

Pre-consultation – Fixed Recoverable Costs Scheme

Summary

MPS manages claims for clinical negligence brought against GPs, dentists and private doctors, whilst the NHS Litigation Authority manages claims arising in the NHS hospital sector. The cost of clinical negligence is taking valuable funds away from the care of patients. It is important to have a debate as to whether the rising cost of clinical negligence is affordable for society.

MPS believes that it is important to create a clinical negligence litigation system that works well for all parties and is fair. However, tough decisions about healthcare funding are made every day; the costs of clinical negligence should not be seen as separate or unconnected from this. The NHS Litigation Authority's total estimated outstanding liabilities (the expected cost of settling all outstanding claims) run to £28.3bn. MPS' analysis of claims shows that GPs are more likely to be sued now than ever before and a full-time UK GP is expected to be twice as likely to receive a claim from their work this year as they were just seven years ago.

It is not unusual for claimants' lawyers' costs to exceed the damages awarded to claimants in lower value clinical negligence claims even where claims are settled at an early stage. Two recent examples include:

- In a recent cosmetic surgery case, damages of £17,500 were agreed within five months of being notified of the claim; however legal costs were claimed in excess of £50,000. The costs were finally settled at £36,000. This is still over double the amount the patient received in compensation.
- In a second case relating to delayed diagnosis of skin cancer, damages of £30,000 were agreed within five months and legal costs were claimed to the sum of £60,000. These costs were eventually settled at £42,000.

Added to this, MPS continues to be notified of claims where patients have entered into legal costs arrangements with their lawyers which predate the civil litigation cost reforms brought into effect by the Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPO) in April 2013. This Act was intended to reduce the costs of civil litigation, but has not yet had this anticipated impact on clinical negligence claims.

MPS is supportive in principle of the introduction of a Fixed Recoverable Costs Scheme for small value clinical negligence cases. This is a positive step forward, but more reform is needed to tackle the rising costs of clinical negligence. The next, and crucial step, is to have a debate on the merits of limiting damages, in particular the costs associated with future loss of earnings and care.

In our experience, damages, in particular, future care costs and earnings, have increased in recent years. We could learn from other countries; in some Australian states there are limits on the loss of earnings at, typically, a multiple of two or three times the average weekly earnings.

As difficult decisions are made about what the NHS can afford, it is crucial that we ask ourselves whether it is appropriate and affordable to continue to pay such large sums in damages and costs. MPS believes that these funds could be better spent on patient care for all.

MPS response to questionnaire

The Government proposes to introduce fixed recoverable costs for all cases where the letter of claim is sent on, or after, the proposed implementation date of 1st October 2016. Although this could affect cases where solicitors are already instructed but a letter of claim has not been sent, it leaves at least 12 months for such claimants to submit a letter of claim and so avoid the application of the proposed fixed recoverable costs regime.

1. Do you agree with this proposed approach to the transitional provisions?

MPS agrees with the proposed approach and the timelines involved. However, as part of the consultation process, it is important to consider how to mitigate the risk that there may be a large number of claims notified to claimants solicitors just prior to the introduction of any reforms. This was behaviour that we saw just prior to the new rules on recoverability of additional liabilities being introduced on 1 April 2013 where claimant solicitors aggressively marketed for clinical negligence claims to take advantage of the more generous pre-April 2013 costs rules. We would welcome the Government's thoughts on ways to prevent such a situation from arising again.

We welcome the proposal that the Fixed Recoverable Costs Scheme will be dependent on the point at which the letter of claim is served as opposed to the point that the claimant solicitor accepts the claimant's instructions.

If your answer is no, please explain how you consider the transitional provision should be set, having regard to the need for the effect of fixed recoverable costs to apply as soon as practicable.

N/A

The Government considers that the Fixed Recoverable Costs (FRC) scheme could be applied in clinical negligence to cases up to a value of £250,000 in damages and will apply both to pre-issue costs and post-issue, pre-trial costs.

2. Up to what value of damages do you think should be applied to the FRC regime?

- a. Up to £25,000**
- b. £25,0001 - £50,000**
- c. £50,000 - £100,000**
- d. £100,000 to £250,000**

Why do you believe this to be the right threshold?

MPS agrees in principle with the Government's proposal that the FRC scheme should apply to clinical negligence cases with a damages value of up to £250,000. We also agree that this should apply to pre-issue, post-issue and pre-trial costs. We also believe that the FRC scheme should include solicitors' and barristers' fees to ensure that fee earning activity is not unnecessarily outsourced to barristers.

However it is important to test the various models to ensure there are no unintended consequences and that they work in practise for all relevant parties.

Initial estimates by the NHSLA are that if a FRC scheme were to be introduced for claims between £1,000 and £100,000, savings to the NHS could be in the region of £80 million per annum. However, initial estimates suggest a further £25 million per annum could be saved if the threshold were set at £250,000¹. We understand that these are just initial estimates, but if correct, this would represent substantial savings to the public purse. This is money that could be more effectively spent on patient care. We also note that Lord Justice Jackson, further to his 2011 report, called for 'a scheme for fixed costs in the lower reaches of the multi-track²' and spoke of cases up to £250,000.

It is important that the scheme should be applied throughout the life of a claim up to trial. If cases were to fall out of the scheme once there had been a denial of liability, there is a risk that Letters of Claim would, in some cases, be drafted in such a way so as to generate a denial. This would prevent the resolution of those claims during the pre-action protocol stage. This would be a negative outcome for both defendant and claimant, as cases would be unnecessarily delayed, resulting in higher costs and the extra anxiety that prolonged litigation can cause.

There is a risk that claims may be over-inflated, whatever the upper threshold for fixed costs, in an attempt to engineer a claim to fall outside the remit of the FRC scheme. To mitigate such a situation, it is crucial that the existing sanctions that courts can impose to deal with exaggerated claims are applied consistently and appropriately. We consider that these sanctions should be sufficient to act as a deterrent.

It is also important that a FRC does not encourage claimants' solicitors to cut corners for example, by serving non-compliant Civil Procedure Rules letters of claim. This was a behaviour we have noticed in post-April 2013 claims where some claimant solicitors have attempted to run claims with very little pre-issue investigation, leaving the defendant to incur the costs of investigating what can be unmeritorious claims.

The Government is also concerned with the number and cost of expert reports obtained in lower value cases, which can add to the disproportionate costs incurred. The Government is therefore considering a proposal to cap experts' fees at a maximum recoverable sum which fairly reflects the likely number and cost of experts' reports needed in such cases. Under this proposal, the cap would apply to all reports both on liability/causation and on quantum/diagnosis.

3. Do you agree that capping experts' fees in this way would be a useful way forward?

MPS agrees that reform is required in relation to the use of claimant experts in lower value clinical negligence cases. We believe that, alongside a FRC scheme, there is a need to reduce expert fees, which will assist in preventing disproportionate costs in comparison with damages. We also believe that it is right that there should be a cap on the number of experts instructed in claims.

However, we recognise that, in order to maintain an adequate pool of quality experts, any system of capped or fixed expert fees must be reasonable and fair. We urge the Government to consider how best to achieve this important balance.

Currently, the regulations allow the recoverability of 'After the Event Insurance' (ATE) premiums to fund the costs of expert reports on liability and causation for clinical negligence claims, with no cap on

¹ Department of Health, Civil Procedure Rule Committee, Fixed recoverable costs in clinical disputes, 10 July 2015

² *ibid*

the numbers or the costs of the experts. This is an anomaly, as the recoverability of ATE premiums for expert reports is not allowed in other personal injury claims. We believe that these rules need reform and we would recommend that ATE premiums should not be recoverable in any FRC scheme for clinical negligence claims.

If your answer is no, how would you propose that the use of experts and the cost of their reports might best be managed, particularly before the first case management conference?

N/A

Our provisional thinking is that the fixed recoverable costs and ancillary rules should be sufficient to control behaviour on both sides and that no further sanctions would be required than currently appear in the rules for fixed recoverable costs generally. We consider that to this extent, the behaviour issues likely to be encountered in introducing fixed recoverable costs for clinical negligence will be no different from those encountered in other personal injury claims.

4. Do you agree that no special provisions will be required to control behaviour in clinical negligence claims?

MPS agrees that current sanctions should be sufficient to control behaviour.

If no, what sort of Rules do you feel would assist in controlling behaviour alongside Fixed Recoverable Costs?

N/A

For pre-issue costs, the Government is proposing a sliding scale for the fixed recoverable costs, calculated by reference to the level of damages agreed. This type of approach has been used successfully with other fixed recoverable costs regimes; it has obvious benefits in terms of applying proportionality and it is also acknowledged that it should encourage the solicitor to ensure that damages are recovered at the appropriate level. (The proposal for post-issue, pre-trial costs is likely to be for fixed costs in various stages according to when the case is settled.)

5. Do you agree with a sliding scale pre-issue?

MPS agrees that there should be a sliding scale of costs pre-issue. It is good to learn lessons from other FRC schemes and to implement what we know works best elsewhere. However, as explored in answer to question two, there is a risk that claims may be exaggerated at each threshold in an attempt to engineer a claim to move into the next scale category. To mitigate such a situation, it is crucial that the existing sanctions that courts can impose to deal with exaggerated claims are applied consistently and appropriately. We consider that these sanctions should be sufficient to act as a deterrent.

It is also important to ensure that there is a low, lower limit in any sliding scale. This is because a large proportion of dental cases fall under £25,000 and we see a great disparity between damages and costs in such cases. We therefore would like to see the first threshold set at £10,000.

Some recent examples of dental cases with a wide disparity between damages and costs include:

- A claim alleging failure to diagnose and treat periodontal disease. This settled for £5,000 but the bill of costs submitted by the claimant's solicitors totalled just over £47,000. Costs were finally agreed at just over £20,000 which is still over four times the level of damages that the patient received.
- A claim alleging a burn to the claimant's face following treatment for a restoration of an upper right molar. The case settled for £6,500. The bill of costs was claimed at more than £39,000, but was reduced on assessment to just over £10,000. This represents a 74.20% reduction.

If no, please explain what you would consider to be a more appropriate fixed costs structure for pre-issue cases.

N/A

About MPS

MPS is the world's leading protection organisation for doctors, dentists and healthcare professionals. We protect and support the professional interests of more than 300,000 members around the world. Our benefits include access to indemnity, expert advice and peace of mind. Highly qualified advisers are on hand to talk through a question or concern at any time.

Our in-house experts assist with the wide range of legal and ethical problems that arise from professional practice. This includes clinical negligence claims, complaints, medical and dental council inquiries, legal and ethical dilemmas, disciplinary procedures, inquests and fatal accident inquiries.

Our philosophy is to support safe practice in medicine and dentistry by helping to avert problems in the first place. We do this by promoting risk management through our workshops, E-learning, clinical risk assessments, publications, conferences, lectures and presentations.

MPS is not an insurance company. All the benefits of membership of MPS are discretionary as set out in the Memorandum and Articles of Association.

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