Evaluating the proposed fixed costs for clinical negligence claims

An Independent Review

January 2017

Published to gov.uk, in PDF format only.

www.gov.uk/dh

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Contents

Acknowledgements

This report was undertaken at the request of the Department of Health, and with the assistance of the NHS Litigation Authority. I am grateful to Julie Badon of the DH for facilitating the exercise and to Helen Vernon and John Mead of the NHS LA for allowing me access to the data used in support of the proposals. I am also grateful to Vicky Morris of Weightmans PLC and Daryl Norvock of Acumension for their assistance with the data.

I would like to emphasise that this review was first commissioned in October 2015, after the Department's pre-consultation on the proposal to introduce fixed costs for clinical negligence claims up to £250,000 in value. The material I was provided with to review was an early draft of the consultation document, which has now been superseded[1]. The changes in the latest version of the consultation document were partly in response to recommendations I made in this report.

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Disclaimer

The views expressed are those of the author and are not necessarily shared by the Department of Health

[1] DH Note: in addition to the change of threshold, the Department has withdrawn two methodologies for setting the FRC rates (options 1 and 2 in this report) and one method of application (sliding scale approach). The withdrawn options and rates are discussed in this report.

1: Introduction and Terms of Reference

This report was commissioned by the Department of Health with the agreement and co-operation of the NHS Litigation Authority. The terms of reference agreed for this work were as follows:

> *Review of the material listed below and the production of a short report assessing the appropriateness and potential impact of the proposed fixed costs. The relevant material required is:*
>
> *a. Confirmation and a detailed description of the methodology used by the DH to arrive at the fixed costs proposed, including assumptions and evidence used to support these assumptions*
>
> *b. Some means of assessing the impact of the Department's proposals by reference to data on the actual base costs recovered on recent clinical negligence claims in relation to damages and complexity.*

2: Background and Context

While the motivation behind the government's proposals for introducing fixed recoverable costs for clinical negligence claims lies partly in the need to reduce public expenditure on the NHS, it is important to acknowledge the implications of the proposals for other stakeholders. What is proposed is a change in the civil procedure rules for such cases. The NHS is not the only defendant in clinical negligence cases, and the proposals will have consequences for injured patients and their legal representatives.

Controlling the level of recoverable costs on civil claims has been a continual theme over the last 15 years or so, and indeed the recommendations of the Jackson review as implemented in the Legal Aid Sentencing and Punishment of Offenders Act (LASPO, 2013) were designed to strengthen this control without damaging access to justice. Fixed costs for fast track personal injury claims were an important part of those reforms, introduced with the intention of allowing a predictable recovery of reasonable costs, with benefits to both claimants and defendants.

Claimant solicitors benefit from the fixing of recoverable costs due to the consequent reduction in the volatility of revenue from the flow of claims, making their cash flow more predictable and thus reducing the need for excessive capital. Providing that the fixed costs are set at a reasonable level, claimant solicitors are able to set off more costly cases against less costly cases under the so-called “swings and roundabouts” principle such that revenue from fixed costs on a block of disparate claims is sufficient to cover total profit costs on those claims. Defendants benefit from the ability to control the market failure which is inherent in a cost-shifting regime - where those who pay for the work have no means of controlling how much is done. This cost-shifting “externality” has been linked to the lack of control over the costs of civil litigation in recent decades.

Jackson LJ’s proposals were published in his final report on the costs of civil litigation. Jackson’s solution was to retain cost-shifting, but to control the effect of the cost-shifting externality. The most important first step was to unwind the principle of recoverable success fees and ATE premiums, which had so badly exacerbated the cost-shifting externality from the year 2000 onwards. But because this would take back the gains made by claimants in that year, Jackson also felt he needed to soften the blow by enhancing general damages by 10%, and by introducing one-way cost shifting. Perhaps the second most important step was Jackson’s recognition that the fundamental problem of the cost-shifting externality would still remain even with non-recoverable success fees, and therefore he argued strongly for the introduction of fixed costs throughout the fast track. These should reflect reasonable work needed to be done, and therefore should vary across claim types and be proportional to damages, with a reduction where there was an early admission of liability. And finally, because he viewed the increased use of referral fees in the market as a symptom of the weak cost control by claimants, he recommended they should be banned, and that the fast track fixed costs should ultimately be adjusted downwards to reflect any reasonable savings accruing from the ban.

LASPO removed civil legal aid from remaining areas of personal injury litigation (including most clinical negligence claims[2]) on the grounds that experience with CFAs is now mature enough to allow the private sector to shoulder the cost risk that can occur in these potentially large cases. Clearly this assumption requires that the CFA market operates efficiently, and therefore the Act also incorporated most of the recommendations made in Jackson LJ’s

[2] The exceptions being birth-related neurological injuries to children within 8 weeks of the birth.

report[3]. Perhaps the one major omission was his proposal to introduce a comprehensive set of fixed costs for all fast track claims. In effect, the prior existence of the MoJ's RTA Portal process complicated matters insofar as it incorporated a set of fixed costs for non-disputed RTA claims with a value below £10,000. The MoJ's preferred solution was to extend the Portal scheme to other types of undisputed claims with values up to £25,000, and at the same time to review the levels of fixed costs in the light of the referral fee ban. This solution was implemented in LASPO, with considerably reduced fixed costs within the portal, but it did require some provision to be made for fixed costs for other, disputed, fast track claims. This was achieved by implementing the fixed cost recommendations in Appendix 5 of Jackson's report, adjusted downwards by the same amount as those costs within the Portal. The figures in Appendix 5 of Jackson's report were based on my analysis of data relating to (then) current recoveries of both costs and damages for a large number of personal injury claims. The proportional relationship between recovered costs and damages was estimated statistically for different stages of the litigation process, and for different types of claim, and then adjusted downwards to reflect the perceived efficiency gains to be made by claimant solicitors from the increased predictability of the fixed cost regime.

Jackson LJ's hope was that fixed costs would ultimately be applicable to all fast track civil claims, and as yet this has not materialised. The latest proposals in the consultation document for fixed costs in clinical negligence claims should therefore be seen in this context. The proposals do not include use of the Claims Portal, but are nevertheless intended to cover both disputed and undisputed claims.

3: Review of Methodology

3.1: Scope

The proposed fixed costs are to apply to all disputed and undisputed clinical negligence claims with a value up to £250,000. This covers a much greater range of claim values than the fixed costs for other types of personal injury. The argument given in the consultation document for not replicating the scope of the other personal injury schemes is that, because of the wider spread of settlement values, "a cut off level of £25,000 would not provide a system that covered a reasonable percentage of claims". By my calculations, some 64% of

[3] For clinical negligence claims, Jackson's recommendation that ATE premiums should be non-recoverable have been implemented in part: it remains possible for claimants to recover the premiums needed to cover the cost of expert reports on liability and causation.

all clinical negligence claims have a value below £25,000[4]. I am not sure why that figure – almost two thirds of all claims - is not deemed to be reasonable. To my knowledge the cap of £25,000 in other personal injury schemes was not determined in order to fulfil a particular quota of claims, but rather because the "swings and roundabouts" principle would be less appropriate for claims beyond that limit, as some PI firms may have limited numbers of such higher value claims, and would therefore be exposed to a cost risk[5]. Of course, it is possible that, due to the generally higher claim values in clinical negligence, the cost risk would be acceptable for claims over £25,000 in value, but it would be good to see some evidence for this.

The inclusion of both disputed and undisputed claims in the same scheme is, in my view, the correct approach to take. The lack of coordination between fixed costs inside the Claims Portal (undisputed claims) and outside (disputed claims) is something which I have criticised elsewhere[6]. It potentially leads to a distortion in relation to the defendant's decision to admit liability.

3.2: Time analysis by stage of litigation

The proposed flat rate fixed costs are set out in Table 4 of the consultation document. They are divided into value bands (up to £25,000; £25,001 to £50,000; £50,001 to £100,000; £100,001 to £250,000) and stages of litigation (Pre-issue; issued but not allocated; allocated but not listed; listed). These stages match those used in Appendix 5 of the Jackson report, and therefore also match the stages in the recoverable fixed costs for disputed personal injury claims introduced in LASPO. The latter were estimated as explained above – drawing on statistical analysis of data relating to costs and damages for a large number of realised personal injury claims at differing stages of litigation.

By contrast, the methodology adopted to determine the fixed costs in the consultation document is based on estimates of the time spent on tasks needed to be undertaken on representative (but hypothetical) clinical negligence claims in each combination of value bands and litigation stages. These estimates were provided by an advisory group apparently experienced as fee earners in clinical negligence claims from both defendant and claimant sides[7]. The calculations for each value/stage category were made by aggregating up the totals of time expected to be spent on all of the tasks (assessment, preparation, expert

[4] DH sources suggest the proportion could be 60% based on NHS LA data.
[5] Note that this cost risk is not the same as the risk of losing claims, which is compensated through the success fee; it is rather the uncertainty over what cash flow can be expected on claims which are won.
[6] P. Fenn (2012): "Evaluating the low value Road Traffic Accident process", MoJ Research Series 13/12.
[7] Although I understand that none were currently engaged in claimant work.

instruction etc.) and then costing these tasks at appropriate hourly rates (see section 3.3 below). The expected times for each task are the product of the average time per task multiplied by the expected frequency of these tasks, as agreed by the advisory group. This approach is, I think, similar to that undertaken by the MoJ in order to ascertain the fixed costs for low value undisputed personal injury claims within the claims portal (although I am unaware of any publicly available data provided on that process).

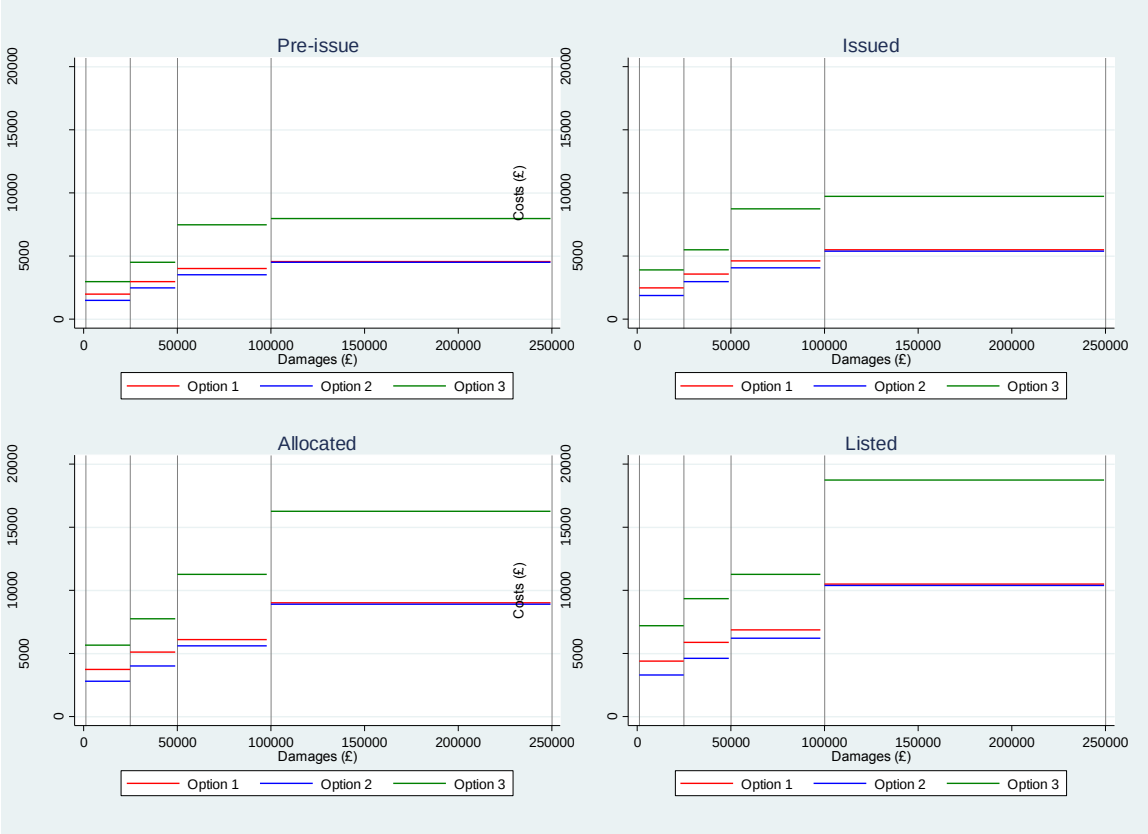
Given the nature of the methodology used, it is very difficult for an independent assessment to be made of the appropriateness of each fixed cost proposed in the document. I believe that the advisory group were asked to consider a "typical" case within each phase of litigation – i.e. one of average complexity. However, because these are still hypothetical constructs, it is possible that a different group of experts would agree on a different set of required tasks, and the nature of the exercise means there is no scientific or statistical way of determining which was "better" or more appropriate. It is of course possible to compare these derived fixed costs with what was actually recovered in terms of profit costs on a number of cases in each phase of litigation (see section 4 below), but these realised costs could include inefficient claimant practices about which defendants have complained. The same could apply to the possibility of using actual data from firms' time allocations in support of their billing system, although data of this kind could in principle be reviewed alongside expert opinion in order to improve the robustness of the fee-earner times used to calculate fixed costs.

3.3: Hourly rates

There are three alternative sets of fixed costs provided in the consultation document.[8] The only difference between them relates to the assumption about the hourly rates at which to cost the fee earner times derived from the advisory panel's deliberations. The latter included beliefs about the tasks that could be allocated to different tiers of fee earner, with differing levels of experience, so what remained was to determine the appropriate hourly rates to apply to the different types of fee earner. Option 1 assumes that fee earners time could be paid at the legal aid rate. Option 2 uses an "expense of time" exercise undertaken by NHS LA advisors to calculate hourly fees using salary levels observed for different fee earners involved in clinical negligence work, as well as an assumption about the average mark-up on salaries required for overheads. Option 3 uses current GHR rates.

[8] DH Note: What Professor Fenn refers to as options 1 and 2 have been withdrawn from the published consultation document.

Figure 1



My view is that option 3 (GHRs) is the most appropriate one. First, the firms working on clinical negligence claims funded by CFAs operate under very different business conditions by comparison to legal aid contractors. They do not have access to a guaranteed block of claims from the LSC, and therefore need to budget for marketing, client acquisition and risk assessment costs as part of their overhead. Second, while a new attempt to estimate appropriate hourly rates under current market conditions using an expense of time approach may indeed be overdue, it remains the fact that the MR has not accepted the recommendations of the CJC costs committee on this, and it does not seem conceivable that the courts could use one set of hourly rates (the GHRs) for detailed assessment of clinical negligence claims costs when a different set of hourly rates was used to underpin the fixed costs for these cases. If this were to change, then of course the revised GHRs could be used, but I'm not aware of any imminent plans.

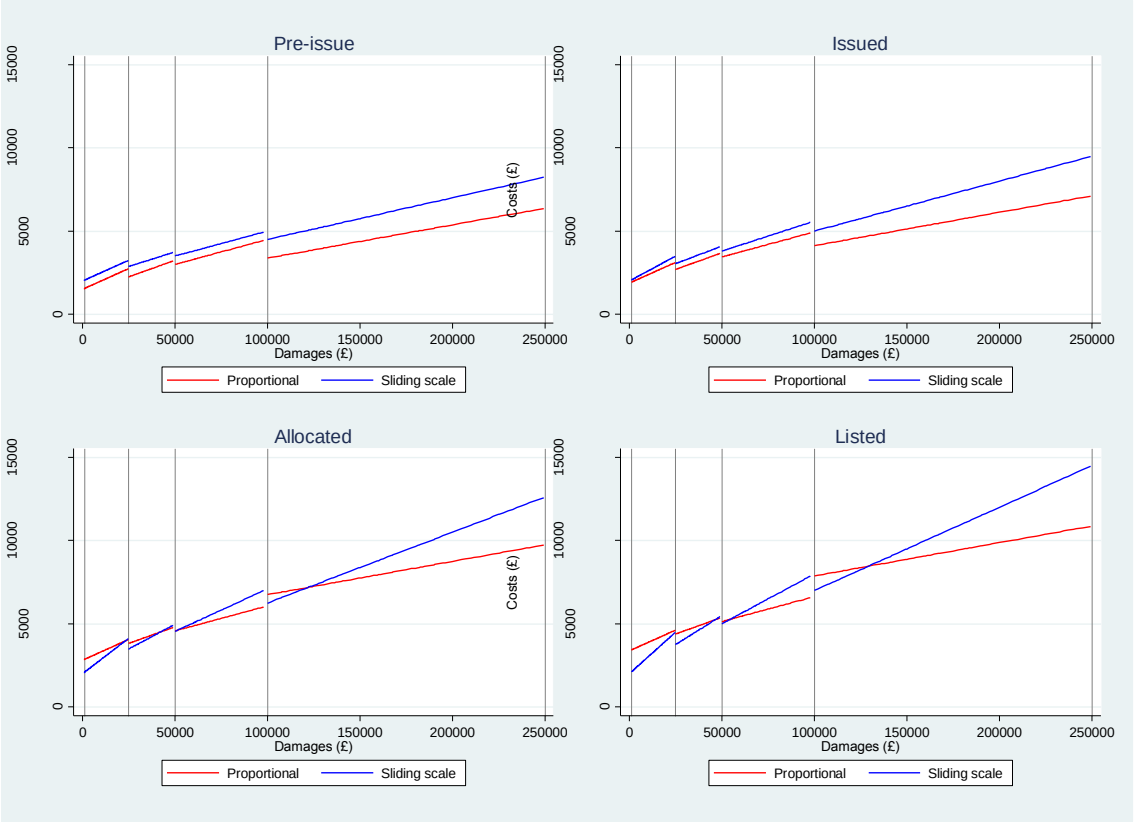
3.4: Proportionality

In addition to the three fixed cost options shown in the consultation document (and illustrated in Figure 1 above), there are also two further options presented in that document, relating to options for making the proposed fixed costs proportional to damages within the value bands. That is, while the proposed fixed costs in Table 4 of the consultation document do increase for higher value bands, within those bands they are flat rate, meaning that, for example, the same fixed cost applies to a claim for £1,000 of damages as to a claim for £25,000, and moreover the same fixed cost applies to a claim for £100,000 of damages as to a claim for £250,000. This certainly seems to be at odds with the view that complex claims typically should require more work in relation to both liability/causation issues as well as quantum issues. Flat rate fixed costs provide no financial incentive for claimant solicitors to work for increases in their client's damages, which may work against their client's interest. Moreover, it also runs the risk of affecting behaviour in the vicinity of the thresholds between levels of fixed costs. If there is a significant jump in the fixed cost in moving from, say, £90,000 to £100,000 of damages, then both sides will be incentivised to promote/resist the settlement valuation around that interval. This change in behaviour would therefore be solely driven by the fixed cost regime, and would have nothing to do with the underlying merits of the case. It is, therefore, preferable to recognise the advantages of proportionality in any fixed cost regime[9], with an avoidance of arbitrary value thresholds at which the fixed costs change. The two alternative proportionality possibilities put forward at question 4 of the consultation document can be illustrated in Figure 2 below[10]:

[9] Indeed, the best known international example of a jurisdiction using fixed recoverable costs, in Germany, adopts a proportional approach throughout its fixed cost tables.

[10] DH Note: the sliding scale option has been withdrawn.

Figure 2



The first possibility ("proportional") adapts the flat rate fixed costs in option 1 to include a lower fixed cost in each stage, together with a proportional element as a percentage of damages, where the latter declines for higher value cases. The second possibility is referred to in the consultation document as a "sliding scale", apparently designed to provide an extra incentive to settle cases at an early stage. This takes a fixed minimum (£2,000) plus a percentage of damages where the latter again declines with higher value cases, but in this case the rate of decline differs across stages of litigation. The rationale for this sliding scale option is not very transparent; the effect (if I have represented it correctly) is for proportional fixed costs within each value band, but with the degree of proportionality being greater at later stages of litigation. If the intention is to incentivise early settlement, then a simple reallocation of the proportional fixed costs across litigation stages would be a more straightforward way of doing this.

3.5: Admission of liability

As stated above, the proposed fixed costs for clinical negligence are designed to apply to both contested and uncontested claims within the same scheme. This allows for the fixed costs to be coordinated such that the differences are less likely to distort behaviour. The approach chosen in the consultation document is to allow a simple deduction of 15% from the fixed costs if liability was admitted at an early stage (within 4 months of the letter of claim) and the case was settled pre-issue. If the case was settled post-issue, then the deduction for early admission would be 10%. Although no evidence is put forward to justify these figures, they are explicitly linked to the proposals put forward for early admission in Table B of Appendix 5 of the Jackson Report (i.e. based on my own analysis of low value personal injury claims). These were never implemented due to the subsequent development of the Claims Portal as the main means by which the fixed costs of undisputed claims were determined.

4: Current Costs

In order to assess the reasonableness, proportionality, and likely impact of the fixed cost proposals outlined in section 3 above, it is necessary to benchmark against the current levels of recovery, where profit costs are not fixed, but are instead subject to negotiation between claimant and defendant, and ultimately to the usual principles of costs assessment under the CPR.

To this end I have been provided with data on all 9,140 clinical negligence claims against the NHS LA which were closed between April 2012 and April 2015[11]. Of these, 1,937 involved costs only (Part 8 litigation), and I therefore exclude those, leaving 7,203 claims. This sample can be broken down by the level of damages awarded, and by the stage of litigation at which settlement occurred: the following table illustrates this breakdown.

Table 1

	Litigation stage				
Damages	Pre-issue	Issued	Allocated	Listed	Total
£1,000-£25,000	3,257	1,097	170	73	4,597
£25,001-£50,000	525	454	152	54	1,185
£50,001-£100,000	255	289	168	99	811
£100,001-£250,000	114	169	174	153	610
Total	4,151	2,009	664	379	7,203

Low value claims tend to settle early in the process, and the majority of claims listed for trial are those with damages over £50,000. Pre-issue, low value (less than £25,000) settlements represent 45% of all claims.

[11] Included in this sample are claims run under both pre- and post-LASPO rules. Although the date the CFA was agreed is not available, a rough idea of the numbers pre-LASPO can be given as 4,797 (where the letter of claim was before April 1st 2013), leaving 2,406 run under post-LASPO rules.

4.1: Stages of litigation

The mean outcomes of this sample for each value band and stage of litigation can be summarised as follows:

Table 2

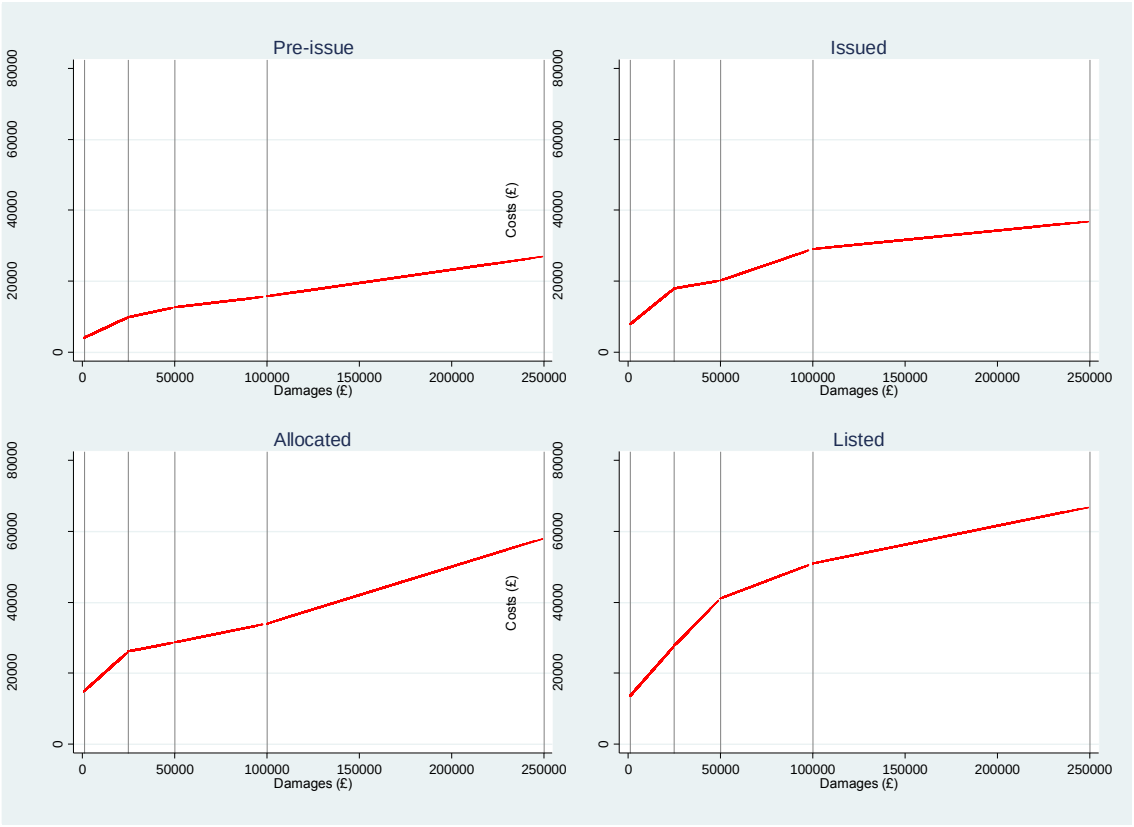
		1	2	3	4
	No. of claims	Mean Damages (£)	Mean Profit Costs recovered (£Net)	Mean Success Fee (£Net)	Mean ATE premium (£Gross)
Pre-issue					
£1,000-£25,000	3,257	9307.67	6063.05	2726.01	1950.88
£25,001-£50,000	525	37374.07	11128.56	5119.61	2494.82
£50,001-£100,000	255	71649.33	14290.58	6902.08	3108.64
£100,001-£250,000	114	155452.79	21553.47	9343.3	3624.1
Issued					
£1,000-£25,000	1,097	12128.79	12551.6	6046.48	6541.47
£25,001-£50,000	454	37838.82	19344.7	9900.58	9295.95
£50,001-£100,000	289	74697.26	24643.94	11281.32	9733.42
£100,001-£250,000	169	165824.51	31974.42	14586.94	11609.56
Allocated					
£1.000-£25.000	170	13920.65	20973.6	10693.95	8338.92
£25.001-£50.000	152	39856.12	27651.86	13874.97	10318.09
£50.001-£100.000	168	79195.91	35381.17	16470.77	12985.93
£100.001-£250.000	174	173207.53	46160.45	20335.14	16403.41
Listed					
£1.000-£25.000	73	13864.93	22145.43	11417.83	13570.56
£25.001-£50.000	54	42449.14	36478.9	18853.14	19127.58
£50.001-£100.000	99	79078.34	48487.56	23975.77	20253.58
£100.001-£250.000	153	178965.96	60701.47	25862.23	20116.83

Mean profit costs, success fees and ATE premiums increase with both damages and litigation stages as might be expected. Prior to April 1st 2013, these were all recoverable from the defendant, and the table clearly shows that, for low value cases such as those with damages below £25,000, the mean aggregate of these recoveries exceeded the mean damages paid to the claimant, even where the claim was settled pre-issue.

4.2: Proportionality

While Table 2 shows a clear pattern of increasing profit costs on cases in higher damage bands, it does not show the extent to which costs rise in proportion to damages *within* those bands. To explore this, I used the NHS LA data to estimate lines of best fit between costs and damages within each band for each stage of litigation[12]. The results are shown in the following figure.

Figure 3



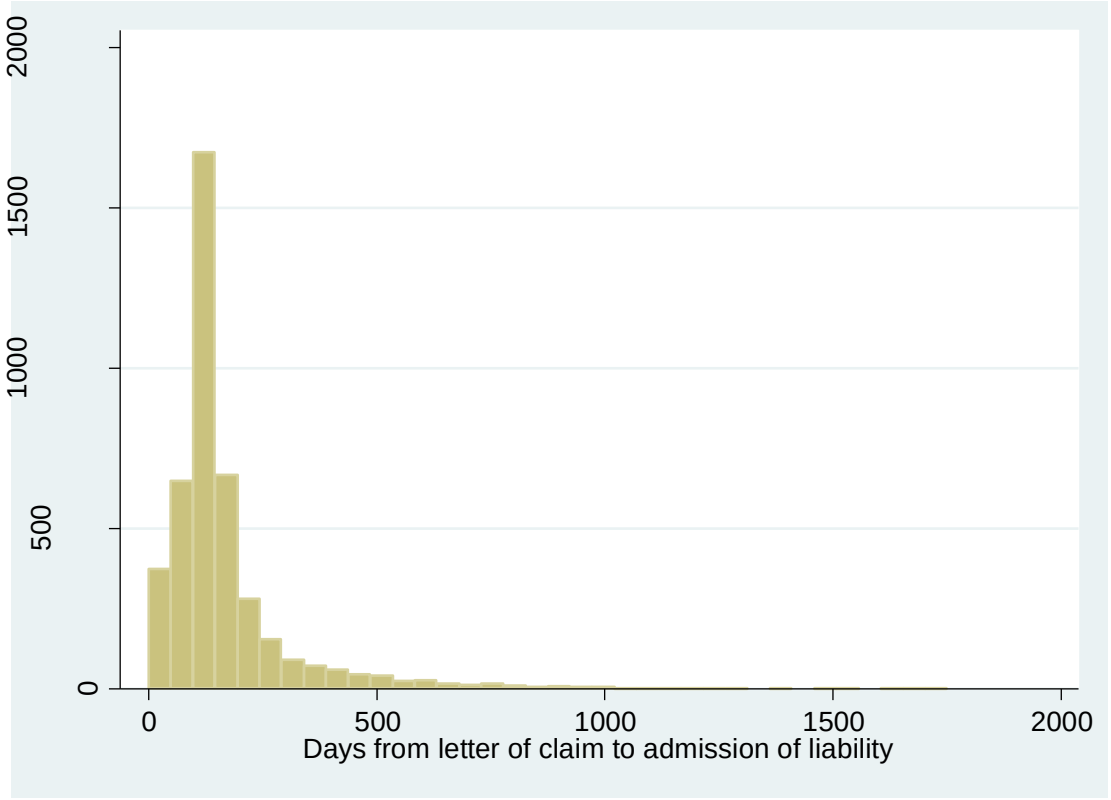
This figure shows how profit costs increase with damages across the whole range of claim values, but at a decreasing rate.

[12] I did this using ordinary least squares regression analysis, constraining each successive line to start where the previous one ends.

4.3: Admission of liability

Using the same NHS LA data, the following figure shows the distribution of time taken from the letter of claim to the defendant's admission of liability, where liability was admitted (4,568 claims, or 63.4% of the total):

Figure 4



The number of admitted liability claims where admission took place within 4 months (120 days) was 1,958, or 42.9% of all claims where liability was admitted.

In the table below I set out the mean profit costs recovered (net) for pre-issue and post-issue settlements of differing values, and compare claims with an early admission of liability (i.e. within 4 months of the letter of claim) with other claims (i.e. those where no liability was admitted, or where liability was admitted at a later stage beyond 4 months).

Table 3

		Mean profit costs (£)		% reduction
	Number of claims	Early admission[13]		
		No	Yes	
Pre-issue				
£1,000-£25,000	3,257	6251.59	5710.42	8.66%
£25,001-£50,000	525	11648.51	10377.79	10.91%
£50,001-£100,000	255	15361.32	12521.04	18.49%
£100,001-£250,000	114	23354.15	17652	24.42%
Total	4,151	7924	7121.52	10.13%
Post-issue				
£1,000-£25,000	1,340	14459.34	12179.76	15.77%
£25,001-£50,000	660	23198.04	19483.45	16.01%
£50,001-£100,000	556	33513.18	24421.91	27.13%
£100,001-£250,000	496	46082.16	43134.49	6.40%
Total	3,052	24885.36	21833.13	12.27%

It seems that the figures included in the consultation document, allowing a 15% reduction for pre-issue settlements and 10% for post-issue settlements, are broadly consistent with the evidence for low value claims (i.e. below £25,000). However, there is evidence in Table 3 that early admission of liability for claims of higher value, whether settled pre-issue or not, results in significantly greater reductions in costs, possibly because the rewards for successfully disputing a denial of liability are much greater for such cases.

[13] Early admission = admission of liability within 4 months of letter of claim

5. Discussion

To compare the current cost recoveries with the proposed fixed costs, the following table sets out, as an example, option 3[14] (based on GHRs) of the consultation document (column 1), and then shows the mean additional funds (column 2) that would be required by claimant solicitors receiving those fixed costs in order to match the average revenue obtained from the combined sum of recovered profit costs and success fees in recent years.

Table 4

		1	2	3	4
	No. of claims	Proposed fixed costs (Option 3)	Mean client charge required to maintain current revenue	% mark-up on costs required to maintain current revenue	% share of damages required to maintain current revenue
Pre-issue					
£1,000-£25,000	3,257	3000	5658.04	188.6	88.18
£25,001-£50,000	525	4500	11817.1	262.6	33.68
£50,001-£100,000	255	7500	13368.39	178.25	19.8
£100,001-£250,000	114	8000	22525.71	281.57	15.81
Issued					
£1,000-£25,000	1,097	3900	14482.7	371.35	165.08
£25,001-£50000	454	5500	22686.68	412.49	65.56
£50,001-£100,000	289	8750	26831.76	306.65	38.31
£100,001-£250,000	169	9750	36590.13	375.28	23.99
Allocated					
£1,000-£25,000	170	5650	25584.41	452.82	247.47
£25,001-£50,000	152	7750	33753.29	435.53	96.26
£50,001-£100,000	168	11250	37593.24	334.16	52.58
£100,001-£250,000	174	16250	50639.47	311.63	31.84
Listed					
£1,000-£25,000	73	7225	25303.92	350.23	245.28
£25,001-£50,000	54	9325	48697.55	522.23	140.71
£50,001-£100,000	99	11250	60711.74	539.66	84
£100,001-£250,000	153	18750	69415.19	370.21	43.85

[14] DH Note: Now option 1 in the published consultation document.

I refer to the gap between the current revenues and the proposed fixed cost as the required "client charge" on the assumption that the extra revenue would have to be raised from the client's damages. In column 3 of the table I have calculated this client charge as a required percentage mark-up on profit costs, and in column 4 I calculate it as a required percentage of mean damages. On CFAs entered into since April 1st 2013, claimant solicitors now recover success fees from their clients[15]. The table shows the effect of charging for both success fees and unrecovered costs under the proposed fixed cost regime (with no change in behaviour)[16].

Clearly, if there were to be no change to current behaviour and revenue requirements by claimant solicitors, many of these claims would simply not be viable for claimants. In particular, those of low value (e.g. below £25,000) which were anticipated to require litigation would be unlikely to obtain representation. It is beyond the scope of this report to speculate in detail about whether behaviour would in fact change in the face of this new, cost-sharing environment, but in broad terms there are several possibilities:

1. Claimant solicitors could reduce their profit costs, due to the improved predictability of their cash flow under a fixed cost regime;
2. Claimant solicitors could reduce their profit costs, due to the availability of scale efficiencies through merger and specialisation (economies of scale and scope)
3. Excessive over-charging by some solicitors could be mitigated given that the client will be meeting the bills.
4. Claimant solicitors could reduce the level of success fees by accepting only those claims which were very likely to succeed, and therefore unlikely to require litigation.
5. Claimant solicitors could cross-subsidise the risky, low value claims from revenue obtained on less risky, high value claims.
6. Alternative means of funding clinical negligence litigation could emerge

Given the uncertainties over the extent to which any of these possibilities develop, the impact of the fixed cost proposals on the number of claims brought against potentially negligent health care providers would be unpredictable. Any major reduction in the propensity of patients to identify negligence could of course have wider implications for patient safety.

[15] The mean success fee as a percentage of costs for pre-LASPO claims was 58%; for post-LASPO claims it was 55%.

[16] ATE premiums are also now partly non-recoverable, although one-way cost shifting should keep these relatively low.

While the levels of the proposed fixed costs are significantly lower than current mean profit cost recoveries, the proportionality assumptions are also at variance with the observed best fit relationships between costs and damages, as shown in Figure 3 above. To illustrate this, the table below shows the best fit relationships as a combination of a lump sum and a percentage of damages, to aid comparison with the proportionality proposal in the fixed cost consultation document.

Table 5

	Profit costs: current best fit		**Fixed cost: Option 1 - proportional[17]**	
	Lump sum (£)	% of damages	Lump sum (£)	% of damages
Pre-issue				
£1,000-£25,000	3,850	24%	1500	5%
£25,001-£50,000	9,900	11%	2250	4%
£50,001-£100,000	12,650	6%	3000	3%
£100,001-£250,000	15,750	7%	3375	2%
Issued				
£1,000-£25,000	7,400	42%	1875	5%
£25,001-£50,000	18,000	9%	2700	4%
£50,001-£100,000	20,200	18%	3450	3%
£100,001-£250,000	29,050	5%	4125	2%
Allocated				
£1,000-£25,000	14,450	47%	2812.5	5%
£25,001-£50,000	26,150	10%	3825	4%
£500,01-£100,000	28,700	10%	4575	3%
£100,001-£250,000	34,000	16%	6750	2%
Listed				
£1,000-£25,000	12,900	59%	3375	5%
£25,001-£50,000	27,700	53%	4387.5	4%
£50,001-£100,000	41,050	20%	5137.5	3%
£100,001-£250,000	50,900	10%	7875	2%

The differences between the actual percentage relationship with current damages and that proposed in the consultation document for proportional fixed costs is quite marked, and

[17] This option is used in the consultation document to illustrate proportionality – there is no equivalent illustration for option 3.

particularly so for low value claims below £25,000 in damages. To the extent that the current relationship is the one which rewards solicitor effort on behalf of their client, it might be expected that a further behavioural change would result in lower agreements on damages[18]. However, this prediction depends on what arrangements materialise in respect of the client charge where this is capped at a percentage of damages. One alternative approach to setting the fixed costs in order to reflect actual evidence on the degree of proportionality would be to take the "best fit" relationships shown in Table 5 and Figure 3, and adjust these down proportionately to reflect (a) the expected improvements in efficiency and/or (b) the desired extent of cost-sharing with claimants.

Finally, in relation to the proposed percentage reductions in fixed costs for early admission, I have shown in Table 3 above that these are broadly consistent with the evidence for low value claims (i.e. below £25,000). This is perhaps not too surprising given that they were based on the deductions illustrated in Table B of Jackson's Appendix 5, which in turn were based on my estimates from low value personal injury claim data. However, there is some indication that most higher value clinical negligence claims, particularly those above £100,000 in value, would currently experience a much higher percentage reduction in costs if liability was admitted at an early stage. The implication of diluting the incentive for early admission of high value claims would be to raise the possibility of fewer early admissions on these claims, and higher costs to be borne by claimants, than would otherwise be the case. If the fixed costs proposals are to apply to claim values over £25,000, it would perhaps be worth considering increasing the difference between the fixed costs for claims where liability was not admitted early and for those where it was. This would provide an obvious mechanism by which to encourage less adversarial behaviour as well as resulting in an increase in the speed with which successful claimants received compensation.

[18] For a review of the possible unintended behavioural consequences from fixing costs, see P Fenn and N Rickman, "Fixing Lawyers' Fees Ex Ante: A Case Study in Policy and Empirical Legal Studies", *Journal of Empirical Legal Studies*, Volume 8, Issue 3, 533–555, September 2011

6: Conclusion and Recommendations

In view of the stated objective of this report – to independently assess the appropriateness and potential impact of the proposed fixed costs as set out in the DH's consultation document – I have presented arguments and examined evidence on the reasonableness, proportionality, and likely impact of the proposals. I accept that the work undertaken by the DH and NHS LA to underpin the fixed cost tables has been thorough and informative. However, I have set out a number of reservations in my report:

1. *Scope*: the arguments put forward for extending the scope of the fixed cost tables beyond £25,000 in value are not persuasive [section 3.1]
2. *Hourly rates*: some of the hourly rate assumptions used to cost fee-earner time inputs would be inconsistent with those used in detailed assessment [section 3.2]
3. *Time analysis*: the analysis undertaken by a panel of experts with a view to estimating the time inputs required on hypothetical cases is difficult to evaluate scientifically and therefore likely to be contentious [section 3.3]
4. *Proportionality*: the proposed relationship between fixed costs and damages is unsupported by evidence and could potentially lead to unintended behavioural consequences [section 3.4]
5. *Admission of liability*: the proposed reduction of fixed costs due to an early admission of liability could be strengthened, particularly for claims of higher value [sections 3.5 and 4.3]

Given these reservations, and given the potentially significant impact of the proposed recoverable costs on patients' access to legal representation and net compensation [section 5], I have the following recommendations in relation to possible ways forward:

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[19].
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

[19] Jackson LJ, *Fixed Costs – The Time Has Come*, IPA Annual Lecture, 28 January 2016.

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[20]. Further reductions could be made if changes in the claimant risk profile were anticipated.

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 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[21].
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.

Clearly, recommendations 2 and 3 above would require the input of (and evidence from) a number of informed parties, in addition to the technical analysis that I have suggested. I would be happy to be involved in this process if the DH wish to set it up.

[20] 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.
[21] 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.

7: Appendix

Illustrative fixed cost options for clinical negligence claims (including reductions for admission of liability within the protocol period[22])

Settlement stage and claim value	Option 1[23] 10% reduction		Option 2[24] 20% reduction		Option 3[25] 30% reduction		Early admission: % reduction
	Lump sum (£)	% of damages*	Lump sum (£)	% of damages*	Lump sum (£)	% of damages*	
Pre-issue							
£1,000-£25,000	3,465	22%	3,080	19%	2,695	17%	**10%**
£25,001-£50,000	8,910	10%	7,920	9%	6,930	8%	**15%**
£50,001-£100,000	11,385	5%	10,120	5%	8,855	4%	**20%**
£100,001-£250,000	14,175	6%	12,600	6%	11,025	5%	**25%**
Issued							
£1,000-£25,000	6,660	38%	5,920	34%	5,180	29%	**10%**
£25,001-£50,000	16,200	8%	14,400	7%	12,600	6%	**15%**
£50,001-£100,000	18,180	16%	16,160	14%	14,140	13%	**20%**
£100,001-£250,000	26,145	5%	23,240	4%	20,335	4%	**25%**
Allocated							
£1,000-£25,000	13,005	42%	11,560	38%	10,115	33%	**10%**
£25,001-£50,000	23,535	9%	20,920	8%	18,305	7%	**15%**
£50,001-£100,000	25,830	9%	22,960	8%	20,090	7%	**20%**
£100,001-£250,000	30,600	14%	27,200	13%	23,800	11%	**25%**
Listed							
£1,000-£25,000	11,610	53%	10,320	47%	9,030	41%	**10%**
£25,001-£50,000	24,930	48%	22,160	42%	19,390	37%	**15%**
£50,001-£100,000	36,945	18%	32,840	16%	28,735	14%	**20%**
£100,001-£250,000	45,810	9%	40,720	8%	35,630	7%	**25%**

* The percentage of damages applies to each band separately (e.g. for the £25,001-£50,000 band, it is the percentage of damages in excess of £25,000)

[22] DH Note: the difference between the figures used in Table 5 of the consultation document with those used in the Appendix to Professor Fenn's report is a result of Professor Fenn "smoothing" the latter to remove the apparent precision of the estimates in the Appendix, which are statistical "best fit" relationships, but subject to confidence intervals so should not be interpreted as the only "true" relationship. This is the equivalent to the rounding used in Options 1, 2 and 3.

[23] Option 1 represents a 10% reduction relative to the current observed "best fit" relationship between profit costs recovered and damages (see Figure 3 and Table 5).

[24] Option 2 represents a 20% reduction relative to the current observed "best fit" relationship between profit costs recovered and damages (see Figure 3 and Table 5).

[25] Option 3 represents a 30% reduction relative to the current observed "best fit" relationship between profit costs recovered and damages (see Figure 3 and Table 5).