is admittedly in the limited context of soft-tissue injury claims arising from road traffic accidents, where objective symptoms and even the mechanism of injury may not be immediately apparent. Whilst the introduction of this ban did originally lead us to question whether it would be seen as appropriate for clinical negligence claims to be settled without requiring a separate report on condition and prognosis, in our later discussions we accepted that there may be situations where that would be appropriate.

6.11 The main reason for this is that in most cases, the injury has arisen in a clinical context which is already well-documented and where the nature of the injury can be objectively demonstrated even without a medical report. The consequences of certain injuries can be readily predicted, especially where the patient has no ongoing symptoms at the time the claim is presented.

6.12 The use of expert reports on breach and causation might be seen as another way round the need for separate reports on condition and prognosis. However, the breach and causation report will usually be prepared without interviewing the claimant: the important part of the expert's work in such cases is in reviewing the medical records. There is also the risk that the breach and causation expert may then be commenting on areas outside their specialism.

6.13 There is an additional difficulty in that the recoverable element of any ATE premium is restricted to that covering the cost of expert evidence on breach and causation, but excluding work done on condition and prognosis assessments.

"No expert" cases

6.14 An anomaly was that Professor Fenn's analysis showed consistently that in around 25% of cases, no expert evidence was obtained at all, i.e. no reports on liability or quantum. The categories of case in which claimant practitioners in particular recognised that this could happen was quite small, confined to cases where essentially there would not be any argument on liability (such as "never events").

6.15 We were not able to identify conclusively the types of case where it was often the

case that no report was obtained, although some considered it likely to occur where claimant firms and defendant bodies both had in-house clinical expertise (an example was given of one firm handling a significant volume of dental claims).

6.16 The existence of these cases has led in part to the development of the LT proposals.

Use of experts in lower value clinical negligence claims

6.17 According to Professor Fenn's research, the majority of cases worth up to £25,000 involve one claimant expert on breach and causation. The working group agreed that parties could have up to 2 experts on all aspects including breach and causation and stay within the FRC scheme.

6.18 Not all cases require an expert on condition and prognosis. The defendant group suggested that a list could be drawn up for the types of cases where they are not needed, although time did not permit much progress in drawing up such a list. The claimant group felt this was not appropriate: they considered that the need for medical reporting depended on the features of an individual case more than on case type.

More efficient use of experts?

6.19 Those representing the interests of experts on the working group were asked what measures they considered as potentially effective in reducing costs. In general, whilst accepting that poor practice in instructing experts is not widespread or uniform, they recommended a reduction in legal time and inefficiency in the instruction of experts, which should result in fewer hours logged by experts and a corresponding reduction in fees.

6.20 In particular, they were receptive to the idea of model form reports and making instructions from solicitors clearer and simpler. For example, they expressed the belief that there is no need for solicitors to draft a chronology. They also noted the importance of clear instructions from their instructing solicitors.

6.21 Another area where practice could be changed, hopefully reducing experts' costs, was by improving the quality and relevance of the records they receive. The working group had already agreed that records obtained would be limited to those from relevant treatment centres and the claimant's GP and that they should be clinically paginated (for further explanation, see 3.52). However, the expert must have the right to call for additional records where they believe those are reasonably required to inform their opinion. Care would need to be taken to restrict such requests to the necessary minimum.

6.22 There is inevitably a trade-off, between the time spent by the solicitor in sorting records and producing clear instructions and the time spent by the expert in dealing with those instructions. Time will have to be spent by one or the other and the reasonable and proportionate cost of that time recovered.

6.23 Seeing merit in some of the concerns raised by claimants and experts, the working group decided that experts' reports should be based on a model checklist/list of chapter

headings that provides defendants with the information necessary for them to reach a conclusion, but limits the exposure claimants face for presenting their evidence first. Such a report model/checklist could also reduce some of the work experts have to do to prepare these reports, although it should be structured so that it still allows the expert to set out fully their opinion and the factors relied on in reaching that opinion. The working group was also receptive to experts' comments relating to instructions.

6.24 The proposal of a model/checklist (see appendix K) is not intended as a straightjacket, but ensure some uniformity and efficiency in reporting. There is no suggestion that more restrictive templates, such as those used in the low-value personal injury protocols, should be adopted.

Single joint experts

6.25 The working group was asked to consider the possible use of single joint experts. In its 2017 consultation, DH noted that the government proposed the appointment of a single joint expert to provide an opinion on breach of duty and causation at an early stage.

6.26 It is important to put this in context. There is nothing wrong in principle with the use of single joint experts in any type of case. The concept was one advocated by Lord Woolf in his work which led to the introduction of the Civil Procedure Rules in 1999. In some areas of practice, including personal injury, the use of a single joint expert helps to narrow some of the issues between the parties.

6.27 The difficulty in clinical negligence claims is that in any case where breach and causation are disputed, expert evidence is essential in order to determine whether there has been negligence in accordance with the appropriate legal tests. The use of a single joint expert in such circumstances would amount to determination of the claim by expert evidence.

6.28 Whilst it may seem superficially attractive as a means of controlling costs, the use of a single joint expert in such circumstances would probably only lead to both sides obtaining input themselves from other independent experts, either before the appointment of a single joint expert or after their opinion was given. Each issue on breach and causation could therefore involve three experts, rather than two as at present.

6.29 There is also the legitimate concern that determination by expert in cases involving the NHS would then be carried out by experts with at least some links to the NHS. We are not suggesting that the experts appointed in such circumstances would be anything other than independent; but that might not be the perception of individual claimants who believed that the NHS was at fault.

6.30 In the event the working group has hopefully addressed concerns over the use of opposing experts, specifically the costs involved, in a different way: by recommending the use of neutral evaluation in disputed liability cases as an alternative to expensive court proceedings. That recommendation is dealt with in detail in chapter 4, but for the purposes of this chapter could be viewed as the use of a single barrister jointly agreed by the parties, to

provide an opinion. It therefore creates an obvious parallel.

6.31 It may well be possible to press for the use of single joint experts for instances where separate experts are required in non-core disciplines or on condition and prognosis. The defendant group has proposed that in LT cases, the need for any additional evidence on quantum should be met by joint instruction of a single expert. The claimant group says that this proposal is not agreed, but it is hard to see why it should be contentious. The established convention, of the claimant choosing to instruct the expert, need not be retained for condition and prognosis in LT cases.

Sequential exchange of experts' reports

6.32 As part of the effort to reduce costs by shortening the amount of time it takes to settle claims, the claimant group expressed a desire to see defendants issuing denials or admissions earlier. The defendant group have made it clear that the best way to achieve this would be for the claimant to serve evidence alongside the letter of claim. Upon receiving the letter of claim and accompanying evidence, the defendant should then have enough information to make a decision about liability and possibly quantum.

6.33 The claimant group expressed reservations about sequential exchange. Their main concern was the possible advantage the defendant would gain from the claimant having to serve their evidence first. In particular it was felt that the defendant's experts, having first view of claimant evidence, would tailor their reports accordingly, having an adverse impact on the principles of a level playing field and access to justice. To counter this, the claimant group said their expert would need the right of reply. They were also concerned that sequential exchange could increase costs because the provisional nature of initial reports could lead to further reports, at additional cost.

6.34 The working group discussed the claimant group's concerns at length, considering the various possibilities for addressing their concerns. Options included the disclosed report being a provisional without prejudice report, or an initial short form report. Another option mooted was exchanging of witness statements prior to expert reports.

6.35 The defendant group remained firmly in favour of sequential exchange. They said that defendants see too many letters of claim which they would regard as speculative and which they would be surprised to see supported by expert evidence. Time and cost is expended in investigating and rejecting those claims. The need for the claimant to serve evidence on breach and causation with the letter of claim would be expected to lead to fewer speculative claims, with consequent savings in defence costs and allowing resources to be directed to considering meritorious claims.

6.36 In particular, the defendant group expressed approval for the pressure to settle quickly that sequential exchange would place on defendants in general. The requirement for the defendant who intends to dispute liability to serve a supporting expert's report in response was felt to be a key part of the culture change required and beneficial to the claimant, who will be able to see at an early stage exactly how the defendant supports their argument. A blanket denial of allegations will no longer be possible.

6.37 Representatives of the interests of experts were generally sceptical about costs savings related to sequential exchange, due in large part to the amount of work the expert would have to do. They also expressed concerns about the impact sequential exchange would have on the pool of experts prepared to engage in this work. The number of experts prepared to undertake clinical negligence work is already small, due in large part to the fraternal nature of the medical profession. The fear expressed was that sequential exchange would cause professional harm by requiring experts to report using partial information – a situation few are likely to accept, making it even more difficult to find experts and driving up the level of fees.

6.38 The working group, with the exception of SCIL and AvMA and the Welsh claimant representative (himself the chair of SCIL), concluded that sequential exchange of experts' reports is workable and recommended, as long as suitable safeguards are in place as discussed in chapter 3. It would discourage speculative claims. It would put defendants in the position of being able to make a decision early on, resulting in quicker resolution. Defendants who wish to deny liability would have to produce their expert and witness evidence in support; only those cases where a defence is properly arguable and supported would therefore proceed.

6.39 In terms of the time spent by experts, the introduction of neutral evaluation in disputed cases, in place of time-consuming litigation, may result in freeing up of experts' time in attending court, producing supplementary reports for use at trial or engaging in experts' meetings.

Experts' fees

6.40 The working group investigated whether it was possible to construct a matrix approach to setting fixed fees or a range of fixed fees for different categories of expert. A two or three band approach was considered: two bands, with a lower one covering experts in those categories where experts' fees tended to be lower and a second band for the remaining categories; or three bands, with a higher upper band covering experts in those categories where it is felt fees cannot be fixed, for example due to scarcity of the specialism they represent. In this higher upper band, the fees of experts would not be limited but the claims would be allowed to remain within the FRC scheme.

6.41 It might be possible to set fees for the two other bands using the data that Professor Fenn collected from several sources, including many within the working group. This now includes data showing hourly rates for specialisms, frequency of instruction by specialism, mean damages and costs by specialism, frequency and mean costs of types of reports.

6.42 Concerns were expressed throughout by the claimant group that any proposal to limit the recoverable cost of experts' fees should not have the effect of leaving a shortfall in the fee charged, which the claimant would then have to pay out of their damages. Equally there was a feeling that if busy experts were told they had to reduce their charges, they might well find other work to occupy their time. There was no desire to reduce the available pool of experts, as has been seen to happen because of limited fees in cases funded by legal aid.

6.43 The Welsh claimant representative referred to the experience under the Speedy Resolution scheme (the forerunner to Putting Things Right), where expert fees were fixed. This caused very significant problems, in that claimant lawyers simply could not obtain the evidence at a lower cost when expert fees were fixed (and defendants could not identify experts that could provide reports at the lower rate in a timely fashion). A list of experts was produced but claimants had great difficulty in identifying appropriate experts. The difficulties and delay caused were such that in the subsequent Redress scheme, expert fees are not fixed and the full fee is paid by the defendant.

6.44 The Chair asked those representing experts' interests to consider the possibility of fixed fees. They were sceptical of the reliability of the data collected and had no means to test the impact of introducing any suggested fee structure on the available market. They added a practical difficulty that if expert fees are fixed there would need to be much greater clarity around the ultimate value of damages at the time of initial instruction. Otherwise an expert would be engaged on one fee structure, only to find this was not recoverable if a wrong damages valuation had been provided.

6.45 They also noted that using an average of fees in a particular bracket would not work well: it would bring those charging less up to the average, whilst possibly not attracting those charging more. If the fixed fees were set above the average to retain the interest of experts, the inflation risk was obvious. On the other hand, if fees were set too low, experts would withdraw from the market and claimants would face difficulties pursuing claims. No solution was particularly attractive.

6.46 A point was also made repeatedly that those in the room (representing the interests of expert witnesses generally) did not have any mandate on behalf of the professional bodies of clinicians such as the Royal Colleges, some of whom had been approached to join the working group but did not respond. They could not therefore engage on any negotiation of fixed fee levels.

6.47 The working group was unable to agree specific fees for experts and considered that the problem may not be the rates that experts charge, but the increased costs incurred because of inefficient and unnecessary use of experts' time. Focusing on changing the behaviour around instruction and use of experts (see 6.19-6.24 above) may be the best and most effective way of controlling the fees of experts.

ATE

6.48 In 2013, when the general recoverability of ATE premiums was abolished as part of the original Jackson reforms, there was a limited saving provision for clinical negligence claims. That part of an ATE premium covering the cost of a report or reports from experts on liability or causation remains recoverable from the defendant in successful cases.

6.49 Where claimants take out ATE to cover against this risk and the risk of paying other disbursements, or opponents' costs in other circumstances (such as following a Part 36 Offer), only part of the premium is recoverable. It has proved difficult to separate the recoverable

and non-recoverable elements of the risk, leading to defendant concerns that the recoverable element may be distorted upwards to make the product more attractive to the claimant. Equally the claimant group note any adverse impact on the non-recoverable element will directly affect the amount of compensation received by the claimant.

6.50 The funding of expert fees was a specific part of our terms of reference. Separate papers from NHS Resolution and from an ATE insurer considered three options put forward by NHS Resolution:

1. Abolish recovery of premiums altogether;
2. Leave recovery exactly as it is now;
3. Some form of control on the level of recovery (NHS Resolution suggested a cap at relatively low level).

6.51 We concluded that there was real doubt whether abolishing recoverability would be within the scope of our terms of reference, without some more specific direction from DHSC or MoJ. The context in terms of policy on access to justice is that recoverability was retained alongside withdrawal of legal aid when LASPO was brought into force in 2013. A change to the rules on recovery would need some form of primary legislation.

6.52 That said, the overall cost of recoverable ATE in clinical negligence claims was said by the defendant group to be a real concern which needs to be addressed. They indicated that a positive decision to leave recovery unchanged was not an attractive conclusion either.

6.53 The only viable option to be considered was therefore some form of control over recoverability. Options discussed included:

- A straight financial limit or cap on the recoverable premium;
- A formula based on the actual or anticipated fees for experts on liability or causation;
- Restricting the procedural circumstances in which the premium or all of it could be recovered.

The last point could include allowing a period of grace, in which a defendant admitting liability or agreeing to pay for experts' reports could avoid having to meet any ATE cost. Another alternative might be to restrict the recovery of ATE premiums in cases where it was agreed an expert's report should not be required.

6.54 ATE insurers and members of the claimant group argued that it would be difficult to impose any controls in a market where the impact of modifying the rules on recoverability was still being assessed. The imposition of controls at one point in the process might only have the effect of leading to higher premiums at other points.

6.55 They also argued that there were real concerns about the impact on claimants if there was any difference between the recoverable premium for particular cover and the premium the claimant had to pay. Although there was some acceptance that there is already an element of premium that is not recoverable at law, the concerns expressed to us suggested that the existence of recoverability alongside non-recoverable elements has taken away the expected effect of market forces. It is not at all clear that changes in this space would in fact lead to higher premiums if claimants knew they had to pay those premiums themselves.

6.56 At an early point in our discussions on ATE, we were made aware of two cases relating to the recoverability of ATE premiums in clinical negligence cases which were being appealed to the Court of Appeal: *West v. Stockport NHS FT* and *Demouilpied v. Stockport NHS FT*. Those cases were listed in the Court of Appeal in mid-June 2019 and at the time of writing this report, were to be informed by a report from Mr Justice Kerr and Master Leonard as Assessors, to be produced following a 5-day hearing and covering the following issues:

a) The origin and characteristics of the policies and premiums in issue in the appeals;
b) The approach to setting the premiums which fall within the scope of the 2013 regulations[23];
c) The approach to setting the 'non-recoverable' element payable out of the insured's damages;
d) An analysis of the operation and features of the ATE market offering policies of a form described in section 58C of the Courts and Legal Services Act 1990 including the approach to the assessment of risk, and the consequences for premium setting and insurance;
e) The likely effect of a reduction in the recoverable level of premiums on the availability of such policies in the market; and
f) Such consequential factual matter as the Assessors consider appropriate.

6.57 In the circumstances it appeared inappropriate for the CJC working group to attempt to consider and negotiate these issues in parallel and without the benefit of the detailed work undertaken by the court.[24]

Conclusions

6.58 In the time available and with the focus on process improvements and legal costs, it was not possible to make much headway on experts' fees or the recoverable cost of ATE. The data collected may prove helpful in future analysis of experts' fees.

6.59 Options were put forward to improve the way in which experts were instructed and the form of reports. These included:

- clear instructions that provide all the information experts need, setting out clear questions to answer
- clinically paginated records, limited to records from treating facilities/those providing follow-up treatment and the claimant's GP
- solicitors not to produce chronologies
- a model form of checklist or subject headings for reports

6.60 It is hoped that such improvements would naturally reduce the time experts need to spend in preparing reports and therefore reduce fees.

[23] The Recovery of Costs Insurance Premiums in Clinical Negligence Proceedings (No. 2) Regulations 2013
[24] Judgment in these cases was handed down on 17 July 2019 as this report was being finalised. No account has been taken of the decision or the detailed reasoning of the Court of Appeal.

6.61 A matrix-type structure for fixed experts' fees was considered, but no progress could be made. Experience of a similar scheme in Wales was instructive. There were also real concerns about the risk that fixing levels of fees might either leave claimants bearing the additional cost or reduce the number of experts willing to take on cases. Neither result was considered acceptable.

6.62 The sequential disclosure of experts' reports could have a positive effect on costs overall, without necessarily increasing the work done by experts, as long as there are adequate safeguards.

6.63 The use of single joint experts was not supported, except for reports on condition and prognosis in the LT.

6.64 Cases pending in the Court of Appeal on recoverable ATE premiums in clinical negligence claims meant there was little purpose in the CJC attempting further enquiry or analysis in this difficult field.

CHAPTER 7: LEARNING AND PATIENT SAFETY

Purpose of this chapter

7.01 The purpose of this chapter is to summarise our work on learning and patient safety, as part of considering how to implement a FRC scheme.

Work undertaken

7.02 No one could possibly deny that the most obvious way of controlling the overall cost of clinical negligence claims is to reduce or even eliminate the incidents which lead to such claims. Patient safety should therefore be at the forefront of efforts being made by the NHS and others. Learning from those mistakes that are still made is also vital: the claimant group repeatedly made the point that this is as strong a motivation for many claimants as the obtaining of proper redress.

7.03 The working group has considered the subjects as far as it could, given the limitations of the CJC's statutory remit and the focus on trying to agree a process suitable for FRC. Patient safety was raised in discussions in many of the core and wider group meetings. SCIL and AvMA each provided copies of their schemes designed to improve patient safety. NHS Wales provided information on its Putting Things Right scheme of redress. The Chair met separately with AvMA and NHS Wales in the early stages of the CJC's work. DHSC and NHS Resolution also presented on the work they are currently undertaking in this area.

7.04 What follows includes a summary of the information provided, as a guide to work being done in this important and challenging area. Regard should also be had to AvMA's edited position statement in particular at appendix G.

7.05 Our terms of reference in this area are relatively limited:

> *To have regard to how any improved process or scheme of FRC might affect issues of patient safety, including the way in which case outcomes are reported back to healthcare providers for learning purposes*

7.06 Our conclusions on this aspect can be found below: see also the discussion in respect of FRC at 5.61 onwards.

SCIL's proposals

7.07 SCIL represents around 90 firms who specialise in clinical negligence. Membership is open only to firms with at least one lawyer holding Law Society or AvMA clinical negligence accreditation. Its scheme focuses on the use of safety champions to improve matters for patients. Safety champions would be responsible for overseeing patient safety and learning and would need to be given autonomy to make decisions.

7.08 Safety champions would be expected to request cases from clinical negligence practitioners in order to consider lessons learned. They should also have an obligation to

write to NHS Resolution (or other indemnifiers as necessary) to confirm lessons learned, as well as be expected to keep a record of "repeat offenders", training and monitoring, etc. Patient safety should be added to board agendas, and safety champions should also attend board meetings on a quarterly basis in order to provide an update to trustees on patient safety.

7.09 They would ensure that the duty of candour is uniformly being implemented by NHS trusts. This would allow the NHS to save significant costs when details of medical accidents are shared and lessons are learned; negligent mistakes are admitted early and there is a willingness to enter into meaningful discussions to settle claims early.

7.10 Communication with claimants is of paramount importance under the SCIL scheme. Safety champions would be required to write to claimants after settlement setting out what lessons have been learned by defendants and any actions taken or to be taken arising out of the subject matter of claims.

7.11 One of the important roles safety champions would play would be in alerting other bodies about specific cases. When relevant, they should report to NHS Resolution to advise on risk and potential legal action, thereby reducing delay. It should also be within the remit of a safety champion to refer matters to the Care Quality Commission for any further action the CQC considers necessary.

AvMA proposals

7.12 AvMA's position in the working party is unique, in that they do not represent lawyers, but rather access to justice and patient safety. The AvMA scheme from 2016 is based on a detailed patient safety letter designed to facilitate a thorough investigation and provide for learning opportunities.

7.13 Where any breach of duty or clinical failing has occurred, even if it does not result in an admission of liability or settlement, a patient safety letter which sets out all the breaches of duty and clinical failings identified must be prepared by a risk manager, senior complaints officer, NHS Resolution case handler or lawyer.

7.14 The patient safety letter should have 3 functions:

1. To set out the breaches of duty or clinical failings identified so these can be addressed by the healthcare provider.

2. To challenge how robust the healthcare provider's internal procedures have been in investigating the breaches and clinical failings and whether they should have been identified earlier. In particular it should review:

    i. The healthcare provider's investigation and management of patient safety incidents, especially the quality of any SI report or similar process followed
    ii. The healthcare provider's handling of the complaint process (where appropriate)

iii. Consideration of the letter of claim and letter of response
iv. Confirm and identify the learning from the incident for improving patient safety, and actions taken or planned as a result
v. Compliance with the duty of candour at each stage since becoming aware of a clinical failing or an incident that gives rise to a claim

3. The patient safety letter should be published by the healthcare provider. This will ensure a greater degree of public accountability.

7.15 The patient safety letter should be sent to the patient and their representative for approval and comment within a given period of time.

7.16 The patient safety letter and the healthcare provider's response should be published on the provider's website, so the public is aware of them. If the breaches of duty/clinical failings involve individuals then the letters should be anonymised.

7.17 Relevant external organisations, such as the CQC, the relevant commissioner of the service and NHS Improvement, should be provided with a copy of each patient safety letter and consider them as part of their monitoring/regulation of the provider.

7.18 At around the time of the mediation, by which point the focus was very much on finalising process proposals and trying to agree fixed costs, AvMA submitted a further proposal. This broadly involved the claimant's solicitor identifying patient safety issues in the letter of claim of letter of notification (see form of words suggested in the claimants' templates at appendix K). The defendant's substantive response would be set out in a separate patient safety letter to accompany the letter of response, which would indicate how any patient safety issues have been dealt with, as well as explaining steps taken to mitigate the chance of recurrence. The patient safety letter would be sent to the claimant and to regulators/commissioners as well as NHS Resolution or NWSSP – L&RS.

7.19 This was not discussed at the mediation in any detail, in view of the focus on trying to agree the level of FRC.

<u>Welsh Redress</u>

7.20 Within the Redress scheme, learning from events with the objective of improving standards in patient safety is foremost.

7.21 All compensation claims are scrutinised by the Welsh Risk Pool and reviewed when either failings are identified or at the very latest when liability is conceded and reviewed again upon closure. This is to ensure that the responsible body has in place a suitable detailed procedure for learning from events, into which such failings can be channelled. In turn this is designed to guarantee that appropriate action plans are developed, monitored, evaluated and audited, to make certain that any necessary remedial action is taken and any general lessons disseminated. The learning from events process should include a governance review process to provide reassurance to the Health Body that learning has been undertaken and is effective.

Learning from serious incidents

7.22 All serious patient safety incidents are required to be reported to the Welsh Government. In addition to this, all patient safety incidents (irrespective of seriousness and degree of harm) are required to be reported through local reporting systems to the National Reporting and Learning System (NRLS). All Never Events are defined as serious incidents and should be reported to Welsh Government and the NRLS. Information reported to the NRLS is collated nationally to identify shared learning and any action required. The Welsh Government issues Patient Safety Alerts and Notices based on national learning from the reporting of serious incidents and reporting to the NRLS.

7.23 All serious incidents should be subject to an investigation in the same way as a concern or complaint is investigated, with the intention being 'investigate once, investigate well'. Once completed, an incident closure summary which includes findings, recommendations and learning identified for the organisation should be sent to Welsh Government. In exceptional circumstances a copy of the investigation report in addition to the incident closure summary form may be requested.

7.24 The outcome of any investigation must be used to maximise opportunities for learning, quality improvement and improving patient safety. This should be a key element in the overall attempts to reduce adverse events and avoidable harm to patients/service users in line with the aims set out in the "1000 Lives Plus" programme and organisations' local priorities. As well as local learning, organisations are expected to contribute to the wider opportunities for shared learning. This should be identified when completing the incident closure form.

7.25 Issues and learning arising from incidents will be considered at the National Quality and Safety Forum in order to determine any action required, particularly at a national level. Regular reports will also be compiled for the Director General/Chief Executive NHS Wales and the executive team to help inform policy development and priorities.

Learning from concerns

7.26 Responsible bodies must ensure they have arrangements in place to review the outcome of any concerns which are managed and investigated under the regulations. This will allow responsible bodies to identify areas for improvement and learn from concerns.

7.27 All organisations (NHS trusts, Local Health Boards, primary care practitioners and independent providers) must put in place practical, but proportionate, arrangements to allow the regular and ongoing review of concerns to ensure that service improvements are identified and acted upon. This is likely to be through organisations' existing Quality and Safety Committee structures. When learning from concerns, organisations must act upon issues raised and monitor improvements and changes made.

7.28 Lessons learned must be shared within the organisation to improve services provided and avoid the recurrence of similar concerns. Local policies and procedures must specify

processes and mechanisms for communicating internally lessons learned, across all activities and to all staff. A centralised format for Learning from Events Reports is in place.

7.29 Furthermore, responsible bodies must share lessons learnt outside their organisations to improve the wider provision of services and avoid the recurrence of similar concerns in other areas. Local policies and procedures must specify processes and mechanisms for communicating externally lessons learned, bearing in mind the principles of patient confidentiality. A key forum for sharing learning is through organisations participating in peer-review meetings.

DHSC activities

7.30 One of the problems that the working group came up against was the need to address patient safety in a way that improves the situation for patients without placing undue inconvenience on practitioners. This was a point DHSC made in their detailed presentation to the group. They informed members that DHSC is working on a scheme for improving patient safety that will work at a broader "macro" level, thereby avoiding the need to engage in an unnecessary level of local investigations and allowing a blame culture to grow – a problem that could negatively affect the medical profession and patients' ability to access necessary medical care. The goal is to increase safety and learning at all levels of the NHS without calling into question the abilities of practitioners. This, DHSC believe, would be best for all interested parties and reduce the number of adverse incidents.

7.31 The claimant group makes the point that within this context, there must still be accountability for individual actions. Whilst a blame culture would create negative consequences, a more open and transparent process where individual failures are discussed and learning takes place must be seen as a positive.

7.32 DHSC have recently confirmed that they recognise there is more that can be done by the NHS and others to draw insight and learning from claims. In particular there could be benefit from looking at frequently-occurring types of harm triggered by recurring risk types. NHS Resolution is exploring an approach which considers:

- developing a pilot scheme around one particular problem area,
- drawing suitable insight from expert reports commissioned by defendants in other areas, and
- depending on the findings of these two projects, whether further outputs on less-severe harm could deliver real benefit alongside reports on more serious harm and how such work might be prioritised within their work programme.

7.33 The claimant group comments that as they understand it, these plans focus on an area – midwifery and birth injury claims – which will not commonly feature claims valued at no more than £25,000. They indicate that they have yet to see any proposals to address claims in this value band, which form the majority by number of all clinical negligence claims.

7.34 NHS Resolution already produces its 'did you know' pamphlets, to highlight the need for improved practice in certain areas. Additionally, NHS Resolution also employs clinical

fellows each year to produce reports on a specific area of claims, e.g. mental health suicide or cerebral palsy. They also publish scorecards for each trust, giving detailed breakdowns for their claims and encouraging trusts to use the data to concentrate on specialities/locations which generate large numbers of claims and high value cases.

Other defendant views

7.35 The defendant group consisted largely of those representing indemnifiers rather than the interests of defendants themselves. Even NHS Resolution is at one step removed from the trusts responsible for treatment. Whilst the defendant group are also concerned about issues of patient safety, they argued that it is difficult to do anything in the context of a legal claims process where the primary focus is on presentation of and response to a claim for compensation.

Summary and recommendations

7.36 These discussions have necessarily been quite broad and have largely involved DHSC and those with a particular interest on behalf of patients in learning and patient safety, such as AvMA and SCIL. AvMA raise a number of detailed comments in their edited position statement at appendix G. We urge DHSC and others representing defendant bodies to consider those comments with a view to improving the response of their organisations.

7.37 One theme that emerged from all the work presented to the group is the need for a cultural change to improve patient safety. Reporting of incidents needs to become more commonplace for the benefit of patients; but clinicians cannot be made to feel singled out, otherwise there is a risk to the provision of medical treatment available to the public.

7.38 There is evidence of positive steps towards increasing the involvement of patients and clinicians in the learning process. More obviously needs to be done to build on initiatives such as NHS Resolution's 'did you know' pamphlets. This should further contribute to the necessary culture change and create a feeling of partnership.

7.39 In the context of the working group's overall terms of reference, the focus ultimately has to be on legal costs and legal claims process, with safety and learning aspects limited to considering two specific points:

- whether any changes would have an adverse impact on patient safety;
- whether the way in which claims outcomes are reported should be changed.

7.40 In terms of reporting, we feel that it is important to highlight that there should be some process for reporting back following any claim. The bodies that presented to the working group have offered ideas, and we encourage the government to explore these options possibly with a view to drawing the best ideas from all sides. In creating a reporting scheme, it should be remembered that private sector reporting may not match that of the NHS.

7.41 In terms of the legal process, we consider that the recommendation for early

sequential disclosure of experts' reports should have a positive impact on learning and patient safety. Defendant bodies will see the support, via expert clinical opinion, for the allegations being made against them. Only those cases where their own expert evidence is supportive will be defended. Whilst we accept that cases may then settle without the defendant obtaining their own expert evidence, the expert opinion from the claimant is available to be used to support the outcome.

7.42 The process of neutral evaluation in liability disputes should also be seen as positive. The written output from the evaluation could form a ready-made and independent summary for reporting back within the defendant organisation. Of course, much depends on how defendants use the evaluation obtained, but it is reasonable to assume that an evaluation which rejects the defendant's expert evidence and supports the claimant's case will be taken seriously and used as the basis for reporting back the outcome.

7.43 As a small point on the structure for fixed recoverable costs, we adopt Paul Fenn's endorsement of existing FRC schemes which include an element linked to the level of damages paid (usually a percentage of the agreed settlement). This does at least mean that there is a correlation between the extent of the harm/loss suffered by the claimant and the legal costs paid to the legal representative (see also 5.62).

7.44 AvMA reiterate the point that for many claimants, it is very important for them to know that healthcare providers recognise the failings in the care provided and take steps to prevent any recurrence. We accept this point, but it is difficult to see how further account can be taken of it in work to streamline the process and deliver FRC.

7.45 AvMA also contend that any impact on access to justice will have a negative effect on patient safety and learning. That relies on two assumptions: that the claims process is an integral part of recognising failure in patient safety and learning from it; and that the introduction of FRC will have an impact on access to justice.

7.46 The CJC is not qualified to comment on the first assumption in 7.45, but rejects the second. The use of FRC generally is now well-established and supported by reports from Sir Rupert Jackson and others. The detailed contents of this report, on which it is expected DHSC will consult, should demonstrate clearly the work that has gone into trying to devise a fair process and system of FRC that will still enable claims to be brought.

Conclusion

7.47 There is no doubt that the discussions have improved the understanding on all sides of the issues on learning and patient safety and have opened up avenues of dialogue, which we hope will now be maintained. The CJC is pleased to have played a small part in facilitating those discussions; as an advisory body on issues of civil justice, it can do little more on this topic than encourage the organisations on all sides to continue working together in the interests of patients.

7.48 As part of our terms of reference we have considered the impact our recommendations on legal process and fixed recoverable costs will have on issues of safety

and learning. We do not consider there to be adverse impacts. The systems of sequential exchange and neutral evaluation and the structure of the costs recommendations themselves should be seen (in a small way) as positive outcomes.

CHAPTER 8: CONCLUSIONS AND RECOMMENDATIONS

8.01 This chapter summarises the recommendations as to FRC and the process improvements which are to work alongside those costs. It also considers other recommendations which arise from the matters covered in the report.

8.02 We emphasise again that the recommendations for a more streamlined process and a scheme of FRC are only considered suitable for lower value clinical negligence claims, with a value of no more than £25,000.

Pre-issue process

8.03 There is room for improvements to the process pre-issue. The proposed scheme is built around:

a) a standard track and a light track;
b) exclusion of categories of case which are likely to be complex or sensitive;
c) the claimant retaining responsibility for obtaining and sorting the medical records, but limiting the records required;
d) sequential exchange of experts' reports and witness statements (ST), as long as appropriate safeguards are put in place;
e) a letter of claim (ST) which discloses the claimant's case and is accompanied by an offer to settle;
f) a letter of notification (LT) which contains more information on alleged liability and on quantum;
g) a letter of response which discloses the defendant's case and responds to the offer;
h) the claimant's right to reply;
i) a mandatory stocktake and discussion if the case cannot be settled after the reply;
j) mandatory neutral evaluation if the case has not settled after the stocktake.

8.04 The LT is designed for claims that incur fewer legal costs, because liability is not in dispute. Any other case types that could start in the LT will only remain if the defendant agrees to pay compensation on a full liability basis.

8.05 Sequential exchange of experts' reports on breach and causation is a key part of the recommendations for the ST, which will deal with cases where liability is likely to be in dispute.

8.06 Certain cases are excluded from the FRC scheme due to their complexity and sensitivity. There is some remaining disagreement on exclusions, especially fatal claims. If the disputed cases are included, that is likely to have an impact on the costs in the FRC scheme.

8.07 There are a few outstanding issues on process, but these do not have a material impact on the overall process or on the costs proposals.

8.08 These recommendations represent the majority view, although not accepted by all in the claimant group. They reflect the balance that needs to be struck between process

improvement and costs control.

Cases which do not settle

8.09 MNE is an attractive but novel solution, put forward by the parties at a relatively late stage to address some difficult problems related to preparing for litigation. It could remove the need for changes to post-issue process and resolve some more difficult aspects of pre-issue process.

8.10 MNE would be a mandatory step, but the outcome would not be binding on either party. Unnecessary or unreasonable litigation could be deterred in practice by appropriate sanctions. In this way we believe that the recommendation complies with Article 6 ECHR, but this is a matter on which the government should seek its own advice.

8.11 The evaluator would be chosen from an agreed panel of specialist clinical negligence barristers. The evaluator's fees would be shared equally at the outset and met by the defendant if the claimant succeeds.

8.12 Not all members of the claimant group agree with the proposal for MNE. There are obvious concerns about whether it would work effectively. The Bar also has some concerns, both for them as evaluators and for the parties. It has been suggested that the proposal could be piloted, but it is difficult to see how this could work in practice.

Fixed recoverable costs

8.13 The parties came close to agreeing figures for FRC. In the absence of a concluded agreement, the proposals of the claimant and defendant groups for the level of FRC are summarised in Tables 4 and 5 below, all figures are exclusive of VAT and disbursements:

Table 4 - Standard Track

Stage	Description	Claimant	Defendant
1	All steps up to and including stocktake	£6,000 plus 40% of damages agreed	£5,500 plus 20% of damages agreed
2	From stocktake up to and including neutral evaluation	£2,000 in addition to stage 1	£500 in addition to stage 1

Table 5 - Light Track

Stage	Description	Claimant	Defendant
1	All steps up to 21 days after letter of response is due	£2,500 plus 25% of damages agreed	£1,000 plus 10% of damages agreed
2a	From 21 days after letter of response up to and including stocktake	£1,500 plus further 5% of damages agreed, in addition to stage 1	£500 in addition to stage 1
2b	From stocktake up to and including neutral evaluation	£500 in addition to stages 1 and 2a	£500 in addition to stages 1 and 2a

8.14 The structure of a base figure plus a percentage of damages, in common with existing

FRC schemes, provides an additional incentive for the solicitor to obtain the appropriate level of damages for the claimant.

8.15 A possible approach is set out in appendix H by which government might look to resolve the difference between the parties on the ST, together with the possible result of applying that approach.

8.16 Although a similar exercise is not yet possible for the LT, a solution for the ST would be expected to cover at least 75% of the volume of cases within the FRC scheme.

8.17 We were not able to make any material progress on the level of experts' fees or on ATE premiums. Court of Appeal cases involving an enquiry as to the workings of ATE in clinical negligence claims were ongoing and represented the more appropriate forum in which to investigate and reach conclusions on recoverable ATE premiums.

8.18 A fixed fee would be paid to the evaluator for an MNE, with different fees for evaluation on liability only or liability and quantum. Proposals from the Bar (supported by the claimant group) and from the defendant group are as follows:

Table 6 – evaluator's fee for MNE

Type of evaluation	Bar/claimant group	Defendant group
Liability and quantum	£2,000	£1750
Liability only	£1,500	£1250
Quantum only	£1,500	£750

8.19 Government will need to decide which fees to adopt: as the process is new, a cautious approach, i.e. to adopt the Bar's figures except for quantum only, might well be appropriate but with careful monitoring of take up and outcomes.

8.20 Sanctions need to be considered for non-compliance with time limits. Claims should remain within the FRC scheme, subject to an appropriate penalty.

Experts

8.21 More data was collected on experts' fees and on the use of experts, which may assist government in further analysis of the level of experts' fees. Problems are highlighted with the concept of fixing experts' fees.

8.22 Improvements could be made to the way in which solicitors instruct experts in practice. A range of measures was proposed, which could help to control the time spent by the expert and therefore the expert's fees for producing the report.

8.23 The use of single joint experts was not supported. However, the instruction of a single specialist barrister, agreed by the parties, to conduct MNE has obvious parallels.

Learning and patient safety

8.24 Patient safety and learning from mistakes are a vital part of any measures to reduce the incidence (and therefore the cost) of clinical negligence claims.

8.25 In the context of the working group's overall terms of reference, the focus is ultimately limited to considering whether the introduction of FRC or process changes would have an adverse impact on patient safety.

8.26 We are satisfied that nothing in the recommended process or FRC would have an adverse effect on patient safety. The systems of sequential exchange and neutral evaluation and the structure of the costs recommendations themselves are (in a small way) positive outcomes.

8.27 The CJC is pleased to have played a small part in facilitating discussions on issues of patient safety and learning from clinical mistakes; as an advisory body on issues of civil justice, the CJC can do little more than encourage the organisations on all sides to continue working together in the interests of patients.