Title: Fixed Recoverable Costs (FRC) for the Resolution of Clinical Disputes Protocol **IA No:** DH3237 **RPC Reference No:** **Lead department or agency:** Department of Health **Other departments or agencies:** **Ministry of Justice, NHS Litigation Authority**	**Impact Assessment (IA)** **Date:** 10/12/2015 **Stage:** Development/Options **Source of intervention:** Domestic **Type of measure:** Other **Contact for enquiries:** Julie Badon **01132-**254-6283

Summary: Intervention and Options

RPC Opinion: GREEN

Cost of Preferred (or more likely) Option				
Total Net Present Value	**Business Net Present Value**	**Net cost to business per year** (EANDCB in 2014 prices)	**One-In, Three-Out**	**Business Impact Target Status**
£91m	£263m	-£22m	In scope	Not a regulatory provision

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

The problem under consideration is that the recoverable legal costs involved in settling clinical negligence claims are considered to be excessive, especially for lower value claims. Currently there is no upper limit on reimbursed legal fees paid to claimants with respect to costs incurred. Claimant legal fees are disproportionate with respect to damages awarded and associated defendant costs. This work has become more necessary as the changes to costs in other personal injury claimant markets mean that non-specialist lawyers are now picking up clinical negligence work leading to a significant increase in overall legal costs.

What are the policy objectives and the intended effects?

The objective of a fixed recoverable legal costs structure is to restrict the legal costs awarded by courts to individual claimants, thereby making costs recoverable more proportionate to the value of damages and to rebalance the potential cost liabilities of claimants and defendants.
Intended effects are improved productive efficiency through reduced negotiation costs and a more rational fee system. The measure will result in a transfer of resources which may increase overall welfare if the shift of costs from public and private sector defendants to individual claimants is in line with society's preferences. Claimants will retain the right to negotiate fees with their solicitor.

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

Option 0: Do Nothing (base case)
Voluntary regulation option (not quantified): Mutual agreement has been attempted by NHS LA and remains a viable option as part of the consultation.
Option 1 (the preferred option): Introduce a mandatory new Fixed Recoverable Costs (FRCs) regimes for clinical negligence claims above £1,000 and up to £25,000 (similar to the scheme that operates in other personal injury claims). The level of recoverable costs and method of implementation are included within the consultation. The prefferred option is where the highest levels of disproporionality between claimant recoverable costs and damages awarded is.

Will the policy be reviewed? It will be reviewed. **If applicable, set review date:** 07/2022

Does implementation go beyond minimum EU requirements?		Yes / No / N/A		
Are any of these organisations in scope?	**Micro** Yes	**Small** Yes	**Medium** Yes	**Large** Yes
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)		**Traded:**	**Non-traded:**	

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

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

Summary: Analysis & Evidence

Policy Option 1

Description:

FULL ECONOMIC ASSESSMENT

Price Base Year 2015	PV Base Year 2015	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low:	**High:**	**Best Estimate:** £91

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Optional			
High	Optional			
Best Estimate			£88	**£757.5**

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

The main costs the policy fall on individual claimants through reduced legal reimbursement. This has been quantified for cases occurring in NHS Providers with a high level quantification for impact on private insurers. For clinical negligence claims made above £1,000 and below £25,000, if caseloads were to remain at 2014-15 levels, then there would be a reduction in costs of approximately £88m .The impact on taxpayer is £146-£158m pa and on private insusuers £35mpa..

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

Disutility to defendants (insurers) from earlier payment of costs.

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Optional			
High	Optional			
Best Estimate			£98.6m	**£848.7m**

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

Reduced legal costs paid out by all defendants. This has been quantified for cases occurring in NHS Providers with a high level quantification for impact on private insurers. For clinical negligence claims above £1,000 and up £25,000 estimated at £88m pa on recoverable fees. This represents a transfer of costs from insurers to individual claimants. The savings to taxpayer is £146-£158m pa and £35m pa to private insurers. Admin savings of £16m pa to claimants and defendant.

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

Utility benefits to claimants from faster resolution and payment of costs
Improved predictability of cash flows for legal representatives,
Wider societal benefits if the weight given to savings (to defendants, mainly public sector NHS) is greater than costs to individual claimants (not quantified).

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

Analysis assumes no change from 2014/15 caseload characteristics i.e. volume of received claims, settlement numbers, damages awarded, willingness to bring a claim or take on a claim do not change. This is a simplifying assumption in the analysis which reflects the uncertainty of the impact of the recent reforms in civil litigation. Given this uncertainty, the analysis presents results for a single year post implementation and discounts this over the policy appraisal period.

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			Score for Business Impact Target (qualifying provisions only) £m:
Costs: £0	**Benefits:** £42	**Net:** £42	

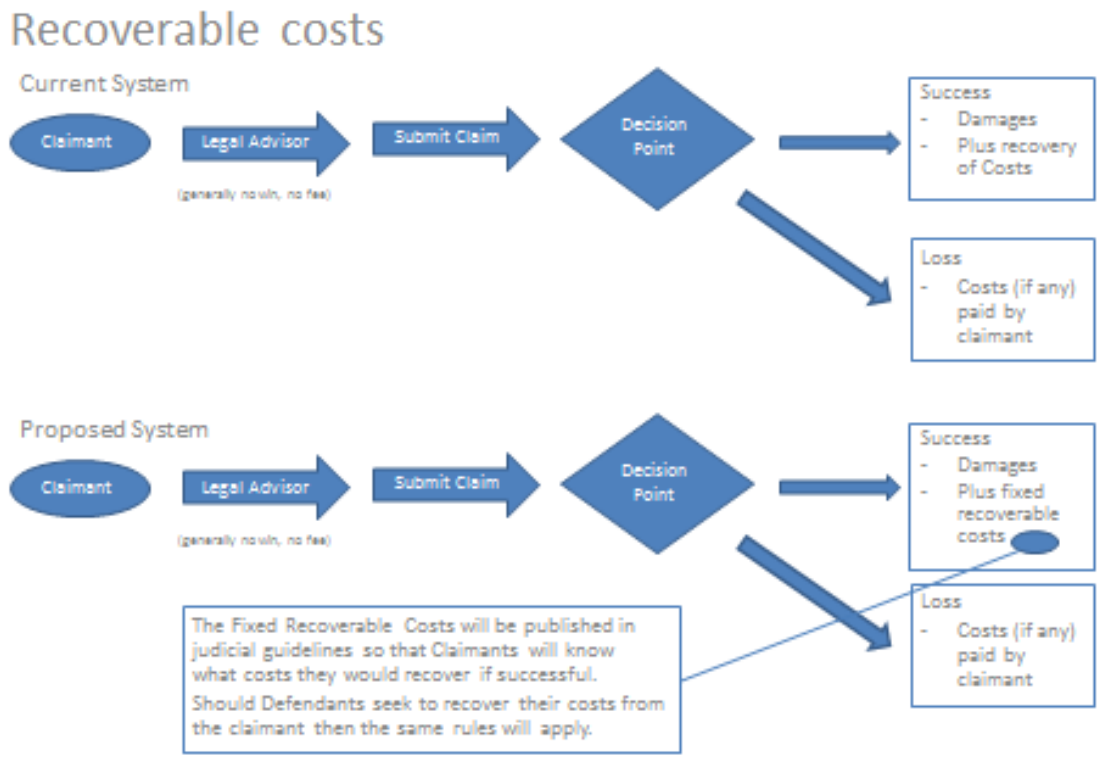
Evidence Base (for summary sheets)

1. Background on the impacts

1.1 This IA relates to proposals to introduce fixed recoverable fees with respect to clinical negligence cases. It will impact on costs awarded to individual claimants for legal costs incurred in pursuing clinical negligence occurring in NHS and independent healthcare sectors.

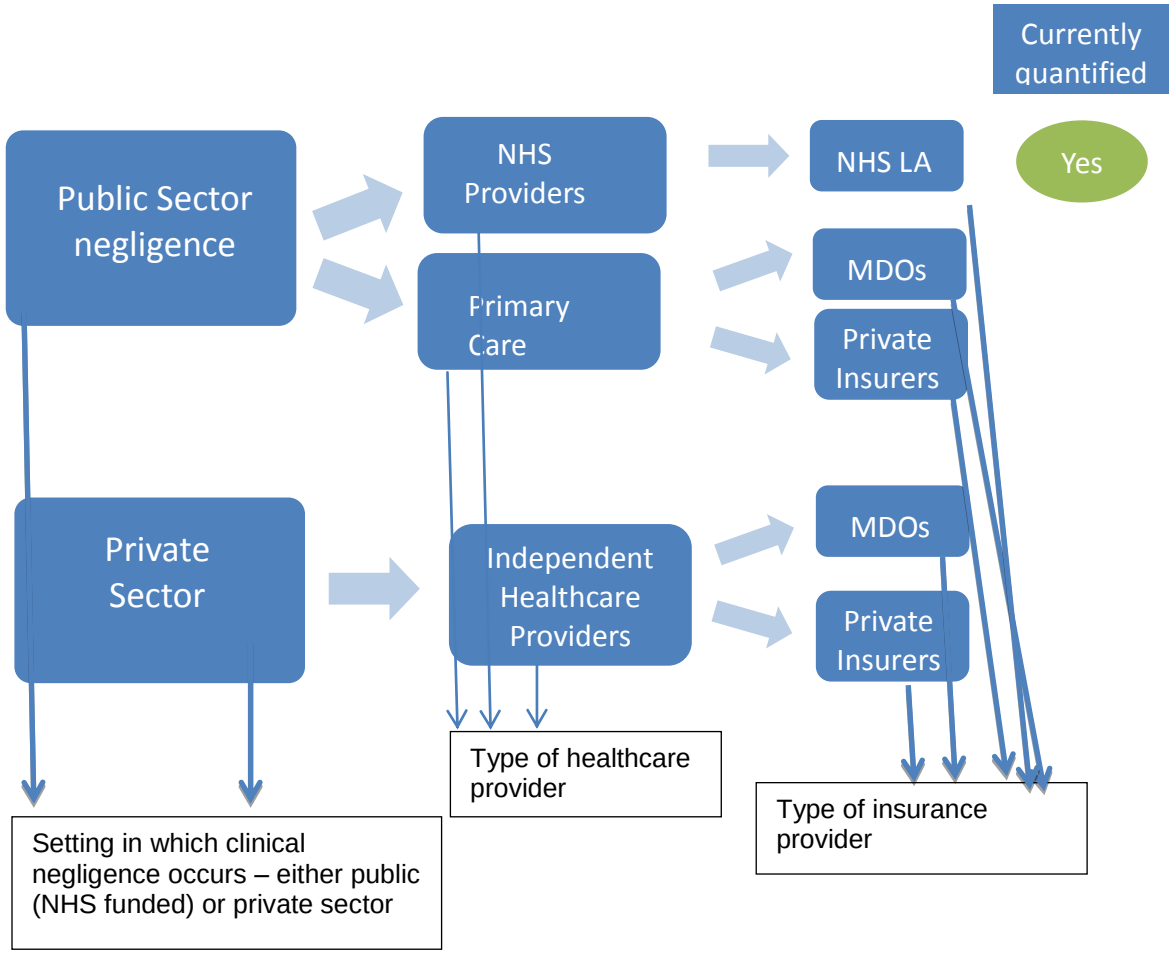
1.2 The main impact is to rationalise the legal award recovered by individual claimants for clinical negligence. It seeks to amend the rules by which courts are able to award compensation for legal costs to individual claimants. It therefore does not directly impact on the contract between claimants and their legal representatives (e.g. solicitors). The main impact on costs will be directly on individual claimants through the amount awarded by courts. This is shown in Figure 1 below.

Figure 1: Proposed change to recoverable costs system



1.3 In terms of benefits, we expect there to be savings for both public and private sector defendants i.e. the insurers. This is a mirror of the costs referred to in para 1.2 and reflect the reduced legal costs payable by organisations and associated administrative costs.

Figure 2: Proposed impacts of recoverable costs system



1.4 Clinical negligence can occur in either the public or privately funded healthcare sector. The proposals seek to amend the recoverable legal costs and therefore impact businesses that provide indemnity for non NHS Providers – i.e. primary care and independent healthcare providers. The net impact is expected to be a positive regulatory impact i.e. an overall OUT. This is as a result of the lower level of reimbursement and administrative savings from the proposals.

1.5 However there is a lack of detailed costings on the impact of the reforms on the private sector so the overall estimates are indicative of the impact rather than precise estimates at this stage. We are planning to consult more formally with private insurers and non for profit providers of clinical indemnity cover in order to understand scope of savings for this sector and extract more comprehensive data to estimate the impact.

NHS Providers

1.6 Claims for clinical negligence against NHS providers (or other similar bodies commissioned to undertake services by the NHS e.g. in Independent Sector Treatment Centres) in England are handled primarily by the NHS Litigation Authority (NHS LA) under the Clinical Negligence Scheme for Trusts (CNST). NHS LA is a Special Health Authority which runs a number of risk pooling schemes, on behalf of the Secretary of State for Health. It indemnifies the NHS against clinical negligence, employers, public and professional liabilities. Independent sector organisations providing NHS funded care are also eligible to join CNST scheme.

1.7 Claims for clinical negligence occurring in primary care or independent healthcare settings that are privately funded are not covered by NHS LA. Instead indemnity is provided by the private sector via Medical Defence Organisations (MDOs), or other private or charitable insurers. (see note 1)

1.8 Table 1 shows recent trends in NHS LA activity. During 2014-15 18,258 clinical negligence claims were notified to DWP as part of their social security benefits recovery unit. Of these, 11,497 were notified against the NHS Litigation Authority (NHS LA) (around 63 per cent). NHS LA's expenditure largely depends on the number of claims and fees paid to individuals with respect to legal costs. In 2014/15 96% of NHS LA claims expenditure (£1,223 million) related to the resolution of clinical negligence claims. (See note 2).

1.9 During the period 2009-10 to 2014-15, expenditure on claimant legal costs increased by around 73 per cent from £169m in 2009-10 to £292m in 2014-15. This contrasted with an increase of 69% on defence legal costs and 39% increase in damages awarded. Expenditure on clinical negligence defence solicitors as a proportion of total clinical negligence costs (for all damage tranches) has increased from 7.8% in 2009-10 to 8.8% in 2014-15. For clinical negligence expenditure, this ratio has increased from 21.5% in 2009/10 to 25% in 2014-15.

Table 1: NHS LA's expenditure from 2009-10 to 2014-15

	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15
NHS LA claims expenditure (£m)	827	911	1,329	1,309	1,244	1,223
Total number of clinical claims received	6,652	8,655	9,143	10,129	11,945	11,497
Total number of clinical claims settled	5,936	7,428	7,797	8,033	8,935	10,896
Expenditure on clinical negligence claimant solicitors (£m)	169	173	278	275	259	292
Expenditure on clinical negligence defence solicitors (£m)	61	69	70	76	93	103
Expenditure on damages (£m)	557	622	930	908	841	774
Total clinical negligence costs (£m)	787	863	1,277	1,259	1,193	1,170

1.10 In Wales there is an NHS redress process for clinical negligence cases. Redress 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 need to give consideration to whether the fixed costs regime should apply to cases where patients have opted to follow the NHS redress process in Wales.

Non NHS providers

1.11 The independent acute healthcare sector in England represents approximately 7% (£5b) of NHS Providers income whilst primary care spending (excluding prescribing) is around 18% (£13b). However data on the number of claims, damages awarded and legal costs paid in the non NHS Provider sector is much more constrained due to the diverse nature of the independent healthcare sector and commercial in confidence concerns. There is no single repository of data that can provide information on the size and scope of the claims in these sectors akin to CNST scheme which makes analysis limited. (See note 3).

1.12 We have had informal discussions with the 2 largest non NHS clinical indemnity providers (Medical Defence Union and Medical Protections Services). These suggest they

are facing the same problems as NHS LA i.e. disproportionality of claimant legal costs and increases in case volumes. Figures from latest annual reports suggest their combined future liability is around £1.3b compared with £28.6b for NHS LA which suggests a more limited direct impact.

1.13 Table 2 shows the size of the 2 largest MDO providers we have identified as providing clinical indemnity and shows NHS LA for comparison purposes.

1.14 During this initial phase, we have attempted to get data from private medial insurers. However it has been difficult to get robust sample data to quantify impact of the proposals. Only 1 MDO (representing approximately 4% of claimant costs paid by NHS LA in 2014) was able to provide detailed data for the consultation IA and so analysis was limited. There is great concern due to the commercial in confidence position for those organisations so very important that this cannot be separately identified. We are planning to consult more formally with private insurers and non for profit providers of clinical indemnity cover in order to understand scope of savings for this sector and extract more comprehensive data to refine the numbers. Our intention is to obtain sufficient sample data from the sector to enable a more robust estimate of the impact to be quantified at final IA stage.

Table 2 – Comparison of medical insurers, analysed by provisions for future liabilities and claims costs

	Estimated Provisions for Future Liabilities (£m)	Claims & Legal Costs (£m)
Medical Protection Society (source: strategic report 2014)	941	316
Medical Defence Union (source: Reports and Accounts 2014	313	148
NHS Litigation Authority (source: Reports and Accounts 2014/15)	28,610	1,193

Problem under consideration

1.15 The current regime enables claimant solicitors to recover their fees on an hourly base. It is one of the last remaining areas of personal injury where claimant solicitors are able to recover costs on this basis; motor, employers' and public liabilities are now all managed through fast track portals with low fixed costs. As a result it has opened up several imperfections on the clinical negligence legal market, especially for lower value claims – above £1,000 and up to £25,000.

1.16 Table 3 shows the scale of disparity between damages paid, defence costs and claimant costs in the lower value cases i.e. up to £50,000 damages, the claimant legal costs awarded were around 1.5 times greater than the damages paid and over 6 times greater than defence costs.

Table 3: Numbers and payments for clinical negligence claims closed with damages awarded up to £250,000 in 2014/15 as at 31/03/2015 (NHS LA data, excluding Wales)

Damages Tranche £	No. of Claims	Damages Paid £	Defence Costs Paid £	Claimant Costs Paid £
1,001 - 10,000	2,165	10,682,045	5,420,782	31,924,512
1,001 - 25,000	3,462	33,118,832	10,829,275	68,648,698
1,001 - 50,000	4,370	66,774,847	16,882,714	106,193,056
1,001 - 100,000	4,999	112,913,706	23,990,454	144,566,616
1,001 - 250,000	5,427	182,137,125	32,439,737	184,158,054

1.17 Data (for all cases) from Northern Ireland suggest a lower uplift of claimant costs compared to defence cost, in the region of 2 times greater, shown in table 4. (See note 4).

1.18 NHSLA data shows that in 2014-15, claimant legal costs represented around 52 per cent of the value of claims with damages below £100k. The costs of litigation often exceed the value of the underlying damages. This has increased significantly over past few years – see Figure 3 below.

1.19 Many solicitors firms which are not specialised in clinical negligence claims nevertheless seek hourly rates well in excess of the recommended rates; and considerably higher than NHS LA pay their defence solicitors, for routine work carried out by unqualified staff. The figure below shows the disparity between defendant and claimant fees.

1.20 The majority of claimant costs claims are currently settled by negotiation between claimant solicitor firms and defendants. Claimant solicitors routinely and voluntarily accept significant reductions, indicating a practice of excessive claims for costs in this area.

1.21 Cost claims may also be assessed by the courts. Across all claims for costs assessed by the courts in 2014/15, there was an average 33% reduction in the legal bill for claimant solicitors.

1.22 NHS LA has found evidence in some cases of a firm charging £400 per hour with 100% uplift (so £800 per hour) for unqualified lawyers. One firm tried to charge £1,440 per hour. On settlement of one claim for damages worth £1,000, the NHS LA received a bill from the claimant's solicitors totalling £83,131. This was regarded as excessive and contested at court. The judge awarded the solicitors £4,903, just 5.89% of what had been claimed.

1.23 For example in 2014/15, excessive cost claims were reduced by £97m following challenge by NHS LA. See Figure 5 below. (see note 5)

1.24 The MDOs report similar issues in their data. For example the Medical Defence Union, which provides indemnity insurance for doctors and other members of the medical profession (reports in their 2012 and 2013 Report and Accounts) that medical negligence claim volumes increased by 20 per cent between 2011 and 2012, and by a further 20 per cent between 2012 and 2013.

Table 4: Comparison of NHS LA and Northern Ireland Legal Costs

	Defence Costs Paid	Claimant Costs Paid	Ratio of Claimant Costs to Defence Costs
Northern Ireland DHSSPSNI, 2015	£6,408,955	£13,599,711	2.12
NHS LA	£50,443,467	£249,447,226	4.95

Figure 3: Claimant costs as a proportion of total damages award (where damages are below £100,000) (NHS LA data, excludes Wales)

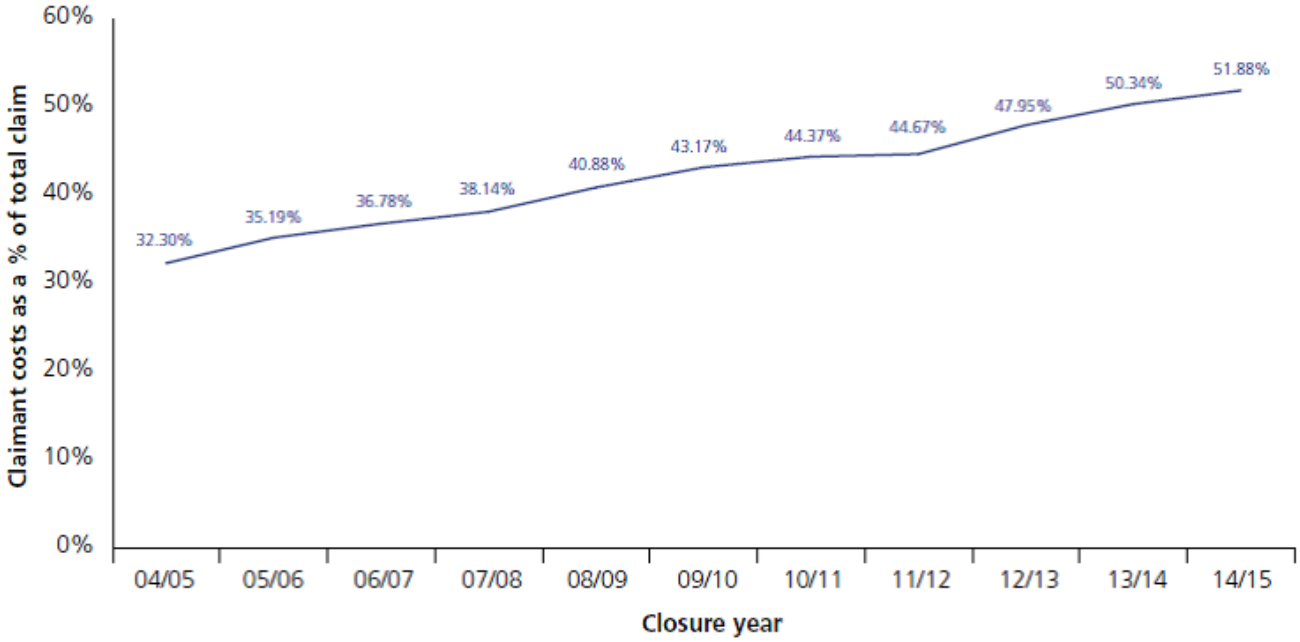


Figure 4: Percentage of legal (defence and claimant) costs to damages (NHS LA data, excluding Wales)

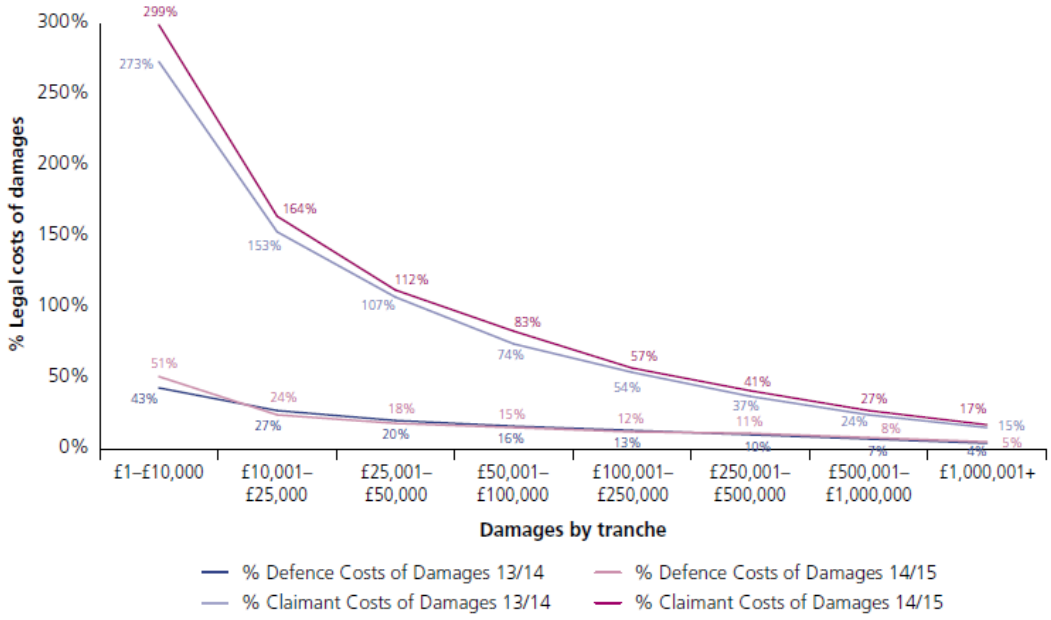
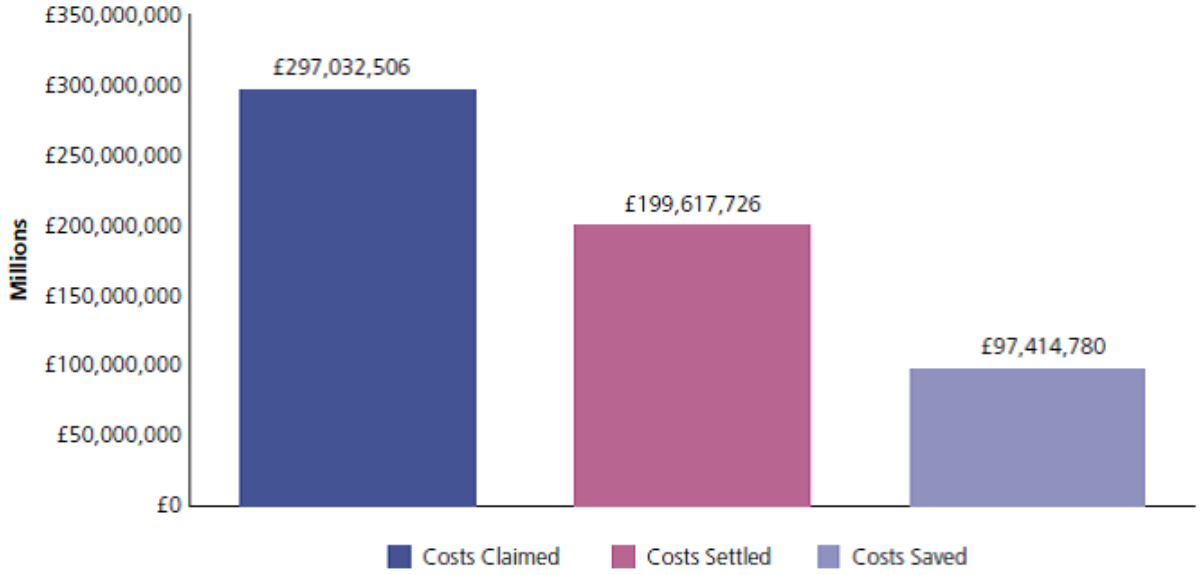


Figure 5: Legal costs awarded to individual claimants on all claims resolved in 2014/15 (NHS LA data excluding Wales)



Excludes claims for costs under £50,000 negotiated in-house or by panel solicitors

Rationale for intervention

2.1 The proposal aims to maintain the current access to justice to patients whilst ensuring that the level of legal costs awarded by courts is both reasonable and proportionate to the overall value of the claim. The rationale for government intervention is based on 2 underlying failures.

2.2 The first could be called a 'government failure' from the past when the system was designed. The current system is that claimants contract with lawyers, and the lawyers' fees are passed on to a third party (insurers) for payment. However the third party, insurers is unable to control the size of the fee claimed. This gives an incentive to inflate fees above their cost, as well as to incur inefficient costs, as neither party to the contract loses out from this. This could be described as a cost-shifting externality.

2.3 This leads to the second rationale for failure on efficiency grounds. In some cases, and especially for lower value claims, the costs awarded by courts are believed to be above their actual costs, creating opportunities for abnormal profits for claimant solicitors. The current reimbursement regime leads to an unfair playing field between solicitors as, for similar legal cases, claimant solicitors are able to recover higher fees than defence solicitors, who work to fixed cost arrangements. Extra work and risks undertaken by claimant solicitors explain only partially the difference in fees between defence and claimant solicitors. Further the current regime creates incentives for high transaction costs and a misallocation of time and resources by solicitors which would be better spent on legal activity. Using less resource to secure the same outcome would result in improved productive efficiency.

Policy objectives

2.4 The policy objective is to ensure that claimant legal costs are proportionate to damages awarded particularly in low value claims where disproportionality of cost is most acute. The intended effects are to enable claims to be settled more quickly and efficiently without affecting patient's access to justice. It will also provide consistency with other civil justice reforms of the last Parliament, namely that the risks of litigation, as a matter of public policy and where justified, should be borne by claimants than defendants.

2.5 The proposal should raise overall economic welfare if the transfer of costs from the NHS i.e. cost savings to claimants is in line with society's preferences.

2.6 Introduction of FRC are part of a wider set of reforms to clinical negligence. These are

- **Improving Patient Care by** reducing the incidence of clinical negligence through improved training, organisational learning, greater collaboration on the ground, and improved professional standards;
- **Improving Customer Care by** ensuring all NHS organisations are responsive to their users, with initiatives such as 'Duty of Candour' encouraging an open and transparent culture and effective use of mediation; and
- **Improving Litigation by** ensuring that appropriate and cost effective legal processes are in place for both claimants and defendants.

2.7 This proposal is focused on the 'Improving Litigation' strand of reforms. Whilst the other two areas are not directly within the scope of this consultation, substantial efforts within DH and the NHS are underway to ensure improvements within all these areas. This includes improving access to medical records, offering alternatives to court and improving the rules to encourage early settlement.

2.8 Although the proposals are DH led, it is expected they will also affect Wales given they involve changes to the Civil Procedures Committee rules. Welsh data has therefore been used in quantifying the impacts.

Description of options considered (including do nothing)

Option 0: Do nothing (base case)

2.9 These reforms have been introduced as part of the wider Jackson reforms to civil litigation. Significant reforms to the recoverability of legal costs were made as part of the Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPO) however the impact of these has been mixed. These include: ceasing to make success fees and ATE insurance premiums recoverable from unsuccessful opponents, the banning of referral fees from claims management companies, the removal of Legal Aid for clinical negligence cases and implementing 'qualified one way cost shifting'.

2.10 The do nothing option assumes the wider reforms are implemented.

Voluntary option

2.11 As has been mentioned before, it is widely recognised by stakeholders that the current process for clinical negligence claims does not work as well as it should. Combined with the pressure on Government finances, it is considered that a "Do Nothing" approach is not tenable. The Department will continue to implement the wider programme of improving patient safety and customer care, regardless of the outcome of this consultation.

2.12 Alternatives to these proposals have previously been explored by DH. For two years since 2011, NHS LA had been in discussions with organisations representing the claimant clinical negligence legal market to scope a voluntary lower value claims (up to £25,000) scheme. The objective was to speed and simplify the processes and ensure that patients who were due compensation received it promptly. There were a number of objections to the proposal, including

- the proposed upper limit of £25,000 was considered too high by some organisations;
- the level and methodology for FRC rates, which had been proposed by NHS LA;
- The absence of an agreement to apply costs sanctions where there was an unreasonable failure to participate.

2.13 As a consequence of these objections and the lack of progress it was decided that the only alternative was to develop proposals for a mandatory FRC scheme, which are being brought forward in this document.

2.14 The Department is also aware that some stakeholder groups are currently in discussion with the NHS LA about a voluntary FRC scheme. Any proposal put to Government by the legal profession would need to be carefully considered to determine whether f the Government's objectives would be fully met.

2.15 The Government takes the view that FRC should be introduced on a mandatory basis in order to avoid the potentially l uneven playing field which a voluntary scheme might create between claimant lawyers who sign up to it and those who do not. There would also need to be a consistent agreed definitions of:

- Costs to be included within FRC,
- How the FRC rates are to be calculated; and
- To which claims FRC would apply to (i.e. what would be the upper limit and whether there were any exemptions).

2.16 Any new system needs to be straightforward for all those involved to operate and having multiple processes could lead to confusion and inefficiencies within the claims process. This

leads to the conclusion that mandatory rules need to be introduced to set out the arrangements for processing clinical negligence claims and the appropriate recoverable costs. There are penalties to enforce compliance if the process is not followed.

Option 1: Introduce a mandatory Fixed Recoverable Costs (FRC) scheme for Clinical Negligence Claims (CNC)

2.17 The recommended option is to introduce FRC for claims above £1,000 and up to £25,000. Detailed analysis of time, grade and complexity of tasks were identified in the four tranches of damages to give a bottom up costings shown in Annex C .An independent report on the methodology used has been commissioned by DH and will be published alongside the consultation.

2.18 The proposals are aimed at incentivising settlement at an early stage and avoiding costly litigation. They are not intended to limit the resources that go directly to patients in compensation for injuries received due to clinical negligence.

2.19 It is proposed to have a limited number of specific exemptions from the FRC scheme which recognises there may be merit in paying claimant costs on a different basis on a number of cases of clinical negligence. Views on these will be sought during consultation

Costs and benefits – assumptions

2.20 This IA identifies both monetised and non–monetised impacts on individuals and business in England and Wales with the aim of understanding what the overall impact might be. It aims to value costs and benefits in monetary terms where possible; however there are significant gaps in our understanding of the quantified direct impacts on the private sector which we hope to improve during consultation and the impact on claimant numbers given recent reforms in litigation.

2.21 The LASPO reforms were intended to limit the growth in costs of clinical negligence cases, however the current evidence does not suggest that has been the case and the number of cases has increased from 6,652 claims in 2009/10 to roughly double that figure in 2014/15.

2.22 As we cannot be sure of the impact of the proposed reform on future claims volumes, we have made a simplifying assumption of applying the changes to the latest available data and summing over 10 years. This provides information on the relative impacts of the proposed options and a scale of possible savings over the medium term rather than definitive levels of savings to be realised.

2.23 For modelling purposes we have assumed that overall case characteristics i.e. duration, settlement stage, outcome of liability do not change. We have also assumed the willingness of a patient to make a claim and the willingness of a solicitor's firm to take on a claim does not change as a result of the proposals. Figures are presented separately for the first year following implementation and discounted based on a simplifying assumption of no behavioural change to the wider reforms. These are discussed in the risk section.

2.24 The costs and benefits have been identified for individual claimants, legal profession (mainly claimant solicitors who specialise in clinical negligence claims), and defendants (i.e. public and private sector insurers). These are summarised in the table below. (see note 6)

Table 5 Summary of costs and benefits

	COSTS	BENEFITS
Individual claimants	Reduction in costs awarded (direct, out of scope)	Utility from quicker resolution of cases and earlier payment of award (unquantified)
Legal profession (mainly claimant solicitors)	Potentially reduced income (indirect, not quantified)	Reduced negotiation and administrative costs (direct, in scope) More predictable fees (unquantified)
Defendants –public sector (taxpayer) insurers	Disutility from quicker resolution of cases and earlier payment of award (unquantified)	Reduced legal costs paid (direct, out of scope) Reduced negotiation and administrative costs (direct, out of scope)
Defendants - private insurers	Disutility from quicker resolution of cases and earlier payment of award (unquantified)	Reduced legal costs paid (direct, in scope) Reduced negotiation and administrative costs (direct, in scope)

2.25 **For individual claimants**, the key impact of the policy is to reduce amount of costs that can be recovered from defendant insurers. This is a direct impact of the policy on claimants but is out of scope in terms of regulatory impact as it does not affect businesses directly. It is an award made through courts.

2.26 **For the legal profession, i.e. claimant solicitors** the main benefit is the reduced negotiation and documentation costs involved in dealing with claims. This is a direct impact and in scope in terms of regulatory impact. Claimant solicitors are also likely to benefit from an increased predictability of cashflows from the fixing of recoverable costs, as highlighted in the independent report by Professor Fenn on evaluating proposals for FRC.

2.27 There could also be impacts on their income but this will depend on the behavioural response of the industry and claimants to any change. In the long run, as claimants bear a larger proportion of legal costs, this may change the number of claims that they choose to make. This in turn could put pressure on claimant solicitors to charge lower fees, and thus reduce the amount of income that they make. This is an indirect cost and given the number of unknown behavioural responses, it has not been quantified.

2.28 **For defendants**, the main benefit is cost savings from fixed recoverable legal costs. Savings to the public sector defendants i.e. NHS LA would be reinvested in the front line NHS services delivering healthcare benefits. This is defined as procurement spending by the public sector and therefore out of scope in terms of regulatory impact. Savings to the private sector on the other hand is a direct impact of the policy and therefore included in the regulatory impact estimates.

2.29 There are also likely to be administrative savings from reduced negotiation and documentation costs to both public sector and private sector insurers. These are direct impacts but only the latter are included in regulatory impact calculations.

2.30 The following table shows a summary of the quantified impacts. Costs are shown as negative amounts and benefits as positive values. All amounts are in 2015/16 £ million prices. The range on costs benefits reflect the upper/lower estimates outlined in Annex C. (see note 7)

Table 6 Summary – Quantified impacts of Fixed recoverable costs £m

		Direct impact on business	Total	Present value total
Costs				
Claimants	Costs awarded to claimants for legal costs incurred for negligence in NHS Providers	No	**- 710**	**-611**
Claimants	Costs awarded to claimants for legal costs incurred -non NHS Providers negligence	No	**-170**	**-146**
Total Costs			**--880**	**-757**
Benefits				
Public sector insurers - e.g. NHS LA	Savings from fixed recoverable costs on negligence in NHS Providers	No	**710**	**611**
Private sector insurers	Savings from fixed recoverable costs on negligence in non NHS Providers	Yes	**170**	**146**
Public sector insurers - e.g. NHS LA	Admin savings	No	**39.7**	**34.4**
Claimant solicitors	Admin savings	Yes	**66.1**	**56.8**
Total Benefits			**985.7**	**848**
Net Benefit, NPV			**106**	**91**
Net impact on business			**236.1**	**202.8**

Costs: The main costs are:

A: Costs to individual claimants

2.31 A key impact of the proposal is to shift costs from insurers to individual claimants to ensure they are aware of the legal costs incurred. It is assumed that the proposals will not impact on the overall willingness of an individual to bring about a claim since they are based on principal of removing distortions in recoverable legal fees rather than access to justice. In other words, the change affects costs recoverable from the opposing party. This is a direct impact therefore on individual claimants and is out of scope in the EANDCB calculation.

2.32 Indicative estimates of the impact using 2014/15 settlement volumes and costs suggest costs of approximately £88m pa (undiscounted), depending on the fixed rates applied. This equates to a discounted cost of £1,558m to £1,661m over 10 years on the assumption of no change from the 2014/15 position. These estimates are based on bottom up analysis of claims data from public sector defendants (from NHS LA and equivalent data from Wales).

2.33 For claims in the non NHS provider sector we have used NHS LA data to pro rata the impact. The figure (£35m) is therefore indicative of the likely impact rather than a robust evidence based assumption. A 12 week consultation will engage with the private sector to gain further evidence on the scale of impact and allow a robust estimate at final IA stage.

B: Cost to claimant solicitors

2.34 There will be no direct impact on claimant solicitors as the change affects the fees awarded by courts to individuals rather than solicitors. Any impact is likely to be indirect and based on behavioural response of the legal profession to changes in the level of legal fees awarded.

C: Cost to defendants- non monetised

2.35 It is expected that the proposals should involve cases being settled more quickly than would otherwise be the case. This would generate cash flow costs for defendants which may take the form of reduced investment income. This has not been monetised.

2.36 We have assumed there are no significant familiarisation costs for defendants or solicitors. The legal profession are familiar with the concept of fixed recoverable costs from other areas of negligence e.g. road traffic accidents and so are not expected to incur any significant upfront costs from the introduction of a similar scheme for clinical negligence. We will seek views on this during consultation.

Benefits

2.37 The main quantified benefits of FRC are a mirror of the main costs of the proposals. They fall on public defendants (e.g. NHS LA) and private insurers. (see note 8)

A: Benefits to individual claimants –non monetised

2.38 It is expected that the proposal should involve claims being settled more quickly than would otherwise be the case. This would provide claimants with increased benefits from having earlier access to damages awards which could be invested creating increased wealth. This impact has not been monetised.

B: Benefits to claimant solicitors

2.39 The Jackson report suggests “a fixed costs regime is bound to generate business process efficiencies in the form of reduced management costs or overheads”. The proposals are expected to result in less time spent by claimant solicitors in negotiating costs or maintaining documentation for cost assessment, generating time and cost savings.

2.40 Using NHS LA costs of commissioning cost negotiators as a proxy, we expect the savings to be in the region of £10m pa. This has not been tested with the legal profession so is an indicative estimate. It is based on assuming the savings for claimant solicitors will be

higher than defendant solicitors (£6m) because they spend longer on average preparing/defending legal costs. Evidence on this will be asked during consultation.

2.41 FRC regime will also enable claimant solicitors to plan better as there will be a more predicable outcome in monetary terms for cases below the threshold. The system will also incentivise earlier resolution of cases, which should reduce their time and effort in lower value cases. This is a non monetised benefit. We will seek views on the impact of this during consultation. (see note 9)

C: Benefits to defendants (insurers) - overall

2.42 Benefits accrue to the taxpayer and to private sector insurers who provide indemnity cover. The benefits to defendants are a mirror of the costs to individual claimants. The proposals represent a transfer of recoverable legal costs (savings) from the defendants to individual claimants who may or may not absorb the differential.

2.43 Indicative estimates of the impact using 2014/15 settlement volumes and costs suggest savings of approximately £88m pa (undiscounted), depending on the fixed rates applied. (This equates to a discounted benefit of £1,558m to £1,661m over 10 years on the assumption of no change from the 2014/15 position. These estimates are based on a bottom up assessment of claims data from public sector insurers (NHS LA and Wales) and a top down assessment of the impact on private sector insurers (who cover primary care and independent healthcare providers). (See note 10).

2.44 The high level approach to quantifying the impact on private sector is because of lack of detailed data from this sector. We believe the impact is likely to be positive for insurers i.e. result in savings and so reduce costs to business i.e. deregulatory impact. There may also be impacts on healthcare providers themselves over and above any impact on insurers and this is something which will be explored during consultation.

2.45 In order to provide an indicative estimate for the purposes of the consultation IA, we have used NHS LA savings based on £75bn activity income (source = NHS Accounts 2014/15) to pro rata the impact on non NHS provider spend of approximately £18bn. Assuming likelihood of claims is similar to NHS providers, this suggests savings of £17m pa (= (18/75)*£71m). This figure should be used with a high degree of caution; it is provided for illustrative purposes of the likely positive impact on private insurers from the proposal and will be explored during consultation.

2.46 Defendants are also expected to make savings from reduced administration of cases and negotiation of costs. Using the current NHS LA negotiation contract as a proxy for negotiation costs suggest savings of around £6m pa for the public sector.

Net Impact of Option 1

2.47 Individual claimants are likely to be adversely affected by this proposal which seek to restrict the legal fees they can reclaim, whereas defendants –both public and private sector are likely to benefit from it. This cost shifting may have economic welfare benefits if the resource allocation resulting from this proposal is more in line with society's preference. In addition to the transfer there is estimated to be an efficiency gain as the same outcome is achieved at lower overall cost. Overall we estimate there to be a positive NPV of £91m based on the savings from reduced administrative costs.

Risks and sensitivities

2.48 We have assumed no impact on case volumes, case outcomes and settlements. There is a risk however that claimant solicitor might be less willing to take on cases which are

relatively more expensive to pursue and/or individuals will be less likely to make a claim due to wider reforms in litigation and clinical negligence. Whilst we expect there might be changes at an individual case level with some firms exiting the market, we assume that other firms will enter or existing firms might expand given the fair return provided under the proposals so in aggregate there is no change.

2.49 We have modelled the impact of different claims growth scenarios compared to base case of 0% due to the uncertainty around this assumption. This suggests the impact could be significantly greater than the base case.

Wider impacts – Small and Micro Business Assessment (SaMBA)

2.50 The consultation will gather evidence on the shape of the clinical negligence market. Currently we only have data for the legal profession as a whole. Small legal firms are likely to be disproportionately affected by the reforms. The market is dominated by a high number of firms with less than 10 partners – over 95% firms hire between 1 and 10 employees and a majority of firms counts between one to four partners. We have considered the number of solicitors as a proxy for number of employees as we do not have the data. By using this proxy, we estimate that 58% of solicitors are likely to be working in small and medium legal firms. The number of sole practitioners has increased by 20% since 2010. The barriers to entry are considered to be low; the only significant one is the professional qualification required to practice as a solicitor

Table 7 Number of firms and number of solicitors, analysed by size of practice

Number of Partners	Number of firms	As a %age of all Legal Practices	Number of Solicitors	As a %age of all Solicitors at Legal Practices	%age change in number of solicitors since 2010
Sole Practitioner	4,271	45%	8,084	9%	20%
2-4 partners	3,952	41%	20,396	23%	2%
5-10 partners	851	9%	13,361	15%	2%
11-25 partners	286	3%	10,207	11%	-6%
26-80 partners	121	1%	13,287	15%	-16%
81+ partners	61	1%	24,972	28%	23%
All firms	9,542	100%	90,306	100%	4%

Source: Statistical Report 2014 – The Law Society.

2.51 Recent anecdotal evidence suggests there has been an influx of new firms into clinical negligence market as FRC has been introduced in other sectors e.g. road traffic accidents, public liability and Employer liability cases. There are some voluntary accreditation schemes for clinical negligence lawyers but there are no incentives for lawyers or firms to join. However, we want to examine how these schemes work in practice.

2.52 Additionally the proposals are expected to increase the opportunities for mediation and ADR forms as alternative to litigation are encouraged.

2.53 We have considered whether it would be possible to exempt small legal firms from these proposals. However we have concluded that this would be impossible both from a practical point of view and because it would reduce the efficacy of the proposals and distort the market. This would also reduce claimant choice.

Annex A – Post Implementation Review (PIR) Plan

1. **Review status:** Please classify with an 'x' and provide any explanations below.

	Sunset clause		Other review clause	x	Political commitment		Other reason		No plan to review

It will be important to review the policy here and ensure that it is delivering the intended outcomes and (a) improving the cost to damages ratio for claimant solicitor costs and (b) improving the claimant to defendant costs ratio. In addition there will be a political desire to ensure access to justice is maintained. This should occur 5 years after implementation to enable the effects to be measured. This will follow along similar lines of the review of the RTA policy by MOJ that then extended the policy to cover employer liability and public liability and lifted the threshold from £10,000 to £25,000.

2. Expected review date (month and year, xx/xx):

10	21	/		

Rationale for PIR approach:

Describe the rationale for the evidence that will be sought and the level of resources that will be used to collect it.

- **Will the level of evidence and resourcing be low, medium or high? (See Guidance for Conducting PIRs)**

(The PIR guidance states that the strength of evidence sought for PIRs should be proportionate to the scale of the regulation and its expected impact).

The evidence would be sought through NHS LA based on the available claims data over the period of the Fixed Recoverable Cost regime

- **What forms of monitoring data will be collected?**

What forms of monitoring data were collected? – Claims data and in addition probably qualitative data from claimant and defendant lawyers on the implications through key stakeholder groups.

What evaluation approaches were used?– will use Impact assessment mainly, but also socio-economic implications to ensure access to justice was maintained
How have stakeholder views been collected? - feedback mechanisms, consultations and some research potentially.

- **What evaluation approaches will be used? (e.g. impact, process, economic)**

We will need to use a variety of evaluation approaches including impact on improved cost to damages ratio for claimant solicitor costs and improved claimant to defendant costs ratio – which will be evidenced by factual data from NHS LA claims data – but also we need to look at the impact on access to justice and improvements in patient safety and customer care to support the system.

Important also to look at the economics and consider if the threshold should be increased or decreased based on the access to justices and improvements.

- **How will stakeholder views be collected? (e.g. feedback mechanisms, consultations, research)**

We will utilise feedback mechanisms for members, for other providers of cover so MDOs, the professional bodies and key stakeholders engaged in representing both defendant and claimant lawyers.

Annex B – NPV cost calculation

Assumptions

- 10 year appraisal period – 2015/16 to 2024/25
- 3.5% discount rate applied to financial savings; 1.5% discount rate applied to QALY health gains
- 0% claims growth – to be tested in consultation
- The number of claims is based on 2014/15 claims data covering England and Wales.
- An estimate for the average claimant solicitor fee has been calculated using 2014/15
- The expected legal cost is calculated by multiplying the number of settled claims by the average expected claimant solicitor fees.
- Savings to defendants are based on opportunity cost of QALYs. Assumes marginal cost per QALY is £15,000 and the societal value of QALYs is £60,000

If the financial savings for NHS Litigation Authority and other health providers were ploughed back into front-line healthcare, these could be used to generate additional quality of life benefits for patients. These would generate much greater societal value as shown in table below. However, as these are indicative figures only, they have not been used for the NPV calculations.

Option 1 Quality-Adjusted Life Year (QALY) Analysis

Option 1	Option A
2015/16	£70,947,898
2016/17	£68,548,693
2017/18	£66,230,622
2018/19	£63,990,939
2019/20	£61,826,994
2020/21	£59,736,226
2021/22	£57,716,160
2022/23	£55,764,406
2023/24	£53,878,653
2024/25	£52,056,670
Total (discounted)	**£610,697,261**

Annex C – Proposed Fixed Cost Rates

We are consulting on two options to set the level of FRC reimbursements in the accompanying consultation document. These have been externally reviewed by Professor Fenn and confirms that the work undertaken by the DH to underpin the FRC reimbursements has been thorough and informative. His report will be published alongside the consultation document.

Option 1: Current GHRs:

We estimated the amount of time required at each stage based on the available data and took account of the new streamlined processes, and applied this to the current Guideline Hourly Rates (GHRs). This produced the results as set out in Table 7.

Table 7: FRC Rate Option 1: Current GHRs

Stage	Maximum Reimbursement
Pre-issue	**£3,000**
Post-issue/pre-allocation	**£3,900**
Post-allocation/pre-listing	**£5,650**
Post-listing	**£7,150**
Expert Witness Fees (see Chapter 6)	**£1,200**
Notes: Factual Witness Costs, Trial Court 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). Based on GHR National 1 rate.	

Option 2: Cost Analysis Approach

The second option (for which we do not have indicative rates) is to use the current costs reduced by the new streamlined processes in the FRC regime introducing greater efficiency into the scheme. This will take into account claims that have not been taken forward by claimant lawyers but on which they will have incurred costs. This would require more work and we have commissioned Professor Fenn to undertake this work**.**

Notes and References

Note	Para	Comment
1	1.7	Medical Defence Organisations (MDOs) are not for profit mutual organisations that provide indemnity for individual clinicians working in primary care and private sector. For example GPs, locum and salaried GPs as well as doctors undertaking private work or working in independent hospitals not covered by the NHS schemes. There are 3 MDOs operating in UK, and the 2 biggest, Medical Defence Union and Medical Protection Society dominate this sector
2	1.8	DWP Compensation Recovery Unit (CRU) data available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/424356/cases-registered-cru-2014-15.csv/preview
3	1.11	Data Sources: The UK private health market , The King's Fund 2014 and NHS Group accounts
4	1.17	https://www.dhsspsni.gov.uk/news/statistical-press-release-clinicalsocial-care-negligence-cases-northern-ireland-201415
5	1.23	The data source for Figures 3, 4, 5 is the NHS LA Annual Account 2014/15
6	2.23	Evaluating the proposed fixed costs for clinical negligence claims by Professor Fenn published as Annex C of the FRC consultation document.
7	2.29	This range may be overinflated as the case numbers include pre-LASPO cases that were submitted in 2014.
8	2.36	Jackson Report: https://www.judiciary.gov.uk/wp-content/uploads/JCO/Documents/Reports/jackson-final-report-140110.pdf
9	2.40	This range may be overinflated as the case numbers include pre-LASPO cases that were submitted in 2014.
10	2.42	The independent acute healthcare sector in England is approximately 7% (£5bn) of the total income of NHS Providers income whilst primary care spend (excluding prescribing) is around 18% (£13bn).Source Kings Fund, NHS accounts