REPORT OF THE CIVIL JUSTICE COUNCIL'S WORKING GROUP ON FIXED RECOVERABLE COSTS IN LOWER VALUE CLINICAL NEGLIGENCE CLAIMS

APPENDICES

APPENDIX A

TERMS OF REFERENCE

The terms of reference for the Clinical Negligence Working Group are as follows:

1. To consider and recommend an improved process for clinical negligence claims, where the claim has a value of £25,000 or less;

2. To draw up:

    a) a structure for fixed recoverable costs (FRC) for such cases to attach to the new process;
    b) figures for FRC in the proposed structure; and
    c) figures for the costs of expert reports;

3. 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;

4. To consider how expert reports should be commissioned and funded, including the feasibility of single joint experts for at least some claims, as part of the improved process;

5. To report with recommendations by end of September 2018.

APPENDIX B

Data and associated analyses[1]

Paul Fenn

1. Background

In 2018, my report to the DHSC in relation to their consultation ("Fixed Costs for Clinical Negligence Claims: A Cost Analysis Approach") proposed a statistical methodology for the determination of fixed costs: namely the estimation of "best fit" relationships between current recovered costs and damages for claims settled at different stages of litigation. These relationships (expressed as a combined lump sum and a percentage of damages) would arguably, if used to determine fixed costs, ensure that the revenue received by claimant solicitors under fixed costs would be the same as that recovered currently with existing processes. My report pooled data from claim settlements in 2015/6 provided by Acumension, SCIL, Fletchers and other claimant firms in order to estimate such relationships and these are reproduced in Table 1 below:

Table 1: Best fit relationships by stage of settlement: revenue neutral fixed costs using 2015/6 data

	Lump sum (£)	**% of damages**
Pre-issue	£4,767	30%
Issued	£7,821	56%
Allocated	£16,487	56%
Listed	£20,999	56%

However, because the DHSC's proposed scheme was to be restricted to claims with no more than 2 experts, I suggested that the fixed cost formula would be adjusted down to allow for this, and my report drew on data from SCIL showing that the overall reduction in costs due to the exclusion of cases with more than two experts was approximately 20%[2] . Furthermore, data from Acumension were used to estimate further reductions (10% pre-issue; 20% post-issue) that would be made to claims where the defendant settles early (i.e. within the protocol period – 120 days). Table 2 below sets out the proposed fixed costs in my report, incorporating the best-fit relationships and the subsequent deductions as explained above.

[1] This section summarises the various data presentations made to the WG. It does not include all of the tables and figures presented. The full set is available in PowerPoint form.

[2] Although it should be noted that the DHSC's proposals for a new process assumed that claims with more than two *liability* experts would be excluded, with the possibility of a third expert for quantum issues. Also the calculations in Table 2 assume the same percentage reduction for all claims – Table 18 in section 6 below shows revised calculations assuming different percentages for pre- and post-issue settlements.

Table 2: Proposed fixed costs using 2015/6 data

Stage:	Clinical negligence claims with value less than or equal to £25,000
Pre-issue	£3,800 + 24% of Damages Reduced by 10% if there is an early admission of liability
Post-issue, pre-allocation	£6,250 + 45% of Damages Reduced by 20% if there is an early admission of liability
Post-allocation, pre-listing	£13,200 + 45% of Damages Reduced by 20% if there is an early admission of liability
Post-listing, pre-trial	£16,800 + 45% of Damages Reduced by 20% if there is an early admission of liability

It should be noted that the proposed fixed costs set out in my report to the DHSC and reproduced above were intended to be illustrative only. The statistical estimates were based on reasonable numbers of settled claims from both claimant and defendant sources, but nevertheless they are subject to confidence intervals – they are estimates of the "true" relationship between costs and damages based on sample data from 2015/6, and as such should not be taken to be precise (i.e. other samples could yield different estimates). Moreover, they are derived from observations on actual claim outcomes, and are therefore based on the operation of current processes. Any proposed change to process, as was the central brief of the CJC Working Group (WG), would necessarily imply changes to the appropriate fixed cost formulae. The intention of the figures in Table 2 was, therefore, to produce a starting point from which the WG could begin their deliberations[3].

2. Data

While my report to the DHSC drew on data provided by Acumension, SCIL, APIL and Fletchers on claims settled up to April 2016, I asked those data providers and other members of the WG for any updates as well as new data sources that might help with their deliberations. Acumension, APIL, SCIL and Fletchers provided updates to cover additional claims settled up to April 2018, and new sources of data were made available by MPS, RSA and NWSSP. The following table shows the total numbers of settled claims made available for analysis, by source and stage of settlement.

[3] Notwithstanding these caveats about the reliance that might be placed on these illustrative figures in Table 2, I was asked to revisit this table by the claimant representatives subsequent to the mediation. For a revised version of this table, see section 6 below.

Table 3: Data made available to assist the WG, by source and stage of settlement

	Claims settled up to April 2018 (less than £25k)			
	Pre-issue	Issued	Allocated	Listed
Acumension	6,030	1,845	420	207
SCIL	202	45	33	5
MPS	653	139	21	5
Fletchers	699	86	19	1
NWSSP	180	42		
RSA	68			
APIL				

The updated Acumension dataset provided a useful insight into the development of claim outcomes by settlement stage over the years since April 2012. The following two tables show the frequency and mean recovered costs of claims by settlement stage for the full range of financial years between 2012/3 and 2017/8. Table 4 shows an apparent drop in claim numbers in 2016/7 followed by a recovery in 2017/8. However, closer inspection of the monthly totals indicates that there was a marked reduction in the number of claims settled during the latter part of 2016/7, with a marked increase in the early months of 2017/8. Smoothing of the data therefore suggests a trend reduction in claim frequency since the first LASPO year (2013/4). Table 5 shows a pronounced reduction in mean recovered costs in 2016/7, presumably reflecting the delayed settlements at the end of that year; again, smoothing the data indicates a trend reduction in mean recovered costs since 2013/4.

Table 4: Claim frequency by settlement stage [Acumension data – claims up to £25k]

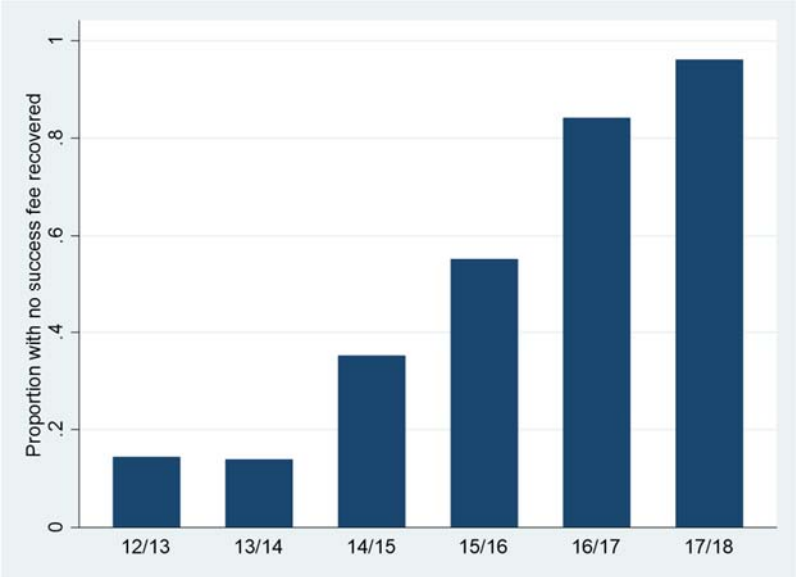
	2012/3	**2013/4**	**2014/5**	**2015/6**	**2016/7**	**2017/8**
Pre-issue	843	1,220	1,062	981	822	1,102
	76.99%	74.62%	65.76%	62.76%	73.79%	74.46%
Issued	209	348	451	403	185	249
	19.09%	21.28%	27.93%	25.78%	16.61%	16.82%
Allocated	27	48	74	117	69	85
	2.47%	2.94%	4.58%	7.49%	6.19%	5.74%
Listed	16	19	28	62	38	44
	1.46%	1.16%	1.73%	3.97%	3.41%	2.97%
Total	1,095	1,635	1,615	1,563	1,114	1,480
	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Table 5: Mean recovered costs by settlement stage [Acumension data – claims up to £25k]

	2012/3	2013/4	2014/5	2015/6	2016/7	2017/8
Pre-issue	5760	5918	6162	6443	6172	7305
Issued	11865	11967	12565	13459	12643	14693
Allocated	24094	19046	20054	21637	19775	22430
Listed	22911	18895	19416	25927	25201	28048
Total	7628	7742	8583	10162	8738	9847

The gradual changes to claim frequency and outcomes since 2013/4 presumably reflects the increasing impact of the new LASPO rules governing settled claims. The following chart (Figure 1) draws on the Acumension dataset to show the rapid increase in the proportion of claims settled under post-LASPO rules in recent years (i.e. with no recovered success fee). By 2017/8, it appears that less than 5% of all claims settled for under £25k in that year were funded by pre-LASPO CFAs with recoverable success fees.

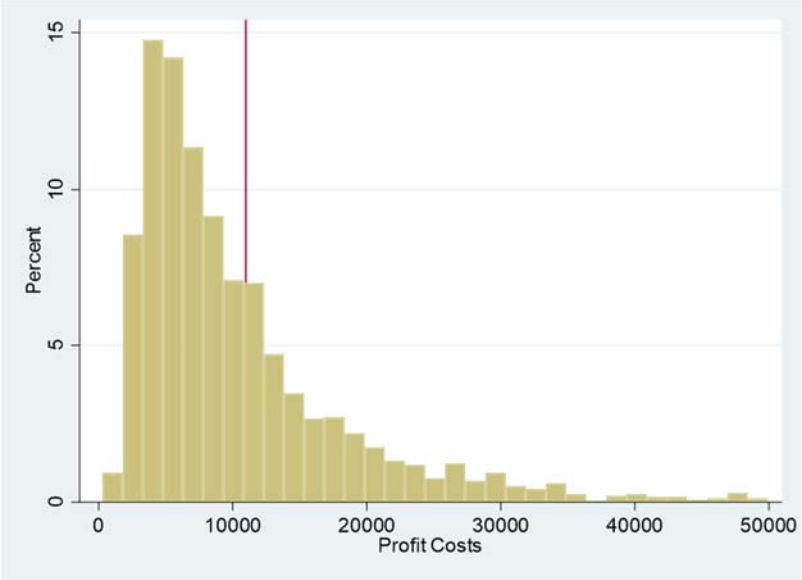
Figure 1: Proportion of settled claims with no recovered success fee [Acumension data – claims up to £25k]



3. Analysis

Having summarised the datasets made available to the WG, this section analyses these data to explore how they might help the WG in relation to the determination of fixed costs. Essentially, the introduction of fixed costs would replace "normal" costs – based retrospectively on hourly rates and work done, as agreed by negotiation between the parties – with a fixed amount in each case. This means that, if the amount of work done does not change on a case-by-case basis, and the fixed costs are set broadly in relation to the mean of current recovered costs, there will be some claims which would receive more under a fixed cost regime, and some less. The next chart (Figure 2) captures the current extent of variations in the amounts of recovered costs on clinical negligence claims under £25k using data from Acumension.

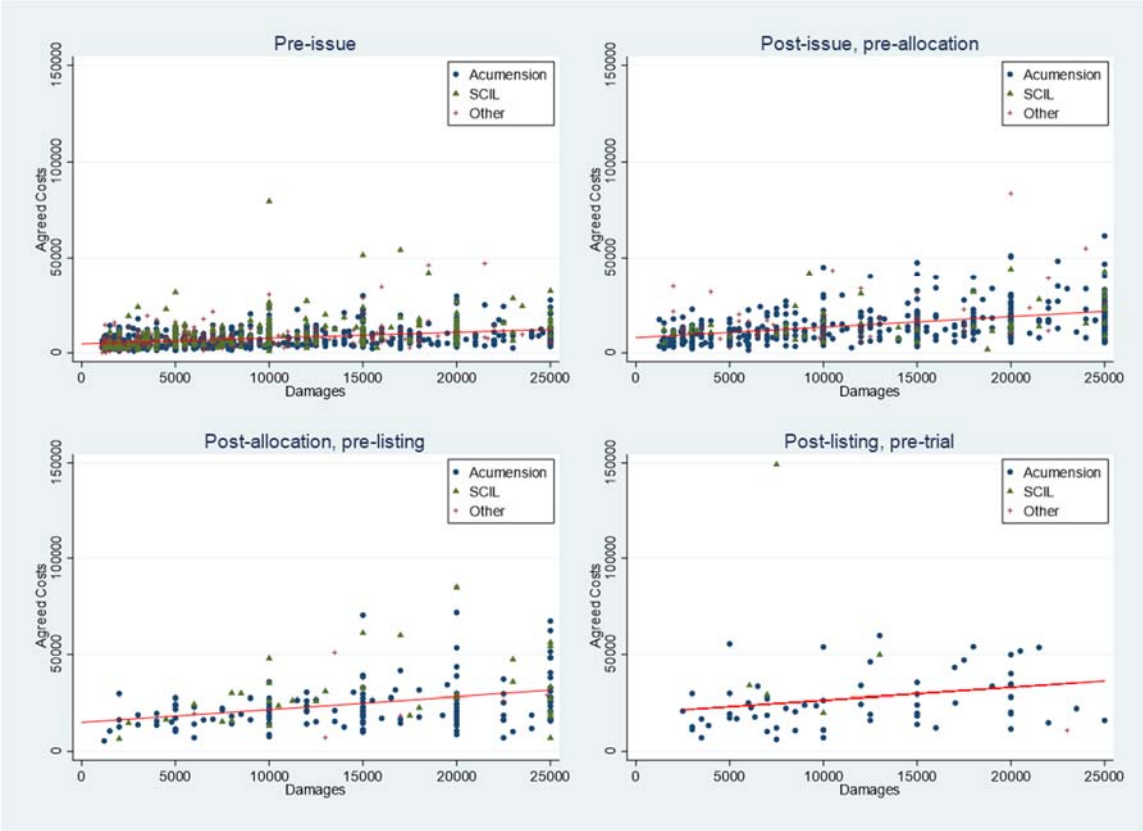
Figure 2: Distribution of Recovered Profit Costs: clinical negligence claims under £25k [Acumension]



The red line in Figure 2 indicates the mean level of recovered costs for those claims in the sample, and the "losers" and "gainers" can be seen either side of that line. Clearly, simply setting the fixed cost for all clinical negligence claims at the current overall mean results in some major gains and losses relative to the current regime, and this would place a significant level of cost risk on claimant solicitors. However, if the fixed costs can be designed to reflect some of the case-level variations observed in Figure 2, the cost risks can be mitigated. In what follows I attempt to show how the data can reveal some of the sources of variation in claim costs, and therefore help design the structure of any fixed cost regime.

Previous analyses of the determinants of recovered profit costs in personal injury claims have consistently shown that they are strongly correlated with (a) the stage at which the claim is settled (a measure of case complexity), and (b) the damages agreed at settlement (a measure of case value). It is for this reason that most other fixed cost regimes have formulae based on settlement stage, with a lump sum and a percentage of damages. The following chart (Figure 3), taken from my report to DHSC, illustrates this using clinical negligence claim data from both claimant and defendant sources. The chart shows that recovered costs rise as litigation progresses; and the "best fit" lines (in red) show that, within each stage of settlement, those claims with higher damages have higher recovered costs.

Figure 3: Recovered costs in relation to settlement stage and damages [settlements under £25k]



In addition to settlement stage and damages, there are other factors which can explain the variations in recovered costs between claims. Typically, we expect claims to incur more costs when the type of claim is more complex, and when more expert evidence or counsel are required. The following charts (Figures 4 – 6) use examples from various datasets to illustrate these differences. In each case the charts show the distribution of recovered base costs in "low" and "high" cost categories defined by these characteristics of the claims.

Figure 4: Recovered costs in dental and medical claims [MPS 2017/8 settlements under £25k]

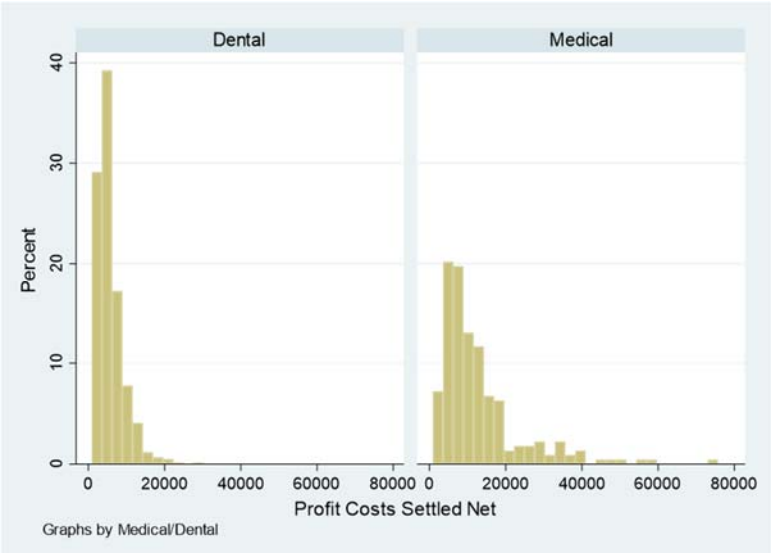


Figure 5: Recovered costs in claims with and without expert evidence [SCIL 2015/6 settlements under £25k]

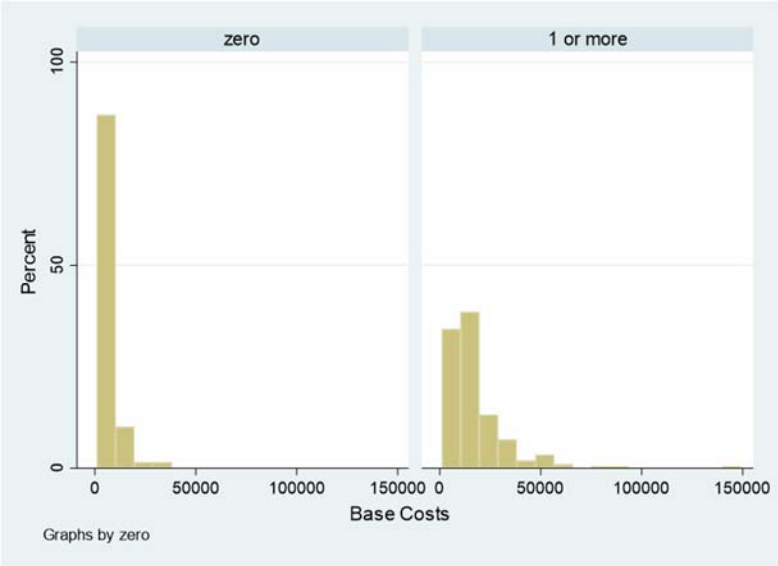
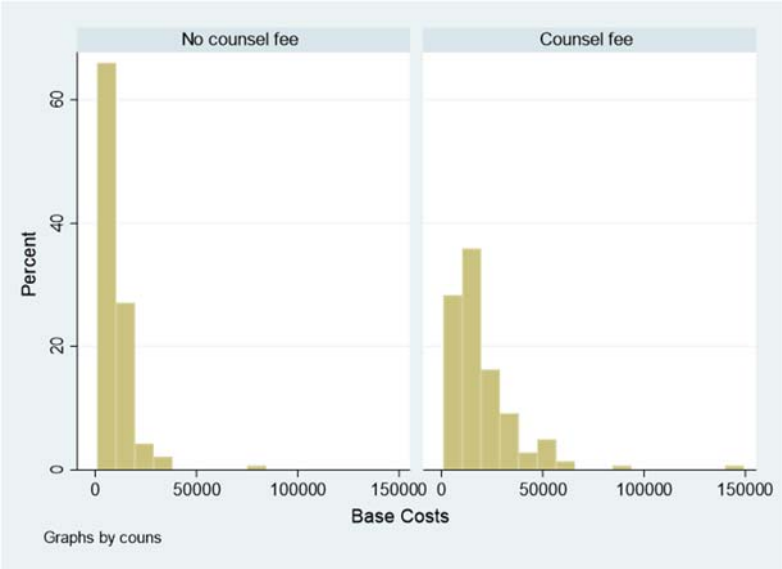


Figure 6: Recovered costs in claims with and without counsel [SCIL 2015/6 settlements under £25k]



While Figure 6 shows the additional base costs incurred by solicitors in claims where counsel were and were not required, it does not include the direct costs of counsel, which were recovered as disbursements. The following tables show, respectively, the numbers of pre- and post-issue settlements where counsel were used (Table 6), and the mean counsel fees paid and recovered as disbursements on those claims, by stage of settlement (Table 7). Taken together, these tables show that counsel is only used in around a third of all pre-issue settlements, and when they are used pre-issue the average fee paid is around £2,700. By contrast, as expected counsel are used in the majority of post-issue settlements, and the average cost of counsel increases considerably for claims that settle after the defence.

Table 6: Use of counsel by stage of settlement [SCIL 2015/6 settlements under £25k]

	Pre-issue		Post-issue		Total	
	N	**%**	**N**	**%**	**N**	**%**
No counsel fees incurred	127	63.5	14	16.9	141	49.8
Counsel fees incurred	73	36.5	69	83.1	142	50.2
Total	200	100	83	100	283	100

Table 7: Mean counsel fees paid on claims where counsel was used [SCIL 2015/6 settlements under £25k]

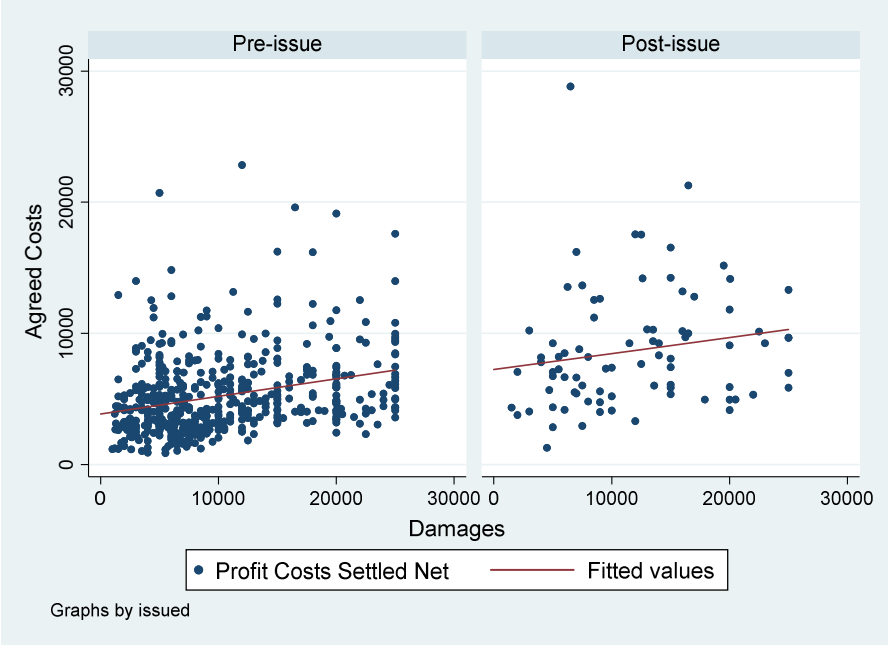
Stage	Mean counsel fee (£)	Freq
Pre-issue	2,713	73
Post-issue	2,777	35
Post defence	4,577	30
Post expert witness	11,916	4
Total	3,382	142

4. Process

The analyses summarised above were presented to the WG as a way of showing the structure of current recovered costs, reflecting the operation of current processes. In this section I summarise the next phase, which focussed on the possibilities for using current data in order to capture the impact of process changes on costs.

The following chart (Figure 7) uses MPS data on dental claims as an example to envisage the effect of adding more processes pre-issue in order to reduce the likelihood and cost of post-issue settlements (so-called “front-loading”). The chart shows how the relatively high costs on average for post-issue settlements could be reduced if all those claims settled pre-issue instead and lower costs were agreed. However, if the additional processes introduced pre-issue raised costs for all claims, including those which currently settle pre-issue, the overall net gain may be reduced or even eliminated.

Figure 7: Front-loading - Impact on likelihood and cost of proceedings (MPS data, dental claims 2017/8)



Other process developments could include those discussed in my report to the DHSC – namely, the inclusion of rewards for early admission of liability by defendants, and the exclusion from the scheme of certain more complex claims based on the number of experts required. The following tables (8 and 9) taken from my report illustrate the potential savings from these process changes if implemented in the fixed cost scheme.

Table 8: Effect of process changes leading to early admission on mean costs [Acumension data]

	Mean profit costs (£)		**% reduction**
	Early admission		
	No	Yes	
Pre-issue	£6,240	£5,738	8.04%
Post-issue	£14,915	£12,351	17.19%

Table 9: Effect of exemptions for complex cases on mean costs [SCIL data]

Experts	**Mean Costs**	**Mean Damages**	**N**	**%**
No more than 2	11,900	10,216	237	84
3 or more	30,331	14,806	45	16
Total	14,842	10,948	282	100

As the WG moved towards an extensive re-thinking of the current process, there was a need for evidence on two further issues:

1. Whether it is possible to identify separate groups of claims which fall into "low" and "high" cost categories such that they might attract different fixed costs if allocated to a "light" or "standard" track.
2. What could be uncovered about the relationship between delay and costs.

4.1 "Standard" and "Light" tracks

Table 10 below identifies low and standard cost groups in both the SCIL and Fletchers datasets by reference to those claims which had reported no use of medical evidence (i.e. zero experts). Table 11 shows that these groups could be characterised as a "best fit" proportional relationship with damages.

Table 10: Mean costs and damages by track for pre-issue settlements up to £25k

Track	Mean Costs*	Mean Damages	N
SCIL, 2015/6			
Light (no expert, no counsel)	£5,471	£5,915	55
Standard (one or two liability experts)	£12,171	£10,263	130
Fletchers, 2017/8			
Light (settled without medical evidence)	£4,960	£6,113	52
Standard (settled with medical evidence)	£10,959	£9,029	134

*Net of VAT and additional liabilities

Table 11: Best fit relationships by track – pre-issue settlements up to £25k

	Lump sum (£)	% of damages
SCIL [2015/6]		
Light	£4,302	20%
Standard	£8,171	39%
Fletchers [2017/8]		
Light	£4,041	15%
Standard	£8,968	22%

It was also possible to use data from MPS and RSA to show that certain types of claim (e.g. dental cases, care home cases) were characterised by relatively low costs on average. These results are summarised in Table 12 below.

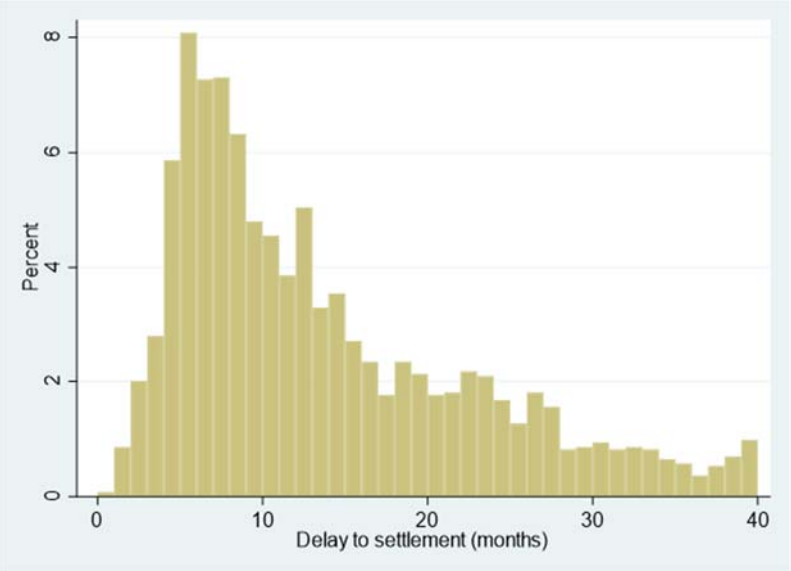
Table 12: Mean costs and damages for pre-issue settlements up to £25k [MPS/RSA]

Track	Mean Costs*	Mean Damages	N
Dental (MPS)	£5,251	£10,135	512
Medical (MPS)	£9,204	£9,321	141
Care Home (RSA)	£7,412	£9,598	135

4.2 Delay

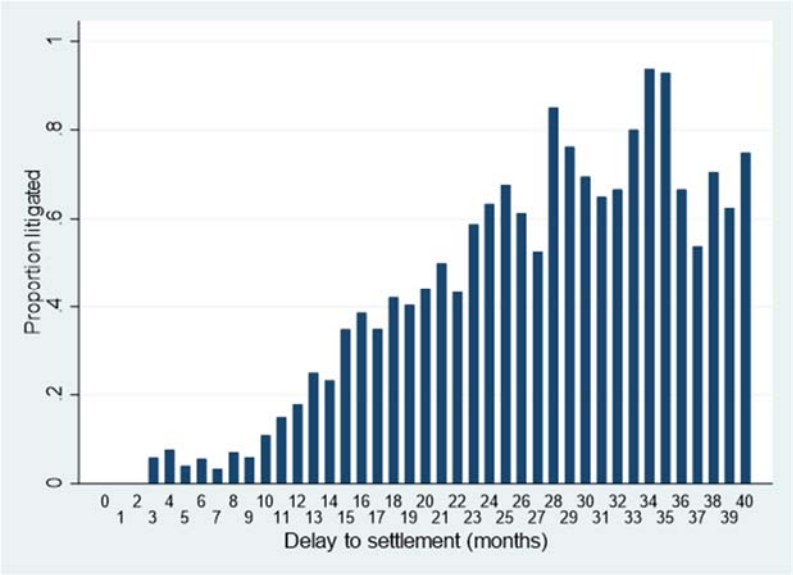
In the chart below (Figure 8), I use Acumension data to show the distribution of settlement delay for clinical negligence claims under £25k in value.

Figure 8: Distribution of delay to settlement, all claims settled in 2016/7 and 2017/8 [Acumension]



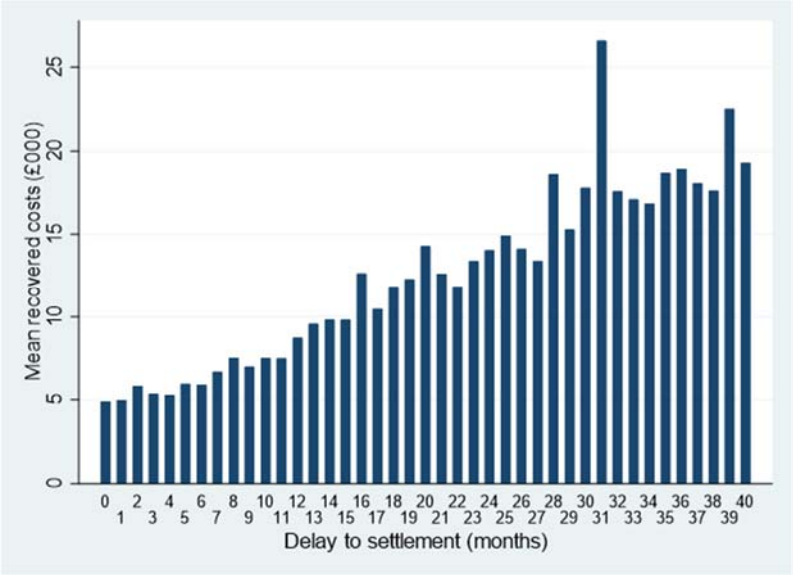
The distribution is quite skewed, with the majority of such claims settling within a year, but with a significantly long tail of high duration claims (the chart is truncated at 40 months). Most of the claims in this long tail (e.g. lasting over 18 months), are those which have been litigated and settle post-issue; this is clearly shown in the following chart, Figure 9, which plots the likelihood of litigation against delay.

Figure 9: Proportion litigated by delay to settlement, all claims settled in 2016/7 and 2017/8 [Acumension]



Because of this increase in the litigation risk with claim duration, there is a clear association between delay and recovered base costs, as shown in the next chart (Figure 10).

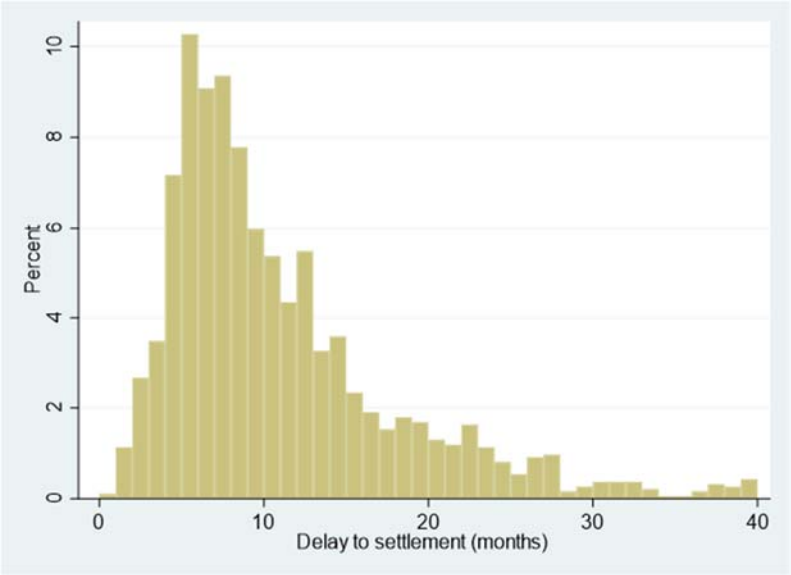
Figure 10: Recovered base costs by delay to settlement: all claims settled for <£25k [Acumension 2016-2018]



So, clearly, one means by which recovered costs can be moderated is by reducing the numbers of claims which proceed to issue, and this was a particular driver of the WG's deliberations over the new process.

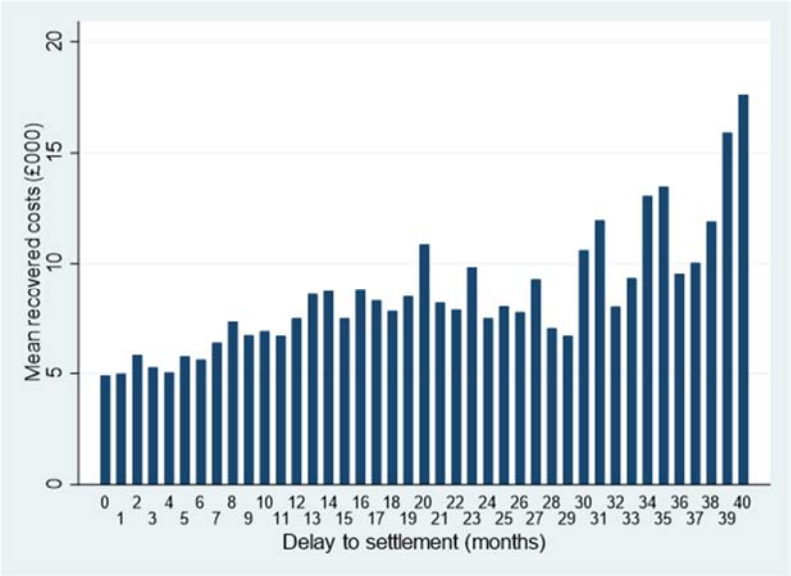
Of course, even when claims do settle pre-issue, delay can still be an issue. The following chart (Figure 11) shows the distribution of settlement delay for all pre-issue settlements in the Acumension dataset for 2016/7 and 2017/8.

Figure 11: Distribution of delay to settlement, pre-issue claims settled in 2016/7 and 2017/8 [Acumension]



It can be seen by comparing Figure 11 with Figure 8 that the long tail is substantially reduced, but nevertheless still exists to some extent. The next chart shows how the delay that occurs in the period between 6 months to one year does lead to a significant increase in pre-issue costs.

Figure 12: Recovered base costs by delay to settlement: pre-issue claims settled for <£25k [Acumension 2016-2018]



Consequently one issue which generated some discussion within the WG was the possibility of changing the incentives faced by the parties in order to encourage earlier pre-issue settlement. The following table draws on data from Acumension, Fletchers and MPS medical claims and shows how the statistical relationship between costs and damages changes for claims that settle early (under 6 months), later (from 6 to 12 months), or late (over 12 months). The differences in the lump sums between claims that settle under 6 months and those that settle between 6 months and a year vary between £898 and £2,078 depending on the source of data. These figures arguably provide an indication of kind of reward that might be provided to defendants (in the form of reduced recoverable costs) in order to incentivise early settlement.

Table 13: Best fit relationships between costs, damages and delay [Acumension, Fletchers, MPS : claims settled pre-issue for <£25k, 2016-2018]

	Acumension		**Fletchers**		**MPS (Medical)**	
	Fixed fee	Percent of Damages	Fixed fee	Percent of Damages	Fixed fee	Percent of Damages
Claims settled under 6 months	3550	23%	4772	24%	4250	26%
Claims settled between 6 and 12 months	4448	23%	6850	24%	5678	26%
Claims settled over 12 months	6869	23%	10821	24%	9751	26%

5. Cost of experts

The WG was also asked to consider the appropriate level of fixed fees for experts that were used within the scheme. Table 14 shows the mean expert fee per expert recorded in the SCIL dataset, for claims under £25k that settled at different stages of litigation. So, for instance, there were 133 claims which settled pre-issue where expert fees were recovered; the mean fee per expert was £1737, and the mean number of experts was 1.6. This implies a mean total recovered disbursement for expert fees per pre-issue claim of £2780 (1.6*£1737). By contrast for those 39 claims which settled post-issue but pre-defence the mean total recovered disbursement for expert fees per pre-issue claim of £4740 (2.1*£2257).

Table 14: Mean fees paid per expert by stage of litigation at settlement [SCIL, 2015/6]

Stage	Mean expert fee per expert	Mean number of experts (>0)	Number of claims
Pre-issue	£1,737	1.6	133
Post-issue	£2,257	2.1	39
Post-defence	£2,067	2.8	33
Post-expert witness	£4,337	2.4	5

Data on disbursements paid on expert fees was helpful, but nevertheless the WG was hoping for more disaggregated data which would allow a breakdown of fees by type of report (e.g. liability or quantum), and specialty of the expert. Some additional claim-level data were provided by APIL, with a breakdown of the experts used on those claims into two categories: causation & breach, and "other" (which might be presumed to be quantum evidence only). The following table (Table 15) shows the breakdown of the number of each type of expert. Table 15 confirms the earlier result that some 25% of all claims used no experts of any type.

Table 15: Number of causation and breach experts (APIL, clinical negligence claims under £25k)

No. of experts	Total	Causation and breach	Condition and prognosis
0	17	22	37
1	19	38	29
2	29	7	1
3	2		
Total	67	67	67

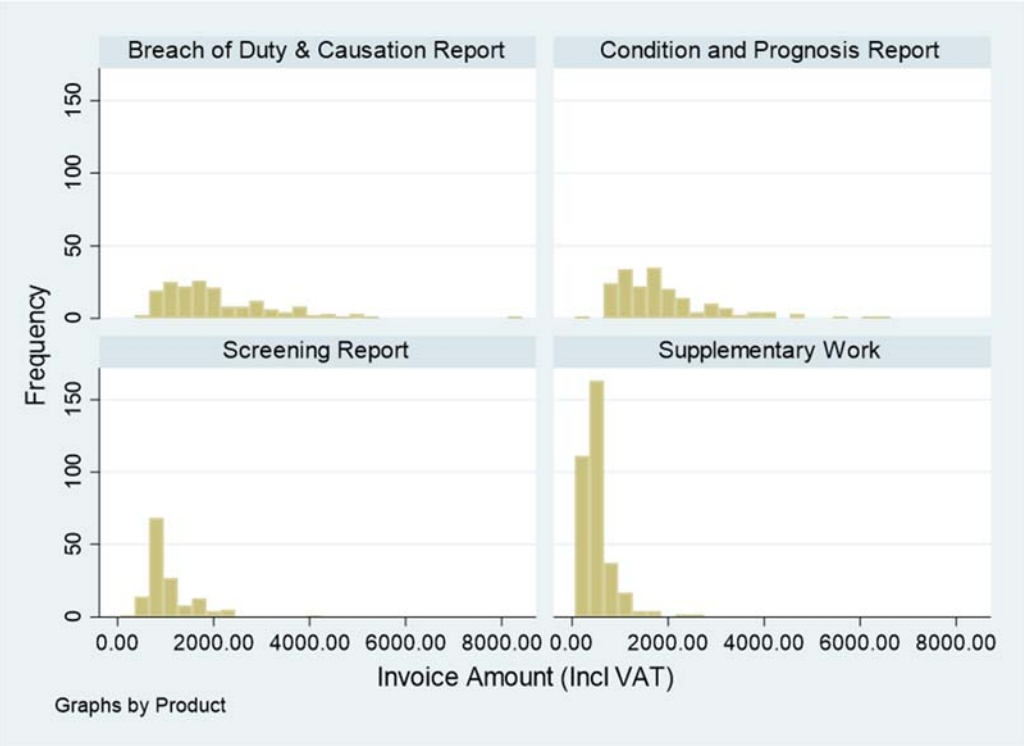
More detail on expert fees was helpfully made available to the WG by Premex, a leading Medical Reporting Organisation (MRO). This dataset allowed us to see a breakdown of the number of reports by type of report, the typical mix of different types of report across claims, and the average payment per invoice on those reports (as well as the range of costs around that average). The exercise undertaken by Premex to determine case value required additional work by some of their clients, and consequently was only available for a subset of the total number of claims. Hence Table 16 provides the mean invoice payment by type of product for 297 claims where the case value was known to be under £25k. Each claim consisted of a mix of invoices, and may be for more than one expert and more than one product type per expert. The total payment per claim for the sample of 297 claims under £25k was £3,457. Given that these will have included both pre- and post-issue settlements (and indeed some claims not yet completed), this figure seems broadly compatible with the figures derived above from the SCIL data.

Table 16: Mean invoice payment per product type, 297 claims with value under £25k [Premex data]

Product Group	Mean (£)	Freq.
Breach Of Duty Report	1861.24	52
Breach of Duty & Causation Report	2004.17	74
Breach of Duty, Causation, Condition and Prognosis	2265.00	2
Causation Report	2362.30	46
Condition and Prognosis Report	1872.52	187
Screening Report	1053.54	141
Supplementary Work	499.59	340
Total	1219.55	842

The mean invoice payments shown in Table 16 are of course simply averages over a wide range of payments. The chart below (Figure 13) shows the distribution of invoice payments for the four key types of product.

Figure 13: Distribution of invoice amounts, claims valued under £25k [Premex]



Finally, the Premex data allowed the WG to see evidence relating to the differences in expert fees paid to different clinical specialties. The following table (Table 17) shows in rank order the mean payment per invoice for all claims by main specialty recorded[4]. In order to maximise the statistical power when ranking specialties by levels of fee payments, Table 17 draws on data for all claims, not just those under £25k.

Table 17: Mean invoice payment by specialty of expert, all claims [Premex]

Expert Type	Mean (£)	Freq.
Prosthetist	4655.48	4
Rehabilitation Medicine	3988.64	50
Neuropsychiatrist	3825.44	25
Neuropsychologist	3082.33	86
Chiropractor	2709.56	3
Occupational Therapist	2626.33	67
Anaesthesia and Pain Management	2477.46	199
Speech and Language Therapist	2466.43	11
Miscellaneous	2049.85	1,102
Oncologist	1995.2	572
Psychiatrist	1902	746
Neurologist	1897.02	434
Paediatrician	1879.59	225
Rheumatologist	1863.9	84
Neurosurgeon	1788.73	627
Haematologist	1788.63	143
All Physicians	1781.64	653
Nephrologist	1695.38	158
Anaesthetist	1691.72	130
Urologist	1645.75	571
General Surgeon	1625.64	2,097
Obstetrics & Gynaecology	1620.23	1,092
Physiotherapist	1620.01	63
Psychologist	1603.06	213
Cardiologists	1595.53	448
Orthotist	1583.96	20
Endocrinologist	1551.18	81
Geriatrician	1546.94	73
Nurse	1524.77	447
Hepatologist	1521.74	65
Spinal Surgeon	1516.67	114
Pathologist	1466.33	28
Plastic Surgeons	1461.85	560
Gastroenterologist	1447.46	343
Ophthalmologists	1434.07	569
Oral & Maxillo Facial Surgeons	1317.84	129
Microbiologist	1231.51	230
Dental Surgeon	1225.15	336

[4] Note therefore that the mean payments are an average over all the different products provided by those specialists, including screening and supplementary work.

Cardiothoracic Surgeon	1214.17	124
Consultant Orthopaedic Surgeon	1178.01	2,632
ENT Surgeons	1170.87	309
A&E Specialist	1136.54	515
Orthodontist	1120.61	42
Podiatrist	1117.44	61
Neurophysiologist	1112.19	7
Dermatologist	1108.18	127
Radiologist	1093.11	578
Family Dentists	1023.6	2
General Practitioner	986.97	1,374
Audiologist	845	3
Medical Photography	750	1
Osteopath	564	3
Total	**1535.57**	**18,578**

6. Assessment: proposed fixed costs

The evidence summarised in sections 1-5 above was made available to all members of the WG during their deliberations over a new process for low value clinical negligence litigation, and, while broad agreement on that new process was achieved, no proposals for fixed costs or fixed expert fees were forthcoming from either side. Subsequent to the mediation process which followed, I was asked by the claimant representatives to revisit the proposed fixed costs that I had put forward in my report to the DHSC (based on current process, adjusted for exclusion of claims with more than two experts)[5]. In particular, they asked to see the implications of splitting apart the updated data from claimants and defendants to see what difference this would have made; and also they asked for a recalculation of the adjustment factor for the exclusion of claims with more than two experts, taking into account the difference between pre-issue and post-issue use of experts. I agreed to do this, and the following table (Table 18) shows the results presented to them.

Table 18: Revised proposed fixed costs from those in Fenn (2016)

	Clinical negligence claims with value less than or equal to £25,000	
Stage:	**Fletchers/SCIL/IM 2015-2018**	**Acumension 2015-2018**
Pre-issue	£5,350 + 32.5% of Damages Reduced by 10% if there is an early admission of liability*	£3,950 + 23% of Damages Reduced by 10% if there is an early admission of liability*
Post-issue, pre-Allocation	£9,500 + 35% of Damages Reduced by 20% if there is an early admission of liability*	£5,650 + 42% of Damages Reduced by 20% if there is an early admission of liability*
Post-allocation, pre-listing	£17,700 + 35% of Damages Reduced by 20% if there is an early admission of liability*	£10,450 + 42% of Damages Reduced by 20% if there is an early admission of liability*
Post-listing, pre-trial	£32,700 + 35% of Damages Reduced by 20% if there is an early admission of liability*	£14,500 + 42% of Damages Reduced by 20% if there is an early admission of liability*

At the end of the mediation process, there was still no agreement on fixed costs, but each side has set out their final position for both standard and light track claims as summarised in the main report. Each side accepted that the fixed costs should be proportional to damages (i.e. they should be calculated as a lump sum plus a percentage of damages).

[5] As reproduced in Table 2 of this report. Note also the point made in footnote 2 above: the adjustment for two experts of any kind does not capture the possibility that there may be up to three experts including one for quantum issues under the proposed process (which would increase the costs).

So, given the final positions of each side, together with a recommended set of fixed costs for the standard track from the Chair, it is of interest to explore how these various proposals compare with the current situation in relation to base costs recovered and paid. Arguably, the data on current claim outcomes as collected and described in this report should allow this to be done. In particular, given claim level data on both recovered costs and damages for claims settled both pre- and post-issue, it is simply a case of applying the proposed fixed cost formulae to the claims in the datasets, and comparing this with the actual costs recovered.

In order to compare the effect of the proposed fixed costs at different settlement stages it was necessary to make an assumption about which claims would settle at stage 1 of the new process, and which would go on to stage 2 and a neutral evaluation. In the tables below, the working assumption I have made is that all claims currently settled pre-issue and immediately after issue (i.e. pre-allocation) would under the new process settle at stage 1. I assume all claims currently settling post-allocation would be referred for evaluation, and would therefore also incur stage 2 costs as well as a fee for the evaluator (£1000)[6]. Finally it is assumed that no claims reject the evaluator's recommendations, and hence no court-based proceedings take place. These assumptions are of course subject to uncertainty, and sensitivity analyses could be undertaken, but the tables do nevertheless provide a simple way of assessing impact. Tables 19 and 20 (claimant and defendant data respectively) show the calculations for the standard track (including the Chair's proposals), and Tables 21 and 22 shows similar calculations for the light track (i.e. with no experts needed).

Table 19: Comparison of proposed fixed cost formulae with current costs for all standard track claims up to £25k [SCIL/Fletchers data]

	N	**Proposed fixed costs (mean)**			**Current costs (mean)**
		Defendants	Chair	Claimants	
Pre-issue	671	7,194	8,291	9,389	9,780
Post-issue, pre-allocation	120	7,709	9,064	10,419	18,700
Post-allocation, pre-listing*	35	9,730	11,596	14,461	29,297
Post-listing*	4	9,303	10,954	13,606	23,471
Total	**830**	**7,386**	**8,555**	**9,772**	**11,959**

*Assumes stage 2 fixed costs + £1000 evaluator fee for all post-allocation settlements

[6] In tables 19 and 21 I assume that the liability for the evaluator's fee will ultimately rest with defendants in all successful cases and should therefore be taken into account for illustrative purposes, as representing a cost that would not be incurred but for these changes. While this is yet to be formally accepted, the current proposal and recommendation is that each side pays 50% and the claimant recovers their share if they win, which appears to be consistent with my assumption. In tables 20 and 22, however, the defendants have supplied calculations in which they have not taken the evaluator's fees into account. This is partly because the responsibility for the fees is not yet agreed; and partly because they do not believe that the comparison should include a sum not paid as profit costs. As to the latter point, whilst it would not be a sum paid to the claimant's solicitor as profit costs, it would be a cost to the defendant and so is needed for any comparison of overall cost of the FRC scheme with the current cost.

Table 20: Comparison of proposed fixed cost formulae with current costs for all standard track claims up to £25k [Acumension data]

	N	Proposed fixed costs (mean)		Current costs (mean)
		Defendants	Claimants	
Pre-issue	1853	7,570	10,140	8,683
Post-issue, pre-allocation	367	7,830	10,660	16,028
Post-allocation, pre-listing*	122	8,714	13,428	22,948
Post-listing*	97	8,999	13,999	30,260
Total	**2439**	**7,723**	**10,536**	**11,360**

*Assumes stage 2 fixed costs for all post-allocation settlements

Table 21: Comparison of proposed fixed cost formulae with current costs for all light track claims up to £25k [SCIL/Fletchers data]

	N	Proposed fixed costs (mean)		Current costs (mean)
		Defendants	Claimants	
Pre-issue	225	1,486	3,715	5,374
Post-issue, pre-allocation	6	2,117	5,292	7,718
Total	**231**	**1,502**	**3,756**	**5,435**

*Assumes stage 2 fixed costs + £1000 evaluator fee for all post-allocation settlements

Table 22: Comparison of proposed fixed cost formulae with current costs for all light track claims up to £25k [Acumension data]

	N	Proposed fixed costs (mean)		Current costs (mean)
		Defendants	Claimants	
Pre-issue	423	2,338	6,513	7,423
Post-issue, pre-allocation	9	2,745	7,736	13,452
Post-listing*	3	3,533	9,100	20,975
Total	**435**	**2,355**	**6,557**	**7,641**

*Assumes stage 2 fixed costs for all post-allocation settlements

What do these tables tell us? First, it looks as though there are overall savings to be made from the new process, although it must be re-emphasised that this is conditional on the assumptions made about the costs of what would previously have been litigated claims. The main savings with the claimants' proposals for the standard track come from a reduction in the number and costs of post-

issue settlements due to the introduction of a neutral evaluator in their place. It is very difficult to know whether the assumptions made here are over-optimistic or not, given the absence of experience with the new process. The defendants' proposals for the standard track would, by contrast, yield significant savings even for those claims settling pre-issue, given the lower level of fixed costs proposed, but clearly there is a difference in opinion between defendants and claimants as to the prospects of a reduced workload at stage 1 of the new process.

For light track cases, there seems to be more of a consensus about the feasibility of savings on stage 1 settlements. Nevertheless, there is a bigger differential between claimants and defendants about the extent of the reduced workload that is possible in the light track by comparison with the current process for dealing with such claims.

Finally, it was possible to replicate the same approach for the lower cost dental claims using the dataset provided by the MPS. The parties were unable to agree at mediation as to the suitability of the light track process for those specialised (e.g. dental) claims which may still require expert evidence, yet require significantly reduced workloads compared with typical standard track claims. If the proposed light track process and fixed costs were applied to dental claims, Table 23 shows the comparison with current costs using MPS data. The savings from the claimants' proposed fixed costs negligible here, partly because there are relatively few post-issue settlements. The lower fixed cost proposals by the defendants does still yield significant savings, although again, claimants will dispute the extent to which the new process reduces workload.

Table 23: Comparison of proposed fixed cost formulae with current costs for all dental claims up to £25k [MPS data]

	N	**Proposed fixed costs (mean)**		**Current costs (mean)**
		Defendants	Claimants	
Pre-issue	512	2,013	5,034	5,251
Post-issue, pre-allocation	78	3,718	9,155	8,322
Post-allocation, pre-listing*	4	3,194	7,581	13,979
Total	**594**	**2,245**	**5,592**	**5,713**

*Assumes stage 2 fixed costs + £1000 evaluator fee for all post-allocation settlements

APPENDIX C

Claimant Position Statement

This document confirms the claimant group's position on how fixed costs can be adopted in CN. This document confirms the views of the claimant group with the caveat that the views expressed are not endorsed by SCIL.

SCIL are to submit a separate position statement on behalf of their members. Michael Horne QC will also be submitting a separate position statement on behalf of the Bar Council, PIBA and PNBA. As AvMA are an independent charity with a focus on maintaining and improving access to justice and patient safety, they will also be submitting their own position statement.

The process as detailed is largely agreed save for the below. A twin track process with differing cost regimes for both 'Light Track' (LT) and 'Standard Track' (ST) is supported. The implementation date for the process should be date of retainer.

For any change of process to be successful, there must be a proper framework with strict timescales and penalties/incentives for both parties to ensure a fair process with a change of behaviour whilst allowing access to justice for claimants.

Terms of Reference

The terms of reference for the working party was -

- To consider and recommend an improved process for clinical negligence claims, where the claim has a value of £25,000 or less;
- To draw up (i) a proposed structure for FRC for such cases to attach the new process, (ii) figures for FRC in the proposed structure, and (iii) figures for the cost of experts reports;
- 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;
- To consider how expert reports should be commissioned and funded, including the feasibility of single joint experts for at least some claims, as part of the improved process;
- To report with recommendations by the end of September 2018.

Suggested Process

1. Light Track (LT)

- Cases are to proceed in the LT if the claimant believes that liability is unlikely to be disputed and that the case suitably fits the criteria.
- The claimant states that the defendant has 8 weeks to respond to confirm that they will settle the case on a full liability basis failing which the claim will move to ST.
- If medical evidence is required for quantum, the claimant will instruct on a joint basis.
- A case will proceed to mandatory telephone discussion/stocktake and if settlement can not be reached to an Early Neutral Evaluation process.
- Time lines must be adhered to or the case moves to ST.

2. Standard Track (ST)

- It is agreed that a LoC is served with expert evidence in support of breach and causation and factual witness evidence.
- Both expert and witness evidence are to be in template form.
- It is not agreed that it is mandatory for condition and prognosis evidence, along with an offer to settle, to be served with the LoC. This will cause significant delay to case progression.
- Medical experts may not be able to provide a C&P report with a certain and final prognosis in a time frame during which the defendant would wish to have a LoC.
- Quantum investigations to be undertaken within protocol period and offer to be made at earliest appropriate opportunity.
- Consideration needs to be given to the likely implications of service of expert reports earlier than the current process upon the cost of ATE.
- It is not agreed that cases can or should, where possible, settle without C&P evidence. Whilst some firms do settle without expert C&P evidence, the reasons are unclear. Some firms rely on inhouse medical input.
- It would not be appropriate for solicitors to have responsibility for giving a view on medical matters without the benefit of C&P expert evidence. This would also give rise to an increase in professional negligence allegations.
- C&P expert evidence is required as a client is not able to accurately give instructions on the likely future impact of their injury.

- Once a case has been accepted into ST limitation is suspended.
- If breach and/or causation are denied a LoR is to be served along with expert evidence in support and factual witness evidence. Both to be in template form.
- If the LoR details an admission, an apology should be provided for the claimant and reasons for their admission.
- A LoR is to be served on the claimant within a strict time of 4 months, as now, to be extended to 6 months maximum. If a LoR is not served in this period, then the case moves out of FRC.
- It is not agreed that the defendant should be afforded a period of 6 months extended to 12 months to provide a LoR. Such a period is contrary to the ethos to having a swifter process.
- It is not agreed that a £100 is to be paid to the claimant for each month's extension post 6 months as this is derisory to the claimant and lacks incentive to adhere to timelines in a change of process or lead to a change in behaviour.
- It is not agreed that a claimant right to reply is restricted to medical experts only. The claimant and/or medical expert are entitled to reply to LoR and the defendants witness and medical evidence within an 8-week period. This has particular relevance in consent cases.
- Mandatory telephone discussion/stocktake is to take place within 6 weeks of LoR providing an admission or if a denial within 6 weeks of the claimant/expert reply.
- If the parties are unable to bring the matter to a conclusion the case will proceed to Early Neutral evaluation

3. Neutral Evaluation

- There are concerns re access to justice and as such the claimant group will defer to counsel, however the belief is that there should be an option for an appeal process.
- There is to be an agreed panel of experienced counsel with a minimum of 8 years call.
- It is for the claimant to choose counsel from the agreed panel.
- It is suggested that the cost of this process is to be split between the parties however consideration needs to be given to the implications of ATE insurance. There is concern that if the claimant is to pay for a mandatory stage in a process where they

may lose, ATE will have to be available to cover the costs faced if they do lose or there will be an access to justice argument.

- If counsel finds in favour of the claimant during this process, the claimant is to receive 100% of the damages.
- If the costs of this process are too low there is the risk that it will be difficult to find counsel of sufficient experience to provide an appropriate assessment.

- It has been suggested that there is a 'Pilot' to correctly trial this process to ensure that it would work in practice. There are concerns regarding access to justice, ATE, how counsel would reach a conclusion if the medical experts are diametrically opposed, how an appeal process would work. Given the significance of this change, and it being the first such scheme in the multi-track, it is appropriate to trial this to ensure that the impact is positive and it does not lead to unforeseen consequences.

4. Exemptions

The claimant group believe that the following cases should be exempt from FRC.

- Cases allocated to small claims track
- Cases valued above £25,000
- Cases where limitation has been raised as issue
- Cases involving more than one defendant
- Cases involving more than one claimant
- Cases involving more than two medical expert disciplines across all medical reporting
- All fatal cases
- Protected parties – those lacking in capacity.

The claimant group state that infant cases can remain in FRC with a 'bolt-on' for the additional work undertaken including IAH. With regards to secondary victims, it is suggested that they remain in FRC if the primary victim is also subject to FRC, and vice versa.

5. Limitation

- Limitation is suspended on entry to the scheme by service of a Letter of Notification and remains suspended until 12 weeks after exit from the scheme.
- In the first 28 days after service of the Letter of Notification the Defendant can expressly raise limitation as an issue in writing and if this was to occur then the

limitation waiver would cease 28 days from this notice (as the case would exit scheme).

6. Incentives /Penalties

- For a change in process and FRC regime to be successful there must be a change in attitude and behaviour. Penalties and incentives are key to ensure adherence.
- There must be penalties for both parties at key stages for failing to act in time or at all and an incentive for early admission and settlement.
- If the defendant fails to respond in time for the LoR or unreasonably delays progression, the case is to fall out of FRC.
- This avoids delay and reduces cost and will result in a reduction in the number of cases proceeding to ENE.

7. Timelines

- For a change of process to be successful the parties must adhere to strict timelines.
- Failure to do so must lead to penalties.
- Delay must be avoided for there to be a swift commercial process.

8. Patient Safety

- There is to be clear and sufficient information given in both LoN and LoC for the defendant to consider patient safety and learnings.
- The defendant is to provide a commitment to patient safety and to confirm what has been learned and steps taken to improve safety in the future, in a defined and separate section of the LoR.

9. Costs

- The claimant group have reviewed the costs in a line by line analysis of the scheme.
- This review involved consideration of proportionality whilst assuming significant efficiencies will be adopted in a fixed cost process.
- The claimants' were able to reach a position of these bottom line figures whilst being mindful on access to justice for the claimant.
- The claimant group are however concerned that the costs reflect a reduction of the existing arrangement, yet the amount of work required of claimant solicitors

increases under this scheme. As such there is uncertainty about how sustainable this will make the majority of clinical negligence claims.

- Should firms be unable to provide this service, then it will become an access to justice argument, which will disproportionately impact those most at risk who are in vulnerable positions. For example, those that have a lower loss of earnings claim, so more likely to have a claim of this value, will be adversely affected.
- Cost suggested by either party are as follows. It is not agreed that there should be a 'splitting the difference' approach between the claimant and defendant figures.

Table 1 - 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 plus 40% of damages agreed	£500 in addition to stage 1 plus 20% of damages agreed

Table 2 - 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% (30%) 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 plus 30% damages agreed	£500 in addition to stages 1 and 2a

10. Experts Reports

- Despite expert reports being part of the working parties' terms of reference this has not been considered in any length.
- The claimant group are of the view that medical expert reports cannot be capped or subject to a fixed fee.

- Imposing a fixed fee or cap on expert reports will leads to a reduced market of suitable experts, delay in provision of the report and concerns regarding access to justice for claimants.
- There is the risk that claimants would have to subsidise experts fees, impacting the claimant's damages received and raising concerns re access to justice.

APPENDIX D

DEFENDANT GROUP POSITION STATEMENT

The Defendant Group includes representatives from NHS Resolution, NHS Wales Shared Services Partnership: Legal & Risk Services, the Medical Defence Organisations and Insurers of Care Homes/non-medical professionals and clinical negligence practitioners. It is important to recognise the Group's claim portfolios are different both in relation to average damages paid between £1 - £25,000 and the sums paid to Claimant lawyers under the current process. NHS Resolution damages and costs are higher than the other members of the Defendant Group. NHS Wales also need to mindful of the existing PTR Regulations (*NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011)*

The Defendant Group is fully supportive of the proposed streamlined Standard Track and Light Track processes, subject to the comments set out in this document.

1. COSTS

Table 1 - 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	£750 in addition to stage 1

It is accepted there are unquantifiable savings from those cases that will not be pursued within the new Scheme as Claimants will be required to serve supporting witness and expert evidence with a Letter of Claim. The Defendant Group has not however been able to increase its cost proposals beyond those above as some representatives of the Defendant Group are already paying less in costs under the current process than those put forward above.

We acknowledge stage 1 requires the greatest work by the Claimant lawyer to provide the Letter of Claim with the supporting evidence. The Defendant Group do not support the 40% of damages as we consider there is a danger of generating bad behavior with Claimant lawyers holding out for increased damages to increase Claimant costs. This may potentially push more cases into Early Neutral Evaluation ("ENE"). Furthermore, this would also result in unreasonable and disproportionate costs payments. We consider 20% an appropriate level, which minimizes this risk.

In relation to stage 2, the Defendant Group cannot understand the costs being incurred to justify a fee of £2,000. This is the ENE stage, which will only require the selection of the Evaluator. The process of selection will be from an agreed panel (see comments below) and so there are limited costs in this stage. We had initially put forward £500 for stage 2 but

increased this to £750 in the spirit of compromise following further discussion. We cannot support any further increase or a stage 2 fee of £2,000.

Table 2 - 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

We consider the Defendant Group costs proposal to be reasonable.

This is an even more streamlined process than the Standard Track. We cannot see how the Claimant Group can justify the stage 1 fee of £2,500 for collating the records, liaising with Claimant and drafting a Letter of Notification. We consider £1,000 generous for this stage.

At stage 2, the Parties are instructing a joint quantum expert, if required, and quantifying the claim, worth £25,000 or less. How can a fee of £1,500 be justified? We consider £500 reasonable. The instruction of an expert will be in template format so the costs should be further minimised. The Defendant Group will also volunteer that Defendants should prepare the first draft of the letter of instruction to the expert for approval, which further reduces the work required from the Claimant lawyer.

The Defendant Group agree the Light Track applies in the following circumstances:

- 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 Scheme).
- There is a Never Event.
- There is a Serious Incident (SI) Report, which identifies care below a reasonable standard of care (including investigations under the Welsh Putting Things Right Scheme).
- There has been an Inquest and the Coroner has determined either care amounted to neglect or that death would not have occurred but for the identified neglect.

In addition to the above the Defendant Group proposes (i) dental claims; (ii) care home claims; and (iii) cosmetic claims should all also start in the Light Track regardless.

If these three types of claims fall of out of the Light Track the Defendant Group propose that these cases proceed to the Standard Track costs but with lower costs on the basis that the current costs paid by Defendants for these types of claims are so much lower than other claims in this tranche of damages. The Defendant Group propose the following costs:

Stage	Description	Defendant
1	All steps up to and including stocktake	£2,500 plus 15% of damages agreed
2	From stocktake up to and including neutral evaluation	£500 in addition to stage 1

It should also be borne in mind a very substantial benefit for Claimant lawyers is that the new proportionality test was implemented as a central plank of the Jackson reforms to help deliver access to justice at a proportionate cost. If fixed costs are introduced, then the paying party's ability to apply the 'global proportionality test' under a fixed costs regime to the 'total amount of assessed costs' (i.e. assessed profit costs, disbursements, and the ATE premium) will be diminished.

Implementation of fixed recoverable costs will also deliver a range of key business benefits to Claimant law firms, including certainty of work in progress, quicker claims resolution, expedited payment of invoices and improved cash flow, direct savings on costs lawyer fees, and reduced operational claims handling costs (due to a streamlined claims handling process and quicker claim resolution).

2. EXCLUSIONS FROM FIXED RECOVERABLE COSTS SCHEME

The Defendant Group are of the view any new Scheme should include as many types of cases as possible. The Defendant Group do not agree the following should be excluded:

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

These claims are no more complicated to warrant exclusion. The Defendant Group propose that where judicial approval is required for these claims, e.g. if a claim involves a minor or a claimant who lacks capacity, that there should be an additional fixed fee which is added to the above fixed fees to cater for this additional step. This is how the Welsh PTR Scheme is predicated.

We suspect that with fatal accident claims the Claimant Group want to exclude these claims due to the Inquest costs. If not, this would raise a number of unjustified anomalies. For example, it would be hard to justify why a fatal accident claim for a former spouse should be excluded, where a cancer claim by someone whose life expectancy was only reduced by a few years is included? The existing control mechanisms (damages valuation and number of experts) are adequate to filter out fatal claims that are genuinely unsuitable for this Scheme. The Defendant Group propose fatal accident claims are included but Inquest costs are excluded from this process, with recoverability allowed with the existing caveats, to allow fatal accident claims to be included in any new Scheme. The Defendant Group considers this is important as the new Scheme will allow a more streamlined process and swifter resolution of these cases, which would be of real benefit to bereaved families.

- **NEAUTRAL EVALUATOR FEES**

The Defendant Group proposes that this is shared equally in the first instance, but met by the Defendant if the Claimant succeeds. It is important that there is a downside to the Claimant if ENE fails.

We propose the following fees:

- £1,250 + VAT (liability only)
- £1,750 + VAT (liability & quantum)
- £750 + VAT (quantum only)

We have increased our proposed fees to those originally put forward to ensure the fees are sufficiently attractive for Barristers to agree to join any ENE panel. It should also be borne in mind that ENE fees should not be based on London Barrister fees only as any ENE panel will also include regional Barristers, who have lower fees.

The Defendant Group does not agree with the Claimant Group that the Claimant should be entitled to choose the Barrister from an ENE panel. Whilst the NHS Resolution mediation scheme works well using a similar model, that is a much more modest scheme involving one defendant organization only and the role of a mediator is very different to the quasi-judicial role under consideration as part of this Scheme.

The proposal from the Claimant Group would make the task of selecting and then updating a panel difficult and contentious. It would only take one ‘outlier’ to be included (ie a barrister popular with Claimant lawyers but considered partisan by Defendants) and the integrity of the whole scheme would be jeopardized as Claimants would be at liberty to choose him/her. The likelihood is that any panel will probably include a number of outliers.

The Defendant Group propose a random selection from a panel or a cab rank rule, perhaps with one veto per party.

Defendant Group
02.07.19

APPENDIX E

POSITION STATEMENT OF THE BAR COUNCIL, PIBA AND PNBA

Fixed Recoverable Costs for Clinical Negligence claims with a value below £25,000

This Position Statement is submitted on behalf of the Bar Council, the Personal Injuries Bar Association and the Professional Negligence Bar Association. For convenience, the three representative organisations will be referred to collectively as 'the Bar'.

As requested, the document will be brief and will focus on what are understood to be outstanding areas of disagreement on process and costings.

Process

1. It is imperative to maintain the ability of claimants to access high quality legal advice and representation in claims with a value of less than £25,000.

2. The Bar considers that particular weight should be attached to the views of claimant solicitors, who are best placed to determine whether the balance between the steps involved in the scheme and the level at which the fixed costs are set is workable and viable.

3. The Bar has no significant disagreement with the processes up to the conclusion of the 'stock-take' as outlined in the 'Short Outcome Report'. In particular, the Bar

   (a) supports the division of claims into a Light Track and Standard Track with different steps and costs for each track;

   (b) agrees that the scheme should be designed to minimise the time to settlement with strict time limits and sanctions for failure to comply;

   (c) considers that, on balance, the sequential exchange of witness statements and expert evidence with the Letter of Claim and, in turn, the Letter of Response is more likely to achieve early resolution;

   (d) is strongly in favour of the compulsory negotiation imposed by the 'stock-take'.

4. The Bar has significant reservations over the proposals for determination of the claim if the stock-take does not result in settlement. Representatives from the defendant group have proposed a determination of liability and/or quantum on the papers, a process which they term Early Neutral Evaluation ('ENE'). That is a misnomer. If the evaluation is binding on the parties, it is a form of arbitration.

5. The Bar does not support ENE for liability issues if it is to binding on the parties as the defendants suggest:

   (a) The defendants propose a 'paper-only' determination by the evaluator.

   (b) There are a significant number of cases where determination of liability will turn upon accepting one disputed factual account over another, or upon the merits of a *Bolam* defence (i.e. whether there is a body of opinion that would have acted as the clinicians did and, if so, whether it withstands logical scrutiny).

   (c) The inability to test that evidence in cross-examination risks an unfair outcome: without the benefit of forensic probing at an oral hearing, it is more likely that the evaluator will conclude that the claimant has failed overcome the burden of proving his or her case.

   (d) Regardless of whether it is a review or rehearing, a right of appeal is incapable of curing that problem because it suffers from the very same problem.

6. The Bar therefore has significant reservations over

   (a) whether the defendants' proposal for compulsory and binding ENE is lawful, in that it may well not be EHCR Article 6 compliant; or even if in strict terms it is compliant

   (b) whether it is desirable, because it is a defendant-friendly process.

7. Before the CJC could recommend or the MoJ/ DHSC adopt such a proposal, independent advice from a leading silk on Art.6 compliance of the defence proposal would be essential.

8. The Bar could support a form of ENE <u>provided that</u>

   (a) it is non-binding on the parties;

   (b) the evaluator gives an opinion on the prospects of success in percentage terms and/or the likely quantum if the claim were to succeed (rather than a binary judgment as to whether the claim succeeds or fails and if the latter what the award is);

   (c) if the parties do not compromise after ENE they are still able to litigate the claim on the multi-track, albeit that the outcome of the ENE could be referred to once judgment has been given.

9. The Bar considers that ENE in that form will prove a very useful additional filter to encourage early settlement even if it takes that non-binding form. For the claimant, solicitors and counsel acting on a CFA are unlikely without very good reason to take a claim forward after a negative ENE determination. Similarly, ATE insurers would require a very good reason to extend cover in those circumstances. The defendant would be exposed to paying non-fixed costs between issue and trial. With appropriate rule changes if they failed to better the ENE determination or were unreasonable in continuing in the face of it, the defendant could also face consequences akin to CPR r.36.17, i.e. an uplift on the claimant's fixed costs pre-issue, indemnity costs post-issue, an additional sum of damages and interest. Together, these controls should act as an appropriate disincentive against claims which should have been compromised after ENE proceeding to trial. This should significantly reduce the already small number of claims where proceedings are issued.

10. If ENE is to be undertaken, the Bar agrees with the claimant and defence proposal that it should be undertaken by counsel with a speciality in clinical negligence claims. The Bar accepts that the evaluator should be chosen from a panel. Rather than impose an arbitrary minimum number of years' call, or a particular split between claimant and defendant work before the barrister is able to apply for inclusion on the panel, acceptance should be based upon the demonstration of sufficient competence and experience. Clearly, the details of such a scheme will require further consultation.

11. Because the proposed scheme is such a radical departure from existing process (especially if the ENE is binding arbitration), the Bar considers that it should be subject to a compulsory pilot - perhaps in a number of defined geographical areas. It should only be implemented in full if the pilot scheme establishes its efficacy and sustainability for claimant firms.

12. In terms of the disputed exemptions from the scheme, the Bar's position is that the following should be excluded:

    (a) All claims brought under the Fatal Accidents Act 1976 (i.e. where it is alleged that the negligence caused the death): such claims require considerable time and effort in client management.

    (b) Claims involving psychiatric injury to secondary victims where there is also a claim by a primary victim which falls outside the scheme.

The Fixed Costs

13. Whilst the costs incurred under existing processes cannot be determinative of what the costs should be under the revised scheme, Professor Fenn's analysis of the level of costs recovered under the existing rules on proportionality will necessarily inform the appropriate level of fixed costs.

14. As we understand it, neither the claimants nor the defendants want to introduce a scheme that disincentives the use of counsel.

15. We suggest that it would not be wise to do so. The benefits which specialist counsel can bring to a case include: (1) independent advice - the 'fresh pair of specialist eyes'; (2) acting as 'quality control', helping weed out weak cases and identifying those with merit; (3) focused analysis and formulating and/or pleading the case; (4) testing the evidence with the forensic skill and experience of a trial advocate; (5) a cost-effective service.

16. In his Review of Civil Litigation Costs: Supplemental Report Fixed Recoverable Costs, Lord Justice Jackson recognised the merit of using counsel: see e.g. (§5.2-5.3)

> *"The involvement of counsel at an early stage, both in advising and drafting, brings substantial benefits. Independent counsel bringing a fresh eye to the case can focus the litigation and sometimes bring about settlement."*

17. A scheme which does not properly provide for the involvement of counsel

    (a) risks more cases being poorly prepared and analysed, more cases under-settling and more cases being pursued when they should not be;

    (b) would have a substantial negative impact on the junior Bar and imperil the pool of advocates for both claimants and defendants in higher value claims in the future.

18. The use of counsel in clinical negligence claims with a value of <£25,000 is more common than might be thought.

19. Professor Fenn has analysed a number of data sets on costs under the existing procedures. He has confirmed that the datasets from Fletchers, Irwin Mitchell and Acumension all exclude fees for counsel. The Bar therefore cautions against using figures from those datasets as a guide to the fees for the new scheme without an upwards adjustment to reflect counsel's fees.

20. The data provided by SCIL is the only dataset which includes figures on the frequency of instructing counsel and the fees recovered.

21. Professor Fenn's analysis of that data shows that counsel was instructed in 142 out of 283 cases (50.2%). Of those 142 cases, 73 settled pre-issue. Professor Fenn has been able to identify the mean cost for counsel at each stage of the litigation. Where counsel was involved, the mean counsel's fee per case was £3,382. Averaged out across all 283 cases in the dataset, that equates to just under £1,700 for counsel per case.

22. If existing costs are to be used as a guide to appropriate fixed costs under the new scheme, a sum to reflect use of counsel must be included, otherwise the total figure is necessarily an underestimate of the costs involved.

23. The Bar accepts that for the scheme now proposed counsel's fees should be included as part of the overall fixed costs. Our earlier proposal that there should be a ring-fenced element for certain items of work (e.g. pre-issue conferences, drafting statements of case) is no longer apt, particularly if (with non-binding ENE) counsel's fees post-issue will be recoverable as a disbursement in the usual way.

24. When setting the level of the fixed costs, the Bar makes the following points:

    (a) First, the proposed scheme requires more 'front-loading' of work by claimants than previously. If that is not properly remunerated, claimant firms will withdraw from this part of the market and deserving claimants risk being unable to bring claims in this value bracket.

    (b) Secondly, the aim of the revised process is to ensure that more claims settle earlier. That should deliver a significant saving on defence costs, which must be taken into account in evaluating the scheme. There appears to have been no attempt to quantify those savings.

    (c) Thirdly, there must be enough in the 'pot' for fixed costs to allow claimant solicitors to continue to involve counsel on appropriate claims.

25. Taking those factors into account, and subject to a successful pilot scheme, the Bar supports the figures for the Standard Track put forward by the claimant group.

26. In relation to the fee for the evaluator if ENE is undertaken:

    (a) For the scheme to work, it is imperative to use evaluators of suitable experience and calibre. Such practitioners are more likely to be senior juniors with already busy mixed claimant and defendant practices. Whether they apply to become an evaluator is a matter of genuine choice rather than a necessary part of the 'day job'.

(b) The fee needs to recognise (1) the quasi-judicial responsibilities involved; (2) the fact that it is likely only to be the most complex or difficult cases in the value bracket that reach ENE, and such cases are likely to be most time-consuming for the evaluator; and (3) the fact that counsel will need to bear the burden in time and potentially cost in applying to and remaining on any panel.

(c) Unless the fees for the evaluator are sufficiently attractive, the scheme will simply not attract evaluators of sufficient experience and calibre.

27. The Bar considers that fees (to which VAT will need to be added) are likely to be required to attract suitable evaluators:

(a) Liability and quantum: £2,000.

(b) Liability only: £1,500.

(c) Quantum only: £1,500.

28. To prevent erosion by inflation, the fixed fees on the Standard and Light Track and the evaluator's fee will need to be reviewed on a regular basis or linked to a suitable index.

MICHAEL HORNE QC

27 June 2019

APPENDIX F

POSITION STATEMENT ON BEHALF OF THE SOCIETY OF CLINICAL INJURY LAWYERS (SCIL)

Background

SCIL represent 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; half of the firms who hold such accreditation are members of SCIL. Our policy making body is the member firms, not the executive or individuals.

1. The Terms of Reference

The working group's terms of reference were:

a) To consider and recommend an improved process for clinical negligence claims, where the claim has a value of £25,000 or less;
b) To draw up (i) a structure for FRC for such cases to attach to the new process, (ii) figures for FRC in the proposed structure, and (iii) figures for the cost of expert reports;
c) 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;
d) To consider how expert reports should be commissioned and funded, including the feasibility of single joint experts for at least some claims, as part of the improved process

In our view, the most important term of reference is the third: patient safety. The key to reducing the cost of clinical negligence is to improve patient safety by learning from errors to ensure that patterns and system errors are identified and rectified to avoid harm.

2. Exclusions

SCIL's position is that cases with more than 2 experts should be excluded; if a third expert is required for liability or for condition and prognosis, the case should be excluded. That position is consistent with Lord Justice Jackson's recommendation to exclude cases with more than 2 experts per side from the proposed Intermediate Track. The cost modelling carried out by Claimant group (and by Professor Fenn) was on the basis that there are no more than 2 experts.

SCIL's position is that all fatal cases i.e. where death is caused or accelerated by the alleged negligence should be excluded. Most of such cases will involve a death at the hands of the State and the families of the deceased must be allowed a fair and independent investigation of that claim for the State to discharge its legal obligations under the Human Rights Act, but also its moral obligations. Fatal claims and grieving families require particularly sensitive handling and involve additional work, for example obtaining probate and attending inquests to gather evidence. Fatal claims are unsuited to a "cheap and cheerful" process.

3. The Process

SCIL are opposed to sequential exchange of expert evidence on liability. The proposed process would require the Claimant to serve "trial ready" expert evidence on liability before seeing the Defendant's factual evidence. Experts instructed by Claimants would be at an obvious disadvantage as, unlike experts instructed by Defendants, their reports would be prepared without sight of the factual evidence of the treating clinicians or the Defendant's expert evidence. The Claimant's expert's initial report would almost always carry less weight than that of the Defendant.

It is impossible to see how a supplementary letter from the expert would address this imbalance, but it is easy to see how any modification of opinion in the supplementary letter would become the target of cross examination and would be detrimental to Claimants.

Aside from the procedural unfairness, the rationale for sequential exchange is said to be that Defendants need the Claimant's expert evidence to settle cases. That is superficially attractive, but unsupported by the evidence Professor Fenn obtained from Acumension, NHSR's costs lawyers[i], which showed that in 2017/18 91.28% of cases settled before allocation: i.e. before any requirement for the Claimant to serve any factual or expert evidence on liability.

To put it another way, the proposed Process would mandate the Claimant to carry out work required in only 8.72% of cases under the current system: that would, if costed fairly, increase the cost of bringing a claim *(which SCIL have pointed out throughout this process and this risk has been recognised by the Chairman and Vice Chairman of the working Group, by Claimant members of the group and by judicial members of the group*).

The only pre-issue saving in the Standard Track would be to reduce Defendants' pre-issue costs if liability is admitted based on the Claimant's expert evidence. That does not however reduce the Claimant's pre-issue costs; it would in fact increase them if costed fairly.

4. Mandatory Neutral Evaluation

SCIL are opposed to Mandatory Neutral Evaluation on liability.

Claimants should, if they choose, be able to elect alternative methods of ADR, which could include Early Neutral Evaluation but should always have the right to seek judicial determination of their claim, or else their rights under the Human Rights Act 1998 are likely to be infringed.

The additional costs proposed by the Defendants for Neutral Evaluation are grossly insufficient for the work that will need to be carried out to advise a Claimant of the process, prepare the necessary documents for submission to an evaluator, consider any documents submitted by the Defendant, to consider the evaluator's ruling and advise the Claimant on the outcome and next steps.

Similarly, if the fee for the evaluator is set too low, the scheme would fail to attract evaluators of the calibre required for any scheme to be trusted by either side. The fee should be paid by the Defendant in any event - if it is not, ATE premiums will increase.

Any evaluation of liability on paper will favour Defendants. Without the opportunity to test the witnesses, an evaluator faced with diametrically opposed experts or factual witness accounts would be likely to conclude that the Claimant has failed to discharge the burden of proof.

If the parties agree to Neutral Evaluation, it should be without prejudice whether on liability, quantum or both.

It has been suggested by the CJC that if there is a non-binding determination and the Claimant elects to proceed to trial but fails to beat that offer by a margin (the figure of 20% is suggested), there should be a costs penalty. This suggestion would be grossly unfair; it would punish only Claimants and infringe upon their right to judicial determination of their claim. It is to be contrasted with the provisions of CPR Rule 36.17(2). SCIL wish to make it clear that we do not agree that the CJC should explore ways to restrict the right of a Claimant to request a judicial determination of their claim and we do not consider this to be within the Terms of Reference.

5. Costs Proposals

Proposed costs for the process are not agreed within each group and SCIL remain opposed to FRC. In the absence of agreement on the number of experts and exclusions they are costing different processes and the Claimant costs figures would be higher if the Defendants' position on experts and exclusions were adopted.

The figures are:

Stage	Description	Claimant	Defendant
1	All Steps up to and including stocktake	£6,000 plus 40%	£5,500 plus 20%
2	From Stocktake up to and including ENE	£8,000 plus 40%	£6,000 plus 20%

Light Track			
Stage	Description	Claimant	Defendant
1	All Steps up to 21 days after Letter of Response	£2,500 plus 25%	£1,000 plus 10%
2a	From 21 days after Letter of Response so and including Stocktake	£4,000 plus 30%	£1,500 plus 10%
2b	From Stocktake up to and including ENE	£4,500 plus 30%	£2,000 plus 10%

In responding to the Defendant costs proposals, we suggest three starting principles:

a) The costs in the current system are a useful starting point;
b) The proposed process will involve greater work pre-issue than the current system and so the pre-issue costs should not be lower than the current system; and

c) Professor Fenn has stated that the data on the current system from the Claimant organisations is more likely to be accurate than that provided by the Defendant groups because it does not involve guesswork as to how settlements were apportioned between solicitors' fees and disbursements

Professor Fenn produced illustrative figures for pre-action work in the Standard and Light tracks, based on costs agreed by the parties or assessed by the Court in the current system:

Standard Track (no more than 2 experts on liability and condition and prognosis)	
SCIL Data	£8,171 plus 39%
Fletchers Data	£8,968 plus 22%
Light Track (no experts on liability or condition and prognosis)	
SCIL Data	£4,302 plus 20%
Fletchers Data	£4,041 plus 15%

NB: Professor Fenn's Standard Track figures are for cases with no more than 2 experts NOT cases with 2 liability experts and further experts on condition and prognosis. His Light Track figures are for cases with NO experts, whereas the proposed system allows for a condition and prognosis expert. If additional experts were to be included, the costs would rise.

Any temptation to "split the difference" should be resisted. The figures proposed by the Claimants for the new process are not the starting point for a negotiation: they are close to the figures calculated by Professor Fenn based on the data sets he considered most reliable, even though the new process would involve significantly more work pre-issue. By contrast, the figures proposed by the Defendants are well below those calculated by Professor Fenn, even though the new system would involve more work and appear to be tactical rather than realistic, especially as their evidence base is not clear.

6. After the Event Insurance (ATE)

In clinical negligence the part of an ATE premium which insures the cost of obtaining expert evidence is recoverable from the losing Defendant. The premium in respect of all other disbursements, including expert reports on condition and prognosis, is not recoverable from the Defendant and must be paid by the Claimant from damages. Therefore, any step which increases the non-recoverable premium will lead to claimants losing damages to pay for ATE.

SCIL's position is that ATE should remain recoverable in respect of the cost of obtaining liability reports.

If expert evidence on condition and prognosis must be served before agreement on liability, this is likely to increase the non-recoverable part of ATE premiums and erode damages, for the reasons stated above.

If Neutral Evaluation is introduced with a requirement that the Claimant contributes to the evaluator's fees, this is also likely to increase ATE premiums and, if that aspect of the premium is not recoverable, to further erode damages. SCIL's position is therefore that

either the Defendant pays the evaluator's fee in any event, or any part of the ATE premium referable to the Evaluator's fees should be recoverable.

It should be noted that there has been no evaluation as to whether the ATE market would remain sustainable if the process were introduced.

7. Experts' Fees

The parties have not proposed fixing recoverable expert fees and SCIL's position is that experts' fees should not be fixed.

SCIL's position is that Single Joint Experts are not suited to liability.

Conclusions

The proposed process is not an improvement on the current system: it increases the amount of work required to be carried out and, if costed fairly, would increase the costs of bringing a claim. The proposed process would favour Defendants and infringe Claimants' rights to judicial determination of their claims. The process makes no reference to or provision for learning and improving patient safety – which should be central to efforts to reduce the cost of clinical negligence.

The foreseeable consequences of introducing this process for fixed costs, particularly at the levels proposed by the Defendants, is that specialist lawyers will no longer be able to act for the victims of clinical negligence. Victims will be forced to act as litigants in person or to instruct non-specialists, claims farmers or unregulated, unqualified and uninsured paid McKenzie friends in an attempt to obtain access to justice, which will increase demand upon judicial/court resources and so offset any costs savings.

The process fails to meet the CJC terms of reference, most strikingly in relation to patient safety and is not supported by SCIL, who submitted to the CJC an alternative scheme which would reduce costs, provide for learning and improved patient safety, but it was not considered by the working group. The Government should consider the SCIL Scheme as an alternative to this process.

[i] **Table 1. Claim frequency by settlement stage**
Acumension data – claims up to £25k

Pre-issue	1,102	74.46%
Issued	249	16.82%
Allocated	85	5.74%
Listed	44	2.97%
Total	1,480	

APPENDIX G

This is an edited version of a position statement submitted by AvMA on 26 June 2019

…

Context

2. AvMA holds a unique position within the CJC working party. We do work closely with claimant clinical negligence lawyers, but we are not an organisation for lawyers. We are an independent charity; our primary objective is to improve patient safety and access to justice for people who have suffered avoidable harm in healthcare. Avoidable harm includes incidents where unintended/unexpected harm appears to have occurred as a result of errors or omissions in any kind of healthcare.

3. It is important to stress that the claimant group would have preferred wider terms of reference, which analysed the root causes of high costs in clinical negligence and the variety of ways in which costs can be reduced without damaging access to justice. Proposed terms of reference were submitted by AvMA, APIL and the Law Society which reflected this[7]. These proposals were rejected by the MoJ and DHSC.

4. It is also important to stress that the actual terms of reference for the working group have not yet been followed. Crucially, the working group has not conducted an analysis of to what extent, if any, the current proposed process represents an "improved process" to the current process or its likely effect on access to justice, let alone other processes which might have been explored. This, despite requests that this be conducted and assurances that it would be.

5. The claimant group has concerns about the serious risks for claimants' access to justice which the current process under consideration carries. We are also concerned that insufficient attention has been given to the patient safety element of the terms of reference, and the process of the working group itself.

6. The process currently under consideration only emerged very late in the life of the working group. There has been insufficient time to give due consideration to it and the strict confidentiality rules attached to the working group has prevented the possibility of testing the ideas with the wider claimant community.

7. Long before the CJC working party was convened AvMA recognised the need and called for a bespoke process for clinical negligence claims valued at £25,000 or less. This was clearly set out in our response to the LASPO Bill in 2013.

8. As documented in our response to the DH consultation 2017, AvMA does not oppose fixed costs per se, however the costs applied to that grid of costs must be realistic and

[7] https://www.avma.org.uk/?download_protected_attachment=FINAL-ToR-Agreed-AvMA-TLS-APIL-30.11.17.pdf

commercially viable to enable solicitors to undertake low value clinical negligence work properly at a profit.

9. Our primary reason for being included as a member of the CJC working party was to be able to contribute to the CJC working party's remit to consider how any new process will affect patient safety and learning.

(i) The level of costs proposed for LT and ST with explanation and comments on the cost proposals

Level of fixed costs proposed

10. It is not for AvMA to tell lawyers how they should run their business; we do not advise on what the correct level of remuneration should be. We are not going to comment on the figures proposed for either LT or ST, save to say that it is impossible to tell how experienced claimant lawyers will respond to the latest cost proposals.

…

Protection of client damages & access to justice

15. The proposed fixed costs scheme is intended to work with Conditional Fee Agreements (CFA). Unlike success fees which are ringfenced at a maximum of 25% of a client's general damages and past losses, shortfalls in costs that occur under a CFA are not similarly ringfenced. The scheme does not offer any protection for client damages.

16. The current proposed levels of fixed costs under both LT and ST are so low that it increases the likelihood that claimant lawyers will only take on those cases which they are almost certain will win. Each firm will have their own risk assessment to identify what they consider to be a viable case; cases will stand or fall at the first risk assessment hurdle based on their prospect of success. The effect will be that firms will almost certainly "cherry pick" cases.

17. This means that the more complex, low value claims which are time consuming, costly to prove and risky are going to find it harder to find representation. Lawyers will also be more attracted to the high value claims because of the proposed 40% costs award that is calculated on damages recovered.

18. If this scheme is introduced it will increase the risk that many low value claims will not be taken on by lawyers particularly if the issues are complex. The cost of proving those claims is going to be higher, those additional costs will not be recovered on a fixed costs scheme; lawyers will look to the client's damages to recover their shortfall in costs due under the terms of the CFA.

19. If claimant lawyers are forced to look to their client's damages to recover their costs this risks client damages being severely reduced or even wiped out altogether by their solicitor own client costs.

20. If this situation arises then it will cease to be in a client's interests to bring any sort of legal claim. It carries reputational risks for claimant clinical negligence lawyers. It will not help to address patient safety issues as the cases will no longer be captured by the litigation process. There will be no accountability for healthcare providers and no access to justice for the injured party.

Cases under settled

21. Lawyers taking on difficult to prove low value claims may also be forced to recommend their client accept low offers and under settle the claim. If the cost of continuing with the litigation to achieve reasonable settlement is fixed and where no effective sanctions are imposed then the actual costs of achieving an increased award of damages, will simply be payable out of the client's damages. In real terms, the client will have achieved an increased settlement with one hand but will have paid for the privilege of securing what was rightly theirs with the other.

An improved process

22. Forcing lawyers to operate in a way that risks them having to make significant deductions from client damages does not amount to an improved process. It will not meet the public's needs and requirements and will serve only to reduce access to justice.

…

Patient safety:

78. Despite being a clear term of reference, this has barely featured throughout the process. The opportunity to introduce an innovative process has been lost through the failure to give this issue any real consideration.

79. The current position on patient safety appears to be based on the claimant lawyer setting out clear information on this issue in both the Letter of Notification (LoN) and the Letter of Claim (LoC). In response the defendant is to provide a commitment to patient safety and confirm learnings in the Letter of Response (LoR).

80. Setting out patient safety issues in the LoN (LT) or LoC (ST) is preferred to other possible options which have been discussed including that the expert be responsible for setting out the patient safety issues. In the latter case, the proposal was that the expert template report would include a specific section to allow them to identify and raise patient safety issues.

81. One of the difficulties with relying on the expert to set out patient safety issues in this way is that if the defendant accepts the claimant evidence and settles, there is no need for them to instruct an expert. Consequently, the defendants could avoid responding to the expert's patient safety concerns by making an admission. Similarly, in LT cases, by definition, no

expert is to be instructed and so the opportunity to communicate patient safety concerns was lost at the outset.

82. However, even where the claimant sets out the patient safety issues in the LoN/LoC it is far from clear how the defendant will respond. It is our view, that organisations such as NHS Resolution (or equivalent organisations, MDU, MPS etc) need to take ownership and responsibility for actioning the concerns raised in the LoC/LoN. It is not enough to say that these organisations will provide a commitment to patient safety – that is not an action plan. That approach does not mean that the defendant organisations will investigate the issues, it does not enable them to demonstrate that they have learned lessons and set out how they have addressed those failings to prevent them happening again.

83. Steps need to be taken at the trust/healthcare establishment where the issue arose. However, the learning from litigation needs to be disseminated more widely to all trusts/healthcare providers across the country to reduce the likelihood of the same mistake repeating itself. Alternatively, where the same practices or procedures are being employed elsewhere that they can revise their approach before harm occurs.

84. The current proposals do not go far enough, and It is far from clear what the defendant obligations to respond is intended to be.

85. AvMA believes that more could and should have been done to address the patient safety issues.

86. Despite attempts to engage on this issue it has not been possible to get any real traction with either the DH, NHS Resolution or any of the other defendant organisations on this point. The stock response from these organisations has been to say that ***"all indemnifiers agree that patient safety and learning is important, however the difficulty is that indemnifiers cannot commit to imposing anything on the healthcare professional/Trust, who are outside their control."***

87. AvMA considers this response unacceptable, there has been a clear and disappointing failure by defendant groups to take ownership of this issue and to try and develop a workable solution.

88. Although the current proposal of setting out the issues in the LoN/LoR is better than nothing, the lack of commitment and willingness to invest in learning from litigation and to avoid or reduce the incidence of similar injuries arising demonstrates a cavalier approach that denigrates the importance of this issue.

89. There needs to be much more detail around what organisations are going to do and how they are going to action a response to the patient safety issues once they are reported to them. Simply reporting patient safety concerns without more concrete proposals about the nature of the action and response expected risks no action being taken at all.

90. The current proposals are too weak, they risk the reporting of patient safety issues simply being seen to be done, rather than it being seized upon as an opportunity to do something effective.

91. In our experience, patients want to know what the hospital has done to address the patient safety issues, they don't want mistakes repeating themselves and the same thing happening to someone else. For many patients this is as important as an award of damages.

92. AvMA has put forward its own suggestions on patient safety but these have never received a substantive reply from either the DH, NHS Resolution, or any defendant group. SCIL has also put forward patient safety suggestions, which have not been discussed either.

…

Dated:26th June 2019

Lisa O'Dwyer
Director Medico-Legal Services
Action against Medical Accidents (AvMA)

APPENDIX H

A POSSIBLE APPROACH TO FRC

1. This appendix sets out a possible methodology to enable government to resolve the remaining dispute between the parties on FRC for the ST. It includes an assessment of a possible resolution, which could be produced by using that methodology.

2. Throughout our work, the CJC has made it clear that it would only report either a consensus on the level of fixed recoverable costs, i.e. an agreed position, or the final positions of the parties if no agreement is possible. That remains our position. However, in view of the progress made by the parties towards an agreement and their willingness to allow the CJC to report their respective final positions, it may be appropriate to suggest to government how it might go about resolving the remaining differences between the parties at least on the ST.

3. We have therefore set out below a possible methodology for assessing the relative merits of the parties' positions; and an indicative assessment of the information currently available for the ST, based on that methodology. Where possible this assessment is arrived at by reference to data and other objective information.

4. A similar exercise is not considered possible for the LT. Although the figures proposed by the parties are lower than for the ST, as would be expected, the gap between them is more significant in relative terms. There is also only a limited amount of data and other objective information, in part as there remains some difficulty in identifying from data the types of case which would go into the LT.

5. The suggestion in this appendix has been criticised by the claimant group in particular (although it affects the interests of both parties) as not leading to an evidence-based solution. SCIL and AvMA add the point that any reduction of proposals for FRC via a form of commercial compromise could lead to adverse effect on either the willingness of lawyers to take on claims at all or in terms of the risk of claims being under-settled.

6. We are content that the suggestion should still be put forward for consideration by government and, if they consider it appropriate, for consultation. Government has committed to introducing FRC and this appendix provides a possible approach to resolving the apparent deadlock between the parties.

<u>Methodology</u>

7. Each side has provided its final proposals for the ST and for the LT. They need to be viewed as a package: simply by way of example, the proposals on each side for the evaluation stage in LT are the same (£500) but the proposals for that stage in the ST diverge significantly.

8. The methodology proposed is straightforward. The starting point is that this should be seen as in effect a commercial negotiation, in which the appropriate outcome is likely to be somewhere between the positions of the two parties. Of course each side will say, as in any negotiation, that the final position adopted is their bottom line/top line and that any further movement beyond that line will have a detrimental effect on the interests of their clients. Those

comments will have to be judged on their merits, in the context of claims which are of lower value but still of importance to the individual claimant. The overall context of people injured by the actions of those responsible for their care, usually a state body, also needs to be considered.

9. The suggested approach is explained below in paragraphs 10 to 12.

The suggested approach

10. The first step is to understand the extent of the gap between the proposals of the parties and to compare this with the benchmark of data already available for the cost of the current pre-issue process (excluding disbursements)[8]. This can be done by the following:

a) take average damages for ST as derived from claimant data, recognising that this is a "broad-brush" proxy for working out the FRC for the value range of cases;
b) work out FRC for average damages on each formula supplied by claimant and defendant, so that each proposal is shown as a single figure for the average damages level;
c) record the difference between the parties at that average settlement level: again in broad brush terms, this shows the gap between the parties overall.

11. The second step is more evaluative: to consider the impact of the proposed changes to the claims process. This involves balancing a number of factors:

a) the change in work to be done as a result of the new process – for instance if there is front-loading, this may justify an increase in the sum allowed. Similarly if the case no longer needs to be prepared for litigation, some initial costs may be saved;
b) whether exclusions from the FRC scheme will have a material impact on the costs overall for cases remaining in the system: if these cases are generally likely to be more complex, this may justify a reduction in the sum allowed;
c) whether the test on proportionality has any impact: this is a separate factor operating to control costs, beyond those of reasonableness and necessity; but in relatively complex types of case such as clinical negligence, its limiting effect may be modest.

12. These two steps are likely to produce a range of possible outcomes for Stage 1 at least. The third and final step is therefore to consider where in the range the FRC should sit and how this should be structured to include a percentage of damages. For stage 2 this should probably be a fixed fee: the parties agreed a figure for the same LT stage (2b), can that be applied with a suitable adjustment for the ST?

Applying this approach in practice

13. As an illustration of the first step using the calculations set out in paragraph 10:

[8] See Professor Fenn's report at tables 19 and 20, appendix B

a) the average ST claim settles for damages of £9,077 (£8,471 for pre-issue settlements).
b) table H1 below sets out the parties' ST proposals, as applied to that damages figure :

Table H1

Stage	Description	Claimant	Defendant
1	All steps up to and including stocktake	£6,000 plus 40% of damages agreed = £9,389	£5,500 plus 20% of damages agreed = £7,194
2	From stocktake up to and including MNE	£2,000 in addition to stage 1 = £9,389 + £2,000	£750 in addition to stage 1 = £7,194 + £750

The proposed cost for work done in stage 2 is £2,000 by the claimant group, £750 by the defendant group (the defendants' original figure was £500 but they agreed to increase it following discussion on 4th June).

c) At stage 1, the difference is £2,195. At stage 2, the gap is an additional £1,250.

14. As for the second step outlined in paragraph 11, the parties' positions may assist on evaluating factors a) to c):

a) The claimant group say there will be more front-loading of cost on experts' reports, preparing witness statements etc. The defendant group say the front-loading happens already and this work will largely be done now. Both sides have stripped out any cost of experts' meetings, but these are nearly always post-issue now. Some work will be required to instruct the neutral evaluator and review their opinion for stage 2, which is new, but this should be contained and is allowed separately.
b) Some more complex cases will be excluded – query whether any of these will have fallen within the data set (limited to cases with two experts) in any event. Some fatal claims and claims involving protected parties may have been included.
c) Clinical negligence claims in the ST which require expert evidence on breach and causation are inherently more complex than the typical claim worth up to £25,000. This may mean that proportionality has little impact on setting the level of FRC in ST cases.

15. The third step, as per paragraph 12, is to review the possible range of outcomes, to form a view as to where in the range the FRC should sit.

ST stage 1

16.1 The figures on both sides are higher than those reported for solicitors' costs in pre-issue stages by Paul Fenn in 2018 following the DH consultation, although those figures made no distinction between cases suitable for the ST and the LT. It is also likely that some cases now to be excluded were included in the data. Against this, there will in practice be none of the costs of litigation and the parties accept that the work needed pre-issue is greater as a consequence. The defendant group also believe that the process requirement for claimants to disclose their expert evidence on breach and causation and to make a Part 36 offer with the letter of claim will both weed out unmeritorious claims and lead to earlier settlements, with less cost to defendants.

16.2 A possible fair approach in the circumstances would be to take the middle of the range, generating an overall stage 1 fixed fee of £8,291 for a case of average value. Using a percentage of damages of 30% (also a mid-point between the parties' positions), this equates to a base figure of £5,750. The mid-point on the percentage of damages, as a component of the overall sum, allows for their respective concerns: that the claimant benefits by their solicitor having sufficient interest in the level of settlement; but that the defendant is protected from any risk of adverse behaviour by that percentage being contained.

16.3 If it is considered that the percentage of damages used should be different, it would be possible to arrive at broadly the same total costs figure for a claim of average value by using an alternative formula:

a) £4,900 + 40% of damages (£8,294)
b) £6,600 + 20% of damages (£8,289)

16.4 As indicated in Chapter 5 at paragraph 5.17, this is no more than a method of structuring the overall anticipated costs themselves, rather than representing any form of uplift from a base cost figure. The decision as to which formula to apply depends on the perception of the importance of the damages percentage as either driving good behaviour, or risking adverse behaviour such as costs building.

16.5 A further refinement could be for the percentage of damages to be reduced for cases towards the top end of the £1,000 to £25,000 value band. This was suggested at one point in discussions between the parties but has not been pursued. The effect of any such approach on higher value cases would have to be carefully considered: it also risks reducing the overall average for FRC in all cases.

ST stage 2

17.1 The work involved at stage 2 for the neutral evaluation is more limited than claimants have made out, but not as restricted as defendants originally suggested. A fair figure for stage 2 might be £750 and the defendants' final position statement accepts that figure. This assessment does take account of the agreement that in the LT, the appropriate cost for this stage would be £500: the ST evaluation could involve more work, but only as a proportion of the LT figure.

17.2 The claimant group and SCIL in particular maintain that this figure is far too low, although the defendant group have increased their original proposal to this sum. We accept that there will be more work involved in preparing a liability dispute for MNE than a quantum dispute, but this follows the mandatory stocktake and discussion for which preparation is already included in stage 1. We consider the proposal to be appropriate.

17.3 The Bar also consider the figure to be too low and cite the need to advise the client on the merits of proceeding to MNE. Again this follows on from the mandatory stocktake and the allowance included for advising the client following that step in stage 1.

Summary

18. The suggested approach explained above produces a possible assessment that the following FRC figures might represent a suitable compromise between the positions of the parties for the ST:

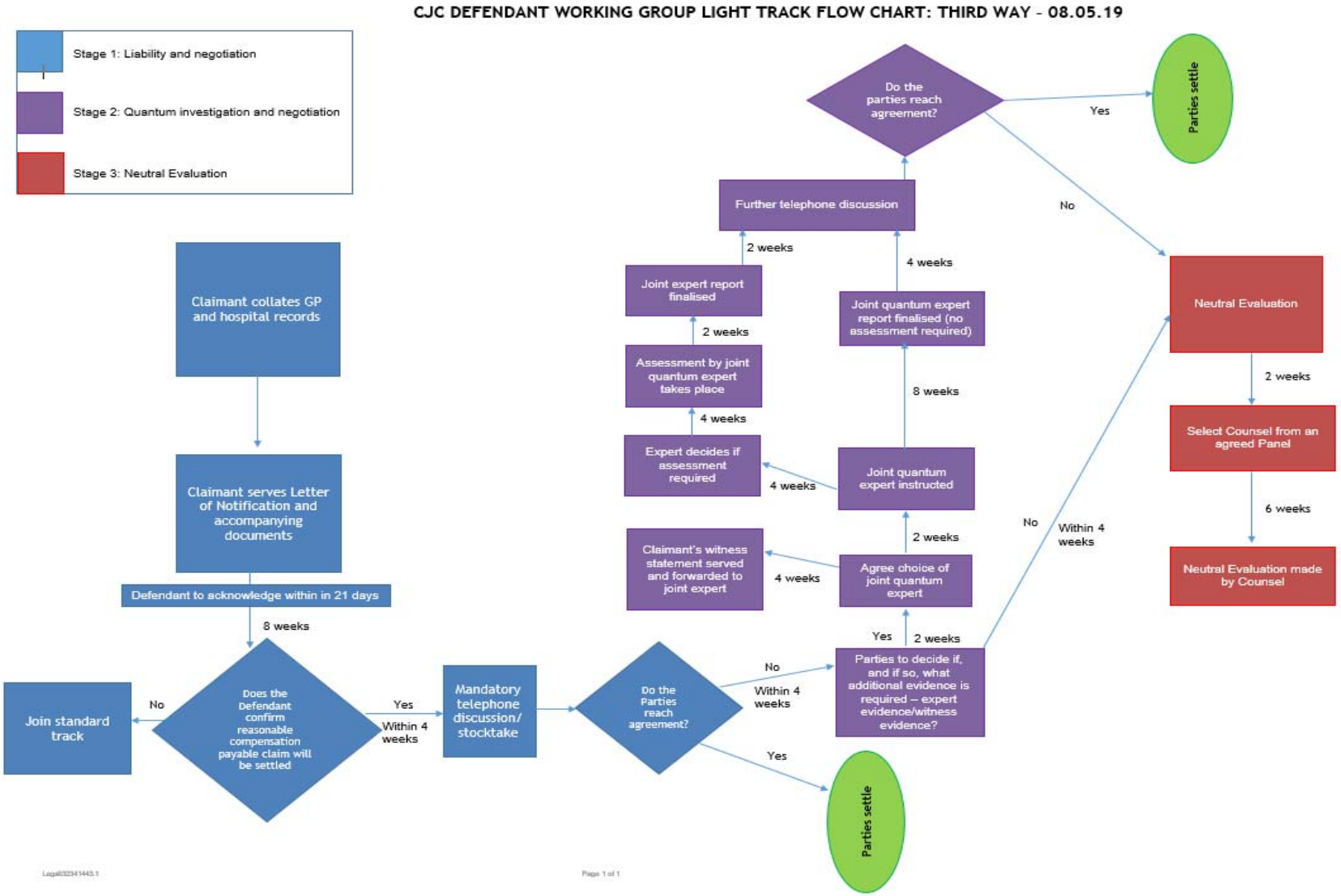
Stage 1	£5,750 plus 30% of damages
Stage 2	An additional £750

19. It would be possible to vary the formula for stage 1, to allow for concerns over any possible adverse behaviour or possibly to lessen the impact of the percentage element for cases at the upper end of the range of damages within the FRC scheme. Any variation for the latter point would need to be evaluated more carefully.

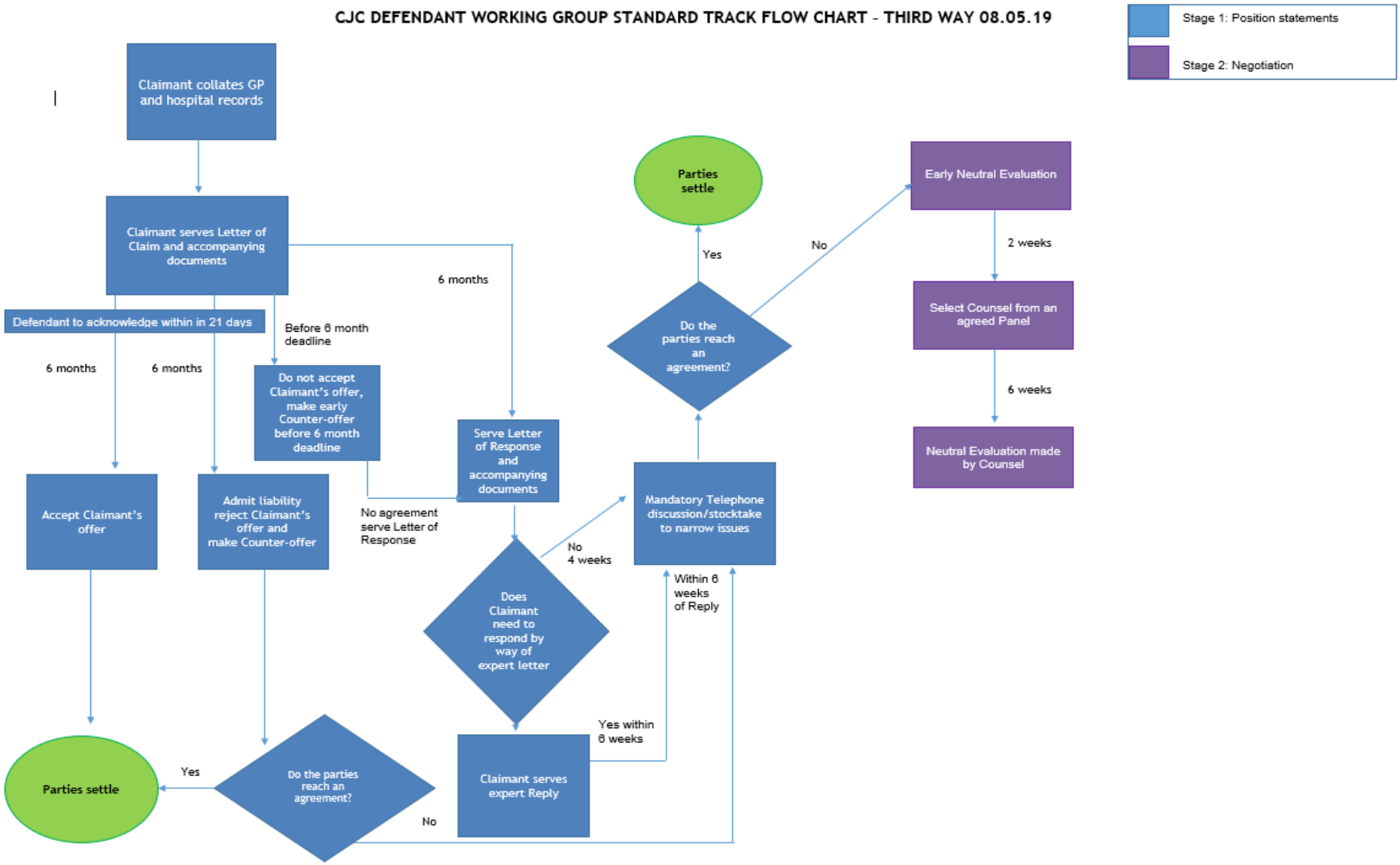
20. Even though this approach could not be applied to the LT, a solution for the ST would be expected to cover at least 75% of the volume of cases within the FRC scheme.

APPENDIX I

LT AND ST FLOWCHARTS

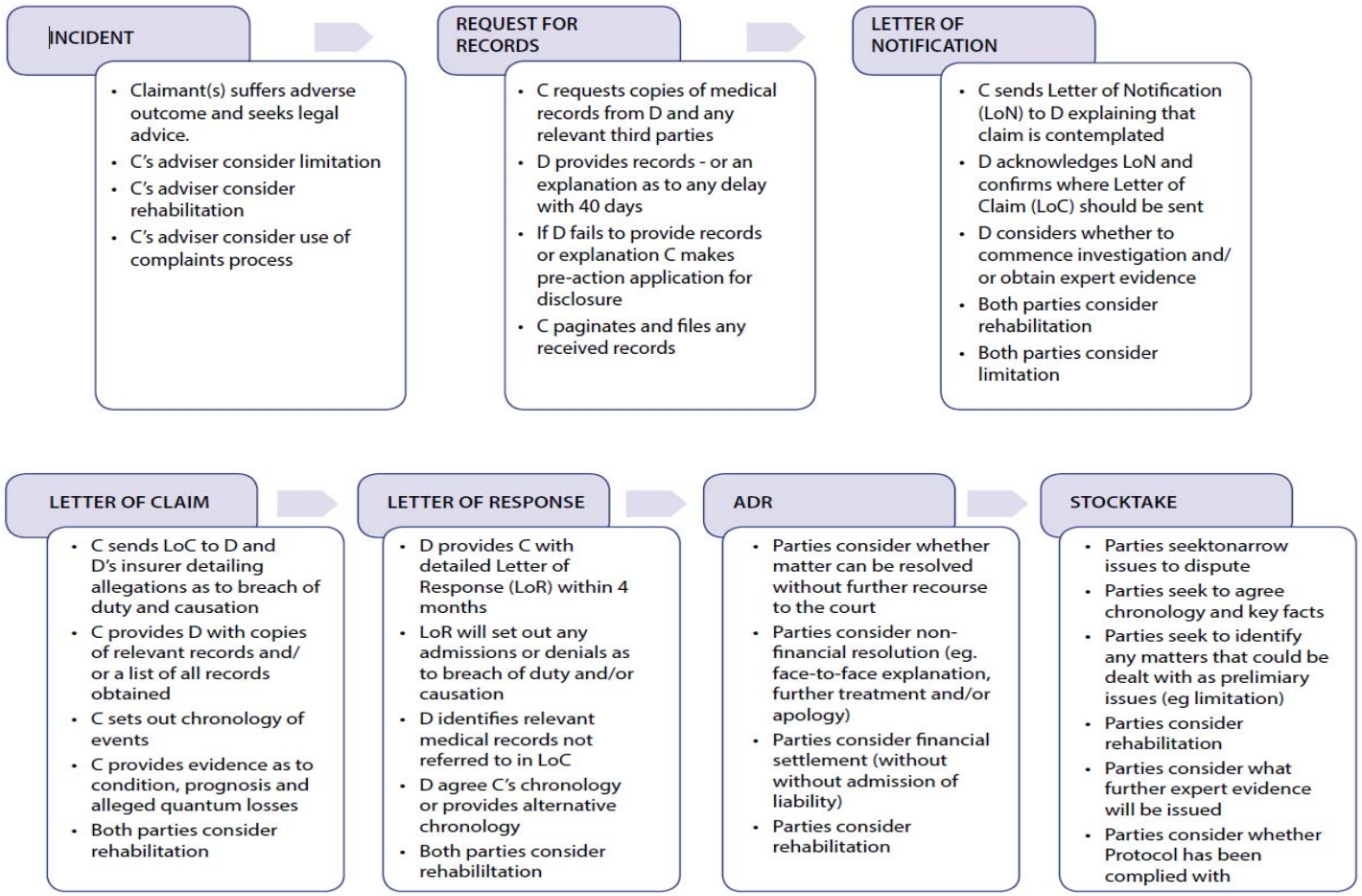


CJC DEFENDANT WORKING GROUP STANDARD TRACK FLOW CHART - THIRD WAY 08.05.19



APPENDIX J

CURRENT PROTOCOL FLOWCHART



APPENDIX K

TEMPLATED DOCUMENTS

Claimants' suggested template Letter of Claim for Fixed Recoverable Costs process

To

Defendant

Dear Sirs

Letter of Claim (Fixed Recoverable Costs)

[Claimant's name] –v- [Defendant's Name]

We have been instructed to act on behalf of [Claimant's name] in relation to treatment carried out/care provided at [name of hospital, GP or treatment centre] by [name of clinician(s) if known] on [insert date(s)]. Please let us know if you do not believe that you are the appropriate defendant or if you are aware of any other potential defendants.

Address for Service of Particulars of Claim

Unless you advise to the contrary we will use the following address and details to effect service of the Particulars of Claim: DETAILS OF HEALTHCARE PROVIDERS ADDRESS FOR SERVICE

Claimant's details

Full name, DoB, address, NHS Number, NI number and details of all NHS hospitals attended as a result of the alleged injury.

Limitation

On the application of limitation principles a claim must be brought within three years of the date of injury or date of knowledge. In this case, it would need to have commenced by xxx (specify date of incident or date of knowledge).

However limitation is suspended on entry to the scheme by service of a Letter of Claim and remains suspended until 12 weeks after exit from the scheme. In the first 28 days after service of the Letter of Claim the Defendant can expressly raise limitation as an issue in writing and if this was to occur then the limitation waiver would cease 28 days from this notice (as the case would exit scheme).

Dates of allegedly negligent treatment/ Events giving rise to the claim

2. No detailed chronology required
3. Include brief summary of key facts on relevant dates, including details of other relevant treatments by other healthcare providers.

Light Track [Delete if not applicable]

Based on the information currently available to us, it is our view that this case meets the criteria for the Lite Track and as such we do not intend to produce expert medical evidence. We have set out the allegations of negligence and brief details on how this case meets the criteria referred to. You should notify us within 28 days [TBC] if you disagree with this approach, otherwise we are entitled to assume that you do not disagree with this approach and will continue to conduct this claim in accordance with the Lite Track Rules.

Allegation of negligence and where applicable details of the how the Lite Track Criteria have been met.

3. A concise outline of each of the allegations of breach of duty said to have caused damage, injury or loss, or reference to paragraphs XYZ of the appended medical report in simpler cases if preferred
4. A copy of supportive witness statement of fact, if any, limited to maximum of 2 witnesses [Note: subject to clarification as to cases where no factual witness evidence is required]
5. A copy of supportive expert evidence [Note: subject to clarification as to cases where no expert evidence is needed on breach of duty]

Allegation of causation

- An outline of the causal link between each of the corresponding allegations of breach of duty above and the injuries complained of ,or reference to paragraphs XYZ of the appended medical report in simpler cases if preferred
- A copy of supportive expert evidence (likely to be the same report dealing with breach of duty unless it is not possible an expert in the same discipline to also opine on causation) [subject to clarification as to cases where no expert evidence is needed on causation]

Conditions and Prognosis:

- Details of the Claimant's injuries and prognosis.
- A copy of supportive expert report [subject to clarification as to cases where no expert evidence on quantum is required];
- Suggestions for rehabilitation;

Damages (set out below or enclose schedule of loss)

(i) General damages (by reference to relevant JCB guidelines and any relevant case law)

(ii) Details of the claimant's special damages are calculated as follows:

- Past care – estimate of amount of care provided, by whom and for how long etc together with hourly rate sought;

- Loss of earnings – details of any statutory sick pay; loss of bonus etc;
- Travel expenses to and from hospital – copies of any receipts available enclosed

(iii) Total estimated value of the claimant's claim: (i) + (ii) above

Patient Safety Issues

- In addition to the breaches of duty set out above, patient safety issues have been identified by the Claimant as follows: [set out list of concerns here eg handover, breaches of hospital policy/protocol; issues identified in SIR and/or any other relevant documents].

- Defendant's Letter of Response should acknowledge the patient safety issues raised by the Claimant in their Letter of Claim but the Defendant's substantive reply to these issues should be set out in a separate Patient Safety letter which should accompany the Letter of Response.

Clinical records/Internal investigations

We enclose an index of all the relevant records that we hold and copies of core medical and quantum documents eg wage slips, P60, receipts.

(Highlight any medical or interns investigation documents required or missing).

Funding

Please note that we have entered into a Conditional Fee Agreement with our client dated xxx in relation to this claim and that our client has taken out a policy of after the event insurance dated xxx with provider xxx under policy number xxx with a level of cover of £xxx.

Please note that we shall seek to recover part of the ATE insurance premium from your client at the conclusion of the claim if successful.

We look forward to receiving an acknowledgment of this letter within 14 days and your Letter of Response within 6 months of the date on which this letter was received. We calculate the date for receipt of your Letter of Response to be [date].

We look forward to hearing from you.

Yours faithfully

Defendants' suggested template Letter of Claim for Fixed Recoverable Costs process

To

Defendant

Dear Sirs

Letter of Claim (Fixed Recoverable Costs)

[Claimant's name] –v- [Defendant's Name]

We have been instructed to act on behalf of [Claimant's name] in relation to treatment carried out/care provided at [name of hospital, GP or treatment centre] by [name of clinician(s) if known] on [insert date(s)]. Please let us know if you do not believe that you are the appropriate defendant or if you are aware of any other potential defendants.

Claimant's details

Full name, DoB, address, NHS Number, NI number and details of all NHS hospitals attended as a result of the alleged injury.

Dates of allegedly negligent treatment/ Events giving rise to the claim

4. No detailed chronology required
5. Include brief summary of key facts on relevant dates, including details of other relevant treatments by other healthcare providers.

Allegation of negligence

6. A concise outline of each of the allegations of breach of duty said to have caused damage, injury or loss, or reference to paragraphs XYZ of the appended medical report in simpler cases if preferred
7. A copy of supportive witness statement of fact, if any, limited to maximum of 2 witnesses [Note: subject to clarification as to cases where no factual witness evidence is required]
8. A copy of supportive expert evidence [Note: subject to clarification as to cases where no expert evidence is needed on breach of duty]

Allegation of causation

- An outline of the causal link between each of the corresponding allegations of breach of duty above and the injuries complained of ,or reference to paragraphs XYZ of the appended medical report in simpler cases if preferred
- A copy of supportive expert evidence (likely to be the same report dealing with breach of duty unless it is not possible an expert in the same discipline to also opine on causation) [subject to clarification as to cases where no expert evidence is needed on causation]

The Client's injuries, condition and future prognosis

- A copy of supportive expert report [subject to clarification as to cases where no expert evidence on quantum is required];
- Suggestions for rehabilitation;

Clinical records

We enclose an index of all the relevant records that we hold and copies of core medical and quantum documents eg wage slips, P60, receipts.

The likely value of the claim

- A copy of outline Schedule of Loss if served separately, or breakdown of general damages (identifying JC Guideline or quantum authorities) and special damages (identifying heads of loss and basic calculations) if capable of setting out within the letter in simpler cases

Offer

- (Part 36) settlement offer [needs to go in separate letter?]

Funding

- Confirmation fixed costs case
- Confirmation of date of CFA (if applicable)
- Confirmation (if applicable) of recoverable ATE premium
- Alternatively confirmation of LSC, BTE or DBA funding (if appropriate)

We enclose a further copy of this letter for you to pass to your insurer, Defence organization or NHS Resolution as appropriate. We look forward to receiving an acknowledgment of this letter within 14 days and your Letter of Response within 6 months of the date on which this letter was received. We calculate the date for receipt of your Letter of Response to be [date].

We look forward to hearing from you.

Yours faithfully

Statement of Truth

Claimants' suggested Letter of Response

To

Claimant

Dear Sirs

[Claimant's name] –v- [Defendant's Name]

We have been instructed to act on behalf of [defendant] in relation to treatment carried out/care provided to [claimant] at [name of hospital or treatment centre] by [name of clinician(s) if known] on [insert date(s)].

Parties

It is accepted that [defendant] had a duty of care towards [claimant] in respect of [details if required] treatment/care provided to [claimant] at [location] on [date(s)].
However, [defendant] is not responsible for [details] care/treatment provided to [claimant] at [location] on [date(s)] by [name of clinician if known].

[if the defendant believes the claim should be addressed to an alternative defendant, that defendant should be specified]

Records and Documents

We hold the following records…
[list all records Defendant holds for the Claimant and provide copies of updated records ie any that post date those previously provided to the Claimant]

We enclose the following documents:
[provide copies of any relevant documents including protocols/guidelines, complaint files, SUI roles or duty of candour documents]

We require copies of the following records…

Comments on events and/or chronology:

We [agree the chronology enclosed with the Letter of Claim] [or set out a revised chronology of events – it is not sufficient to say the claimants chronology is agreed insofar as it accords with the records, any dispute should be set out]

Liability

In respect of the specific allegations raised by the claimant, the defendant [has obtained an expert opinion and] responds as follows:-

[each allegation should be addressed separately. The defendant should explain which (if any) of the allegations of breach of duty and/or causation are admitted and why. The defendant should also make clear which allegations are denied and why. The Defendant must set out it's case on causation – it is not acceptable to state that causation is not being investigated because breach of duty is denied]

Where liability is denied, the Defendant must

1. Serve the statements of the factual witnesses upon whom it will rely
2. [subject to discussion and not agreed] all expert evidence on breach of duty and causation

Quantum

[the defendant must state if quantum is agreed. If it is not, the Defendant must provide a counter schedule and valuation of general damages together with any supporting witness evidence (where appropriate) JC Guidelines, case law and any other documents]

Learning

[The Defendant should set out the steps taken or to be taken to demonstrate learning from the incident and to prevent recurrence or similar events and provide copies of any material produced to facilitate such learning].

Resolving the Claim

[If liability is admitted but quantum is not agreed, the Defendant should make an offer of settlement. If liability is denied the Defendant may either: make a counter offer; propose ADR which will usually be in the form of a telephone discussion; or state that they are not prepared to enter into ADR in which event they should, upon the issue of proceedings, file a witness statement stating why the case is not suitable for resolution by ADR]

The Claimant is requested to acknowledge receipt within 14 days.

Yours faithfully

Agreed-upon expert report model elements

1. Name of Claimant
2. Name of Defendant
3. Expert's name
4. Area of expertise
5. Details of any expert accreditation
6. Expert's contact details
7. Party's details and reference number
8. Documentation considered
9. Key date chronology
10. Opinion on breach of duty and/or causation
11. [Range of professional opinion (where this exists)]
12. Details of any relevant texts[/literature]
13. [Expert Declaration]