Extending Fixed Recoverable Costs to Clinical Negligence Claims up to £25,000 **IA No: 9608** **RPC Reference No:** N/A **Lead department or agency:** Department of Health and Social Care **Other departments or agencies:** Ministry of Justice, NHS Resolution	**Impact Assessment (IA)** **Date:** **Stage: Final** **Source of intervention:** Domestic **Type of measure:** Secondary legislation **Contact:** FRCconsultation@dhsc.gov.uk

Summary: Intervention and Options

RPC Opinion: N/A

Cost of Preferred (or more likely) Option (in 2022/23 prices)			
Total Net Present Social Value	**Business Net Present Value**	**Net benefit to business per year**	**Business Impact Target Status**
£6bn	-£1.1bn to £1.3bn	-£53m to £63m	Non qualifying provision

What is the problem under consideration? Why is government action or intervention necessary?

The claimant legal costs that can be recovered from a losing defendant in clinical negligence claims are considered to be disproportionate, for claims with damages valued between £1,500 and £25,000 ("lower damages claims"), to the value of damages awarded and associated defence costs. For such claims, legal costs recovered by successful claimants are, on average, double the value of compensation to claimants for matters settled in 2021[1]. This puts additional strain on limited NHS budgets and would only increase in the future as damages and claimant legal costs rise. Clinical negligence is one of the last remaining areas of personal injury claims in which the legal costs recoverable from the defendant are not currently fixed for claims with lower damages. The current regime leads to a misallocation of time and resources. Government intervention, through secondary legislation through the Civil Procedure Rules Committee, is necessary to streamline the legal process and bring proportionality to the clinical negligence market.

What are the policy objectives of the action or intervention and the intended effects?

The policy objective is to create a fast, fair, and cost-effective system that benefits claimants and defendants, and reduce the costs to the NHS. Intervention would streamline the legal process for lower damages clinical negligence claims and fix the amount of legal costs that a successful claimant can recover from a losing defendant for pre-action costs. This would make recoverable legal costs more proportionate to the value of damages awarded and rebalance the cost liabilities of claimants and defendants. The intended effects are to promote and enable quicker, more proportionate, and more cost-effective resolution to all.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

- Option 0: Business As Usual (BAU) – the process for handling clinical negligence lower damages claims will remain unchanged.
- Option 1: Implement fixed recoverable costs (FRC) to for all lower damages clinical negligence claims based on a median set of costs between claimant and defendant, as defined by the CJC working group (see below) and introduce a streamlined claims handling process for lower damages clinical negligence claims.

In 2018, following an initial 2017 consultation on FRC proposals, the Department of Health and Social Care (DHSC) and the Ministry of Justice (MoJ) jointly commissioned the creation of a CJC working group. Following its recommendations, a consultation was launched in January 2022. Following consideration of responses to this consultation, the preferred option is option 1.

Other options were also considered as part of the policy development, including proposals by claimant and defendant solicitors, and a midpoint proposal by DHSC. However, they have since then been rejected following the consultation.

Will the policy be reviewed? It will/will not be reviewed. **If applicable, set review date:** April 27

Is this measure likely to impact on international trade and investment?		No		
Are any of these organisations in scope?	**Micro** Yes	**Small** Yes	**Medium** Yes	**Large** Yes
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)		**Traded:** N/A	**Non-traded:** N/A	

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible SELECT SIGNATORY: ..... Date: .....

[1] NHS Resolution (2022). Annual Statistics (Supplementary Annual Statistics, Tables 9.A and 11.A.1). Available at NHSR-Supplementary-Account-Stats-2021-22-Revised-For-Publication-V3.xlsx (live.com).

Summary: Analysis & Evidence

Policy Option 0

Description: BAU – the process for handling lower damages clinical negligence claims will remain unchanged.

FULL ECONOMIC ASSESSMENT

Price Base Year	PV Base Year	Time Period	Net Benefit (Present Value (PV)) (£m)		
2022/23	2023/24	**Years** 20	**Low:** 0	**High:** 0	**Best Estimate:** 0

COSTS (£m)	Total Transition (Constant Price) 1 Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	0	0	0
High	0	0	0
Best Estimate	0	0	0

Description and scale of key monetised costs by 'main affected groups'

Option 0 is the baseline "business as usual" option. The current system will continue with no reform. All associated risks and costs will continue and not change. Options for intervention will be assessed relative to this option.

Other key non-monetised costs by 'main affected groups'

See above.

BENEFITS (£m)	Total Transition (Constant Price) 20 Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	0	0	0
High	0	0	0
Best Estimate	0	0	0

Description and scale of key monetised benefits by 'main affected groups'

Option 0 is the baseline "business as usual" scenario. The current system will continue with no reform. There are no benefits to be achieved and any costs or risks associated with other options will not be incurred. Other options for intervention will be assessed relative to this option.

Other key non-monetised benefits by 'main affected groups'

See above.

Key assumptions/sensitivities/risks **Discount rate (%)**

This baseline assumes that nothing else happens in the short to medium term to change the process for handling lower damages clinical negligence claims. Also, it is assumed that average claimant legal costs continue to rise in-line with historical growth and that claims volume remains broadly stable. Continuation of the system as is, could therefore increase the risk that claimant legal costs continue to grow at a faster pace than compensation to claimants, leading to a continued relative increase in costs to the NHS.

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			Score for Business Impact Target (qualifying provisions only) £m: N/A
Costs:	**Benefits:**	**Net:**	0
0	0	0	

Summary: Analysis & Evidence

Policy Option 1

Description: Implement fixed recoverable costs to lower damages clinical negligence claims based on a median set of costs between claimant and defendant proposals as defined by the Civil Justice Council (CJC) working group.

FULL ECONOMIC ASSESSMENT

Price Base Year	PV Base Year	Time Period Years	Net Benefit (Present Value (PV)) (£bn)		
2022/23	2023/24	20	**Low:** Optional	**High:** Optional	**Best Estimate: 6.0**

COSTS (£bn)	Total Transition (Constant Price) 1 Years		Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Optional		Optional	Optional
High	Optional		Optional	Optional
Best Estimate				1.2

Description and scale of key monetised costs by 'main affected groups'

The streamlined framework is estimated to reduce income from claims for solicitors representing individual claimants by £1.2bn. New administrative costs for NHS Resolution, public defendants acting on behalf of NHS hospitals in England, and other defendant solicitors have been quantified as £21m. Claimant solicitors will face similar administrative costs to navigate the new streamlined process of £21m.

Other key non-monetised costs by 'main affected groups'

Claimant and defendant solicitors and NHS Resolution will face transitional set-up and familiarisation costs, however, they may be minimal as FRC is already in place for other types of personal injury claim. Any additional costs faced by claimant solicitors would be either absorbed by the businesses (potentially reducing their revenue) or passed on to individual claimants. A faster process could disadvantage defendants as they would have to reimburse claimants earlier.

BENEFITS (£bn)	Total Transition (Constant Price) 1 Years		Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Optional		Optional	Optional
High	Optional		Optional	Optional
Best Estimate				7.2

Description and scale of key monetised benefits by 'main affected groups'

The streamlined framework will reduce legal costs reimbursed by public defendants, estimated to create £1bn in savings for NHS hospitals in England, and £1.3bn or other healthcare providers in the public and private sector, £2.3bn in total. The IA also takes account of the opportunity cost to the NHS and social value of benefits from NHS cost savings to produce an estimated societal benefit of £7.2bn.

Other key non-monetised benefits by 'main affected groups'

Claimant solicitors and defendants will benefit from improved predictability of cash flows. A faster process could benefit claimant solicitors and individual claimants as they would be reimbursed earlier.

Key assumptions/sensitivities/risks	Discount rate (%)	1.5/3.5%

We assume that there are no significant changes in future caseload. There are risks to this assumption: 1) implementation could see a temporary spike of new cases, followed by a reduction in claims volume; 2) changes in the propensity of individuals to bring claims, or for solicitors to take them on; 3) changes in damages awarded.

Other key assumptions are that a detailed policy design will ensure enough safeguards are in place to discourage unintended behaviours, and that the proposed sanction measure will successfully incentivise good behaviours and deter or minimise counterproductive behaviours. We assume claimant solicitors will seek to maximise their return from the new process, which means they have an incentive to settle each claim at whatever stage of the process is most beneficial to them. They may of course choose in some claims to issue proceedings following the pre issue process and settle at a later stage and they will not be precluded from doing so.

BUSINESS ASSESSMENT (Option 2)

Direct impact on business (Equivalent Annual) £m:			Score for Business Impact Target (qualifying provisions only) £m:
Costs:	**Benefits:**	**Net:**	
£59m	**£64m**	**£5m**	N/A

Contents

Evidence Base

Introduction

1. This impact assessment (IA) sets out the costs, benefits and risks of the proposed introduction of a fixed recoverable costs scheme for lower damages clinical negligence claims. Table 1, 2, and 3 below, present the best estimate of the costs and benefits of the policy, in cashflow and social value terms. The IA contains several sensitivity analyses of the main assumptions used to derive these estimates. The sensitivity analyses are detailed throughout the IA and summarised in Table 12. Table 12 also contains a detailed breakdown of the costs and benefits summarised below, for different groups.

Table 1: Costs of the policy in cashflow terms (discounted, real 22/23 prices)

Cost		PV of Yearly Projected Cashflow Costs (millions)									
		1	2	3	4	5	6	7	8	9	10
Defendants (NHS)	Admin costs of new process	0	0.6	0.6	0.6	0.6	0.6	0.5	0.5	0.5	0.5
Defendants (all other)	Admin costs of new process	0	0.8	0.8	0.8	0.7	0.7	0.7	0.7	0.6	0.6
Claimant solicitors	Admin costs of new process	0	1.4	1.4	1.4	1.3	1.3	1.2	1.2	1.2	1.1
Claimant solicitors	Legal costs not recoverable	0	2	14	34	54	66	72	74	74	73
Total Annual Cost		**0**	**5**	**17**	**37**	**56**	**69**	**74**	**76**	**76**	**76**

Cost		PV of Yearly Projected Cashflow Costs (millions)										NPV (£m) (20 years)
		11	12	13	14	15	16	17	18	19	20	
Defendants (NHS)	Admin costs of new process	0.5	0.5	0.5	0.4	0.4	0.4	0.4	0.4	0.4	0.4	9
Defendants (all other)	Admin costs of new process	0.6	0.6	0.6	0.6	0.6	0.5	0.5	0.5	0.5	0.5	12
Claimant solicitors	Admin costs of new process	1.1	1.1	1.0	1.0	1.0	1.0	0.9	0.9	0.9	0.9	21
Claimant solicitors	Legal costs not recoverable	73	72	71	70	70	69	68	67	66	65	1155
Total Annual Cost		**75**	**74**	**73**	**72**	**72**	**71**	**70**	**69**	**68**	**67**	**1197**

Table 2: Benefits of the policy in cashflow terms

Benefits		PV of Yearly Projected Cashflow Savings (millions)									
		1	2	3	4	5	6	7	8	9	10
Defendants (NHS)	Reduction in legal costs recovered against healthcare providers	0	2	13	30	48	59	64	65	65	65
Defendants (all other)		0	2	16	38	60	74	80	82	82	82
Total Annual Benefit		**0**	**4**	**29**	**68**	**108**	**133**	**144**	**147**	**147**	**147**

Benefits		PV of Yearly Projected Cashflow Savings (millions)										NPV (£m) (20 years)
		11	12	13	14	15	16	17	18	19	20	
Defendants (NHS)	Reduction in legal costs recovered against healthcare providers	64	64	63	62	62	61	60	59	59	58	1022
Defendants (all other)		81	80	79	79	78	77	76	75	74	73	1287
Total Annual Benefit		**146**	**144**	**143**	**141**	**139**	**137**	**136**	**134**	**132**	**131**	**2309**

Table 3: Summary of costs, savings, and net savings 10 years post implementation and across the full appraisal period.[1]

		2024/25 - 2033/34 Total Cashflow (£m)	20-year appraisal period	2024/25 - 2033/34 Total Social value (£m)	20-year appraisal period
Costs					
Defendants (NHS Hospitals)	Admin cost of new process	6	9	29	53
Defendants (all other)		7	12	7	12
Claimant solicitors	Legal costs not recoverable	536	1155	536	1155
Claimant solicitors	Admin cost of new process	13	21	13	21
Total Costs		**561**	**1197**	**585**	**1241**
Savings					
Defendants (NHS Hospitals)	Reduction in legal costs recovered against health care providers	475	1022	2504	5934
Defendants (All Other)		598	1287	598	1287
Total Savings		**1072**	**2309**	**3102**	**7221**
Net Savings (cashflow)					
NHS		469	1012	2475	5881
All Other		42	100	42	100
Total Net Savings		**511**	**1112**	**2517**	**5981**

Problem under consideration and rationale for intervention

Policy Background

2.Section 46(1)(5) of the Legal Aid, Sentencing and Punishment of Offenders (LASPO) Act 2012 defines clinical negligence as: "a breach of a duty of care or trespass to the person committed in the course of the provision of clinical or medical services (including dental or nursing services)".

3.In clinical negligence claims, the person harmed, or their agents (referred to as the 'claimant'), may seek compensation (also referred to as 'damages') through the courts against those who are seen as being responsible for causing that harm (referred to as the 'defendant'). If the claimant is successful in being awarded damages, the defendant must pay these damages and the reasonable legal costs incurred by the claimant (referred to as 'claimant legal costs'), as well as their own legal costs (referred to as 'defence costs'). In contrast, if the claimant is unsuccessful, the defendant cannot recover their legal costs from the claimant (referred to as 'qualified one-way cost-shifting'), except in a selection of very specific circumstances – so in scenarios where they are unsuccessful, the claimant, or the claimant solicitors, will only be required to cover their own costs.

4.Conditional fee arrangements (CFAs, more commonly known as 'no win no fee'), where the claimant's lawyer does not seek payment of his fees from the claimant if the case is lost, are the most common type of arrangements for seeking clinical negligence compensation. In 2013, NHS Resolution, which handles many of clinical negligence claims in England, recorded 80% of cases as CFA[2]. Under this arrangement, lawyers are entitled to set a percentage of any damages obtained by the claimant should the claim be successful (a 'success fee'). Success fees are recovered by claimant lawyers over and above any legal costs recovered for their work. Following LASPO Act 2012, a losing defendant is no longer liable for paying the successful claimant lawyer's success fee; the liability now rests with individual claimants, and a success fee cannot exceed 100% of normal fees, capped at 25% of damages awarded (referring only to general damages and past losses).

[1] See table 12 for a breakdown of costs and benefits for different groups.

[2] Fenn, P.; Gray, Alastair; Rickman, N. and Vencappa, D. (2016), *Funding clinical negligence cases: Access to justice at reasonable cost?* Nuffield Foundation. Available at Funding_clinical_negligence_cases_Fenn_v_FINAL.pdf (nuffieldfoundation.org)

5.The Department for Health and Social Care (DHSC) previously consulted on fixed recoverable cost (FRC) proposals for lower value clinical negligence claims in 2017[3]. The responses to this consultation broadly showed that claimant solicitors were opposed to FRC, and defendant solicitors were in favour. DHSC also published an illustrative draft of the Civil Procedure Rules which would apply to its proposals and sought views on several key elements. Overall, there was little agreement between different groupings of respondents.

6.FRC has been in place for most lower damages claims regarding personal injury matters since 2013, following Sir Rupert Jackson's 2010 report on reforming legal costs. "Lower damages claims" are claims where the value is estimated to be in excess of the small claims upper limit for non-road traffic accident (RTA) personal injury claims and up to £25,000. The current small claims upper limit for non-RTA personal injury claims is £1,500, which increased from £1,000 in April 2022. Clinical negligence claims were excluded from these initial FRC reforms.

7.In July 2017, Sir Rupert Jackson made recommendations for extending FRC to personal injury claims valued at up to £100,000. He recommended a way forward for addressing clinical negligence claims up to £25,000, proposing that a Civil Justice Council (CJC)[4] working party be formed, with both claimant and defendant representatives, to develop a bespoke process for handling clinical negligence claims valued between £1,000 and £25,000 ('lower damages claims'[5]) with a grid of FRC.

8.DHSC agreed with Sir Rupert Jackson's recommendation and, jointly with the Ministry of Justice, commissioned the CJC to undertake this work. The CJC working group published its report in October 2019 detailing a bespoke scheme for handling these claims[6]. DHSC launched a further consultation in January 2022 with proposals closely based on the solutions set out in the CJC report – a fixed costs scheme with streamlined processes for two distinct claim tracks designed to process and resolve claims quickly and fairly, with predictable costs. The responses to this consultation have informed the preferred option set out in this impact assessment; to reform the clinical negligence market based on the new small claims track upper limit of £1,500.

9.The policy intent of our proposed FRC scheme is to enable more lower damages claims to be resolved more quickly, and more cost-effectively in the pre-litigation stage. The intention is that access to justice will be protected, including through appropriate exclusions from the scheme and that all parties can plan and manage these claims more effectively in the pre-issue phase, without affecting parties' rights to pursue litigation subsequently.

10.The proposals relate to fixing claimant legal costs only – not the compensation that claimants receive. In the overwhelming majority of cases, these legal costs are funded via a conditional fee arrangement between a claimant and their solicitor. We do not expect that claimants themselves will be financially disadvantaged by the fixed costs scheme, due to market adjustments we expect to occur.

11.Claim duration has increased as well as costs over the last decade. The longer cases take to settle, the greater the risk of potential distress felt by patients and their families and the higher the costs. We expect that our proposals, which are designed to reduce average claim duration by at least a third, will benefit claimants in terms of facilitating faster processing of their claims and a more predictable process and timetable. This will mean that successful claimants could receive their compensation faster.

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[3] DHSC FRC consultation and consultation response:
https://www.gov.uk/government/consultations/fixed-recoverable-costs-for-clinical-negligence-claims

[4] The CJC are an advisory, non-departmental public body, sponsored by the Ministry of Justice (MoJ), that are responsible for overseeing and co-ordinating the modernisation of the civil justice system.

[5] 'Lower damages claims' in this impact assessment refers to clinical negligence claims with a value at settlement from £1,501 to £25,000 inclusive.

[6] CJC's full report on FRC recommendations:
https://www.judiciary.uk/related-offices-and-bodies/advisory-bodies/cjc/working-parties/fixed-recoverable-costs-in-lower-value-clinical-negligence-claims/

Problem Identification

12. In the interest of transparency, analysis presented in this section relies on published data which presents various statistics for the £1,000 - £25,000 damage band. However, the cost benefit analysis that follows relies on a £1,500 - £25,000 damage band as it is the intention of the policy for claims within this band to be in scope. Though this discrepancy exists, there is little difference in the statistics and therefore the problem outlined in this section holds.

13. Data provided by NHS Resolution, which indemnifies and handles clinical negligence claims against the NHS on behalf of NHS Trusts and, since 2019, GPs in England, shows that the annual cost of clinical negligence claims against the NHS is rising at a faster rate year-on-year than NHS funding – rising from £0.6 billion in 2006/07 to £2.4 billion in 2021/22 for NHS services in England[7] (in cash terms), a 300% increase[8]. Comparatively, NHS funding rose from £77 billion in 2006/07, to £150 billion in 2021/22 (in cash terms)[9], a 95% increase. [10]. In contrast, prices in the general economy have risen by 40% between 2006/07 and 2021/22, an average of 2.2% per year[11].

14. From 2006/07 to 2022/23, the number of successful clinical negligence claims where damages were awarded has more than doubled, from 3,112 to 6,888.[12] Recoverable claimant legal costs are a significant proportion of the annual bill (£491m[13], or around 20% of the total in 2022/23). These have increased by 402% since 2006/07, compared to a 242% increase in damages and a 191% increase in defence costs.

15. Publicly available data for NHS Resolution claims between £1,000 to £25,000 illustrates the disproportionate nature of these costs with average claimant legal costs (around £21,000 to £23,000 in recent years) more than double the average damages awarded (around £11,000 in 2021/22)[14]. These values include VAT and all disbursements (profit, counsel fees, expert fees, court fees, and admin costs). However, in our cost benefit analysis section, expert fees are not included in the average claimant legal costs.

16. We recognise claimant and defence solicitors have fundamentally different tasks. However, with the average recoverable claimant legal costs standing at more than four times the defence costs incurred (around £5,000 in 2021/22) for claims valued between £1,000 and £25,000[15], we support the CJC view that there is scope for improving the current process.

17. Claims settled between £1,000 and £25,000 represent an important segment of the clinical negligence legal market. For instance, in 2021/22, around 50% of all claims relating to NHS England Trusts and settled with damages are within this segment, and it is reasonable to believe a similar proportion of unsuccessful claims would also be handled by a new fixed recoverable costs process. Taking account of both successful and unsuccessful small claims, this means that

[7] NHS Resolution (2022). Annual Statistics (Annual Supplementary Statistics, Table 1.A). Available at: NHSR-Supplementary-Account-Stats-2021-22-Revised-For-Publication-V3.xlsx (live.com)

[8] The annual cost of clinical negligence claims rose to £2.6bn in 2022/23 (in cash terms), representing a 350% increase from 2006/07. NHS Resolution (2023). Annual Report and Accounts 2022/23. Available at: NHS Resolution - Annual report and accounts 2022/23 (publishing.service.gov.uk). p. 40.

[9] HMT Public Expenditure Statistical Analyses https://www.gov.uk/government/collections/public-expenditure-statistical-analyses-pesa

[10] NHS Resolution (2022). Annual Statistics (Annual Supplementary Statistics, Tables 3.A.3 and 7.A). Available at: NHSR-Supplementary-Account-Stats-2021-22-Revised-For-Publication-V3.xlsx (live.com)

[11] ONS Consumer Price Inflation Time Series CPI INDEX 00: ALL ITEMS 2015=100 - Office for National Statistics (ons.gov.uk)

[12] NHS Resolution (2022) Annual Statistics (Annual Report Statistics, Table C.1). Available at: https://resolution.nhs.uk/resources/annual-report-statistics/ and
NHS Resolution (2023). Annual Report and Accounts 2022/23. Available at: NHS Resolution - Annual report and accounts 2022/23 (publishing.service.gov.uk). p. 44.

[13] NHS Resolution (2023). Annual Report and Accounts 2022/23. Available at: NHS Resolution - Annual report and accounts 2022/23 (publishing.service.gov.uk). p. 40.

[14] NHS Resolution (2022). Annual Statistics (Annual Supplementary Statistics, Tables 9.A and 11.A.1). Available at: NHSR-Supplementary-Account-Stats-2021-22-Revised-For-Publication-V3.xlsx (live.com)

[15] NHS Resolution (2022). Annual Statistics (Annual Supplementary Statistics, Table 13.A.1). Available at: NHSR-Supplementary-Account-Stats-2021-22-Revised-For-Publication-V3.xlsx (live.com)

around 7,000 of the c13,000 claims NHS Resolution settles every year could be affected by the proposed reforms[16].

18. According to the NAO's 2017 report, from 2010/11 to 2016/17, the average time taken to resolve claims rose each year, from 300 to 426 days. We know from analysis of 2021/22 claims data that successful claims which settled with a value between £1,001 and £25,000 had an average "claim duration" (time taken from claim notification to settlement) of 1.3 years, an increase of 46% in claim duration over the last 10 years. The highest increase in average claim duration has occurred in the lower damages clinical negligence claims bracket, along with claims in the lowest damage band (£1 to £1,000).

19. Fixed recoverable costs will apply to healthcare in England and Wales, including privately and NHS-funded hospital care but also primary healthcare services (general practice, community pharmacy, dentistry and eyecare) and community health services. Data from the Compensation Recovery Unit (CRU) suggests in total approximately 16,744 claims were settled within England, Scotland, and Wales (those settled in Scotland would be out of scope of this reform)[17].

Rationale for Intervention

20. Total claimant costs for this value band of clinical negligence claims have quadrupled from 2006/07 to 2021/22, rising much more quickly than defendant costs which have approximately doubled over this time period. Claimant costs are also disproportionate to damages, on average, costs are double the amount of damages that claimants receive for lower damages claims. Finally, we believe there is scope for these claims to be processed and resolved more quickly. The proposed fixed costs regime supported by a streamlined process is intended to address these three issues.

21. Clinical negligence is one of the last remaining areas of personal injury where claimant solicitors can recover costs on an hourly rates basis. As a result, there are few incentives to settle lower damages claims quickly and efficiently.

22. It is for claimant solicitors to decide whether they will agree to represent a client in a particular clinical negligence claim based on a range of factors, including on the merits of the case and the perceived likelihood of success. That decision will also be informed by an estimation, based on experience and the facts of the case, of the potential value of the claim and the legal costs that are likely to be incurred in conducting the claim.

23. Currently, claimants will contract with solicitors, and legal costs are recovered from the defendant if the claim is successful. Under a CFA, claimants may agree to pay their solicitor other unrecoverable amounts from their damages. The approach to additional client charges is variable but might include: a) a success fee; b) the shortfall between costs recovered from the defendant and what the solicitor considers to be the costs incurred. The extent to which charges of this nature are currently made is unclear. Little information is available from claimant solicitors about these charging practices and published material indicates a range of approaches are used. The defendant from whom damages are recoverable in case of a successful claim is unable to control the size of the legal costs claimed. For cases likely to succeed, neither claimant solicitors nor their clients have an appropriate incentive to drive down inefficient costs, as neither party to the contract will be affected (a cost-shifting externality).

24. The checks and balances in the current system have not been effective in addressing the increase in claimant costs seen in recent years. These include guideline hourly rates which guide judges when awarding costs, but are not definitive. Legal costs can also be assessed by the courts, however, this does not occur for all claims, and it also adds extra cost and court time.

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[16] NHS Resolution (2022). Annual Statistics (Annual Report Statistics, Table C.1). Available at NHSR-Annual-Report-Statistics-2021-22-for-publication-V3.xlsx (live.com). We assume 49% of the currently unsuccessful 6,297 claims would be handled by a new FRC process in addition to the 3,340 claims settled in the £1,000-£25,000 damages band.

[17] Number of clinical negligence settlements recorded by the Compensation Recovery Unit (apportioned to England and Wales) https://www.gov.uk/government/publications/compensation-recovery-unit-performance-data/compensation-recovery-unit-performance-data#settlements-recorded-by-cru

25. Whilst claimant solicitors are able to charge an hourly rate within clinical negligence claims, defendant solicitors work to fixed or capped rates. As previously highlighted, average recoverable claimant legal costs stand at more than four times the defence costs incurred for claims against NHS Trusts in England for lower damages claims.

26. The current regime does not incentivise efficient transaction costs and could contribute to a misallocation of time and resources, representing a market failure. Using less resource to secure the same outcome would result in improved efficiency.

Rationale and evidence to justify the level of analysis used in the IA (proportionality approach)

27. The reforms covered in this impact assessment will have cost and time implications for up to 7,000 of the 13,000 people who pursue claims against the NHS per year, their solicitors and the NHS in England and Wales. Available evidence has been used to identify the main costs and benefits to these stakeholders, including those raised by respondents in the recent FRC consultation (January 2022).

28. Estimates for the costs and benefits relating to NHS claims have been modelled and monetised, where data is available and it is possible, and proportionate, to do so. The data relied on for this exercise includes claim level data from NHS Resolution to understand the nature and counterfactual cost of the claims in scope of reforms. The data runs through a top-down model, based on similar modelling used by the Government Actuary's Department (GAD) for supporting NHS Resolution (NHSR) with estimating their annual provision, to produce the costs and savings of FRC in relation to the Clinical Negligence Scheme for Trusts (CNST) only (which accounted for 92%[18] of NHSR's total legal costs in 2021/22). Consequently, the cost and benefits presented in this IA in relation to NHSR claims are an approximation.

29. The FRC reforms will apply to all lower damages clinical negligence cases in England and Wales (unless claims are exempt under specified exclusions), however, the modelling above estimates costs relating to clinical negligence cases in NHS trusts only. Two further steps are taken. Firstly, published data is used to scale the estimates above so that they apply to all NHSR clinical negligence settlements, and not just CNST. Secondly data from the Compensation Recovery Unit have been used to scale the estimate of costs above, to take account of clinical negligence cases in England and Wales which has taken place in other healthcare settings (i.e., outside of NHS Trusts). These analyses are high level and contains uncertainties, which are outlined below. (see 'costs for non NHSR claims' below).

30. Alongside this, further government-wide datasets have been used to provide an as accurate as possible cost estimate for the net present value of the costs and benefits for all individuals that may be in scope. For any uncertainties, such as additional time that may be required to adhere to this policy, assumptions have been made and sensitivity analysis has been carried out.

Description of options considered

31. This impact assessment considers two options:

- Option 0: BAU – the process for handling lower damages clinical negligence claims will remain unchanged.
- Option 1: Implement fixed recoverable costs to lower damages clinical negligence claims based on a median set of costs between claimant and defendant proposals as defined by the CJC working group.

32. Other options were also considered as part of the policy development but have since then been rejected following the consultation. These are:

[18] NHS Resolution (2022). Annual Statistics (Annual Supplementary Statistics, Tables 1.A, 5.A and 7.A). Available at: NHSR-Supplementary-Account-Stats-2021-22-Revised-For-Publication-V3.xlsx (live.com)

- Claimant proposal: proposal based on claimant solicitors' position; the CJC report resulted in two proposals for grid costs following disagreement with the two solicitor groups.
- Defendant proposal: proposal based on defendant solicitors' position.
- DHSC Midpoint proposal: a point between claimant and defendant grid cost proposals for the base fees.

Option 0 (BAU)

33. Option 0 is not recommended but is included in this impact assessment as a baseline to compare other options against. The current arrangements determining how much claimants can recover in legal costs remain in place. Within this, it is assumed that average claimant legal costs per claim will continue to rise in-line with historical growth and that claims volume remains broadly stable.

Option 1 (implement FRC for lower damages clinical negligence claims)

34. This option is the preferred option and has two elements. The first is to introduce a streamlined claims handling process for lower damages clinical negligence claims. The second is to introduce FRC for those same claims based on a median set of costs between claimant and defendant grid cost proposals. The claims exclusions applied follow the defendant proposal exclusions as defined by the CJC working group (see table 3 below).

35. The CJC working group was clear that their remit was to consider and propose an FRC scheme for lower damages clinical negligence claims, where the lower limit is tied to the lower damages claims track limit, currently £1,500, and up to £25,000.

Policy Objective

36. The policy objective is to create a fast, fair and cost-effective system that benefits claimants and defendants and reduces the costs to the NHS. Intervention would streamline the legal process for lower damages clinical negligence claims and restrict the amount of legal costs that a successful claimant can recover from a losing defendant. This would make recoverable legal costs more proportionate to the value of damages awarded and rebalance the cost liabilities of claimants and defendants. The intended effects are to promote and enable quicker, more proportionate, and more cost-effective resolution to all parties without affecting patients' access to justice. Potential impacts on claimants with protected characteristics have been considered and analysed. See the 'Equalities Statement' section below and the separate equality duty analysis which discusses this in more detail.

37. Resolving more lower damages cases pre-issue (before they reach litigation) would also have the effect of freeing up court time and resources. The introduction of fixed recoverable costs is part of a wider set of linked objectives relevant to clinical negligence: improving patient safety and system learning, thereby reducing harm incidents, improving patient experience and response to harm by NHS organisations and improving the cost efficiency and user experience around clinical negligence litigation for all parties.

38. This proposal is focused on the objective to improve clinical negligence litigation. Clinical negligence claims made against the NHS are funded from the core NHS budget; recoverable claimant legal costs use resources that could otherwise have been spent on patient care. The NHS, as one of the primary defendants in clinical negligence cases, could therefore benefit from fixing recoverable claimant costs and making the process more efficient for lower damages clinical negligence claims. Patients who have been negligently harmed and their families (whether their treatment was NHS funded healthcare or non-NHS healthcare), could also benefit from a streamlined process by receiving compensation more quickly.

Summary and preferred option with description of implementation plan

39. Clinical negligence occurs when a healthcare provider breaches their legal duty of care to a patient, which directly causes harm to the patient. Negligence is determined in the courts if each of the following elements of a legal test is demonstrated:

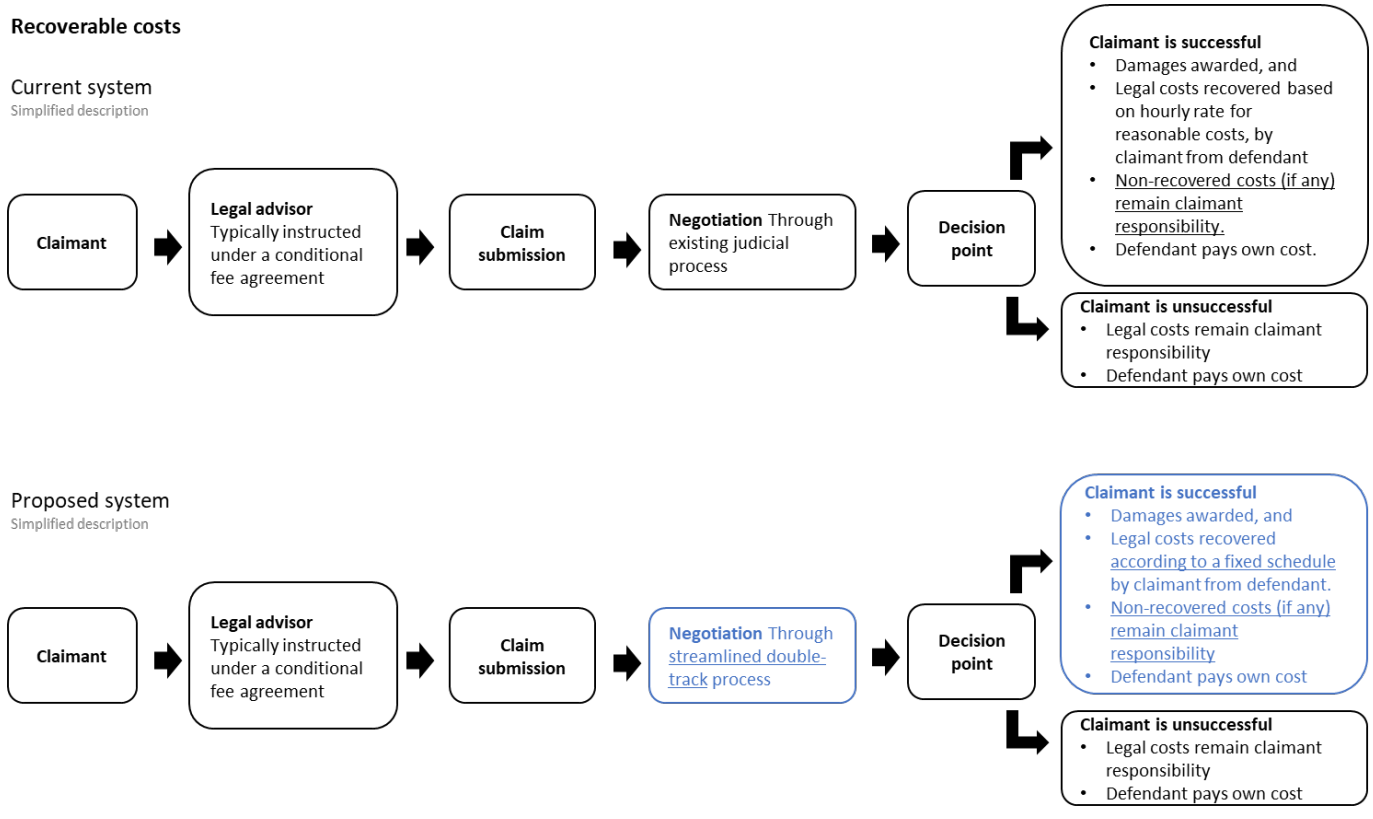
- Duty: that the defendant owed the claimant a duty of care in law. It is generally straightforward for claimants to establish that their healthcare provider owed them a duty of care given the nature of the relationship.
- Breach: that the defendant breached the duty of care. In order to prove whether the healthcare provider breached their duty of care, a claimant will need to show that what the healthcare provider did or failed to do was not supported by a responsible body of clinicians at the time and/or was not logical.
- Causation: that the defendant's breach of duty caused an injury. Having established a breach of duty, the claimant must also demonstrate that the breach caused some injury or damage. This is done by reference to the balance of probabilities test, i.e., was it more likely than not.

40. If clinical negligence liability has been resolved (either by agreement between the parties or through the court) using the test summarised above, or the claimant continues the claim without liability being resolved, lawyers for the parties will enlist medical experts to provide evidence on the claimant's condition and prognosis. This, along with other evidence of past and future loss, will be used to draw up a schedule of past and future losses incurred by the claimant. The defendant responds to these claimed losses. This exchange forms the basis on which damages are considered either by the court or through discussion between parties involved. If the claim is successful, claimant legal costs are recovered from the defendant.

41. The preferred option to reform claimant legal costs is option 1 – to implement fixed recoverable costs to lower damages clinical negligence claims based on a median set of costs between claimant and defendant proposals as proposed by the CJC working group. This will be laid through secondary legislation which will be laid in January 2024. Implementation and adherence to the policy will be expected from April 2024 onwards.

42. Figure 1 below shows the comparison between the current system of option 0 (BAU), and the proposed system of option 1 of implementing fixed recoverable costs to lower damages clinical negligence claims.

Figure 1: Current and Proposed System for Lower Damages Clinical Negligence Claims



Streamlined Claims Handling Process

43. The proposed scheme is built around two claims tracks, a standard track and a light track. The purpose of the light track is to enable swifter resolution of more straightforward cases, especially where liability is not in dispute. The standard track is for any other claims, typically where there is likely to be dispute on liability.

44. For standard track claims:

- An FRC letter of claim which discloses the claimant's case, including medical records, experts' reports on liability, witness statements, any separate report on condition and prognosis, details of losses and supporting documentation; whether the incident/claim has been investigated under the Putting Things Right (PTR) Scheme/ whether a PTR offer was made; and an offer to settle the claim.
- A letter of response which discloses the defendant's case and responds to the offer within 6 months;
- The claimant's right to reply within 6 weeks of the response;
- A mandatory stocktake and discussion if the case cannot be settled after the reply (within 4 or 6 weeks of the response or reply respectively);
- A neutral (but non-binding) evaluation if the claim is not settled at stocktake (to be commissioned within 4 weeks of stocktake).
- 28-day post-evaluation offer period

45. For light track claims:

- An FRC letter of claim (light track) which contains an explanation of the basis for the case being in the light track (including evidence on breach of duty and causation) and any associated documents (such as a serious incident report), medical records, details of losses and any accompanying evidence; and whether the incident/claim has been investigated under the Putting Things Right (PTR) Scheme/ whether a PTR offer was made;
- Response admitting liability (where breach of duty of care is admitted and it is accepted the breach resulted in loss, including injury) within 8 weeks (if longer, claim moves to standard track);
- Stocktake within 4 weeks of response if unresolved;
- A neutral (but non-binding) evaluation if the claim is not settled at stocktake (to be commissioned within 4 weeks of stocktake).
- 28-day post-evaluation offer period

46. For a small number of claims that do not resolve at the 'stocktake' stage of the proposed streamlined process, and are found to require further evidence, the proposals include a "further evidence phase" in the light track. It is anticipated that only a very small percentage of claims would require a further evidence phase. The neutral evaluation would involve an evaluation of the claim to be carried out by a specialist legal professional of a minimum level of experience. This would be a paper-based process, where the evaluator would then provide an opinion on likely outcome on liability, quantum or both. The aim would be to encourage and result in more claims settling earlier, reducing costs and use of court time and resources, and achieving faster resolution for parties.

47. Either party can request a neutral evaluation. Parties will propose evaluators and agree on a choice or counter propose. If there is no agreement, the choice will be put to a Protocol Referee who will appoint an evaluator. The Referee's choice will be final. If a party requests an evaluation and the other party unreasonably refuses to engage, sanctions may apply. The outcome of an evaluation will not be binding on either party. However, if an evaluation recommendation on quantum is rejected by the claimant and the claimant goes on to court and fails to beat the quantum offer by 20%, the claimant will be subject to cost consequences. If the evaluator's recommendation is not accepted by either party, parties are free to make offers and attempt to settle the claim. Parties are encouraged to make and consider offers in a "post-

evaluation offer period" (a period of 28 days from receipt of the evaluator's report). Defendants would be responsible for paying the evaluator's fees.

48. The CJC report proposed a set of claimant and defendant grid costs to be applied to claims that have been handled through this streamlined process. Option 1 of this impact assessment takes a median point between these proposals. This is summarised in Tables 4 and 5 below. It should be noted that the FRC suggested as part of the proposed scheme apply only to costs up to the point where the pre-action protocol for lower damages clinical disputes ends. The intention is to review these costs post implementation alongside the upper limit of the scheme in light of inflation. The modelling currently assumes a rate of 3.5% per annum for legal costs and in the limits of the damages band in which claims are eligible for FRC.

Table 4: FRC for Standard Track Claims

Stage	Description	Claimant	Defendant	Option 1 - Median
1	All steps up to and including stocktake	£6,000 plus 40% of damages agreed	£5,500 plus 20% of damages agreed	£5,750 plus 30% of damages agreed
2	From stocktake up to and including neutral evaluation	£2,000 in addition to stage 1	£500 in addition to stage 1	£1,250 in addition to stage 1

Table 5: FRC for Light Track Claims

Stage	Description	Claimant	Defendant	Option 1 - Median
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	£1,750 plus 18% 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	£1,000 plus further 2.5% of damages agreed, 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	£500 in addition to stages 1 and 2a

49. In claims transferred to the standard track which did not receive a response from the defendant within the first 8 weeks of the light track, 5% of stage 1 light track costs will be recoverable on top of any standard track costs.

50. Certain cases are excluded from the FRC scheme due to their complexity and sensitivity. More claims excluded would result in fewer savings as fewer claims would be subject to FRC. Under option 1 of this impact assessment, the exclusions applied in the modelling follow the defendant proposal as set out by the CJC working group, these claims would not be in scope of an FRC scheme. A full list of exclusions, including some which go beyond the CJC working group proposal, for the proposed FRC scheme is set out in Table 6 below.

Table 6: FRC Exclusions

Claims with damages below £1,501 or above £25,000 at settlement or judgement
Claims where limitation is raised by defendant as an issue
Claims where allegations are made against two or more defendants, where the allegations of negligence against each defendant are materially different
Claims where the allegations of negligence would require the claimant to adduce medical expert evidence as to breach of duty of care and causation from more than 3 medical experts
Claims arising from a still birth or neonatal death, including claims made by secondary victims
Claims with unrepresented claimants (litigants-in-person)

51. At the neutral evaluation stage, a specialist legal professional will give a view on either liability in terms of breach of duty of care and causation, or on the quantum (level of damages), or on both. Evaluator's fees will be paid by the Defendant. A guideline fixed fee would be paid to the

evaluator for a neutral evaluation, with different fees for evaluation on liability or quantum only or on both liability and quantum. Below are the guideline evaluator fees for claims that proceed to neutral evaluation as proposed by the CJC claimant and defendant group and a mixed suggestion under option 1. Option 1 is the option proposed under the FRC scheme.

Table 7: FRC MNE Fees

Type of Evaluation	Claimant	Defendant	Option 1 - Mixed
Liability and Quantum	£2,000	£1,750	£2,000
Liability Only	£1,500	£1,250	£1,500
Quantum Only	£1,500	£750	£750

52. The FRC scheme proposals include a number of proposed sanctions at different stages of the process to ensure that all parties work constructively within the processes set out and abide by the rules. These include:

- Meeting process deadlines – if the defendant response is late on the standard track, the claim falls out of the FRC process – if late replying to the initial letter on the light track, the claim recommences on the standard track and 5% of light track stage one costs are recoverable on top of any standard track costs.
- If other process deadlines are missed – by claimants: there would be an automatic reduction in recoverable costs of 50% - if by defendants: there would be an automatic uplift of 50% to damages agreed at settlement. However, reasonable extensions to these deadlines (excluding the initial defendant response deadlines) may be agreed by mutual consent.
- Evidence bundle: failures by the claimant to provide sufficiently detailed evidence at the outset of the FRC process (such that the defendant is significantly hindered in responding in a timely fashion) could result in a 50% reduction to the costs the claimant is able to recover from the defendant.
- Evaluation participation: If the claimant unreasonably refuses to engage with an evaluation requested by the defendant, there would be an automatic reduction in recoverable costs of 50%. If the defendant refuses to engage with an evaluation requested by the claimant, the protocol is deemed to end and the claimant may proceed to issue proceedings.
- Evaluation cost consequences: if the claimant does not accept the evaluation recommendation on quantum, then fails to beat this by 20% in court, the claimant would be restricted to 50% of costs.

53. We have not modelled the specific effects of this sanctions regime as there is limited data on the prevalence of sanctions for each stage of the streamlined process. The modelling assumes that proposed safeguards incentivise good behaviours as intended.

Disbursements

54. Legal disbursements are payments for services related to a legal claim and are separate from legal fees. Clinical negligence claims in this cohort often include disbursements for expert reports. They may also involve counsel fees or court fees, especially in the subset of claims that involve protected party claimants (adults who lack mental capacity or children). However, in the majority of these claims in the pre-issue period, counsel advice and court proceedings are rarely required and disbursements for these items seldom recovered.

55. We are considering carefully how disbursements should be treated within the FRC scheme. We will publish a short consultation exploring this issue further, proposing a way forward on arrangements for legal disbursements for all claims in the scheme and seeking views. We have undertaken sensitivity analysis on disbursement arrangements in the sensitivity analysis section later on in this impact assessment.

56. We will clarify the outcome of this further consultation having analysed responses, prior to finalising the civil procedure rules in secondary legislation.

Monetised and Non-monetised Costs and Benefits of each Option (including administrative burden)

57. Costs and benefits have been identified for four main affected groups:

    - Individual claimants (members of the public who bring forward a claim for compensation).
    - Claimant solicitors (private businesses which provide legal representation to claimants).
    - Defendants (public and private sector indemnity providers for healthcare).
    - Defendants solicitors (private businesses which provide legal representation to defendants).

58. Unless otherwise stated, all monetised costs and benefits in this impact assessment are estimated in real 2022/23 prices. The implementation year is assumed to be 2024/25. The net present value (NPV) considers the introductory year of 2023/24 as the base year (year 1), with a 20-year appraisal period to 2042/43.

Option 0 (baseline – BAU)

59. As option 0 is the baseline "business as usual" scenario, the current system will continue with no reform. Option 1 will be assessed against this counterfactual.

Option 1 (implement FRC for lower damages clinical negligence claims)

60. FRC proposals are expected to have two main, and inter-related, impacts: one, an efficiency gain in the allocation of resources currently used to settle lower damages clinical negligence claims; two, a transfer of costs from claimant solicitors and individual claimants (cost) to public and private sector defendants (benefit).

61. Firstly, on efficiency gain, the new streamlined double track claims process will incentivise and encourage faster resolution of claims as well as reducing legal costs for defendants.

62. We have illustrated three scenarios for the levels of efficiency that might be achieved:

    - **Low scenario**: no efficiency gains are made; claimant legal costs over and above those recoverable from the defence are recovered by claimant solicitors from individual claimants (e.g. in the form of higher success fees for CFAs) or result in reduced profits for solicitors.
    - **Central scenario**: some efficiency gains are made. We assumed an even split (50:50) between non-recoverable costs that will genuinely disappear and those which will be simply transferred to claimants. We present cost estimates based on this central scenario.
    - **High scenario**: high efficiency gains are made; a simplified process leads to a commensurate reduction legal work no additional costs would need to be recovered from individual claimants.

63. Within this impact assessment, we have assumed that an efficiency gain, where less solicitors' time and/or resources are required to deliver the same outcome for their clients, delivers a benefit to society. We are implicitly assuming that any legal time and/or resource that is no longer required through streamlining would be used to deliver work of similar value to that required prior to reform. It could be equally valid to assume that:

    - work that is no longer required would lead to job losses and therefore reduce, but may not necessarily eliminate, the overall estimated benefit to society,
    - work that has been stopped could free up time for legal firms to deliver higher-value work, and therefore deliver a higher societal benefit.

64. In the absence of specific evidence regarding the value of work no longer required, we considered a middling position (such that work that is no longer required will be replaced with work of similar value) to be appropriate.

65. Secondly a transfer of costs for claimant solicitors, the policy will reduce the amount of costs that can be recovered from defendants, and therefore affect their revenue when claims are brought

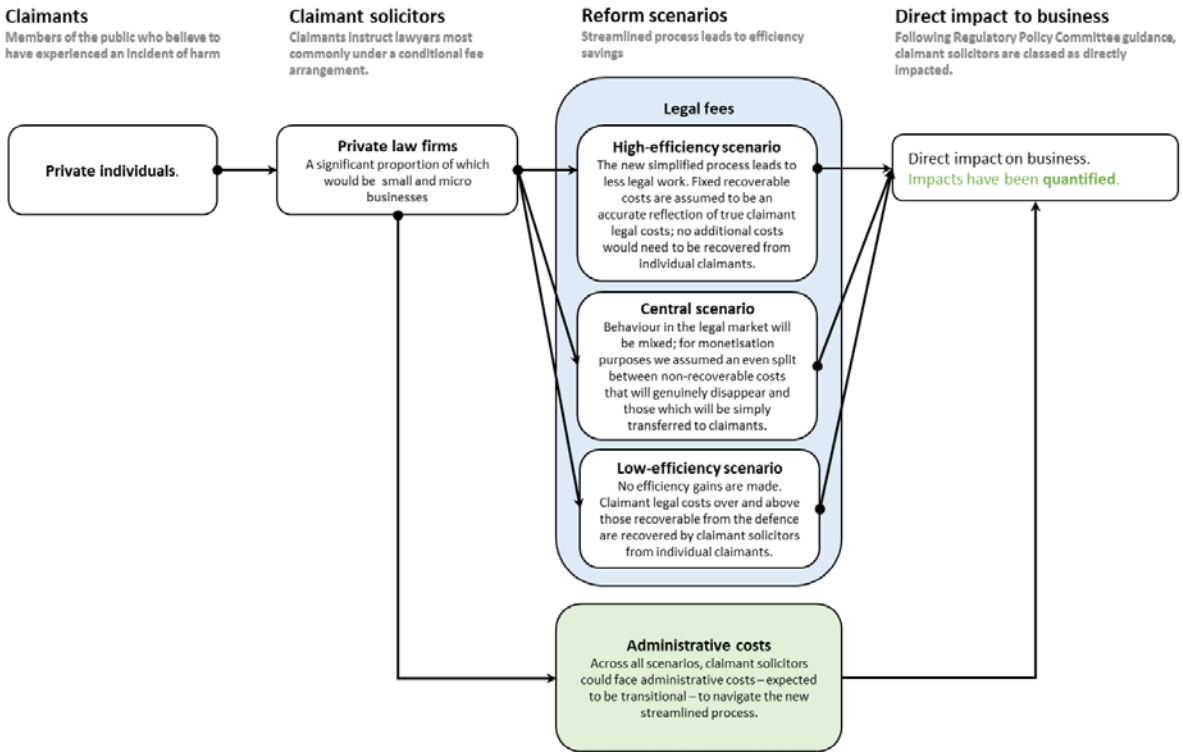
under CFAs. For individual claimants, the key impact would be increased legal costs, typically in the form of higher success fees or solicitor client costs, if firms pass on their unrecovered costs. Although, this effect may be limited, as:

a) success fees will continue to be capped at 25% of damages. Success fees may be at, or close to, this level in the current system for most claims;

b) it is expected the market will adapt to the new process through change in culture and behaviour, with claims management efficiencies minimising shortfall in costs. We have no evidence to suggest there will be a significant change in charges to clients for costs shortfalls in lower damages clinical negligence claims. This is because legal services operate in a competitive marketplace and continue to be provided to claimants where FRC has already been applied. Further, the courts provide avenues for costs scrutiny to ensure amounts solicitors charge their own clients are reasonable.

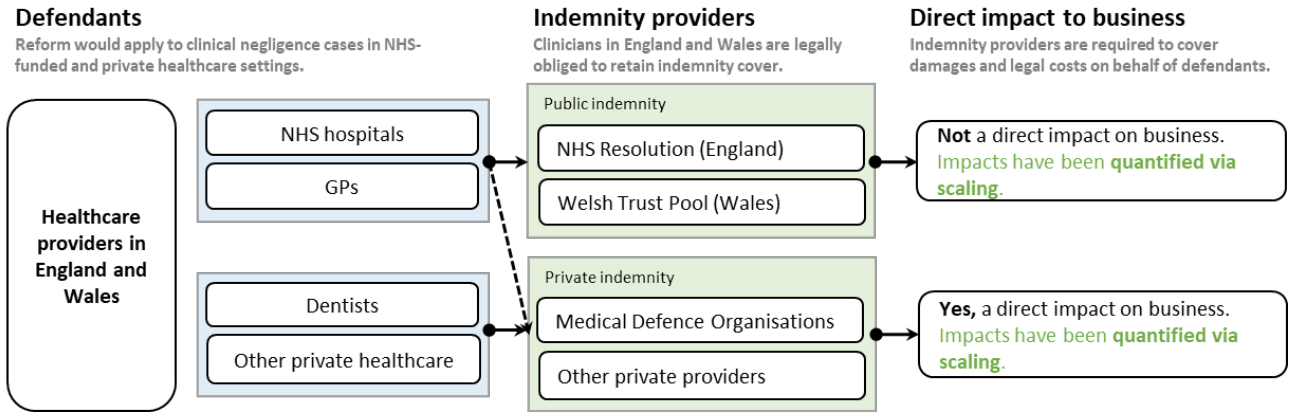
66. The above efficiency and wealth effects have been summarised in Figure 2 below.

Figure 2: Effects on Claimants and Claimant Solicitors



67. For defendants, the key net impact is a cost saving from reduced recoverable legal costs. Savings are initially estimated for the public sector defendants indemnified by NHS Resolution. An adjustment is then applied, to scale these costs to account for other defendants. Additionally, defendant solicitors have an extra add-on cost per claim for earlier investigation work. How defendants are affected is summarised in Figure 3.

Figure 3: Effects on Defendants



68. The detailed modelling below relates to clinical negligence claims handled by NHS Resolution under the CNST scheme (around 10,000 new claims and 5,981 settlements where damages were paid in 2021/22)[19]. However, the FRC regulations will relate to all lower damages claims, whether indemnified by CNST or otherwise. We have, therefore, relied on a broader number of sources to complete our analysis, including DWP's Compensation Recovery Unit publishes statistics for all clinical negligence claims registered in England, Scotland and Wales (approximately 15,500 new claims, and 16,744 settlements in 2021/22)[20]. These are described below, and in Annex B which describes the data sources available in detail.

Remit of Claims Subject to FRC

Incident vs. Notification Year

69. Throughout our modelling, we have assumed reform would be implemented from April 2024 onwards (i.e. from the start of the financial year 2024/25). From this date onwards, new lower damages clinical negligence claims would be subject to FRC. However, there are two possible standard definitions for what constitutes a new claim either based on the claim's incident year or the claim's notification year.

70. If a claim is defined as new based on its incident date, then FRC would only apply to claims where incidents of harm occur beyond April 2024. This means that any claim not yet brought forward by April 2024, but that relates to harm prior to this date, will not be subject to FRC. If a claim is defined as new based on its notification date, then FRC would apply to all claims brought forward from April 2024 onwards, without exception.

71. Option 1 proposes defining new claims on a notification year basis. Reform implementation by notification year results in (transitionally) more claims subject to FRC and consequently more savings.

Uprating the value band upper limit (£25,000) over time

72. Option 1 proposes that the FRC value band upper limit should be reviewed post implementation and at regular intervals thereafter, specifically to consider the effects of claims inflation, using observed levels (or projections) of inflation. In our modelling, we have uprated the value band to ensure that the same number of claims would be subject to FRC in the year of implementation (2024/25) and all subsequent years.

Average Reduction in Claimant Legal Costs handled by NHS Resolution

[19] NHS Resolution (2022). Annual Statistics (Annual Report Statistics, Tables A.2 and C.2). Available at NHSR-Annual-Report-Statistics-2021-22-for-publication-V3.xlsx (live.com)

[20] Compensation Recovery Unit performance data, updated 29 April 2022 https://www.gov.uk/government/publications/compensation-recovery-unit-performance-data/compensation-recovery-unit-performance-data#number-of-cases-registered-to-cru

73. We undertake the following steps to calculate the average reduction in claimant legal costs:

- Using *NHS Resolution's Extract I* (see Annex B) data source, where each claim is assigned either to standard or light track, we calculate the claimant legal cost of each claim valued between £1,500 and £25,000 for option 1.

- We then calculate the average (mean) claimant legal cost per lower damages claim separately for standard and light track claims. We then calculate the overall percentage reduction in claimant legal costs between the counterfactual (actual claim costs) and option 1.

- Separately, using this data source, we determine what proportion of claims should be included under option 1. A further data source was also used to contribute to the inclusions analysis, *Exclusions Data* (see Annex B). We then multiply this inclusion percentage with the associated overall percentage reduction in claimant legal costs.

- For creating projections over time (see Top-Down Model section below), the claimant legal cost percentage reduction needs to be expressed in terms of all claims settled via lump sum[21] as opposed to only those valued between £1,500 and £25,000. To do so, we first express claims valued between £1,500 and £25,000 as a proportion of all claims paid through a lump sum, using *NHS Resolution's Extract II* (see Annex B). We then apply this proportion to the previous average claimant legal cost reduction.

  This is summarised in Table 8 below.

Table 8: Average Reduction in Claimant Legal Costs

Option	Average percentage reduction in claimant legal costs for claims valued between £1,500 and £25,000, without exclusions (A)	Proportion of claims to be included within the FRC remit (B)	Proportion of claims valued between £1,500 to £25,000 as a proportion of all lump sum claims (C)	Average percentage reduction in claimant legal costs for claims valued between £1,500 and £25,000, with exclusions (D=A.B)	Average percentage reduction in claimant legal costs for all claims (E=A.B.C)
Option 1 - Median	39%	85%	50%	33%	17%

Top-Down Model

74. We project clinical negligence costs over time using the DHSC clinical negligence top-down model. This tool is based on a financial model from the Government Actuary's Department (GAD). GAD and NHS Resolution revise model inputs yearly and, for this work, we have used the 2021/22 input version. We assume no changes in damages or legal costs inflation and no changes in claim volume inflation, as well as no change in development (incident to notification) and payment (notification to settlement) patterns.

75. The model uses claim development patterns to account for both the time-lag between an incident of harm occurring and a claim being notified to NHS Resolution, and the time-lag between claim notification and settlement. Claim development patterns allow us to model each year's worth of incidents and how these are paid out over time in a staggered way. This applies to all costs: claimant legal costs, damages and defence costs. The staggered pay-outs are combined to create an expense profile over time.

76. Reduced claimant costs for option 1 are calculated by multiplying the staggered claimant legal cost payments by the average claimant legal cost percentage reduction for all claims notified from April 2024 onwards. To get the final annual savings profile, we take the difference between the counterfactual expense profile and that of option 1. Results are then presented on a real basis (adjusted for inflation using a GDP deflator: 5 years of inflation are forecasted by HMT,[22]

[21] When damages are awarded, claims can settle through a single lump sum or, in the most serious cases, via a combination of a lump sum and periodical payments (generally annually for life). The latter are out of scope for our analysis.

[22] https://www.gov.uk/government/collections/gdp-deflators-at-market-prices-and-money-gdp

then we assume a flat 2% for the remaining years. The net present value (NPV) of real cumulative cashflow savings is calculated using the standard HMT Green Book discount rate of 3.5%.

77. Finally, two adjustments are made. The modelling above relates to CNST only. To estimate total NHSR costs, the modelled results are scaled relative to the number of cases settled with damages (i) under CNST and (ii) all NHSR clinical negligence cases in 2021/22 as below.

	Cases with damages awarded		**Scalar**
	CNST	NHSR all	NHSR all/CNST
2021/2	5,981	6,773	1.13

78. A second adjustment is made using published CRU data, to scale the cost estimate up to include cases in England and Wales which are not indemnified by NHSR. This is discussed in the next section.

Costs of Option 1

Monetised Costs

Costs relating to NHSR claims

79. A key impact of proposals is to transfer costs from defendants to individual claimants and claimant solicitors, to ensure proportionality of legal costs recovered. It is assumed that the proposals will not impact on the overall willingness of an individual to bring about a claim since they are based on the principle of removing distortions in recoverable legal fees rather than access to justice.

80. Based on our modelling above, we estimate a transfer of costs to claimant solicitors of up to £1,022m (discounted, over 20 years) in relation to NHSR cases. Legal costs unrecovered from defendants and passed on to individual claimants (typically in the form of higher success fees or solicitor and own client costs) will lead to individuals keeping less of their awarded compensation. If higher fees were focussed on claimants in lower damages claim, this would mean less funds available for affected individuals, normally relating to pain and suffering compensation and covering limited past costs. However, individuals will have a choice of solicitor firm, and will still be protected by the cap on CFAs that limits success fees to a maximum 25% of damages. Compared to BAU, the ability of claimant lawyers to extract more through higher success fees will be dependent on whether they currently operate close to the 25% limit.

81. The introduction of FRC is expected to marginally increase NHS Resolution's claims management costs. NHSR have provided information on these costs where possible. However, some costs are uncertain and have not been quantified, including the costs associated with additional risk management and the front-loading of resources. Further, for some claims there may be a requirement for a detailed medical report(s) to be commissioned under FRC where under the counterfactual these reports were either not required or would have been required further along in the process. For other claims, there will be the additional cost of evaluation fees which defendants will be required to pay.

82. Note that we expect a streamlined process to reduce costs overall. Even if there is a marginal increase in administrative costs, and other costs are greater or brought forward, e.g., medical reports, we'd expect a faster process to lead to lower defence costs. However, it has not been possible to fully quantify defence cost benefits.

83. To the extent where it has been possible to quantify them, operational costs have been assessed as follows. Under FRC, a total of c.1,500 claims annually were estimated by NHS Resolution as involving additional investigation over and above the current investigation required. NHS Resolution estimated that 3-4 extra staff at band 7 will be required. The number of staff required was multiplied by the average band 7 salary (including employer pension and NI contributions) and adjusted for a London weighting and NHS band 7 staff inflation to arrive at the spread of total

annual cost over time. Separately, a highly uncertain add-on to legal panel firm defence costs per claim was estimated by NHS Resolution to be £200-£300. This figure is multiplied by the c.1,500 claims to arrive at a spread of costs over time. We have drawn up three scenarios based on these inputs, estimating operational costs for NHS Resolution of approximately £7m to £10m (discounted, over 20 years). For the purpose of this impact assessment, we have used the central scenario of 4 extra staff and a £250 add-on cost, resulting in an NPV of £9m.

Table 9: Administrative Costs Modelling for NHS Resolution

Discounted	PV of Yearly Projected Cashflow (£m)																				NPV Total (£m)
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	
3-staff; £200	-	0.5	0.5	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	7
4-staff; £250	-	0.6	0.6	0.6	0.6	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	9
4-staff; £300	-	0.7	0.7	0.6	0.6	0.6	0.6	0.6	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.4	0.4	0.4	0.4	0.4	10

84. Furthermore, claimant solicitors may also face administrative costs to navigate the new streamlined process. Under FRC, the time spent by solicitors on each claim is uncertain, so we have made the working assumption that solicitors will spend a similar amount of time on each claim as NHS Resolution. Using NHS Resolution's estimate of c.1,500 above of the number of claims involving additional investigation over and above the current investigation required, it is likely claimant solicitors will face a similar order of magnitude of administrative costs of £9m that NHSR faces.

Costs for non-NHSR claims

85. The Fixed Recoverable Cost reforms will apply to all lower damages clinical negligence claims in England and Wales (except those exempt under specified exclusions). However, the costs and savings estimated above relate only to the schemes operated by NHS Resolution. The estimates exclude clinical negligence indemnified by insurance companies or discretionary insurers. This includes the majority of dental care (both NHS and private) and most private medical care.

86. To produce a cost for all lower damages clinical negligence cases in England and Wales, these costs are scaled using CRU data as follows. The scaling is necessary to ensure the costs provided in this IA relate to all clinical negligence settlements in the scope of FRC in England and Wales, and not just settlements indemnified by NHS Resolution.

Number of Clinical Negligence Settlements Indemnified by NHSR or Otherwise

87. In 2021/22, 16,744 clinical negligence settlements in England, Wales and Scotland were notified to the Compensation Recovery Unit (CRU), an arm's length body of DWP[23]. By law, those who receive a claim for compensation must register the claim with CRU within 14 days of receipt.

88. The FRC proposals relate to England and Wales only. If we assume that clinical negligence in England, Wales and Scotland is proportionate to population[24], then the settlements for England and Wales would be 92% of total settlements, or 15,335 in 2021/22.

89. In the same period, NHSR settled and paid damages on 6,773 claims relating to NHS clinical schemes[25] in England. Which means that 8,562 clinical negligence settlements in 2021/22 in England and Wales were not indemnified by NHSR.

[23] https://www.gov.uk/government/publications/compensation-recovery-unit-performance-data/compensation-recovery-unit-performance-data#number-of-cases-registered-to-cru https://www.gov.uk/government/publications/compensation-recovery-unit-performance-data/compensation-recovery-unit-performance-data#number-of-cases-registered-to-cru

[24] https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates

[25] Sheet C, Settled Claims by Value, sum of claims which settled with damages paid, Annual statistics - NHS Resolution

Table 10 - 2021/22 clinical negligence claims settled with damages

Total settlements reported to CRU	NHSR settlements (clinical only)	Other indemnifiers (Total – NHSR claims)	FRC cost scalar for non-NHSR relative to NHSR	FRC cost scalar for all indemnifiers relative to NHSR
A	B	C = A - B	D = C / B	E = A / B
15,335	6,773	8,562	126%	226%

Scaling FRC costs and savings

90. The costs in the previous section are modelled for NHSR settlements only. Applying the scalar above to the monetised costs outlined in the preceding section results in the following monetised costs for all claims in scope of FRC (NHSR and non-NHSR):

Table 11 – costs and benefits for NHSR and non-NHSR claims

Description of cost for NHSR claims	Costs for NHSR claims	Cost for non-NHSR claims	Total cost
A	B	C = B * 126%	D = B * 226%
Legal transfer payment for claimant solicitors	£1,022m	£1,287m	£2,309m
Administration costs for defendants	£9m	£11m	£21m
Administration costs for claimants	£9m	£11m	£21m
Total	£1,040m	£1,309m	£2,351m

Uncertainty

91. This is an uncertain estimate. It assumes that the clinical negligence indemnified, and settled with damages, within and without NHSR schemes has a similar profile in terms of settlement size and costs. However, we have no information on the profile of damages supported by other indemnifiers, and whether higher costs cases like obstetrics make up a similar proportion of damages awarded outside NHSR[26]. This is likely to be upside risks on the estimate.

92. The CRU figures are for the England, Wales and Scotland and have been apportioned using population data. It is possible that case mix, litigation rates or the public/private composition of local health economies varies by nation. It's not clear whether this risk would increase or decrease the estimate.

Non-Monetised Costs

93. A more streamlined process as a result of FRC could result in claims settling more quickly than they would have otherwise. It could also result in more detailed medical reports being obtained or obtained earlier by NHS Resolution relative to current projections. A FRC scheme would also generate cash flow costs for public and private sector defendants which may take the form of medical report disbursement costs and reduced investment income.

94. For NHS Resolution, claimant solicitors and public and private sector insurers, there may be some set-up, training and familiarisations costs. However, these are considered to be limited since operating fixed recoverable costs is standard practice in other areas of personal injury.

[26] Figures 17 and 18, p. 57. NHS Resolution (2023). Annual Report and Accounts 2022/23. Available at: NHS Resolution - Annual report and accounts 2022/23 (publishing.service.gov.uk).

Benefits of Option 1

Monetised Benefits

95. The main quantified benefits of reform relate to the transfer of cost from claimant solicitors to the defendants, such as NHSR and other indemnity providers, in the form of lower claimant legal fees. As under option 1, we expect that the average recoverable claimant costs for lower damages clinical negligence claims that settle with damages between £1,500 - £25,000 will fall by 33%.

96. The NHS, as one of the primary defendants in clinical negligence claims, would benefit by freeing up resources currently allocated to recoverable claimant costs, quantified to £1,022m (excluding opportunity benefits from additional NHS expenditure, which are monetised under sensitivity test II below).

97. The total benefit of this scheme, to defendants indemnified by NHSR and other indemnifiers is estimated as £1,022m * 226% (as shown in Table 8) = £2,309m.

Non-Monetised Benefits

98. Under the current system, claims can settle at any time by agreement of both parties. However, we know that on average this takes over a year. The proposals aim to enable faster processing of claims and earlier average resolution times by incorporating agreed pre-issue settlement opportunities via early admission of liability, stocktakes and neutral evaluation. It is therefore expected that the proposals will result in claims settling more quickly than they would have otherwise. This would mean that claimants will see their cases resolved earlier and will have access to damages awards earlier, which could be invested, creating increased wealth. Lower costs on unsuccessful cases (not directly recoverable from individual claimants under conditional fee arrangements) might also increase income for claimant solicitors, which, in turn, could offset any new administrative costs.

99. We expect a streamlined, faster process to also lead to lower defence costs which, in turn, would offset any new administrative costs for defendants. For both claimant solicitors and public and private sector defendants, there will also be a benefit of having more predictable cash flows.

Net Impact of Monetised Costs and Benefits

100. Overall, we estimate there to be a positive NPV of £1.1bn under option 1. Table 12 below summarises the monetised costs and benefits described above (a more detailed breakdown of the results is presented in Annex A). Costs to individual claimants are presented under a central efficiency scenario, with the full range under a low or high scenario presented in brackets. The same approach is used to present total costs and net impacts.

Table 12: Summary of Monetised Costs and Benefits

Implementation Year 2024				(£m)
	Monetised costs/benefits	**Direct impact on business?**	**Median - Option 1**	**Median - Option 1**
Costs			**Present Value Over 20 years (2022/23 prices)**	**Average annual impact (2022/23 prices)**
Defendants (NHS Hospitals)	Administrative cost of new streamlined process	N	9	0.5
			(7 – 10)	(0.4 - 0.5)
Defendants (All Other)		Y	12	0.6
			(9 – 13)	(0.4 - 0.7)
Claimant solicitors	Legal costs not recoverable	Y	1155	58
			(0 – 2309)	(0 – 115)
Claimant solicitors	Admin costs of new process	Y	21	1.1
			(16 – 23)	(0.8 - 1.2)
Total costs			1197	60
			(32 – 2355)	(2 – 117)
Benefits			**Present Value Over 20 years (2022/23 prices)**	**Average annual impact (2022/23 prices)**
Defendants (NHS Hospitals)	Reduction in legal costs recovered against healthcare providers	N	1022	51
Defendants (All Other)		Y	1287	64.4
Total benefits			**2309**	**115**
Net total (=Total benefits – Total costs)			**1112**	**56**
			32 - 2355	2 - 117
Net impact on business (= Benefit – Cost)			**100**	**5**
			(-1058 to 1262)	(-53 to 63)

Direct Costs and Benefits to Business Calculations

101. Of the costs and benefits mentioned above for option 1, only some will directly impact businesses and therefore used for the calculation of the Equivalent Annual Net Direct Cost to Business (EANDCB). In the above analysis, we have modelled direct monetised costs and benefits to businesses.

102. Business costs include legal costs that are no longer recoverable in claims from defendants, that are faced by claimant solicitors, and any administrative costs of handling the new FRC process. As previously described, cost reductions resulting from lower fees under FRC are a transfer of costs from defendants to claimant solicitors. However, it is expected that FRC will result in claims settling more quickly and that claimant solicitors allocate the resulting efficiency gains to work of equal value, partially offset some of the reduction in fees received from FRC claims. Three scenarios are explored above, and the results of the central scenario are given below

103. Under the central scenario we assumed an even split (50:50) between non-recoverable costs that will genuinely disappear and those which will be simply transferred to claimants. Consequently, the EANDCB estimate presented below does not account for the full transfer of

costs from defendants to claimant solicitors. We assume a 50% reduction in legal work and legal costs in response to the new incentive, and a 50% cost transfer to claimant solicitors.

104. Healthcare providers, and their indemnifiers, benefit from the FRC proposals, in the form of lower claimant legal fees. We estimate that NHS trusts will see a benefit of £1,022m, and that other healthcare providers and their indemnifiers, will see a benefit of £1,287m across the 20-year appraisal period. To calculate the EANCB, we assume that the £1,287m benefit accrues to independent healthcare providers, healthcare related businesses or their indemnifiers. This is likely an overestimate, as this group includes some providers who provide NHS services, like dentistry. However, we lack the data to further adjust the EANCB calculation.

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105. An estimate for the EANDCB has been produced using the Business Impact Target (BIT) Assessment Calculator, giving an EANDCB value of -£6.8m. Table 13 below summarises the direct cost to businesses, the relevant annuity factor as provided in the BIT Calculator and the subsequent estimate for the EANDCB.

Table 13: EANDCB Calculation

	Direct Cost to Business	20-Year Annuity Factor	Annualised EANDCB
	A	B	C = A/B
Option 1 - Median	-£100m	14.71[27]	-£6.8m

Risks and Assumptions

106. The consultation responses provided insight into risks that may arise from an FRC scheme that streamlines the claims handling process. These include, but are not limited to:

- A focus on speed rather than quality leading to issues being missed.
- A change in the clinical negligence market due to firms moving away from lower damages clinical negligence claims or an increase in higher value claims (which may have been previously introduced as lower damages claims).
- An increase in non-specialist firms, litigants in person and claims management companies that lack the experience for handling clinical negligence claims. This could lead to an increase in spurious claims which specialist firms may have filtered out, leading to system delays.
- A potential reduction in firms' revenues from increased operational costs. Although, as shown above, this impact is marginal.
- Firms may not be able to take on claims under CFAs and insurers may withdraw from providing insurance to lower damages claims (after-the-event insurance is necessary to investigate clinical negligence claims). This increases the financial risks of an unsuccessful claim for claimant solicitors.

107. The extent of the negative impacts could be argued, as the market is agile and will be able to cope with requirements to adapt to an FRC scheme.

108. Another risk raised is that of claims inflation, namely that claimants will seek to inflate damages beyond the £25,000 threshold for the FRC scheme. However, this is a lower risk as there are checks and balances in the negotiation between parties prior to a claim being issued, and in the court process, if a claim proceeds to litigation to ensure that settlements are reasonable. These will still be present in a future FRC system. Also, whether or not higher damages were claimed, damages settled at below £25,000 would attract fixed costs under these proposals. If claimants sought to escape the fixed costs regime by not settling below £25,000 they would need to justify this decision in the courts.

[27] Impact Assessment Calculator, 'EANDCB Calculations' tab
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1128455/impact-assessment-calculator-january-2023.xlsx

109. A key assumption in the modelling which underlies the costs and benefits presented above is that there will be no change in volume or caseload characteristics from 2021/22 levels. However, since FRC will be applicable to claims that are submitted after reform implementation (assumed to be 2024/25 in this assessment), there could be an incentive for claimants to bring claims earlier than they would have done otherwise in order to avoid being subject to FRC. This could result in an increase in the volume of claims before implementation, then followed by a reduction due to displacement.

110. No significant volume changes means that it is also assumed that there is no change in the underlying willingness to bring a claim from claimants or to take on a claim from claimant solicitors. There is a risk that reform could affect the number of lower damages claims coming forward: either volume could decrease, reducing patients access to compensation for harm caused by clinical negligence, as claimants and solicitors are more reluctant to incur the risk of unrecoverable legal costs. Alternatively, volumes could increase driven by firms taking advantage of a more efficient system to process more cases.

111. MoJs post-implementation review of the more extensive personal injury law reform presented in Part 2 of LASPO[28] – which, in particular, eliminated the recoverability of ATE insurance and success fees from the losing side in the majority of cases – states that "*the high-level available data on the volumes of court claims suggest that the number of claims has reduced slightly and in a manner consistent with the Government's objective of reducing unmeritorious claims, and not to an extent that would indicate a negative effect on access to justice*". However, the outcomes of personal injury law reform do not necessarily translate into the outcomes expected for clinical negligence claims which attract lower case numbers (c.15,500 new clinical negligence cases in England, Scotland and Wales compared to c.489,500 new personal injury cases in total for 2021/22[29]) and the need for medical expert testimony.

112. We assume the proposed sanction measures will successfully incentivise good behaviours and deter or minimise counterproductive behaviours. The fixed costs will apply to all lower damages clinical negligence claims, unless they are excluded by a specified exclusion (including claims where the claimant does not have legal representation.) As a result, even if claimants were to overvalue a claim at the outset, it would still attract fixed costs at the point of settlement. Cost consequences will apply to claims settling under £25,000 that have not followed process deadlines or adhered to other aspects of the process.

113. Claimant solicitors will likely seek to maximise their return from the new process. This would mean that they will have an incentive to settle each claim at whichever stage of the process is most beneficial to them. In such circumstances, we would not be able to predict the number of claims that will be settled at each stage under the new process.

[28] Post-Implementation Review of Part 2 of the Legal Aid, Sentencing and Punishment of Offenders Act 2012 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/777039/post-implementation-review-of-part-2-of-laspo.pdf

[29] Transparency data – Compensation Recovery Unit performance data – Updated 29 July 2022 https://www.gov.uk/government/publications/compensation-recovery-unit-performance-data/compensation-recovery-unit-performance-data

Sensitivity Analysis

Sensitivity Test I – Remit of claims subject to FRC: Incident year definition

114. Option 1 considers claims by notification year, meaning that some incidents of harm that occur before the implementation year would be subject to FRC. Under an incident year definition, only those incidents that occur after implementation would be eligible and so, due to the delay between incident, notification and settlement, there would be fewer claims subject to the new FRC regime over the appraisal period compared to Option 1 and therefore lower costs and benefits (consequently a lower NPV).

115. As in the main body of this IA, estimates are produced for NHSR claims and then scaled to apply to the whole market. A summary of how savings would be affected is presented in Table 14 below.

Table 14: Option 1 Savings under Incident Year Definition

(NHSR Cases only)	Proposal	PV of Yearly Projected Cashflow Savings (millions)												NPV (£m)								
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	
Central Estimate	Notification Year		2	13	30	48	59	64	65	65	65	64	64	63	62	62	61	60	59	59	58	1022
Sensitivity Test	Incident Year		0	1	5	13	24	36	46	52	55	57	58	58	59	58	58	58	57	57	56	811

1) Dash signs (-) denote sub £500k savings/expenses.
2) There are no cashflow savings for the year before implementation year (2024/25, year 2).

(All Cases)	Proposal	PV of Yearly Projected Cashflow Savings (millions)																				NPV (£m)
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	
Central Estimate	Notification Year		4	29	68	108	133	144	147	147	147	146	144	143	141	139	137	136	134	132	131	2309
Sensitivity Test	Incident Year		0	3	12	30	55	81	103	117	125	129	131	132	132	132	131	131	130	129	128	1833

1) Dash signs (-) denote sub £500k savings/expenses.
2) There are no cashflow savings for the year before implementation year (2024/25, year 2).

Sensitivity Test II –Reduced claim volume or no uprating applied to £25,000 damages threshold

116. Under option 1, the volume of lower damages clinical negligence claims is kept the same for the entire projection. In this sensitivity analysis we examine the impact of lower claims volumes, whether through a change in claimant behaviour (i.e. less lower damages claims are brought forward) or because the upper threshold for the scheme remains fixed at £25,000 for the appraisal period. We are unable to predict changes in claimant behaviour, the figures below relate to claims falling out of the FRC remit if the upper threshold remains fixed and takes no account of claims inflation, reducing the volume of claims to which FRC would apply to over time. This results in reduced savings over time. The following methodology allows us to model how the volume of claims under a non-uprated FRC remit would change over time.

117. Using NHS Resolution's Extract II (see Annex B), individual claim damages were inflated by 3.5% per year (the current counterfactual level of growth based on historical trends) to cover 20 years of projections. We then counted the number of lower damages claims subject to FRC and how this number reduced over the 20-year period, creating a proportion reduction time-series. In the top-down model, we multiplied this proportion reduction time-series with the claimant legal cost percentage reduction. This results in lower savings over time. The results are then scaled to apply to the whole market, not just to cases indemnified by NHSR. A summary of how savings would be affected is found in Table 15 below.

Table 15: Option 1 Savings with no uprating

Model (NHSR Cases only)	Proposal	PV of Yearly Projected Cashflow Savings (millions)																				NPV (£m)
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	
Central Estimate	Uprating Applied		2	13	30	48	59	64	65	65	65	64	64	63	62	62	61	60	59	59	58	1022
Sensitivity Test	No Uprating Applied		1	9	23	38	47	50	50	49	47	44	42	41	39	37	35	34	32	31	29	678

1) Dash signs (-) denote sub £500k savings/expenses.

2) There are no cashflow savings for the year before implementation year (2024/25, year 2).

Model (All Cases)	Proposal	PV of Yearly Projected Cashflow Savings (millions)																				NPV (£m)
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	
Central Estimate	Uprating Applied		4	29	68	108	133	144	147	147	147	146	144	143	141	139	137	136	134	132	131	2309
Sensitivity Test	No Uprating Applied		3	21	52	85	106	114	114	110	105	101	96	92	87	83	79	76	72	69	66	1532

1) Dash signs (-) denote sub £500k savings/expenses.
2) There are no cashflow savings for the year before implementation year (2024/25, year 2).

Sensitivity Test III – Financial assessment on the basis of annual expense

118. Our analysis has focussed on budget impacts. However, because clinical negligence claims take several years after an incident of harm occurs to be settled, we can alternatively make a financial assessment on the basis of the annual cost of harm: the estimated total liabilities associated with known and potential claims relating to a specific year of incidents.

119. The annual cost of harm is typically much higher than annual budgets (for NHS Resolution, the annual cost of harm in 2022/23 for CNST claims amounted to £6.3bn whilst expenditure was £2.4bn)[30]; liability savings arising from FRC are, therefore, also higher than direct budget savings. A summary of annual cost of harm savings is found in the Table 16 below. In this table, figures estimated on the basis of information from NHSR are scaled to give a value for the whole market.

Table 16: Option 1 Savings in Annual Expense

Model (NHSR Cases only)	Proposal	PV of Yearly Projected Cashflow Savings / Annual Expense (millions)																				NPV (£m)
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	
Central Estimate	Budget Impacts		2	13	30	48	59	64	65	65	65	64	64	63	62	62	61	60	59	59	58	1022
Sensitivity Test	Annual Expense	73	80	83	85	87	89	90	92	94	96	98	100	101	103	106	108	110	112	114	116	1935

1) There are no cashflow savings for the year before implementation year (2024/25, year 2).

3) Annual cost of harm figures are discounted using April 2021 published HMT PES Discount Rates[31].

[30] Annual expenditure here includes damages payments, legal costs and administrative costs. NHS Resolution (2023). Annual Report and Accounts 2022/23. Available at: NHS Resolution - Annual report and accounts 2022/23 (publishing.service.gov.uk). p. 17, p. 144

[31] NHS Resolution, (2022) Annual Report and Accounts 2021/22. Available at: NHS Resolution - Annual report and accounts 2021/22 (publishing.service.gov.uk), p.22

Model (All Cases)	Proposal	PV of Yearly Projected Cashflow Savings / Annual Expense (millions)																				NPV (£m)
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	
Central Estimate	Budget Impacts		4	29	68	108	133	144	147	147	147	146	144	143	141	139	137	136	134	132	131	2309
Sensitivity Test	Annual Expense		181	187	192	196	200	204	208	212	216	221	225	229	234	238	243	248	253	258	263	4209
1) There are no cashflow savings for the year before implementation year (2024/25, year 2).																						
3) Annual cost of harm figures are discounted using April 2021 published HMT PES Discount Rates[32].																						

Sensitivity Test IV – Disbursements

120. In our consultation, we have posed a number of potential options regarding whether to make disbursements a part of the FRC scheme or separately recoverable. Where a disbursement falls under the scheme, claimant solicitors must account for the disbursement's cost within the fixed grid costs of the FRC scheme.

121. This sensitivity analysis explores the impact of making different packages of disbursements (which are made up Counsel's Fees, Expert Fees, Court Fees and Other disbursements) as either separately recoverable or enveloped within the FRC grid costs.

122. The average costs of each package of disbursements are shown in Table 17 below. In the table, FRC stands for 'Fixed recoverable costs', and SR stands for 'Separately recoverable'. For example, under Scenario A, profit and other disbursements will fall under the FRC scheme, whereas Counsel, Expert and Court fees will be separately recoverable.

Table 17: Disbursements scenarios different positions on disbursements

Scenario	Average Cost	Profit	Counsel's Fees	Expert Fees	Court Fees	Other Disbursements
Non-protected party						
Option 1 - Median	£16,100	FRC	FRC	SR	FRC	FRC
Scenario A	£16,100	FRC	FRC	SR	FRC	FRC
Protected Party						
Option 1 – Median	£23,400	FRC	FRC	SR	FRC	FRC
Scenario A	£20,300	FRC	SR	SR	SR	FRC

123. The core body of this IA presents the estimated costs and benefits for Option 1, where all disbursements except expert fees fall under the FRC scheme, and the remaining disbursements are separately recoverable.

124. As a part of our sensitivity analysis, we consider an alternative scenario to illustrate the impact of some disbursements for protected parties being separately recoverable. The impact on the Net Present Value of this scenario compared to Option 1 is presented in Table 18 below.

Table 18: Sensitivity analysis on disbursements

Model (All Cases)	Proposal	PV of Yearly Projected Cashflow Savings (millions)																				NPV (£m)
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	
Option 1 - Median	Notification Year		4	29	68	108	133	144	147	147	147	146	144	143	141	139	137	136	134	132	131	2309
Scenario C	Notification Year		4	28	67	105	130	140	144	144	143	142	141	139	138	136	134	133	131	129	127	2256

[32] NHS Resolution, (2022) Annual Report and Accounts 2021/22. Available at: NHS Resolution - Annual report and accounts 2021/22 (publishing.service.gov.uk), p.22

125. The table indicates the more disbursements that are covered by the fixed grid costs under an FRC scheme the higher the savings of the scheme as the legal costs recovered against healthcare providers are lower (Option 1). On the other hand, if more disbursements are separately recoverable, the total savings of the FRC scheme will fall slightly, due to relatively higher legal costs from providers being recoverable (Scenario A).

NHS costs monetised at their social value

126. In the main body of the impact assessment, savings have been presented according to their financial value. If the financial savings for NHS-funded healthcare providers were reallocated to frontline healthcare, these could be used to generate additional quality of life benefits for patients. In England, state-backed indemnity schemes are recovered directly from NHS Trusts and other service providers.

127. The standard unit for measuring health benefits is the Quality-Adjusted Life Year (QALY[33]). While it is not possible to know the specific use to which any individual amount of additional funding provided to the NHS will be put, evidence is available of the average number of QALYs expected to be gained for any given amount of additional NHS funding – by whatever means these gains are achieved. This evidence is expressed as an estimate of the cost per QALY gained "at the margin" in the NHS of £15,000. In other words, the best available evidence indicates that additional health benefits of 1 QALY is generated for every £15,000 of additional funding provided to the NHS[34].The NHS cost savings from FRC of £2m-£58m per annum are therefore expected to lead to the provision of an additional 90-3,450 QALYs per annum.

128. Standard impact assessment methodology entails monetising impacts in order to represent their value to society. It is important to note that the value society puts on a QALY is not necessarily the same as the cost at which the NHS can generate additional QALYs. DHSC estimates that society values a QALY at £70,000. The corresponding social value of benefits from NHS cost savings for our reform options is £8m to £395m per annum. The present value of these benefits over the twenty-year period evaluated is £5,934m.

129. Table 19 below provides additional detail. The £5,934m figure relates to NHS Resolution claims only. We do not have the information necessary to produce a corresponding figure for other NHS activity, like dentistry, which is indemnified outside of state indemnity schemes.

[33] A unit of health which combines length and quality of life in a single measure.

[34] See http://www.york.ac.uk/che/research/teehta/thresholds/ and links therein.

Table 19: Option 1 Savings as Social Value

Model (NHSR Cases only)	Proposal	NPV (£m)
Central Estimate	Financial Value	1022
Sensitivity Test	Social Value	5934
1) There are no cashflow savings for the year before implementation year (2024/25, year 2). *2) Social value figures are discounted using a 1.5% discount rate[35].*		

130. The table below takes into account the social value of QALY benefits from NHS cost savings and the financial savings from other providers, and estimates the total societal benefit as £7,221m.

Model (All Cases)	Proposal	NPV (£m)
Central Estimate	Financial Value	2309
Sensitivity Test	Social Value	7221
1) There are no cashflow savings for the year before implementation year (2024/25, year 2). *2) Social value figures are discounted using a 1.5% discount rate[36].*		

131. Taking a similar approach for societal costs (NHS QALY impacts and financial impacts on non-NHS bodies) results in an estimated social cost of £1,240m and, consequently, an estimated social net present value of £5,980m, or approximately £6bn (rounded to the nearest £bn).

Impact on Small and Micro Businesses

132. Information from the Inter Departmental Business Register shows that the majority of firms who provide legal services are small and micro businesses[37], employing 1-9 FTE employees (micro) or 10-49 FTE employees (small)[38].

	Employment Size Band							
	0-4	**5-9**	**10-19**	**20-49**	**50-99**	**100-249**	**250+**	**Total**
Legal activities	25,285	3,270	2,070	1,355	445	305	165	**32,895**
	77%	10%	6%	4%	1%	1%	1%	100%

133. The proposals could make small legal firms less able to compete with larger firms that have greater economies of scale and can provide services 'en-masse' more cheaply. We have used the consultation response to understand why this might be:

- Work will go to larger firms who have the resources to manage fixed costs claims.

[35] For policies that impact health or life outcomes, a reduced discount rate of 1.5% is applied.

[36] For policies that impact health or life outcomes, a reduced discount rate of 1.5% is applied.

[37] Table 4, UK Business: activity, size and location https://www.ons.gov.uk/businessindustryandtrade/business/activitysizeandlocation/datasets/ukbusinessactivitysizeandlocation

[38] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/827960/RPC_Small_and_Micro_Business_Assessment__SaMBA___August_2019.pdf

- Small firms will not have the volume of claims to manage the fixed costs and will be unlikely to have the resources to pivot into higher value claims.
- Small and micro businesses may not be able to risk taking on clinical negligence claims, even those over £25,000, in case the value falls.

134. Therefore, firms with small, specialised departments are likely to be disproportionately impacted. However, smaller firms may be able to be more adaptable than larger firms and, as long as sufficient notice is given, they could manage the implementation of FRC effectively. In fact, if claims require less resources due to the new streamlined process, small and micro businesses may be able to take on more cases, and it may create more certainty of income.

135. We have considered whether it would be possible to exempt small legal firms from these proposals. However, we have concluded that this would be impossible both from a practical point of view (as claimants, not businesses, are the ones who are directly affected by reform) and because it would reduce the efficacy of the proposals and distort the market. It would also reduce claimant choice.

136. Secondly, information from the IDBR shows that a high proportion of the organisations that would benefit from these reforms are small and micro businesses.

	Employment Size Band							
	0-4	**5-9**	**10-19**	**20-49**	**50-99**	**100-249**	**250+**	**Total**
Hospital activities	1,920	105	90	155	155	120	275	**2,820**
General medical practice activities	7,890	1,215	2,510	3,190	610	105	30	**15,550**
Specialist medical practice activities	5,215	375	220	105	20	5	5	**5,945**
Dental practice activities	5,570	3,940	2,345	320	30	5	10	**12,220**
Other human health activities	18,050	2,130	1,070	460	225	115	145	**22,195**
Total	38,645	7,765	6,235	4,230	1,040	350	465	**58,730**
Proportion	**66%**	**13%**	**11%**	**7%**	**2%**	**1%**	**1%**	**100%**

137. The table above shows that the majority of VAT or PAYE registered companies who provide human health services are small or micro businesses. Providers of healthcare will benefit directly from a reduction in the claimant costs which can be claimed in lower damages clinical negligence settlement.

138. It's not possible to estimate the benefit of these proposals for small and micro firms alone. Clinical negligence costs are very complex to model, the rate and size of future claims are dependent on a wide range of factors. Government does not have access to the detailed information required to model future clinical negligence claims, by size of provider, for those indemnified outside of state schemes. Given the complexity, there is no simple proxy we could produce an estimate of benefit by health care provider size.

Wider Impacts (consider the impacts of your proposals)

Equalities Statement

139. The Equalities Duty Analysis (EDA - see separate document) assesses whether the proposed FRC scheme would have a negative impact on those with protected characteristics as listed within the Equality Act 2010. This assessment involved comparing demographic statistics for those who would likely fall within the FRC remit, through being more likely to submit a claim, or

having submitted a lower damages claim, with the wider population. The equalities statement draws on a range of evidence and data including responses to the 2017 and 2021 FRC consultations, an anonymised claims level dataset sample (provided by NHS Resolution), and other published demographic statistics.

140. Overall, the available evidence suggests no direct discrimination from the proposed FRC scheme against any group with protected characteristics. However, disability (based on pre-existing condition and disability following an adverse event) remains an area where the analysis is inconclusive. Analysis is also inconclusive for employment status.

141. The available evidence suggests that those with certain characteristics may be disproportionately impacted but not directly or indirectly discriminated. Disproportionate impacts may fall on older populations and those with pre-existing disabilities, who are over-represented in the inpatient population compared to the general public, and so are more likely to make a claim. Those with lower earnings may also be disproportionately impacted, through their lower earnings making them more likely to fall into a lower compensation band, if loss of earnings is taken into account when agreeing the compensation amount.

142. In addition, it was noted in consultation responses that certain protected parties or children may require additional support as part of the legal process, and so will incur increased costs. These higher costs may lead to claims from these individuals becoming unviable for solicitors or potentially under-investigated, leading to under-compensation for claimants. To prevent disproportionate financial impacts, an additional 'bolt-on' fee of £1,800 recoverable by the claimant has been proposed for these claims.

143. Some consultation responses highlighted concerns that this bolt-on amount may not be adequate to cover necessary disbursements for these types of claims, with potential negative impacts falling on protected party or child claimants. We will hold a short consultation clarifying arrangements for disbursements in the proposed scheme (see Disbursements section above).

144. No data or evidence was available to assess impacts on sexual orientation, gender reassignment, religion or belief, or marriage and civil partnership. The 'Monitoring and Evaluation' section below sets out that future monitoring and evaluation will aim to assess impacts on equalities, including on protected party/child claimants, where it is practical and proportionate to do so.

Environmental Impacts

145. There will be no environmental impacts from this policy.

Impacts on Competition

146. We expect that there could be some impacts on competition in the clinical negligence market. The consultation response highlighted that:

- Some legal firms may move away from lower damages clinical negligence claims, and potentially out of the market. This could lead to an absence of firms in specific geographical areas, as well as reduce claimant choice of solicitors. This may force some claimants to look for virtual solicitors, which could be a problem for those who struggle to access technology.
- Some firms may not take on complex lower damages clinical negligence claims as it may lead to losses being incurred. Some of these claims may be excluded from the FRC scheme e.g. those where there are multiple defendants, more than three liability experts and/or involve a neonatal death or stillbirth. For claims still in scope we expect there to be sufficient safeguards in place to mitigate the risk as part of the policy design, including in the level of fixed costs set, taking into account the work required by lawyers. In particular, there will be an additional 'bolt-on' amount paid to claimant solicitors for those claims involving a protected party or child.
- An FRC scheme could reduce a defendant's unavoidable costs liability and in turn reduce indemnity costs. This may encourage more practitioners to enter the market.

A summary of the potential trade implications of measure

147. There will be no potential trade implications from this policy.

Monitoring and Evaluation

148. Government is committed to evaluating the policies it implements as part of a Post Implementation review (PIR) not less than three years following implementation. We are considering how best to undertake a PIR and the appropriate metrics to evaluate the effectiveness of the policy in meeting our policy intent.

149. The evaluation will consider whether:

- The overall aims of the policy have been met;
- The policy has been implemented effectively;
- Any unintended consequences have been identified and;
- The impacts and effectiveness of these proposals with specific reference to groups with protected characteristics under the Equality Act 2010, where it is practical and proportionate to do so.

150. In doing so, it is likely to focus on:

- The effect of our scheme on overall legal costs of relevant claims
- The effect on time to resolution for these claims
- Impacts on access to justice
- Impacts on equalities, including on protected party claimants
- Effectiveness of arrangements for neutral evaluation
- Effectiveness of sanctions
- Use of exclusion categories
- Use of disbursements
- Impact of inflation
- We will work closely with NHS Resolution and others to monitor routine data on relevant claims and demographic data, where available, to address these and other relevant questions and consider where qualitative methods may add value.

Annex A – Detailed Results

Table A1: Detailed Results (Discounted)

	PV of Yearly Projected Cashflow (£m)																				NPV Total (£m)
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	
Change in legal costs recovered from the defendant (savings are positive)		4	29	68	108	133	144	147	147	147	146	144	143	141	139	137	136	134	132	131	2309
Change in claimant solicitors admin costs		1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	16
		1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	21
		2	2	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	23
Change in NHS Resolution admin costs		1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	16
		1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	21
		2	2	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	23

1) Figures in red denote extra expenses, i.e. costs more under FRC.
2) Dash signs (-) denote sub £500k savings/expenses.
3) There are no cashflow savings for the year before implementation year (2024/25, year 2).
4) Admin costs explore 3 staff and add-on legal costs scenarios: 1) 3 staff, £200 add-on; 2) 4 staff, £250 add-on; and 3) 4 staff, £300 add-on.

1. The results in Table A2 below represent the in-year impact in 2021/22 real prices. The average impact across years 2 to 20 estimates the annual impact excluding the reform transition years.

Table A2: Detailed Results (Constant Prices)

	PV of Yearly Projected Cashflow (£m)																				NPV Total (£m)
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	
Change in legal costs recovered from the defendant (savings are positive)		4	32	79	131	171	195	211	223	235	246	257	268	280	292	304	317	331	345	359	4282
Change in claimant solicitors admin costs		1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	23
		1	1	1	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	30
		2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	32
Change in NHS Resolution admin costs		1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	23
		1	1	1	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	30
		2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	32

1) Figures in red denote extra expenses, i.e. costs more under FRC.
2) Dash signs (-) denote sub £500k savings/expenses.
3) There are no cashflow savings for the year before implementation year (2024/25, year 2).
4) Admin costs explore 3 staff and add-on legal costs scenarios: 1) 3 staff, £200 add-on; 2) 4 staff, £250 add-on; and 3) 4 staff, £300 add-on.

Annex B – Data Sources

NHS Resolution's Extract I

1. De-identified dataset at the individual claim level covering claims handled by NHS Resolution (i.e., filed against NHS Trusts and other service providers) from 2017/18 to 2021/22 and containing c.10,400 individual lower damages claims. Each relevant claim was flagged to reflect whether it would be expected to proceed to standard or light track under FRC. This flag was provided by experts from a specialist firm. 2021/22 data was used as the latest available at the point the track assessment exercise was undertaken by the specialist firm.

2. This dataset is primarily used to calculate what average reduction in claimant legal costs should be expected under option 1. This average reduction (in percentage terms) is then applied to claimant legal costs in the main projection model.

3. This dataset was also used to carry out an exclusion assessment for the number of claims that would be excluded from the remit of an FRC scheme. Specific exclusions considered were whether a claimant is a protected party, if a case had multiple defendants, whether more than two medical experts were needed, whether a claim relates to a fatality and whether a claim relates to a neonatal death.

4. Separately, a specialist firm also provided an assessment of how many claims (in both standard and light track) would proceed to a neutral evaluation– 10% for standard track, and 5% for light track.

Further Exclusions Data

5. Alongside NHS Resolution's Extract I, a further data source was used to carry out the exclusions assessment, specifically for the number of claims that would be excluded from the remit of an FRC scheme due to a limitation issue. This data source was a summary of analysis completed by experts from a specialist firm.

6. Both data sources contribute to estimating the proportion of claims to be excluded from FRC. A collection of NHS Resolution's panel firms had given their evaluation of the exclusion percentage, and we have assumed these exclusion proportions are likely to be representative of all NHS Resolution claims.

NHS Resolutions' Extract II

7. De-identified dataset at the individual claim level covering historical claims handled by NHS Resolution. It contains approximately 212,000 claims spanning claims with a date of notification from 1995/96 to 2021/22. This version does not include the track assessment flag and is primarily used to model the volume of claims that could fall outside the FRC scope over time.