Department of Health

Introducing Fixed Recoverable Costs in Lower Value Clinical Negligence Claims

A Consultation

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Ministerial Foreword

Where the NHS gets something wrong and people suffer, it is quite right that they are able to hold it to account. We support them to do so by

- listening to what they say,
- ensuring proper apologies are made,
- taking action to make sure it does not happen to others,
- providing the right recompense, and, of course
- properly learning the lessons and sharing that across the NHS.

However, a significant (36%) part of the cost of clinical negligence claims against the NHS relates directly to the cost of litigation in claimant and defence costs. For claims under £25,000, claimant recoverable legal costs are on average 220% of damages awarded.[i]

Our proposed reforms to reduce the cost of claims are part of a broad package to improve patient care by encouraging learning across all healthcare organisations. Where litigation is needed, the process will be streamlined so that the injured person and their family reach a resolution more quickly, confident that change will occur, and that harm will not happen to others. Finally, it is right that the Government should endeavour to reduce the cost of litigation so that more resources are available for NHS patient care.

We have taken into account legitimate concerns about access to justice. The preferred option described in this consultation is to fix legal fees, which can be recovered by claimants, in awards of between £1,000 and £25,000, which encompasses the greatest disproportionality between claimant costs and damages, based on recommendations from Professor Fenn and other stakeholders and experience in road traffic accidents. This would cover around 60% of claims settled for damages against the NHS in England in 2015/16.[ii]

I encourage you to send in your comments on our proposals to improve and reduce the cost of clinical negligence litigation.

James O'Shaughnessy

Parliamentary Under Secretary for Health

Executive Summary

This consultation seeks views on the Government's proposal to introduce a mandatory system of Fixed Recoverable Costs (FRC) for lower value clinical negligence claims. The FRC scheme would apply across the NHS, not-for-profit and private healthcare providers and in England and Wales but not Scotland or Northern Ireland.

The proposal to introduce FRC is a key strand of the Government's programme to improve patient care and patient experience, and the efficiency and cost-effectiveness of clinical negligence claims. The FRC scheme would be set out in Civil Procedure Rules (CPR). This would support quicker and more cost effective resolution for all parties and provide greater opportunities for early learning of lessons from harmful incidents to inform safer clinical practice. The Civil Procedure Rule Committee (CPRC) has assisted the Government by developing an illustrative set of Protocol and Rules (Annex D). It should be noted that in providing such support prior to the consultation, the CPRC is not expressing any opinion on the consultation itself.

The annual cost of clinical negligence in the NHS in England has risen from £1.2bn in 2014/15 to £1.5bn in 2015/16 and legal costs were 34% of the 2015/16 expenditure.[iii] The current system of claims resolution is often lengthy and adversarial. This creates the dual problems of delaying possible learning of lessons from incidents, and escalating the costs of litigation when claims are brought. This is particularly the case for lower value claims, where recoverable costs often reach two to three times the value of damages actually awarded. In 2015/16, claimant recoverable costs were 220% of damages awarded in claims between £1,000 and £25,000.[iv] Most parties agree that this is disproportionately high. Our proposition is that the disproportionality and the time taken to settle are not in the best interests of either the patient or the taxpayer.

Proposals for change

This consultation proposes a mandatory scheme of fixed recoverable legal costs for lower value clinical negligence claims. Our proposed scheme would apply to claims above £1,000 and up to £25,000 in the fast track or the multi track but not the small claims track, which would be unaffected by this proposal. The FRC scheme would be set out in revised CPR. The different tracks are explained at paragraph 2.12.

FRC is not a new concept: it has already been introduced for most other categories of personal injury claims up to a value of £25,000 (e.g. road traffic accidents, employer liability and public liability). Clinical negligence is one of the last remaining areas of personal injury law to be reformed, and the Government believes there is a strong rationale for doing so.

The FRC rates denote the amount of reimbursement for legal costs which the successful party is entitled to recover from the unsuccessful party. Illustrative rates are set out in Chapter 4.

We are keen to maintain access to justice for all at a reasonable cost, and have been mindful of this in developing our proposals. Some stakeholders have suggested that the introduction of FRC for low value claims might have an adverse impact on access to justice for those claimants bringing clinical negligence claims of a low monetary value, but complex nature. Our proposals aim to ensure that patients maintain access to justice by streamlining the system and incentivising earlier resolution of such claims, setting FRC rates at the right level and considering appropriate exemptions to the proposed FRC scheme. We ask about these issues in Chapters 4 and 6 respectively.

Patient Safety

The Government agrees with a number of stakeholders (a list of stakeholders we have consulted is at Annex A) that a robust focus on improving patient safety and reducing incidents of harm is the most effective means to tackle the rising cost of clinical negligence. We believe that introducing FRC will contribute to a sustained focus on improving patient safety through learning of lessons and transparency across the healthcare system. The Secretary of State for Health described this in a statement launching the first Global Summit on Patient Safety in March 2016: "… in the end all the experts agree that no change is permanent without culture change. That change needs to be about two things: openness and transparency about where problems exist; and a proper learning culture to put them right."[v] Within this context, we are pursuing three key objectives to reform clinical negligence:

- Improving patient care by ensuring effective learning of lessons from incidents, with the ultimate aim of reducing harm and therefore instances of clinical negligence;
- Improving customer care by ensuring all NHS organisations are responsive to patients' needs, including a focus on openness and transparency through the Duty of Candour and effective use of mediation;
- Improving the litigation system by ensuring that when claims are brought against the NHS, there is an appropriate and cost effective legal process in place for both claimants and defendants.

This consultation supports the third of these work streams by outlining our policy proposals to improve the efficiency of litigation. However, we also want to ensure that any learning of lessons from adverse incidents that give rise to clinical negligence claims is fed back to the frontline as soon as possible, to maximise patient safety in the future. We believe that more timely resolution of claims would also be in the interest of patients and their families, for whom the current process can be frustrating and distressing. Patients tell us that quite often their main priority is to receive a genuine apology and explanation, with an assurance it will not be repeated for others, rather than compensation. However, patients currently sometimes feel the only way of getting an apology is to go down the litigation route.

The introduction of the Duty of Candour in the NHS in 2014 was intended to promote this focus on learning of lessons from, rather than repeating, mistakes in the NHS. The Department of Health has commissioned new research into the implementation of the policies we have introduced to improve the culture of openness and transparency into the NHS; and we believe that the introduction of FRC for lower value claims will complement these policies, encouraging

openness, learning of lessons and early resolution for patients and Trusts wherever possible. The research led by Professor Graham Martin at the University of Leicester;

- will commence in January 2017 and be conducted over the next two years - the expectation is that the timeframe for the research will give sufficient time for our policy proposals to mature in the NHS and enable their impact to be assessed in a meaningful way; and
- look at the efficacy of the different approaches DH has taken for introducing these policies (i.e. regulation vs guidance) and also how the NHS has gone about implementing these policies and the impact they have had.

This consultation

These proposals have been informed by extensive engagement with interested parties and an independent review by Professor Fenn of Nottingham University Business School, whose report is Annex C. This consultation invites views on the preferred option of a mandatory FRC scheme for clinical negligence claims above £1,000 and up to £25,000 allocated to either the fast track or the multi-track.

The questions on which views are sought are:

- whether FRC should be introduced on a mandatory basis;
- the method of introduction,
- how FRC rates should be calculated;
- how expert witness costs should be treated within the proposed FRC scheme;
- the concept of a Single Joint Expert (SJE);
- the draft Protocol and Civil Procedure Rules, supporting early exchange of evidence, and behavioural change; and
- whether there is further evidence, including about the private sector, equalities and health inequalities, the Government should consider.

The Government will carefully consider responses to this consultation and provide a full response. Analysis of the responses will help the Government and CPRC to finalise the policy and rules respectively.

Conclusion

The Government seeks views on the preferred option of introducing a mandatory FRC scheme for clinical negligence claims above £1,000 and up to £25,000 in the fast track or multi track, which will be implemented through revised Civil Procedure Rules. The Rules will support timely resolution, which underpins fast and effective learning of lessons. Funding will be re-directed from litigation to front-line NHS services with the ultimate aim of improving patient safety. FRC will directly target the disproportionality between damages and claimant recoverable costs.

1. About this Consultation

1.1. This consultation seeks views on how FRC should be introduced, including details of which cases FRC should apply to and how the FRC rates should be calculated. These issues are discussed in the following chapters.

Outline of policy proposal

1.2. FRC describes an arrangement in which the legal costs recovered by the successful party in litigation are limited according to agreed rates. This does not, in itself, affect the sum a lawyer charges a client, which is matter of private agreement. Nor does it affect the amount of compensation (damages) awarded to the claimant. It solely affects the legal costs that a claimant can recover from the defendant following a successful claim.

1.3. This consultation seeks views on the proposal to introduce a mandatory FRC scheme for clinical negligence cases in the fast track or multi-track (see paragraph 2.12) where the value of damages awarded is above £1,000 and up to £25,000 in England and in Wales whether they are in the not-for-profit or private sectors. Claims allocated to the small claims track will be unaffected.

1.4. We would particularly welcome responses from the not-for-profit and private healthcare and insurance sectors.

1.5. Our proposed introduction of FRC would require a revision of the Civil Procedure Rules and the introduction of a Pre-Action Protocol to support early resolution of cases in England and Wales. The CPRC has assisted the Government by developing an illustrative set of Protocol and Rules (Annex D). It should be noted that in providing such support prior to the consultation, the CPRC is not expressing any opinion on the consultation itself. The Protocol and Rules are provided as an illustrative example only and may need modification, depending on responses to this consultation. Detailed questions about the Protocol and Rules are in Chapter 6.

Preparatory work

1.6. This consultation has been informed by significant engagement with stakeholders and the public. The intention to consult on the introduction of FRC for clinical negligence claims was announced in July 2015. Since then, we have undertaken a pre-consultation exercise to test the proposals and identify further evidence on the likely impact of the policy. This has resulted in the modified proposal being consulted on now. We also held focus groups with interested parties to refine the scope and detail of the FRC proposal. The Government has worked particularly closely with The Law Society, Association of Personal Injury Lawyers (APIL), Action against Medical Accidents (AvMA) and Society of Clinical Injury Lawyers (SCIL), alongside other interested parties, to understand their views and concerns. Details of respondents to the pre-consultation exercise are in Annex A.

1.7. In the pre-consultation exercise, we tested the value of claims to which any FRC scheme should apply, including an initial hypothesis that the limit should be set at a higher level (£250,000). Following further consideration and open discussion with interested parties, our proposition is that the FRC scheme should initially be in line with the schemes which currently apply in other categories of personal injury, with an upper limit of £25,000.

1.8. In October 2015, the Government asked Professor Fenn to provide an independent review of the proposed methodologies for setting the FRC rates alongside data provided from the NHS Litigation Authority. Professor Fenn was an assessor for Lord Justice Jackson's 2011 review and is an assessor for the current review. He therefore brought a wealth of relevant experience.

1.9. His report (Annex C) gives his view on the introduction of FRC in personal injury claims and how FRC could apply to clinical negligence. It should be noted that his report was based on early thinking and our views have subsequently changed. For example, we have, as a result of his report, reduced the upper threshold from £250,000 to £25,000; and reduced the number of options for calculating the FRC rates.

1.10. Professor Fenn acknowledged that the work undertaken by the DH to underpin the FRC rates has been thorough and informative. His report (Annex C) sets out a number of recommendations. The Government has asked Professor Fenn to take forward the work on recommendations 2 and 3 around using a matrix derived from average base costs to calculate the rates of FRC, and options to reduce the fixed cost where there is an early admission of liability, which we refer to as the cost analysis approach in Chapter 4. This further work will be carried during the consultation period so that it can be considered alongside the consultation responses and feed into decision-making following the consultation.

Private and not-for-profit sectors

1.11. The information available to support the consultation is currently primarily drawn from the NHS or NHS funded activity in England and Wales. Through this consultation process, we would welcome any relevant information from other organisations, for example the private sector, claimant lawyers, and Medical Defence Organisations (MDOs) to support our understanding of how FRC would affect the private and not-for-profit sectors. Any commercially sensitive data included in consultation responses should be identified as such and will be treated in confidence.

Wales, Scotland and Northern Ireland

1.12. FRC will apply to England and Wales but not Scotland and Northern Ireland, which have separate civil justice systems.

1.13. In Wales, the NHS Redress process for clinical negligence cases operates under Regulations made under the NHS Redress (Wales) Measure 2008 and currently applies to cases worth up to £25,000. It is a voluntary scheme and legal advice without charge is

provided to patients who opt to pursue the redress process. The Welsh Government will consider whether the proposal should apply to cases that are covered by the Redress process.

1.14. The NHS Wales Shared Services Partnership (NWSSP), hosted by Velindre NHS Trust, administers the majority of litigation cases in Wales. The NWSSP legal services team act for all the NHS Trusts and Local Health Boards in Wales for clinical negligence cases and through the Welsh Risk Pool Service (a mutual risk pooling arrangement) for the reimbursement of losses over £25,000 incurred by Welsh NHS bodies.

1.15. The Welsh Risk Pool provides similar services to Welsh NHS organisations as those provided by the NHS LA in England, including an integrated approach between claims management, reimbursement and the learning of lessons and support for quality and safety through clinical risk management assessment and the management of concerns and claims reviews. NWSSP through the Welsh Risk Pool made payments in respect of clinical negligence claims in 2014/15 of £58.2m.

How to Respond

1.16. Comments on the proposal can be submitted either

- on line via citizen space (preferred);
- by post to Clinical Negligence FRC Consultation, Acute Care and Quality Policy Directorate; Department of Health; Room 2N22 Quarry House; Quarry Hill; Leeds LS2 7UE or
- by email to FRC-Consultation@dh.gsi.gov.uk.

1.17. **The consultation will close on 1 May 2017.**

Confidentiality

1.18. The Department will manage the information you provide in response to this consultation in accordance with the Department's Personal Information Charter. [vi]

1.19. Information the Department receives, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

1.20. If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply, including obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information, you have provided as confidential. If the Department receives a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality

can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

1.21. The Department will process your personal data in accordance with the DPA, and in most circumstances, this will mean that your personal data will not be disclosed to third parties.

Next Steps

1.22. Following this consultation, the Government will carefully analyse the responses and publish a consultation response document. If it is decided to introduce FRC, the CPRC will be asked to finalise the Protocol and Rules. A post-implementation review will be carried out five years after implementation of FRC. The review will consider, based on the available evidence, whether:

- the overall aims of the policy have been met;
- the policy has been implemented effectively; and
- any unintended consequences have been identified.

2. Current System

2.1. When a successful claim is brought against the NHS and the not for profit and private healthcare providers, the claimant is normally entitled to recover legal costs from the defendant. Under the current system, in lower value claims (above £1,000 and up to £25,000) these legal costs often end up being disproportionately high (see tables 1 and 2) both relative to the overall value of the damages awarded, and in comparison with defence legal costs.

2.2. This issue is not unique to clinical negligence. Following the principle of proportionality set out in Lord Woolf's report (1996) many areas of personal injury litigation have introduced a FRC scheme to bring legal costs more in line with the overall value of the award. Clinical negligence is one of the last remaining areas of low value personal injury claims in which recoverable legal costs are not currently fixed.

2.3. Fixing the recoverability of legal costs does not affect the claimant's entitlement to compensation, or the overall amount of damages awarded. It also does not set a limit on the fee arranged between the claimant and lawyer, which is a matter of private agreement. The prescribed rates denote the maximum amount of reimbursement for legal costs, which the successful party is entitled to recover from the unsuccessful party following litigation.

2.4. These measures are designed to streamline the litigation process, supporting a quicker and more cost-effective resolution for all parties. This will support opportunities for early learning of lessons and re-direct NHS funding into front-line services, improving patient safety.

Current Arrangements

2.5. Claims of clinical negligence against all NHS Trusts in England and other similar bodies commissioned to provide services under a NHS Standard Contract are handled primarily under the Clinical Negligence Scheme for Trusts (CNST). The MDOs provide cover to most individual primary care practitioners and indemnity for private healthcare is usually delivered through a mix of the MDOs and private insurance schemes. In the NHS in Wales, there is a risk-pooling system to support clinical negligence.

2.6. Under current arrangements, recoverable legal costs (i.e. those paid by the losing party) are based on a Guideline Hourly Rate (GHR). These are guideline rates only and the courts may depart from them where appropriate and frequently do. As outlined below, these costs often escalate to more than double the value of the claim. This typically affects claimant legal costs, since it is already relatively common for clinical negligence defence lawyers to work within a fixed fee arrangement.

2.7. The identification of disproportionate expenditure on recoverable claimant costs is not a new issue. In 2010, Lord Young found that the: "current system is too costly, and it takes far too long for some medical negligence cases to be resolved". [vii]

2.8. He proposed extending the framework of the existing Road Traffic Accident (RTA) Personal Injury Scheme (which then covered RTA claims up to £10,000) to lower value clinical negligence claims to reduce costs and speed up the claims process. In 2013, the RTA threshold was raised to £25,000 and the scheme was extended to include Employer's Liability and Public Liability claims to the same value.

2.9. In 2011, Lord Justice Jackson pressed for: “a scheme for FRC in the lower reaches of the multi-track" in cases with damages of up to £250,000. In a further speech in January 2016, he argued for the introduction of FRC to all personal injury claims up to £250,000.[viii]

2.10. Recent reforms to the recoverability of legal costs were made as part of the Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPO). These included:

- reform of the operation of "no win no fee" agreements by abolishing the recoverability of success fees and After The Event (ATE) insurance premia recoverable from unsuccessful defendants (with a limited exception for expert reports in clinical negligence);
- implementing ‘qualified one way cost shifting’ in personal injury claims so that defence costs can be recovered in exceptional circumstances;
- the banning of referral fees in personal injury claims; and
- the restriction of Legal Aid for clinical negligence cases.

Lord Justice Jackson Review of FRC

2.11. On 11 November 2016, the Lord Chief Justice and the Master of the Rolls announced that they had commissioned Lord Justice Jackson to undertake a review of fixed recoverable costs, to be completed by 31 July 2017. The review follows his wider review of civil litigation procedures and costs (published in 2010), in which he first recommended the application of fixed recoverable costs. The Government will consider the recommendations and will consult before any proposals are implemented.[ix]

MoJ Consultation on the Small Claims Limit

2.12. The small claims track is one of three tracks to which all defended civil claims are allocated. The multi-track and the fast-track are the others. A number of factors are considered when a claim is allocated to one of these tracks. These include the monetary value and the nature and the complexity of the claim. The current limit for the small claims track is £10,000 for all claims except personal injury and housing disrepair, which is £1,000.

2.13. The Government is currently considering it's response to the consultation on the proposal to increase the small claims track limit from £1,000 for personal injury claims to £5,000, which was announced in the then Chancellor’s 2015 Autumn Statement. The consultation included two options for increasing the small claims track limit: for road traffic accident

cases; or for all personal injury claims (which would include some low value clinical negligence claims).[x]

2.14. Our proposal for FRC in lower value clinical negligence claims is for FRC to apply to all cases within the damages threshold of above £1,000 and up to £25,000 allocated to the multi track or fast track. Claims allocated to the small claims track will be unaffected, and therefore, our proposals should not be affected by the MoJ consultation on the small claims limit.

2.15. A detailed breakdown of how many clinical negligence claims are allocated to the small claims track, multi-track or fast track is not available. However, anecdotal evidence from the NHS Litigation Authority indicates that the vast majority of clinical negligence claims within the £1,000 to £5,000 damages tranche are allocated to the multi-track.

2.16. Recoverable costs for the small claims track are set out in CPR 27 and are unaffected by the FRC proposal.

2.17. Our assessment of the potential impact of the two options for raising the upper limit of the small claims track set out in the MoJ consultation is in Table 1 below.

Table 1: Effect of Small Claims Upper Limit Consultation on FRC for Lower Value Clinical Negligence Claims

Option	Effect on Lower Value Clinical Negligence Claims
1. For road traffic accident cases	No change - clinical negligence claims would be out of scope of the changes.
2. For all personal injury claims	This option would include clinical negligence, but is unlikely to have a material effect on the volume and costs of clinical negligence included within the proposed FRC scheme. This is because the vast majority of clinical negligence claims between £1,000 and £5,000 are allocated to the multi-track[xi]. Those that are allocated to the small claims track will be treated as currently and have less recoverable costs than those in the multi-track.

Current costs of clinical negligence claims

2.18. The cost of clinical negligence against the NHS in England rose from £1.2 billion in 2014/15 to £1.5 billion in 2015/16. In 2015/16, damages and defence costs were 64% and 8% respectively.[xii]

2.19. In claims between £1,000 and £25,000, over 60% of the total expenditure on clinical negligence in 2015/16 was recoverable claimant costs and 220% of damages awarded. [xiii] This is more than double the proportion spent on damages as shown in Table 1. Legal costs are particularly disproportionate to the level of damages awarded to the injured party

in claims below £25,000. The amount of costs recovered by claimants has risen from 25% (of £1.2 billion) in 2014/15 to 28% (of £1.5 billion) in 2015/16.This includes 'disbursements', such as expert costs, Counsel's fees and VAT. (See table 3D in Annex E).

Table 2: Breakdown of Clinical Negligence Expenditure in Claims above £1,000 and up to £25,000 for the NHS in England 2015/16

Category of Expenditure	Amount £m	Percentage of Total Expenditure	As a proportion of Damages
Claimant Costs	£80,360	62%	220%
Defence Costs	£12,997	10%	36%
Damages paid to Claimants	£36,522	28%	100%
Total	£129,879	100%	N/A

Source: NHS Litigation Authority: Annual Report and Accounts 2015/16

2.20. As noted in Table 2, defence costs are significantly lower and therefore more proportionate to damages than claimant costs. However, this does reflect that the onus is on the claimant to prove liability. Nonetheless, defence costs (excluding the cost of NHS LA and NHS Trusts administering clinical claims) have reduced from 9% (of £1.2 billion) in 2014/15 to 8% (of £1.5 billion) in 2015/16 as shown in Table 3D in Annex E.[xiv]

2.21. Table 3 provides a breakdown of claimant legal costs for cases managed by the NHS Litigation Authority in 2013/14 to 2015/16. This indicates that the proportion of claimant legal costs in relation to damages has risen over time; and that the disproportionality is greatest at the lower end of damages awarded. For claims between £1,000 and £10,000, claimant recoverable legal costs have risen from 273% of damages in 2013/14 to 324% of damages in 2015/16.

2.22. Figures from MDOs and private insurers show similar ratios and trends to those in the NHS. Anonymised data from MDOs and private insurers are included in the impact assessment (Annex F).

2.23. This creates a strong imperative to make recoverable legal costs more proportionate to the overall value of the claim. This will release the benefits identified in paragraph 3.2., including supporting quicker resolution through a less adversarial approach, improved learning of lessons, and reducing the overall cost of NHS litigation to re-direct funding to the frontline of patient care.

Defence Costs

2.24. Some defendant clinical negligence lawyers have been working to fixed fees for claims with a value of up to £100,000. Those instructed by the NHS LA have being doing so for

over two years. Other defendant lawyers are paid either on a similar basis to the NHS LA defence panel or on an hourly rate - these will be agreed with their client.

Table 3: Recovered Claimant Legal Costs as % of Damages Awarded 2013/14 - 2015/16

Damages awarded between	Claimant Costs Recovered as % of Damages Awarded		
	2013/14	2014/15	2015/16
£1,000 and £10,000	273%	299%	324%
£10,000 and £25,000	153%	164%	176%
£25,000 and £50,000	107%	112%	135%
£50,000 and £100,000	74%	83%	99%
£100,000 and £250,000	54%	57%	72%
£250,000 and- £500,000	37%	41%	48%
£500,000 and- £1,000,000	24%	27%	38%
£1,000,000 +	15%	17%	18%

Source: NHS Litigation Authority: Annual Report and Accounts 2015/16

Conclusion

2.25. This chapter has outlined the current system and the origins of the concept of proportionality of legal costs. It has demonstrated that the overall cost of clinical negligence is high and rising and that recoverable costs are disproportionate to damages awarded. The Government's proposition is that introducing FRC for lower value clinical negligence claims will tackle some of these issues and will demonstrate how in the following chapters.

3. Implementation

3.1. Chapters 3 to 6 set out in detail the proposal for introducing FRC for clinical negligence cases with damages up to £25,000. This Chapter focusses on how to implement FRC. Subsequent chapters consider:

- the options for calculating the FRC rates;
- other costs including experts and witnesses; and
- Protocol and Rules to implement FRC.

Should FRC be introduced on a mandatory basis?

3.2. The Government's view is that a mandatory FRC scheme for lower value claims should be introduced to address the disproportionality between claimant recoverable costs and damages awarded and to introduce the following benefits that have already been realised in other FRC schemes:

- improving predictability for cost and budget planning for both claimants and defendants;
- reducing court time on deciding recoverable costs where there has been a dispute; and
- supporting better cost management for all parties.

3.3. FRC will apply to claims within the damages tranche of £1,000 to £25,000 allocated to either the fast track or multi track but not the small claims track.

3.4. The introduction of the proposed FRC scheme will result in savings for the NHS, which will be used to deliver frontline care. We estimate that our proposal will release a saving of approximately £45 million per annum by 2020/21. However this is based on assumptions about the date and method of implementation, the FRC rate and potential exemptions to the FRC scheme - all of which we are seeking views on in this consultation.

3.5. Alternatives to the mandatory introduction of a FRC scheme for claims up to £25,000 have previously been explored by the Department. In 2011/12 NHSLA held discussions with organisations representing clinical negligence claimant lawyers to scope and agree a voluntary scheme for claims above £1,000 and up to £25,000. The objective of the work then, as now, was to speed up and simplify the processes, ensuring that patients who were due compensation received it promptly. Whilst good progress was made at the time, there were a number of objections to the voluntary proposal, including:

- the use of a financial value to define the scope of a FRC scheme was considered more arbitrary than establishing a definition of harm;
- the level of costs attached to the various stages of the process (a number of parties put forward proposals);
- no agreement to apply cost sanctions where there was an unreasonable failure to participate in the arrangements.

3.6. Additionally, it was observed that there was no guarantee that lawyers would participate in a voluntary scheme and therefore an uneven playing field between claimant lawyers would be created (i.e. the market could become distorted). Any new system needs to be straightforward and comprehensive in order that both service users and lawyers clearly understand the level of legal costs that will be recoverable. We believe that a system with multiple processes could lead to confusion and would retain the inefficiencies in the current process.

3.7. In the light of previous FRC discussions and the preparatory work outlined earlier, the government is proposing a mandatory FRC scheme. The Rules will be drafted by the CPRC. They will include the arrangements for processing clinical negligence claims above £1,000 and up to £25,000 in the fast track and multi track, and set out the appropriate rates. The Rules will also contain any exemptions to FRC that are agreed - see paragraphs 6.8 to 6.12.

Question 1: Introducing Fixed Recoverable Costs	Yes	No
Do you agree that Fixed Recoverable Costs for lower value clinical negligence claims should be introduced on a mandatory basis?		
If not, what are your objections?		
If you prefer a voluntary scheme instead, please explain how this would fulfil the same policy objectives as a mandatory scheme.		

Which cases should FRC apply to?

3.8. The Government is proposing that FRC should be introduced for clinical negligence claims above £1,000 and up to £25,000 in the fast track and multi track. The upper FRC threshold of £25,000 does not include VAT or interest.

3.9. A FRC scheme above £1,000 and up to £25,000 would equate to approximately 60% of claims settled for damages against the NHS in England in 2015/16. (Table 4) We are proposing this damages tranche because this is where the greatest disproportionality in recoverable costs exists NHS Litigation Authority data for 2015/16 shows that in claims above £1,000 and up to £25,000, claimant recoverable costs were 220% of damages awarded[xv]. - see Table 3E in Annex E.

3.10. Approximately 21% of claims settled for damages against the NHS in England in 2015/16 were above £1,000 and up to £5,000 (Table 4). However, anecdotal evidence from the NHS Litigation Authority indicates that the vast majority of these cases were allocated to the multi-track with a very small number going through the small claims track. We do not expect this to change.

3.11. Our pre-consultation stage tested a proposed threshold of £250,000. Views on the upper limit were mixed with some respondents suggesting that the threshold should be set higher than £250,000 and others suggesting that FRC for clinical negligence cases should be at most limited to £25,000. We have concluded that this proposed scheme should apply to claims above £1,000 and up to £25,000 in the fast track or multi track. This is in line with Professor Fenn's Independent Review recommendation and the existing upper threshold for FRC in other areas of personal injury.

Table 4: Value of clinical negligence claims closed against the NHS in England in 2015/16

Damages Tranche £ (note 1)	No. of claims	% of total claims	% of claims settled for damages
Nil (i.e. settled for no damages)	4,983	46.2%	n/a
£1 - £1,000	184	1.7%	3.2%
£1,001 - £5,000	1,203	11.2%	20.8%
£5,001 - £25,000	2,272	21.1%	39.2%
£25,001 - £50,000	866	8.0%	14.9%
£50,001 - £100,000	556	5.2%	9.6%
£100,001 - £150,000	202	1.9%	3.5%
£150,001 - £200,000	129	1.2%	2.2%
£200,001 - £250,000	67	0.6%	1.2%
£250,000 +	316	2.9%	5.5%
Total	10,778		

Note 1: the damages tranches includes claims allocated to the small claims track as it is not possible to breakdown the number of claims by track.

Source: NHS Litigation Authority

Question 2: Fixed Recoverable Costs Ranges		
Do you agree that Fixed Recoverable Costs should apply in clinical negligence claims:	**Yes**	**No**
Option A: above £1,000 t and up to £25,000 (preferred)		
Option B: Another proposal		
Please explain why		

How should FRC be introduced?

3.12. Our primary objective for implementation is for it to be as smooth and effective and as soon as practical, whilst allowing time for all parties to become familiar with the new arrangements. With this in mind, we have considered two implementation options:

Option 1: FRC would apply to all cases in which the letter of claim is sent on or after the implementation date.

3.13. FRC would not apply to cases where letters of claim were submitted prior to the implementation date. To encourage swift resolution of existing cases, for letters of claim submitted prior to the implementation date, there will be a transitional period in which the case will have to be settled or issued; otherwise, the new FRC arrangements would apply. This is our preferred option, and we believe will offer greater clarity and smoother implementation. However, the lawyer and client may have already agreed a fee structure, which is higher than the FRC rate and this will need to be considered within the transitional arrangements.

Option 2: FRC would apply to all incidents after the implementation date.

3.14. FRC will not apply to adverse incidents that occur prior to the implementation date. This runs the risk of a very substantial "tail" of claims under the current arrangements well after implementation and so is not our preferred option. If this option were to be pursued, we would want to consider some form of cut-off period to ensure that such cases are presented within a reasonable timeframe.

Question 3: Implementation	Yes	No
Which option for implementation do you agree with:		
Option 1: all cases in which the letter of claim is sent on or after the proposed implementation date.		
Option 2: all adverse incidents after the date of implementation.		
Another proposal		
Please Explain Why		

4. Setting FRC Rates

4.1. This chapter sets out potential methodologies for calculating the FRC rates and illustrative figures. We are consulting on the methodologies only - not the absolute figures. However, we felt it would be helpful to demonstrate what the differences in methodologies mean to the potential rates. The rates will be revised following the consultation depending on responses to Question 4 and Professor Fenn's additional work. These rates will apply to claims allocated to the fast track and multi track.

4.2. The current process, together with arrangements for existing personal injury FRC and offers to settle, is set out in Parts 45 and 36 of the Civil Procedure Rules respectively. We expect that the revised Protocol will streamline current processes, which will support the application of FRC and this will work to incentivise good behaviour on the part of all parties in the process. The rates will be set out in the Civil Procedure Rules.

4.3. We are clear that patients should continue to have the option of taking legal action where something has gone wrong with their care. Therefore we recognise that the level at which FRC rates are set will be key in ensuring that claimant lawyers can recover reasonable costs and are not deterred from taking on these low value cases. Our other policy objectives are to encourage earlier resolution (for the benefit of all parties) and to create a less adversarial climate, which would reduce claimant lawyers' overall costs.

Time Analysis Approach - Options 1, 2 and 3

4.4. Options 1, 2 and 3 are based on a time analysis. An advisory group (commissioned by NHS LA on behalf of DH) provided three possible options for setting FRC rates in 2014/15. The group estimated the amount of legal time required at each stage of the current claims procedures for a case of average complexity; adjusted for a new streamlined approach (summarised in Table 5); used data from cost lawyers who deal with many claims against the NHS (Tables 4A and 4B of Annex E); and then multiplied by Guideline Hourly Rates . The Post-litigation/Pre-listing stage figure in the analysis has been split into two separate stages for the purposes of the consultation, recognising that reasonable costs at each of these will be different. In summary, these reflect how long we think the streamlined processes will take.

4.5. The rates for options 1, 2 and 3 are illustrated in Table 6. The detail of the time estimates that underpin these are contained within Chapter 4 of Annex E and critiqued by Professor Fenn in section 3.2 of his report. The rates shown in Table 6 have been rounded from the original calculations.

Option 1: Staged Flat fee arrangement

4.6. Under this option, the recoverable amount would be fixed irrespective of settlement value, and would depend on the stage at which the claim was settled.

Table 5: Summary of Time Analysis: Minutes Required

				Grade of Lawyer				
STAGE		SYSTEM	ADMIN CLERK	GA	GB	GC	GD	TOTAL
Hourly Rate (note 1)		n/a	£7.20	£217	£192	£161	£118	n/a
Pre issue	Table 4D: preliminary investigations	0	15	0	0	103	0	118
	Table 4E: formal complaint to trusts	0	0	0	0	45	0	45
	Table 4F: liability investigations	0	0	10	0	245	60	315
	Table 4G liability negotiations	0	0	0	0	145	0	145
	Table 4H: quantum investigations	0	10	0	0	229	0	239
	Sub-total minutes	0	25	10	0	767	60	862
	Sub-total £	£0	£3	£36	0	£2,058	£118	£2,215
Post Issue/pre-allocation	Table 4I: issue of proceedings	0	5	10	0	269	0	284
	Sub-total £	£0	£1	£36	0	£721	0	£758
Post Allocation/pre-listing	Table 4J: litigation tasks	0	10	20	0	512	0	542
	Subtotal £	£0	£1	£72	0	£1,373	£0	£1,745
Post listing	Table 4L: claim finalisation tasks	0	0	0	0	19	0	19
	Sub-total £	£0	£0	£0	£0	£51	£0	£51
Total	Table 4M: total	0	30	40	0	1,567	60	1,707
	£	£0	£4	£144	£0	£4,203	£118	£4,470
Table 4N: additional expert		0	0	0	0	201	0	201
		£0	£0	£0	£0	£539	£0	£539
Notes: (1): GHRs are used for lawyers and the hourly rate for the admin clerk is assumed to be national minimum wage. (2) Table numbers refer to tables with Annex E. (3) Figures are rounded. Source: NHS Litigation Authority								

Option 2: Staged Flat Fee Arrangement plus % of Damages

4.7. This option offers a lower fixed sum (the base cost) than option 1 but an additional amount would be calculated as a percentage of the final damages awarded, and would then be added to the base cost. The FRC paid would therefore be dependent on the settlement

value and the stage at which the claim was settled. For example, if a claim was settled pre-issue for damages of £20,000, the claimant FRC would be £3,500 comprising the £1,500 base cost plus 10% of £20,000.

Option 3: Early Admission of Liability Arrangement

4.8. The flat fee rates used for Option 1 are reduced in cases where a defendant accepts liability within a defined period (e.g. the Protocol response period) and proposes settlement. This means the defendant would pay less in costs than if liability was accepted, or the case settled, at a later stage. For example, in a case settled prior to issue of a claims letter, FRC under option 1 would be £3,000; but if the defendant made an early admission of liability, claimant FRC would be reduced to £2,700.

Table 6: Illustrative FRC Rates for Options 1, 2 and 3.

Stage	Option 1: Staged Flat Fee Arrangement	Option 2: Staged Flat Fee Arrangement Plus % of damages	Option 3: Early Admission of Liability Arrangement
Pre-issue	£3,000	£1,500 + 10% of damages: minimum of £1,600 maximum of £4,000	£3,000 less 10% = £2,700
Post-issue/pre-allocation	£3,900	£3,000 + 10% of damages: minimum of £3,100 maximum of £5,500	£3,900 less 15% = £3,315
Post-allocation/pre-listing	£5,650	£6,000 + 10% of damages: minimum of £6,100 maximum of £8,500	£5,650 less 10% = £5,085
Post-listing	£7,150	£6,500 + 10% of damages: minimum of £6,600 or £7,000 maximum of £9,000	£7,150 less 10% = £6,435
Notes: (1) Factual Witness Costs, Trial Fees are in addition to the figures. Counsel costs are included with the figures but exclude trial advocacy. London weighting would be in addition. Recoverable trial costs to be in accordance with Civil Procedure Rule (CPR) 45.38 (Table 9). Excludes VAT and interest. (2) In option 2, the maximum rate is damages of £25,000 respectively. Two options are given for the minimum rate relating to damages awarded of £1,001 and £5,001. The rate recovered will depend on the amount of damages awarded.			

4.9. The Department subsequently asked Professor Fenn to review the methodology for these options in 2015-16. Some the options he refers to in his report concern claims above £25,000, and other approaches that have subsequently been discounted: these have been removed from this consultation. He accepted the work of the NHS LA was thorough and informative and agreed that GHRs were the most appropriate hourly rate of those originally proposed by the Department.

Cost Analysis Approach - Option 4

4.10. Professor Fenn proposed using the same methodology for calculating rates that is used in other FRC schemes for the proposed FRC scheme of lower value clinical negligence claims. They are set out in part 45 of the CPR and based on the current market costs as opposed to estimates of the time required for a streamlined process (options 1, 2 and 3).

4.11. Professor Fenn's proposal is based on the mean relationship between current costs and damages using data from costs lawyers who deal with many claims against the NHS (tables 4A and 4B of Annex E). Professor Fenn produced his own illustrative fixed cost as an appendix to his report (see Annex C). These costs are subject to a reduction corresponding to the assumed efficiency savings from FRC and a further reduction of 10% if there was an early admission of liability. They are nevertheless higher than those produced by the NHS LA. The illustrative rates are shown in Table 7. .

Table 7: Illustrative FRC Rates for Option 4.

Stage	Illustrative Figures		
	Rate	Minimum: damages are £1,001	Maximum : damages are £25,000
Pre-issue	£3,080 + 19% of damages	£3,270	£7,830
Post-issue/pre-allocation	£5,920 + 34% of damages	£6,260	£14,420
Post-allocation/pre-listing	£11,560 + 38% of damages	£11,880	£21,000
Post-listing	£10,320 + 47% of damages	£11,970	£22,070

Source: Professor Fenn

4.12. It has been suggested that factoring in a percentage of final damages awarded may not encourage early resolution. The illustrative rate suggests that the percentage increases by stage from 19% to 47%. Consequently the overall rate increases significantly. However the flat rate has been reduced by 10% to encourage early resolution. There is therefore a balance between encouraging early resolution and reducing the current cost to reflect new efficiencies. We are open to suggestions on what the percentages to be applied should be.

4.13. The Government has asked Professor Fenn to undertake further work with claimant lawyers and other interested parties to refine the cost analysis option in parallel with this consultation. This will feed into decision making about the FRC rates.

Conclusion

4.14. In summary, Options 1, 2 and 3 are based on an estimation of legal time required for this type of clinical negligence case under a streamlined process whereas Option 4 is based on the current market costs.

Question 4: Fixed Recoverable Costs Rates

Looking at the approach (not the level of fixed recoverable costs), do you prefer:	**Yes**	**No**
Option 1: Staged Flat Fee Arrangement		
Option 2: Staged Flat Fee Arrangement plus % of damages awarded: do you agree with the percentage of damages?		
Option 3: Early Admission of Liability Arrangement: do you agree with the percentage of damages for early resolution?		
Option 4: Cost Analysis Approach: do you agree with the percentage of damages and/or the percentage for early resolution?		
Option 5: Another Proposal		
Please explain why		

5. Expert Witnesses and Other Costs

5.1. This chapter sets out proposals for how the costs of witnesses, counsel and trials will be managed as part of the FRC scheme. It also seeks comments on the concept of a Single Joint Expert (SJE) system for clinical negligence claims above £1,000 and up to £25,000.

Expert Witness Costs

5.2. Currently, an additional recoverable sum is available for expert witness costs. There is no standard fee for experts - these are negotiated between the expert and the lawyer. This allows claimants to obtain more than one expert witness report from different experts in relevant disciplines.

5.3. In future, we propose that these costs will only be recoverable at a standard sum. This standard will cover total costs for all expert reports on breach of duty; causation; and condition and prognosis. The level of cap proposed is considered sufficient to allow a claimant to obtain reports from an appropriate number of experts; and will have regard to case type and value. The proposed maximum is up to £1,200 for defendants and claimants alike for claims that settle.

5.4. We are also considering an exemption to FRC for claims where the number of experts reasonably required by both sides on issues of breach and causation exceeds a total of two per party - see paragraph 6.11.

Question 5: Expert Witness Costs	**Yes**	**No**
Do you agree that there should be a maximum cap of £1,200 applied to recoverable expert fees for both defendant and claimant lawyers?		
Please explain why		

Single Joint Experts (SJE)

5.5. During the preparation for this consultation, some parties have suggested that the resolution of claims could be speeded up by both the claimant lawyer and defendant lawyer agreeing to use a single set of experts. The Government is sympathetic to this approach and therefore proposes that an independent Single Joint Expert (SJE) should be appointed to provide an opinion on breach of duty and causation (in broad terms) at an early stage.

5.6. During this process, consideration of all issues about damages and future care will be postponed until the issue of liability is resolved. It is envisaged that in many cases the use of a SJE will accelerate resolution, reduce costs for all parties, potentially promote learning of lessons from the incident and lead to a better resolution to an incident for all parties but,

in particular, for the patient. [xvi] Any new system for clinical negligence claims would need to consider:

- whether a list of experts is held centrally and if so, by whom;
- process and criteria for admission to, and removal from the list;
- cost attribution - how might this best be funded; and
- the rules and processes for selection of an expert in a specific claim.

Question 6: Single Joint Expert	**Yes**	**No**
Expert fees could be reduced and the parties assisted in establishing an agreed position on liability by the instruction of single joint experts on breach of duty, causation, condition and prognosis or all. Should there be a presumption of a single joint expert and, if so, how would this operate?		
Please explain why		

Trial costs

5.7. Trial court costs will need either to be summarily assessed, or referred for assessment if they cannot be agreed. The trial court costs will be paid in addition to the final stage fixed costs. Trial court costs will only apply if the trial actually starts, that is counsel or solicitor advocate addresses the court in a contested final hearing. All costs up to the start of the hearing are included in the final FRC stage. If counsel is used, the additional costs allowed for trial will include both the trial advocacy fee for counsel and the Solicitor's costs of attending at trial and the trial. Recoverable trial costs will be in accordance with Civil Procedure Rule (CPR) 45.38 (Table 9). Although these rates (table 8) are intended to apply to trials in the Fast Track, we intend that these rates should apply to clinical negligence above £1,000 and up to £25,000 in the multi-track and fast track. Your views are sought on this in Question 8. Please also refer to paragraph 5.3 on expert costs.

5.8. In 2015/16, there were 96 clinical negligence cases where the NHS in England was the defendant which went to trial, of which 12 were settled for damages above £1,000 and up to £25,000.

Table 8: Amount of fast track trial costs which the court may award

Damages Value	Trial Costs
No more than £3,000	£485
More than 3,000 but not more than £10,000	£690
More than £10,000 but not more than £15,000	£1,035
For proceedings issued on or after 06/04/09, more than £15,000	£1,650

Source: Civil Procedure Rule (CPR) 45.38 (Table 9).

Other Costs

5.9. The proposed FRC scheme includes counsel costs, which will not be separately recoverable, save for the trial advocacy fee. As Lord Justice Jackson noted in his final report: "(1) the primary aim of fixed costs is to ensure that the total costs reflect the complexity of the case as a whole, not the decisions made as to what type of lawyer should do the work; (2) any system of bolt-ons tends to incentivise the activity which triggers the additional payment. Solicitors will always be better off claiming the Bar fee as an additional item from the opponent rather than having to do that work and pay for it out of their fixed fee." [xvii]

5.10. However, where fees are necessarily incurred for settlement approval by reason of the claimant being a child or protected party as defined in CPR Part 21, these will be separately recoverable and are claimable as additional costs, and therefore separate costs.

Defence Costs

5.11. 'Qualified one way costs shifting' now applies in personal injury claims. This means that, generally, a winning defendant is not able to recover their costs from losing claimants. There are, however, exceptions to this general rule, including where the claimant has been fundamentally dishonest and where the claimant has not won more in damages than was offered for settlement by a defendant (under a 'Part 36 offer'). The question arises as to how the defendant's costs should be calculated in those cases where they are recoverable from the claimant, in a fixed costs scheme where costs are calculated by reference to damages.

5.12. CPR Part 45.29 F already sets out that the fixed costs are calculated by reference to the sum in damages sought by the claimant. We propose that this model is followed for these proposals.

6. Draft Protocol and Civil Procedure Rules

6.1. Revised Civil Procedure Rules will be used to implement the introduction of FRC for clinical negligence cases. These will be based on the rules on fixed costs that are already in place in CPR Part 45. An illustrative draft of the Protocol and Rules developed by the CPRC is set out in Annex D. We plan to ask the CPRC to assist in developing the final version of the Protocol and Rules following the consultation and in developing a practice direction covering post-issue matters.

6.2. We have made the draft rules generally available for information (Annex D) and welcome views on them or the principles underpinning the rules, set out below.

6.3. The amended Civil Procedure Rules will be similar to those that operate for other personal injury FRC schemes. This approach, on which views are welcomed, aims to:

- preserve access to justice and the ability of legal firms representing claimants to do the legal work which must be done, in a more modern, efficient and proportionate way;
- keep the process essentially unchanged for simplicity and avoid unnecessary disruption for vulnerable claimants;
- bring this area into line with other lower value personal injury claims, maintaining the structure in the existing Part 45 as far as possible; and
- consider the possibility for discounting arrangement for reaching early agreement (option 3 of the FRC rate).

Early Exchange of Evidence

6.4. The following table sets out the illustrative process under the proposed Pre-Action Protocol. Our intention is that we require parties to have an early exchange of evidence in order to encourage early settlement. This will need to be reviewed and amended if the Single Joint Expert arrangements are introduced.

Question 7: Early Exchange of Evidence	**Yes**	**No**
Do you agree with the concept of an early exchange of evidence?		
If no, do you have any other ideas to encourage parties to come to an early conclusion about breach of duty and causation?		
Please Explain Why		

Table 9: Draft Process for Early Exchange of Evidence

Stage		Action
1	Incident	Claimant(s) (C) suffers adverse outcome and seeks legal advice C's adviser considers limitation C's adviser considers rehabilitation C's adviser considers use of complaints process
2	Request for Records	C requests copies of medical records from D and any relevant third parties Defendant (D) provides records – or an explanation as to any delay within 40 days If D fails to provide records or an explanation C makes pre-action application for disclosure C paginates and files any received records
3	Letter of notification	C sends Letter of Notification (LoN) to D explaining that claim is contemplated D acknowledges LoN and confirms where Letter of Claim (LoC) should be sent D considers whether to commence investigation and/or obtain expert evidence Both parties consider rehabilitation Both parties consider limitation Both parties consider value of claim
4	Letter of Claim	C sends LoC to D and D's indemnifier detailing allegations as to breach of duty and causation C provides D with paginated bundle of relevant records C sets out chronology of events C serves reports of experts on breach of duty and causation C serves Certificate of Value C provides evidence as to condition, prognosis and alleged quantum losses Both parties consider
5	Letter of Response	D provides C with detailed Letter of Response (LoR) within 4 months LoR will set out any admissions or denials as to breach of duty and/or causation D agrees C's chronology or provides alternative chronology Both parties consider rehabilitation Unless breach of duty and causation are admitted D serves reports of experts D responds to Certificate of Value
6	ADR	Parties consider whether matter can be resolved without further recourse to the court Parties consider non-financial resolution (e.g. Face-to-face explanation, further treatment and/or apology) Parties consider financial settlement Parties consider rehabilitation

7	Stocktake	Parties seek to narrow issues to dispute Parties seek to agree chronology and key facts Parties seek to identify any matters that could be dealt with as preliminary issues (e.g. limitation) Parties consider rehabilitation Parties consider whether Protocol has been complied with

Multiple Claimants

6.5. Where two or more potential claimants instruct the same legal representative, the intention is that FRC will apply in relation to each claimant.

Exit Points

6.6. The existing fixed costs rules set out in CPR Part 45 allow a court to entertain an amount of costs greater than the applicable FRC, but only if it considers that there are exceptional circumstances making it appropriate to do so. There is also a threshold test: if the additional costs do not increase the applicable fixed costs by at least 20%, then no further allowance will be made. These provisions have been working effectively since 2003.

6.7. As clinical negligence claims are likely to cover a wider range and complexity of claims than those already covered by the FRC rules, the Government proposes that the exception should be clarified such that it must be "exceptional circumstances" in the context of a typical clinical negligence claim.

Exemptions

6.8. The Government is considering whether to have any 'automatic exemptions' to FRC. Any exemptions would be set out in the Civil Procedure Rules.

6.9. There are a number of technical exemptions currently within the draft CPRs that mirror other similar FRC schemes:

- claims covered by the Pre-Action Protocol for Disease and Illness Claims; the Pre-Action Protocol for Personal Injury Claims; the Pre-Action Protocol for Low Value Personal Injury Claims in Road Traffic Accidents; the Pre-Action Protocol for Low Value Personal Injury (Employers' Liability and Public Liability) Claims; Practice Direction 3D – Mesothelioma Claims; or where a claim covered by these protocols also involves allegations of clinical negligence;
- where the claimant is a protected party (children only) as defined in rule 21.1(2);
- where the claimant is bankrupt;
- where the claimant resides outside the United Kingdom;

- where the defendant is not a public body and is insolvent or, being a limited company, is dissolved or has ceased to trade; or
- where the claimant is considering applying for a Group Litigation Order or there is a group or series of linked or related cases which are likely to be more appropriately resolved by agreed procedures;
- where the number of experts reasonably required by both sides on issues of breach of duty and causation exceeds a total of two experts per party - see paragraph 6.11 below.

6.10. In addition to the exemptions above, we are considering exemptions to address concerns raised (see Annex B) by some stakeholders about the impact of FRC on low value complex cases. Our intention is to maintain access to justice for those wishing to bring such cases and we are considering whether the limited use of appropriate exemptions to the scheme could support this aim.

6.11. We accept, as recognised through our on-going consultation with a range of parties, that there is no direct correlation between the value of damages awarded to the claimant and the complexity of the case. We know that the average number of expert reports in lower value claims is two and these are often by the same expert.[xviii] Therefore, the intention of the proposed exemption would be to take only the most complex low value claims out of the FRC scheme. We are therefore considering an exemption for claims where the number of experts reasonably required by both sides on issues of breach and causation exceeds a total of two per party.

6.12. We also recognise that child fatalities can be complex cases of an emotive nature, and we have heard concern from some parties about such cases being included. This is why we are considering an exemption for child fatalities arising from clinical negligence and we welcome feedback on this proposal as part of this consultation process.

Interim Applications

6.13. The existing FRC processes for Road Traffic Accidents, Employers Liability and Public Liability control the cost of interim applications. However, that is within schemes limited to the Fast Track (over £1,000 to £25,000), where interim applications are in any event uncommon. It is accepted that the majority of clinical negligence claims will be allocated to the multi-track (£25,000 and above). It is expected in these lower value claims that directions will be dealt with at the Case Management Conference, for which the costs are already factored into the proposed FRC.

6.14. The Government considers that both the use and cost of interim applications should be controlled, and seeks views as to how that is best achieved. In so doing, the Government takes the view that there has been an increased volume of applications made for further time or other variation of rules or the Court timetable.[xix]

London Weighting

6.15. Where the claimant or the defendant lives or works in the area defined by Practice Direction 2.6 to CPR Part 45 and the solicitor practises in that area, then an additional 12.5% (as per the existing FRC rates for personal injury) will be added to the FRC figures set out in Table 4 excluding VAT.

Practice Directions

6.16. Our intention is to ask the CPRC to draft a Practice Direction dealing with post issue handling. It is not our intention to re-consult on this aspect.

Question 8: Draft Protocol and Rules		
Do you agree with the proposals in relation to	**Yes**	**No**
Trial Costs (paragraph 5.6)		
Multiple Claimants		
Exit points		
Technical Exemptions (paragraph 6.9)		
Where the number of experts reasonably required by both sides on issues of breach and causation exceeds a total of two per party. (paragraph 6.11)		
Child Fatalities (paragraph 6.12)		
Interim Applications		
London Weighting		
Please Explain Why		

Question 9: Behavioural Change	**Yes**	**No**
Are there any further incentives or mechanisms that could be included in the Civil Procedure Rules or Pre-Action Protocol to encourage less adversarial behaviours on the part of all parties involved in lower value clinical negligence claims, for example use of an Alternative Dispute Resolution process (ADR)? This would include both defendant and the claimant lawyers, defence organisations including NHS LA, the professionals and/or the organisation involved.		
Please explain why		

7. Evidence and Equalities

7.1. The Government is keen to receive views on whether there is any further evidence that you think will affect our proposals. The consultation stage Impact Assessment and Equalities Assessment are set out at Annex F and Annex B respectively. Final stage assessments will accompany the consultation response document. We are particularly keen to receive views and evidence on the impact of FRC on the:

- private sector - both healthcare providers and insurers;
- clinical negligence legal market;
- expected growth in the number of clinical negligence claims received and settled; and
- equalities, health inequalities and families considerations.

7.2. Question 10 seeks information to enable a final stage impact assessment to be undertaken and to build our knowledge of the non-NHS funded sector but we are also keen to receive views from the NHS in both England and Wales. Our definition of private sector would include mutual, not-for-profit organisations and commercial organisations. The majority of the data that is available on clinical negligence costs refers to NHS acute care in England. Some anonymised data has been provided by the MDOs. However, we would like to develop a greater understanding of the impact on:

- private healthcare providers and insurers, not-for-profit and professionals (particularly those not providing NHS funded services); and
- GPs and primary care professionals.

7.3. The assumption is that as the costs insurers will pay out will reduce, it will result in reduced insurance premia for individuals but we would like views on this.

Question 10: Evidence
Please provide any further data or evidence that you think would assist consideration of the proposal, particularly for other than NHS provision. In particular, we are interested to gather data from private, not-for profit and mutual organisations delivering healthcare. Please identify your organisation in your response. We would be interested in hearing views on: The scale of expected savings if Fixed Recoverable Costs outlined is introduced, the expected growth in the number of claims received and settled over the next 10 years to help in modelling the impact of the proposals, any details on the number and size of legal firms involved in clinical negligence (primarily as claimant lawyers), and any information on the likely administrative savings and set up costs due to introduction of Fixed Recoverable Costs. Please indicate whether your organisation would be willing to work with DH in providing more details on the impact for future IA analysis. This would be provided in confidence and anonymised in any future analysis.
Please provide evidence.

Equalities, Health Inequalities and the Family Test

7.4. The Secretary of State for Health has legal obligations to consider equalities and health inequalities in taking policy forward, and to consider its potential impact on families. The Consultation stage assessment is at Annex B. The Public Sector Equality Duty (PSED) places a duty on public bodies and others carrying out public functions. It aims to ensure that public bodies consider the needs of all individuals in their day-to-day work – in shaping policy, in delivering services, and in relation to their own employees. The PSED is set out in section 149 of the Equality Act 2010, and it applies across Great Britain to public bodies listed in Schedule 19 to the Act (and to other organisations when they are carrying out public functions). The Health and Social Care Act 2012 placed a duty on the Secretary of State to have regard to the need to reduce inequalities between the people of England with respect to the benefits that may be obtained by them from the NHS. The Family Test is not a statutory duty but requires a number of questions to be considered when developing policy.

7.5. To fulfil these obligations, an Equalities Advisory Group was established to consider the implications of the introduction of FRC for clinical negligence claims. The Advisory Group understands that the Government does not intend to reduce access to justice, but thinks there may be the potential for unintended consequences, and suggests low value complex issues may be such an area. The Government has noted this concern and considers that the way of ensuring access to justice is by:

- setting the FRC rates at a level that allows reasonable costs to be covered;
- having exemptions to FRC for certain low value complex cases; and
- speeding up the process so that costs are reduced.

7.6. Question 11 asks for information, both quantitative and qualitative, to support the final stage assessment. The assessment will be reviewed during the development of the consultation response document and further information provided by consultation respondents taken into account. The Government will be working with the NHS LA to understand more fully the impact of the proposed reforms on the claimant demography. The final assessment will be used as the baseline for the post-implementation review.

Question 11: Equalities, Health Inequalities and Families
The Government has prepared an initial assessment of the impact of Fixed Recoverable Costs on equalities, health inequalities and families. This assessment will be updated as a result of the consultation. Please give your view on the impact of these proposals on: Age; Gender; Disability; Race; Religion or belief; Sexual orientation; Pregnancy and maternity; Carers, Health Inequalities and Families.
Please provide evidence.

8. Conclusion

8.1. The proposed introduction of FRC for clinical negligence claims above £1,000 and up to £25,000 for claims in the fast track or multi track is a key part of the strategy to improve learning of lessons across the NHS, increase patient safety, and improve clinical negligence processes. The Government believes that a FRC scheme will improve the proportionality between claimant costs and damages, and claimant and defendant costs in lower value clinical negligence claims. This will support the earlier resolution of claims for the benefit of all parties. FRC will release savings for investment in frontline NHS patient care.

8.2. During the development of the consultation, the Government has sought views from a range of interested parties, and worked particularly closely with The Law Society, APIL, AvMA and SCIL to understand their views and concerns. The CPRC has assisted the Government by developing an illustrative set of Rules and Protocol. The Government recognises that in providing such support prior to the consultation, the CPRC is not expressing any opinion on the consultation itself and is grateful for their assistance to date.

8.3. This consultation is an open process and we would encourage feedback from all parties, including patients, their families or their carers. The questions on which views are sought are:

- whether FRC should be introduced on a mandatory basis;
- the method of introduction,
- how FRC rates should be calculated and applied;
- how expert witness costs should be treated within FRC and the Single Joint Expert concept;
- the draft Protocol and Civil Procedure Rules, including early exchange of evidence and behavioural change;
- whether there is further evidence, including on equalities, health inequalities and families, the Government should consider in taking forward the proposal.

8.4. The Government has asked Professor Fenn to take forward the work on the Cost Analysis Approach during the consultation period so that it can be considered alongside the consultation responses and feed into decision-making. The rationale for this is to consider whether the FRC rates should be based on the current costs or assumptions about the reduced time it would take to settle claims.

8.5. We are grateful for your time in responding to this consultation, which will inform plans to further improve patient safety and make the litigation process as efficient and cost-effective as possible.

Annex A: Stakeholders Consulted

The pre-consultation questionnaire was sent to the organisations below in August 2015. A number of focus group meetings were also held. The Government also had discussions with the CPRC, Wales Government, NHS Litigation Authority and the equalities advisory group.

1	Action against Medical Accidents (AvMA)
2	Association of Personal Injury Lawyers (APIL)
3	The Law Society
4	Forum of Insurance Lawyers (FOIL)
5	Society of Clinical Injury Lawyers (SCIL)
6	Bar Council
7	Personal Injury Bar Association
8	Professional Negligence Bar Association
9	Medical and Dental Defence Union of Scotland (MDDUS)
10	Medical Defence Union (MDU)
11	Medical Protection Society (MPS)
12	Welsh Risk Pool Services (WRPS)
13	British Medical Association
14	Royal College of Nurses
15	Royal College Of Midwives
16	Managers in Partnership and UNISON
17	Chartered Society Of Physiotherapists
18	Northumbria Healthcare NHS Foundation Trust
19	Mersey Care NHS Trust
20	Calderstone Partnership NHS Foundation Trust
21	North Tees & Hartlepool NHS Foundation Trust
22	Wirral University Teaching Hospital NHS FT
23	Salisbury NHS Trust
24	Association of British Insurers (ABI)
25	Lockton Insurance
26	NHS England
27	Royal College of Obstetricians & Gynaecologists

Annex B: Assessment of Equalities and Health Inequalities and the Family Test

1. This consultation stage assessment will be updated following the consultation, including with responses to question 11.

Membership of Equalities Advisory Group

Community	Member
NHS Acute Sector	Paul Dunn, Deputy Chief Executive & Executive Director of Finance at Northumbria Healthcare NHS Foundation Trust.
Claimant Lawyer	Ed Fletcher, Chief Executive Fletcher's Solicitors.
Defendant Lawyer	David Roberts, Partner at Capsticks.
Patients	Mandie Lavin, Trustee, the Patients' Association.
	Sally Taber, Director, Independent HealthCare Complaints Adjudication Service (ISCAS).
	Peter Walsh, Chief Executive, Action against Medical Accidents (AvMA).
Government	Official from the Ministry of Justice.
	Officials from the Department of Health.

Evidence and Data Availability

2. The Ministry of Justice does not collect comprehensive information about court users generally, and specifically those involved in clinical negligence cases, in relation to the protected characteristics. This limits the understanding of the potential equality impacts of the proposals for reform. The following were considered:

    - Responses to the pre-consultation exercise;
    - Evaluating the proposed fixed costs for clinical negligence claims : an independent review by Professor Fenn (Annex C);
    - Saving Lives, Improving Mother's Care: surveillance of maternal deaths in the UK 2011-13 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13 by MBRRACE-UK. [xx]
    - The equalities assessment for the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. [xxi]
    - Data from the NHS Litigation Authority; the Office of National Statistics; the Legal Aid Agency and the Department of Work and Pensions (Annex E);
    - Reports on previous legal reform: Equality, Human Rights and Access to civil law justice: a literature review by Helen Anthony and Charlotte Crilly [xxii] and Funding Clinical Negligence Cases: Access to Justice at reasonable cost by Paul Fenn, Alastair Gray, Neil Rickman, Dev Vencappa ("the Nuffield Foundation Report") [xxiii]

Age

3. Data is available from NHS LA, CRU and ONS - see Annex E. 18% of clinical negligence claims against the NHS in England were from those aged 68 and over and 23% of the claims between £1,000 and £25,000 were by the same age group, which suggests that they are disproportionately represented in lower value claims.

Gender

4. Data is available from NHS LA, CRU and ONS - see Annex E. Data from the NHS Litigation Authority shows that in 2015/16 approximately 56% of clinical negligence claims against the NHS were by women and 44% by men. ONS data for mid 2013 shows that 51% of the population is female and 49% is male. There are differences between the gender data by NHS LA, ONS and CRU and there is not a direct correlation between the gender of clinical negligence claimants and the population as a whole. One reason is the number of gynaecology claims and obstetric cases where the mother is injured. NHS LA data is for claims that are made under all categories of clinical negligence that NHS LA handle and NHS LA code claims on behalf of babies by the gender of the baby. ONS data is for population as a whole and not claimants. CRU clinical negligence data includes claims from the Medical Defence Organisations and insurers as well as NHS LA.

Sexual Orientation and Gender Reassignment

5. There is no data available to support an assessment on this protected characteristic. However, it is recognised that some gay or transgender people find it difficult to disclose their sexuality to healthcare professionals.

Disability

6. There is no data available to support an assessment for the introduction of FRC in clinical negligence on this protected characteristic. Data would be needed on (1) people who become disabled as a result of an adverse incident or (2) disabled people who were the subject of an adverse incident. However, data on the prevalence of disability within the population is available from the Office of Disability Issues - see Annex E.

Race and Religion or Belief

7. There is no data available to support an assessment on this protected characteristic.

8. The MBRRACE-UK report shows that women an ethnic minority group are over represented in cases of maternal death.

9. It has been suggested that the black and ethnic minority community is under-represented in clinical negligence cases as they are also under-represented in making complaints against the NHS. [xxiv]

Pregnancy and Maternity

10. Data is available from NHS LA and the MBRRACE-UK report. NHS LA data shows that Obstetrics and Gynaecology claims accounted for approximately 16% of clinical negligence claims received in 2015/16 and approximately 45% of the value of claims received in 2015/16 - See Annex E.

11. The MBRRACE-UK report sets out the socio-demographic characteristics of women who died between 2011 and 2013 as a result of maternal deaths but did not look at a link to clinical negligence claims. The report demonstrates that the most deprived women have a higher chance (but still low) of dying than women in the least deprived quintile.

Carers

12. An assessment on carers is included within the Family Test section.

Mitigations for PSED

13. The Government notes that there is no data to inform an assessment for some protected characteristics and we would welcome any additional data or evidence. We will consider how people with protected characteristics are impacted – our intention is to maintain access to justice, particularly for vulnerable groups. Paragraph 19 sets out how we propose to deal with complex low value clinical negligence claims within the FRC scheme.

Health Inequalities

14. There is some evidence about which groups may be affected as identified in the PSED section above. Information on how all clinical negligence claims against the NHS are funded is not known because in many cases the method of funding is not disclosed by the claimant's representatives.

15. The impact of LASPO on the civil justice system is not part of this assessment. However, the Nuffield Foundation report suggests that the socio-economic class of clinical negligence claimants has changed since the introduction of LASPO.

Access to Justice

16. Concerns have been expressed, both privately and in the media, about the impact of the previous civil justice reforms and the potential effect of the introduction of FRC for clinical negligence claims. [xxv] The suggestion is that the FRC proposal may reduce 'access to

justice' in some lower value cases, because claimant lawyers may be unable or unwilling to take on claims because they may be unable to fully recover their costs or generate profit. Throughout the consultation, the Government will continue to work with Professor Fenn to look at the methodology for setting the FRC rates and ensure that they are set at a level that will stimulate the right behaviours in the market. The equalities group have identified some types of cases where they feel there may be unintended consequences but this was in the context of a FRC scheme for claims above £1,000 and up to £250,000.

17. The Government has noted the views put forward by the equalities group and welcomes evidence on specific types of cases where there is potential for unintended consequences and suggestions for how these can be mitigated against. The proposal is for a FRC scheme to apply to claimant legal costs and to defendant legal costs where such costs are recoverable. The claimant will agree legal fees with their lawyer as now. The Civil Procedure Rules will include the FRC rates (which they do in other FRC schemes). Therefore lawyers and claimants will become fully aware of the cases to which FRC apply and the associated FRC rate.

18. The Equalities Group identified the following issues as key to mitigation in terms of FRC implementation:

    - the level of FRC rates which is the subject of question 4. In section 5 of his report (Annex C) Professor Fenn has set out a number of ways in which claimant law firms can alter their business model, but this would be a decision of individual firms;
    - the cases to which FRC would apply - Question 8 seeks views on exemptions to the FRC scheme.
    - streamlining the current processes through the Pre-Action Protocol and Single Joint Expert approach for example; and
    - introducing greater certainty over costs recovery per case.

19. Our aim is to ensure that the changes work better to serve patients by ensuring that the clinical negligence system is improved and money can be used to improve patient safety, resulting in fewer clinical negligence cases. We will look carefully at the concerns being raised and consider the implementation methodology to behaviour change, but a primary purpose of these proposals is to encourage the earlier and swifter resolution of more cases, thereby reducing legal costs. We continue to work constructively with a number of clinical negligence lawyers to look at different business models that can work in any new scheme, and Professor Fenn is supporting through his on-going work in this area to support a system that maintains access to justice.

Family Test

20. There is no data to support an assessment other than the data above.

21. It is difficult to draw general conclusions about the impact of a clinical negligence claim on a family because the nature of clinical negligence claims, the demographic profile of claimants and the make-up of individual families vary considerably. However, part of the FRC proposal works to address this by enabling speedier resolution, which will benefit claimants and their families emotionally through enabling earlier closure. Differing types of adverse incident giving rise to clinical negligence claims may affect the claimant's family differently as will their prior health status. Some adverse incidents may have short-term effects and others long-lasting effects and the adverse incident may depend on whether there was an existing condition that was being treated. Similarly, the nature of claim may affect parenting and caring responsibilities differently. The nature of the individual family may affect the likelihood of bringing a claim as well as the nature of the adverse incident. Both these aspects will affect the claimant's caring responsibilities differently and the value of damages may affect their future financial stability.

22. The working assumption would be that if a claimant is adversely affected, their family would also be adversely affected

Annexes C - F Separate Documents

Annex C: Evaluating the Proposed Fixed Costs for Clinical Negligence Claims: An Independent Review by Professor Fenn

Paul Fenn is an Emeritus Professor at the Industrial Economics and Finance Division of Nottingham University Business School, and Senior Visiting Fellow, Health Economics Research Centre, University of Oxford. Professor Fenn is an assessor for Lord Justice Jackson's review of FRC and had the same role previously. He therefore has relevant experience and is highly regarded by the legal community.

In October 2015, the Department asked Professor Fenn to review independently the methodology and data provided from NHS LA to generate the proposed FRC options. Professor Fenn's report gives his perspective on the introduction of Fixed Recoverable Costs in personal injury claims and how it could apply to clinical negligence. The views expressed are those of the author and are not necessarily shared by the Government. Professor Fenn accepts that the work undertaken to underpin the FRC rates has been thorough and informative. He made the following recommendations:

"Recommendation 1: Consideration should be given to a two stage introduction of fixed costs for clinical negligence claims: first, an extension of the current FRCS fixed costs for fast track claims up to £25,000, along the lines of tables 6C and 6D in part 45 of the CPR; second, an extension to multitrack claims over £25,000 in value to be considered for introduction alongside a similar extension to other civil claims up to £250,000 as recently proposed by Jackson LJ. [1]

Recommendation 2: The proposed fixed costs in the consultation document should be replaced with an alternative matrix obtained using the same methodology that was used to calibrate the costs in part 45 of the CPR – namely, a matrix derived from estimated average levels of observed base costs recovered for varying claim values and differing stages of litigation. The proportional relationship observed between base costs and damages could be estimated statistically from observed data on current clinical negligence claims [cf section 4.2 above, Figure 3 and Table 5]. These fixed cost formulae could then be calibrated downwards according to assumptions about the efficiency gains that might be expected from improved cash flow and also any predicted changes to the structure of the legal services market.[2] Further reductions could be made if changes in the claimant risk profile were anticipated.

Recommendation 3: The fixed costs obtained as above could be reduced for claims where an admission of liability was made within the protocol stage. This reduction could be varied

[1] Professor Fenn reference: "Jackson LJ, Fixed Costs – The Time Has Come, IPA Annual Lecture, 28/01/16."

[2] Professor Fenn reference: "I have provided some illustrative examples of fixed cost formulae based on this approach in the Appendix, based on assumed efficiency gains of 10%, 20% and 30% respectively"

depending on stage of settlement and value of claim, using evidence from realised claim outcomes. It could also be varied in order to increase the incentives for early settlement.[3]

Recommendation 4: The impact of any proposed fixed costs should be estimated and made transparent in the way I have suggested in sections 4 and 5 of this report. The fixed costs that are ultimately put in place will need to be monitored over time by an appropriate body."

The Government has now asked Professor Fenn to undertake further work with claimant lawyers and other interested parties based on the cost analysis option in his report, which will be carried out in parallel with this consultation, and used to feed into any final position.

Annex D: Draft Illustrative Protocol and Civil Procedure Rules

These Rules and Protocol have been developed by the CPRC to implement the policy. In providing such support prior to the consultation, the CPRC is not expressing any opinion on the consultation itself. The rules are of a technical nature and likely to be of greater interest to the legal community only and have been drafted based on the preferred option. The rules will be finalised and agreed by the CPRC after the end of the consultation.

Annex E: Data Pack

Key data that has been used to support the development of the consultation is contained in a separate document. This includes the underpinning data used to set the FRC rates together with information on proportionality, equalities, cost and number of clinical negligence claims.

Annex F: Consultation Stage Impact Assessment

The consultation stage Impact Assessment (IA) is at Annex F. A final stage IA will be prepared and published alongside the consultation response.

[3] Professor Fenn reference: "The final column of the fixed cost table in the Appendix suggests some illustrative percentage reductions where liability has been admitted during the protocol period."

Consultation Questions

Question 1: Introducing Fixed Recoverable Costs	Yes	No
Do you agree that Fixed Recoverable Costs for lower value clinical negligence claims should be introduced on a mandatory basis?		
If not, what are your objections?		
If you prefer a voluntary scheme instead, please explain how this would fulfil the same policy objectives as a mandatory scheme.		

Question 2: Fixed Recoverable Costs Ranges		
Do you agree that Fixed Recoverable Costs should apply in clinical negligence claims:	Yes	No
Option A: above £1,000 and below £25,000 (preferred)		
Option B: Another proposal		
Please explain why		

Question 3: Implementation	Yes	No
Which option for implementation do you agree with:		
Option 1: all cases in which the letter of claim is sent on or after the proposed implementation date.		
Option 2: all adverse incidents after the date of implementation.		
Another proposal		
Please Explain Why		

Question 4: Fixed Recoverable Costs Rates		
Looking at the approach (not the level of fixed recoverable costs), do you prefer:	**Yes**	**No**
Option 1: Staged Flat Fee Arrangement		
Option 2: Staged Flat Fee Arrangement plus % of damages awarded: do you agree with the percentage of damages?		
Option 3: Early Admission of Liability Arrangement: do you agree with the percentage of damages for early resolution?		
Option 4: Cost Analysis Approach: do you agree with the percentage of damages and/or the percentage for early resolution?		
Option 5: Another Proposal		
Please explain why		

Question 5: Expert Witness Costs	Yes	No
Do you believe that there should be a maximum cap of £1,200 applied to recoverable expert fees for both defendant and claimant lawyers		
Please explain why		

Question 6: Single Joint Expert	Yes	No
Expert fees could be reduced and the parties assisted in establishing an agreed position on liability by the instruction of single joint experts on breach of duty, causation, condition and prognosis or all three. Should there be a presumption of a single joint expert and, if so, how would this operate?		
Please explain why		

Question 7: Early Exchange of Evidence	Yes	No
Do you agree with the concept of an early exchange of evidence?		
If no, do you have any other ideas to encourage parties to come to an early conclusion about breach of duty and causation?		
Please Explain Why		

Question 8: Draft Protocol and Rules		
Do you agree with the proposals in relation to	**Yes**	**No**
Trial Costs (paragraph 5.6)		
Multiple Claimants		
Exit points		
Technical Exemptions (paragraph 6.9)		
Where the number of experts reasonably required by both sides on issues of breach and causation exceeds a total of two per party. (paragraph 6.11)		
Child Fatalities (paragraph 6.12)		
Interim Applications		
London Weighting		
Please Explain Why		

Question 9: Behavioural Change	Yes	No
Are there any further incentives or mechanisms that could be included in the Civil Procedure Rules or Pre-Action Protocol to encourage less adversarial behaviours on the part of all parties involved in lower value clinical negligence claims, for example use of an Alternative Dispute Resolution process (ADR)? This would include both defendant and the claimant lawyers, defence organisations including NHS LA, the professionals and/or the organisation involved.		
Please explain why		

Question 10: Evidence
Please provide any further data or evidence that you think would assist consideration of the proposal, particularly for other than NHS provision. In particular, we are interested to gather data from private, not-for profit and mutual organisations delivering healthcare. Please identify your organisation in your response. We would be interested in hearing views on: the scale of expected savings if Fixed Recoverable Costs outlined is introduced; the expected growth in the number of claims received and settled over the next 10 years to help in modelling the impact of the proposals; any details on the number and size of legal firms involved in clinical negligence (primarily as claimant lawyers), any information on the likely administrative savings and set up costs due to introduction of Fixed Recoverable Costs. Please indicate whether your organisation would be willing to work with DH in providing more details on the impact for future IA analysis. This would be provided in confidence and anonymised in any future analysis.
Please provide evidence.

Question 11: Equalities, Health Inequalities and Families
The Government has prepared an initial assessment of the impact of Fixed Recoverable Costs on equalities, health inequalities and families. This assessment will be updated as a result of the consultation. Please give your view on the impact of these proposals on: Age; Gender; Disability; Race; Religion or belief; Sexual orientation; Pregnancy and maternity; Carers; Health Inequalities and Families
Please provide evidence.

Glossary

- After The Event (ATE) Insurance protects an insured party from paying certain costs in the event that they lose their case.
- Clinical Negligence Scheme for NHS Trusts (CNST) is an indemnity scheme for clinical claims brought by patients receiving NHS care arising from incidents since 1995. CNST cover is unlimited and the NHS LA funds the total cost of claims. Since April 2013, independent sector providers of NHS healthcare have been entitled to join CNST.
- Civil Procedure Rule Committee (CPRC) was set up under the Civil Procedure Act 1997 to make rules ("the Civil Procedure Rules") of court for the Civil Division of the Court of Appeal, the High Court and the County Court. CPRC is an advisory non-departmental public body of the Ministry of Justice. The Civil Procedure Rules set out the practice and procedure to be followed in civil justice cases, including personal injury cases.
- Duty of Candour: The Duty of Candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. It was introduced in November 2014 for the NHS and April 2015 for other healthcare providers
- Employers' Liability (EL) insurance will help pay compensation if an employee is injured or becomes ill because of the work they do for the employer.
- Legal Aid, Sentencing, and Punishment of Offenders Act 2012 (LASPO) abolished the Legal Services Commission and replaced it with the Legal Aid Agency; removed financial support for most cases involving medical negligence, amongst other things.
- Medical Defence Organisations are mutual non-profit making organisations, owned by their members. There are 3: the Medical and Dental Defence Union of Scotland (MDDUS); the Medical Defence Union (MDU) and the Medical Protection Society (MPS).
- NHS Litigation Authority (NHS LA) handles negligence claims on behalf of NHS organisations and independent sector providers of NHS care in England who are members of NHS LA's schemes. The NHS LA was established in 1995 as a Special Health Authority and is a not-for-profit arms-length body of the Department of Health.
- "Profit Costs" refers to the fee paid to a solicitor for everything other than disbursements – it is the sum paid for the professional work of the solicitor, some (but not all) of which will constitute profit. "Profit costs" are net of VAT and any additional liabilities.
- Public Liability insurance would cover a business if a customer or member of the public was to suffer a loss or injury as a result of its business activities and if that person made a claim for compensation.
- The small claims track is one of three tracks to which all defended civil claims are allocated. The multi-track and the fast-track are the others. A number of factors are considered when a claim is allocated to one of these tracks. These include the monetary value and the nature and the complexity of the claim. The current limit for the small claims track is £5,000 for all claims except personal injury and housing disrepair, which is £1,000.

References

[i] NHS Litigation Authority: Annual Report and Accounts 2015/16:
http://www.nhsla.com/AboutUs/Documents/NHS_Litigation_Authority_Annual_Report_and_Accounts_2015-2016.pdf

[ii] NHS Litigation Authority: Annual Report and Accounts 2015/16

[iii] NHS Litigation Authority: Annual Report and Accounts 2015/16

[iv] NHS Litigation Authority

[v] Jeremy Hunt MP, Secretary of State for Health, Statement to Parliament: 09/03/16
http://www.publications.parliament.uk/pa/cm201516/cmhansrd/cm160309/debtext/160309-0001.htm#16030943000003

[vi] Personal Information Charter: https://www.gov.uk/government/organisations/department-of-health/about/personal-information-charter

[vii] Common Sense report:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/60905/402906_CommonSense_acc.pdf

[viii] Lord Justice Jackson: Fixed Costs - The Time has come, IPA Annual Lecture, 28/01/16.
https://www.judiciary.gov.uk/wp-content/uploads/2016/01/fixedcostslecture-1.pdf

[ix] Senior Judiciary announcement 11/11/16:
https://www.judiciary.gov.uk/announcements/senior-judiciary-announces-review-of-fixed-recoverable-costs/

[x] MoJ "whiplash" consultation: https://www.gov.uk/government/consultations/reforming-the-soft-tissue-injury-whiplash-claims-process

[xi] NHS Litigation Authority

[xii] NHS Litigation Authority: Annual Report and Accounts 2015/16

[xiii] NHS Litigation Authority: Annual Report and Accounts 2015/16

[xiv] NHS Litigation Authority

[xv] NHS Litigation Authority Annual Report and Accounts 2015/16

[xvi] A similar system in relation to the provision of medical evidence is used in support of minor soft tissue injuries arising from road traffic accidents. This is the MedCo system, which was introduced on 6 April 2015 through amendments to the Pre-Action Protocol for Low Value Personal Injury Claims in Road Traffic Accidents.

[xvii] Chapter 15, paragraph 5.13:Lord Justice Jackson report: https://www.judiciary.gov.uk/wp-content/uploads/JCO/Documents/Reports/jackson-final-report-140110.pdf

[xviii] NHS Litigation Authority

[xix] Following Mitchell v News Group Newspapers Ltd [2013] EWCA Civ 1537 and Denton v White and others [2014] EWCA Civ 906.

[xx] Reducing Risk through Audits and Confidential Enquiries across the UK (MBBRACCE-UK), December 2015:
https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202015.pdf

[xxi] NHS Complaints Impact Assessment:
http://www.legislation.gov.uk/uksi/2009/309/pdfs/uksiem_20090309_en.pdf

[xxii] Published by the Equality and Human Rights Commission in October 2015.
http://www.equalityhumanrights.com/publication/equality-human-rights-and-access-civil-law-justice-literature-review

[xxiii] Published by the Nuffield Foundation in 2016
http://www.nuffieldfoundation.org/sites/default/files/files/Funding_clinical_negligence_cases_Fenn_v_FINAL.pdf

[xxiv] Anecdotal evidence Nina Ali and David Fitzpatrick on Betar Bangla Radio on 12/12/15

[xxv] For example, the RTS media survey in September 2015 found that 80% of respondents said that they "will be unable to pursue cases below £25,000"