



Department  
of Health &  
Social Care

# **Fixed recoverable costs in lower value clinical negligence claims**

**A consultation**

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# Foreword

The events of the last two years have shown more than ever before how valued an institution the NHS is, and how much we rely on it. As we begin to emerge from the coronavirus pandemic and its effects, our focus is on ensuring people's healthcare needs continue to be met and that NHS resources are used to best effect.

Throughout this period of significant challenge, the NHS has continued to strive for excellence in patient safety and in its response to harm, building on the sustained focus we have brought to these issues. When things go wrong with some aspect of the treatment and care people receive from the NHS and people suffer harm as a result, the NHS is committed to learning from what's happened and being honest and frank with patients and families.

And if the harm suffered was due to negligence, those harmed are entitled to receive compensation.

At the same time, we know that the cost of clinical negligence claims has risen substantially and is continuing to rise. In 2006/7, the cost was £582 million. In 2020/21, the cost had risen to £2.2 billion<sup>1</sup>. These costs are paid by the NHS and ultimately the taxpayer, money that could otherwise be spent on delivering and improving frontline healthcare services. Legal costs are a significant part of the increase. Over the same period, legal costs rose fourfold<sup>2</sup> and in 2020/21, made up 27% of the total cost of clinical negligence<sup>3</sup>. This is despite the number of claims remaining relatively stable in recent years.

Claimant costs are much higher and have risen more quickly than defendant costs over the same period and the legal costs associated with low value claims are disproportionately high. In 2020/21, the average legal costs recovered from the NHS by claimant lawyers was twice the average amount paid out in damages to claimants, for lower value clinical negligence claims<sup>4</sup>.

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<sup>1</sup> NHS Resolution (2021). *Annual Statistics (Supplementary Annual Statistics, Table 1A)*. London, NHSR. Accessed online at: <https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Supplementary-Annual-Statistics-2020-21.xlsx>

<sup>2</sup> NHS Resolution (2021). *Annual Statistics (Supplementary Annual Statistics, Tables 5A. & 7A)*. London, NHSR. Accessed online at: <https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Supplementary-Annual-Statistics-2020-21.xlsx>

<sup>3</sup> NHS Resolution (2021). *Annual Statistics (Supplementary Annual Statistics, Tables 1A, 5A, & 7A)*. London, NHSR. Accessed online at: <https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Supplementary-Annual-Statistics-2020-21.xlsx>

<sup>4</sup> NHS Resolution (2021). *Annual Statistics (Supplementary Annual Statistics, Tables 9A & 11A.1)*. London, NHSR. Accessed online at: <https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Supplementary-Annual-Statistics-2020-21.xlsx>

We also know that lower value clinical negligence claims can take too long to resolve and would benefit from a streamlined process to speed fair resolution. Over the last 10 years, average claim duration has increased by 46% to 1.3 years for lower value clinical negligence claims, which have seen the greatest rise.

Sir Rupert Jackson recognised these problems in 2017 and recommended that the Civil Justice Council (CJC) should develop a bespoke, streamlined system of fixed recoverable costs (FRC) to address them. This echoed the outcome of our previous 2017 consultation on fixed costs for clinical negligence claims and the government commissioned the CJC to undertake this work.

This consultation sets out our proposals, aligning closely with the work done by the CJC, to implement an FRC scheme for low value clinical negligence claims. Our aim throughout has been to design a scheme that lowers the legal costs of these claims and speeds their resolution, so that people who are eligible to receive compensation do so quickly and without the stress of drawn-out litigation. Our analysis suggests these proposals could save £454 million over the first 10 years. As the vast majority of clinical negligence claims relate to NHS care, this represents a significant annual saving to the NHS budget. By achieving faster resolution at lower cost, we would save money that could otherwise have been spent on delivering and improving vital NHS frontline services.

We have been mindful throughout that any FRC scheme we propose must be straightforward to understand and navigate, and workable and fair for claimants and defendants alike. We have ensured our proposals are carefully tailored to claims with lower financial value. We have also taken care to ensure our proposals do not impede people's access to justice so that people harmed negligently can benefit from our proposed reforms.

I encourage you to send in your comments on our proposals to implement these reforms which I believe would represent a step change improvement in resolving clinical negligence claims.

**Maria Caulfield MP, Parliamentary Under-Secretary of State for Primary Care and Patient Safety**

# 1. Executive summary

## Introduction

The course of the coronavirus (COVID-19) pandemic has highlighted now more than ever the importance of supporting the NHS and ensuring it has the resources to deliver the frontline care we need.

The rising costs of clinical negligence claims are unsustainable and take much needed resources away from NHS frontline services. We are committed to addressing this, in part, by streamlining the legal process for “lower value” clinical negligence claims<sup>5</sup> and introducing fixed costs. Our objective is to create a faster, fairer and more cost-effective system that benefits claimants and defendants and reduces the costs to the NHS.

This consultation seeks views on the government’s proposal to introduce a mandatory system of fixed recoverable costs (FRC) in lower value clinical negligence claims. FRC is a mechanism by which the recoverability of legal costs by claimants is fixed in advance by reference to a table of recoverable costs that apply to all cases within the scope of the scheme.

The proposed streamlined FRC scheme would apply to clinical negligence claims relating to medical treatment provided by NHS, non-profit and private healthcare providers in England and Wales, but would not apply in Scotland or Northern Ireland.

These proposals are part of a broader package of reforms to extend fixed recoverable costs in civil cases. In July 2017, Sir Rupert Jackson, a former judge of the Court of Appeal, published his report on extending fixed recoverable costs.<sup>6</sup> That report was produced at the request of the senior judiciary and the government. It led to a 2019 consultation by the Ministry of Justice (MoJ) on extending FRC to all cases (excluding clinical negligence) within the fast track up to £25,000, as well as implementing a new regime for ‘intermediate’ (currently multi-track) cases up to £100,000. In September 2021, the MoJ published its next steps in implementing an FRC scheme working with the Civil Procedure Rule Committee to ensure the smooth delivery of these reforms.

The proposal to introduce FRC for lower value clinical negligence claims is a key part of the government’s approach to address the rising costs of clinical negligence and ensure

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<sup>5</sup> “Lower value claims”, as referred to in this document and within the definition for claims included in this FRC scheme, are clinical negligence claims where the value is estimated to be in excess of the small claims limit for non-road traffic accident (RTA) personal injury claims, up to £25,000. The current small claims limit for personal injury claims (non-RTA), is £1,000. This is set to rise to £1,500 in April 2022. However, certain unusually complex claims with an estimated value below the small claims limit may also be included in the FRC scheme, as set out in chapter 6 of this consultation document.

<sup>6</sup> Sir Rupert Jackson (2017). *Review of Civil Litigation Costs: Supplemental Report – Fixed Recoverable Costs*. London, Judiciary of England and Wales. Accessed online at: <https://www.judiciary.uk/publications/review-of-civil-litigation-costs-reports/>.

greater consistency and fairness for claimants and defendants (predominantly the NHS) when people have been harmed.

As noted by the National Audit Office in 2017, the overall cost of clinical negligence claims has risen substantially and is continuing to rise.<sup>7</sup> Between 2006/7 and 2020/21, this cost rose fourfold from £0.6 billion to £2.2 billion.<sup>8</sup> Most of these costs are borne by the NHS, with the increases placing significant strain on NHS budgets that could otherwise have been spent on frontline healthcare services.

Legal costs represent a sizeable proportion of this rise. The total legal costs (claimant and defendant) of bringing and processing clinical negligence claims have grown dramatically from £152 million in 2006/7 to £582 million in 2020/21, making up 27% of total clinical negligence costs.<sup>9</sup> Since 2013/14, the volume of claims has remained broadly stable, but despite this, in the period from 2013/14 to 2020/21, legal costs nearly doubled (from £333 million to £582 million.)<sup>10</sup>

For lower value clinical negligence claims (valued at £1,001 to £25,000), the average claimant legal cost per claim doubled from £10,121 in 2006/7 to £22,124 in 2020/21 and average claimant legal costs per claim in 2020/21 were more than 4 times those of average defendant legal costs per claim.<sup>11</sup> And claimant legal costs are also disproportionate to levels of compensation: the average claimant legal cost for the £1,001 to £25,000 value band was twice the average amount paid out in damages to claimants, in 2020/21.<sup>12</sup>

The rise in costs has levelled out in recent years: there are indications that there may have been a cost levelling effect from 2016/17 to 2019/20 when average claimant legal costs remained broadly stable.<sup>13</sup> Research in 2019 has even indicated a reduction in costs

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<sup>7</sup> National Audit Office Comptroller and Auditor General (2017). *Managing the Costs of Clinical Negligence in Trusts*. London, NAO, p.6. Accessed online at: <https://www.nao.org.uk/report/managing-the-costs-of-clinical-negligence-in-trusts/>.

<sup>8</sup> NHS Resolution (2021). *Annual Statistics (Supplementary Annual Statistics, Table 1A)*. London, NHSR. Accessed online at: <https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Supplementary-Annual-Statistics-2020-21.xlsx>.

<sup>9</sup> NHS Resolution (2021). *Annual Statistics (Supplementary Annual Statistics, Tables 1A, 5A & 7A)*. London, NHSR. Accessed online at: <https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Supplementary-Annual-Statistics-2020-21.xlsx>.

<sup>10</sup> NHS Resolution (2021). *Annual Statistics (Supplementary Annual Statistics, Tables 5A & 7A)*. London, NHSR. Accessed online at: <https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Supplementary-Annual-Statistics-2020-21.xlsx>.

<sup>11</sup> NHS Resolution (2021). *Annual Statistics (Supplementary Annual Statistics, Table 11A.1)*. London, NHSR. Accessed online at: <https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Supplementary-Annual-Statistics-2020-21.xlsx>.

<sup>12</sup> NHS Resolution (2021). *Annual Statistics (Supplementary Annual Statistics, Tables 9A & 11A.1)*. London, NHSR. Accessed online at: <https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Supplementary-Annual-Statistics-2020-21.xlsx>.

<sup>13</sup> NHS Resolution (2021). *Annual Statistics (Supplementary Annual Statistics, Table 11A.1)*. London, NHSR. Accessed online at: <https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Supplementary-Annual-Statistics-2020-21.xlsx>.

following the [Legal Aid, Sentencing and Punishment of Offenders Act 2012](#).<sup>14</sup> Most recently, from 2019/20 – 2020/21, we have seen average claimant costs increase again, by approximately 6% (£20,858 to £22,124).<sup>15</sup> Despite these more recent fluctuations in the trend, clinical negligence claimant legal costs remain historically high, especially for the lower value band, and disproportionately high in relation both to defendant costs and to compensation levels.

We believe that the cost savings we expect as a result of implementation of our proposals would represent an important contribution towards addressing the overall rise in clinical negligence costs.

The aim of our streamlined FRC scheme is to promote and enable quicker, more proportionate and more cost-effective resolution of lower value clinical negligence claims so that people who have experienced harm can receive compensation more quickly and the delays, distress and avoidable legal costs associated with these claims are reduced.

We consulted on FRC for lower value clinical negligence claims in 2017.<sup>16</sup> A number of respondents to that consultation said that the success of any FRC scheme would require the development of an appropriate streamlined process to resolve claims quickly and fairly. Sir Rupert Jackson subsequently recommended that the Civil Justice Council (CJC) should design a streamlined process and appropriate cost levels to support an FRC scheme.<sup>17</sup>

Following Sir Rupert Jackson's recommendation, the Department of Health and Social Care (DHSC) and the MoJ jointly commissioned the CJC to look at low value clinical negligence claims in detail and design a bespoke streamlined process and grid of fixed costs for these claims. The CJC's report was published in October 2019 and represents a broad consensus of the members of its working group on improving the handling of clinical

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<sup>14</sup> Fenn, Paul and Rickman, Neil (2019). *The Impact of Legislation on the Outcomes of Civil Litigation: An Empirical Analysis of the Legal Aid Sentencing and Punishment of Offenders Act 2012*. Accessed online at: <http://dx.doi.org/10.2139/ssrn.3326665>.

This research was cited in the 2019 Post Implementation Review of LASPO Part 2 as evidence of a potential downward effect on clinical negligence legal costs: Ministry of Justice (2019). *Post-Implementation Review of Part 2 of the Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPO): Civil litigation funding and costs*, p.40. Accessed online at: <https://www.gov.uk/government/publications/post-implementation-review-of-part-2-of-laspo>

<sup>15</sup> NHS Resolution (2021). *Annual Statistics (Supplementary Annual Statistics, Table 11A.1)*. London, NHSR. Accessed online at: <https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Supplementary-Annual-Statistics-2020-21.xlsx>.

<sup>16</sup> Department of Health (2017). *Introducing Fixed Recoverable Costs in Lower Value Clinical Negligence Claims*. London, DHSC. Accessed online at: <https://www.gov.uk/government/consultations/fixed-recoverable-costs-for-clinical-negligence-claims>.

<sup>17</sup> Sir Rupert Jackson (2017). *Review of Civil Litigation Costs: Supplemental Report – Fixed Recoverable Costs*. London, Judiciary of England and Wales. Accessed online at: <https://www.judiciary.uk/publications/review-of-civil-litigation-costs-reports/>.

negligence claims with a value of up to £25,000.<sup>18</sup> We have considered these proposals in detail while developing the proposals in this consultation.

Our proposals have been informed and shaped by what we learned from respondents to the 2017 consultation. A summary of these issues and how they have been taken into account in the current proposals is at chapter 4.

This consultation seeks views on our proposals for a fully workable FRC scheme, which closely follow the recommendations of the CJC report. If implemented, the FRC scheme proposals we are consulting on would be provided for in the Civil Procedure Rules (CPR). Changes to the rules are implemented following detailed consideration by the CPR Committee.

## Summary of proposals for change

Fixed recoverable cost schemes have already been introduced in most other categories of personal injury claims valued at up to £25,000 damages, including road traffic accidents, employers' liability and public liability. Clinical negligence is one of the last areas of personal injury to be reformed, and the government agrees with Sir Rupert Jackson's conclusion in his report that there is a strong rationale to introduce reforms.

The aim of our proposed FRC scheme is to enable more claims to be resolved more quickly, at lower, more proportionate cost and increase the proportion of claims that can be resolved before involving the courts.

The CJC identified a number of ways in which the current system could be improved to achieve these aims. In designing our FRC scheme, we have aligned closely with the suggestions made by the CJC, recognising that the conclusions expressed in the CJC report were arrived at with input from both claimant and defendant positions and represent a significant joint effort.

These proposals have also been informed by extensive engagement with interested parties and work commissioned from Professor Fenn of Nottingham University Business School. This included an independent review in 2017, a follow-up report in 2018, in relation to DHSC's earlier consultation on fixed recoverable costs for clinical negligence claims, and work done by Professor Fenn to support the CJC working group's report in 2019.<sup>19</sup>

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<sup>18</sup> Civil Justice Council (2019). *Fixed Recoverable Costs in Lower Value Clinical Negligence Claims. Report of the Civil Justice Council Working Group*. London, Courts and Tribunals Judiciary. Accessed online at: <https://www.judiciary.uk/related-offices-and-bodies/advisory-bodies/cjc/archive/fixed-recoverable-costs-in-lower-value-clinical-negligence-claims/>.

<sup>19</sup> 1) Professor Paul Fenn (2017). *Evaluating the proposed fixed costs for clinical negligence claims: An Independent Review*. London, DHSC.



This consultation invites views on proposals for a mandatory FRC scheme for lower value clinical negligence claims according to the definition set out in footnote 5 above and at chapter 6.

The positions on which views are sought on the key features of the scheme are set out in chapter 5 and discussed in detail in chapters 5 to 14. The questions we are seeking views on in this consultation are set out at chapter 17 and information on how to respond is at chapter 18.

The government will carefully consider responses to this consultation and provide a full response. Analysis of the responses will help the government in its consideration of next steps, should the scheme be implemented.

## Conclusion

The government is seeking views on proposals to introduce a streamlined mandatory FRC scheme for lower value clinical negligence claims with grids of fixed costs. The scheme would be implemented through revised Civil Procedure Rules. The aim of our proposals is to support timely and cost-effective resolution and ensure that the legal costs of claims are more proportionate.

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2) Professor Paul Fenn (2018). *Fixed Costs for Clinical Negligence Claims: A Cost Analysis Approach*. London, DHSC.

3) Subsequent analysis undertaken to support the CJC working group process, published as Appendix B of Civil Justice Council (2019). *Fixed Recoverable Costs in Lower Value Clinical Negligence Claims. Report of the Civil Justice Council Working Group*.

## 2. Rationale for reform

### The legal costs of clinical negligence claims - the current system

When a claim brought against the NHS (or a not-for-profit or private healthcare provider), is successful, the claimant is usually entitled to recover legal costs from the defendant.

Under the current system, in lower value clinical negligence claims (between £1,001 and £25,000) these legal costs often end up being disproportionately high relative to the overall value of the damages awarded, and in comparison with the defendant's legal costs.

Claims of clinical negligence against all NHS Trusts and NHS Foundation Trusts in England and other similar bodies commissioned to provide services under a NHS Standard Contract are handled primarily under the [Clinical Negligence Scheme for Trusts](#) (CNST). The [Clinical Negligence Scheme for General Practice](#) (CNSGP) covers clinical negligence liabilities arising in general practice in relation to incidents that occurred on or after 1 April 2019. A further scheme, the [Existing Liabilities Scheme for General Practice](#) (ELSGP), was established in 2020 to provide indemnity cover for NHS clinical negligence claims made against current and former GP members of medical defence organisations (MDOs) in respect of liabilities incurred before 1 April 2019. The CNST, the CNSGP and the ELSGP are operated by NHS Resolution.

MDOs and private insurance schemes provide indemnity for private healthcare, as well as some historical GP liabilities and operate throughout the UK.

In the NHS in Wales, NHS clinical negligence claims are administered by the NHS Wales Shared Services Partnership and there is a risk-pooling system to manage clinical negligence liabilities.

Recoverable legal costs are based on a guideline hourly rate and the number of hours worked. As such they are geared to generate greater rewards for those who do more work that takes longer. Courts can and do depart from these guidelines where appropriate so there is a wide degree of variation in cost awards from case to case and the legal costs of lower value claims often escalate to more than double the value of the claim. This variability typically affects claimant legal costs, since it is already relatively common for clinical negligence defence lawyers to work within a fixed fee arrangement.

Claims also take a long time on average to settle, through a drawn-out, variable and, at times, cumbersome process. The average claims duration (from notification to resolution), for lower value clinical negligence claims, was 1.3 years in 2020/21, a 46% increase from

2010.<sup>20</sup> Sometimes, this involves recourse to the courts which in some cases could have been avoided. These factors delay awards of compensation to people injured as a result of negligent treatment and risk increasing the stress associated with prolonged litigation.

In civil proceedings in England and Wales, the general position is that the losing party pays the legal costs of the winning party. Since 2013, for clinical negligence claims, qualified one-way costs shifting (QOCS), has meant that, in most circumstances, only claimants can recover their legal costs. Whilst this means that claimants are protected from having to pay legal costs, it also means there is little market motivation to keep the costs low.

Our proposed FRC scheme recognises that there is an existing imbalance of risks between claimants and defendants and a corresponding imbalance in incentives to keep costs and delay at a minimum. Our aim is to reduce these costs and delays throughout the claims process through a structural reform that ensures all parties are motivated to process claims efficiently and cost-effectively, so that all parties can benefit from early resolution.

## The case for change

### The rising cost of claims

Overall clinical negligence costs have risen rapidly in recent years, beyond the rate of inflation. This is despite our extensive patient safety programmes. In 2006/7, the overall cost of clinical negligence was £0.6 billion: in 2020/21, the total cost was £2.2 billion,<sup>21</sup> which represents approximately 1.5% of the overall NHS budget.<sup>22</sup>

In 2017, the National Audit Office (NAO) published “[Managing the costs of clinical negligence in trusts](#).” This report identified three key drivers of cost in clinical negligence - the volume of claims, claimant lawyer costs, and damages awarded to claimants.<sup>23</sup> Since the NAO’s report, the landscape of clinical negligence claims has changed slightly. The overall volume of claims has plateaued, but remains high, whilst damages have remained

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<sup>20</sup> NHS Resolution (2021). *Annual Statistics (Supplementary Annual Statistics, Table 17A)*. London, NHSR. Accessed online at: <https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Supplementary-Annual-Statistics-2020-21.xlsx>

<sup>21</sup> NHS Resolution (2021). *Annual Statistics (Supplementary Annual Statistics, Table 1A)*. London, NHSR. Accessed online at: <https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Supplementary-Annual-Statistics-2020-21.xlsx>

<sup>22</sup> HMT (2021). *Public Expenditure Statistical Analyses 2021*. “NHS England - Departmental Expenditure Limits, 2016-17 to 2021-22”. (p18, paragraph 1.31). London, HMT. Accessed online at: <https://www.gov.uk/government/statistics/public-expenditure-statistical-analyses-2021>.

<sup>23</sup> National Audit Office Comptroller and Auditor General (2017). *Managing the Costs of Clinical Negligence in Trusts*. London, NAO. Accessed online at: <https://www.nao.org.uk/wp-content/uploads/2017/09/Managing-the-costs-of-clinical-negligence-in-trusts.pdf>.

on an upward trajectory.<sup>24</sup> We have set out analysis of the drivers of cost in written evidence to the Health and Social Care Select Committee inquiry into NHS Litigation Costs.<sup>25</sup> We continue to work across government to explore these issues.

This consultation sets out our proposed approach to tackling the legal costs element of this rise. Legal costs, particularly the costs incurred by claimant lawyers, have risen in their own right over the last decade and a half, and though costs have levelled out more recently, they remain at a historically high level.<sup>26</sup> Claimant legal costs also remain disproportionately high compared to defendant costs. NHS Resolution negotiates large-scale contracts with defendant panel firms for its legal services, including fixed and capped fee arrangements, competitive hourly rates and performance management. These factors work to control the costs of defendant legal services, ensuring value for money and a high-quality service. At the same time, we recognise that there are features of this work that are specific to claimant lawyers, but we do not believe this accounts for all the difference. In 2020/21, average recoverable claimant legal costs per claim in the £1,001 - £25,000 claims bracket were, at £22,124 per claim, more than 4 times the average defendant legal costs incurred per claim (£4,903).<sup>27</sup>

In part, our proposals are aimed at controlling these claimant legal costs which represents a high, ongoing burden on the NHS and the taxpayer, at a time when the overall volume of claims is not rising.

## Objectives for reform

Our policy intent in proposing implementation of an FRC scheme is to ensure claims are processed quickly, fairly, and cost-effectively, at a cost that is more proportionate to the value of the claim.

These proposals form part of a broader package of reforms to extend FRC costs in civil cases. They are in line with work being carried out by the Ministry of Justice which, following recommendations by Sir Rupert Jackson, consulted in 2019 on extending FRC to all cases (excluding clinical negligence) within the fast track up to £25,000, as well as implementing a new regime for 'intermediate' (currently multi-track) cases up to £100,000. In September 2021, the Ministry of Justice published its next steps in implementing an

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<sup>24</sup> NHS Resolution (2021). *Annual Statistics (Supplementary Annual Statistics, Tables 1A & 4A.1)*. London, NHSR. Accessed online at: <https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Supplementary-Annual-Statistics-2020-21.xlsx>.

<sup>25</sup> Department of Health and Social Care (2021). *Department of Health and Social Care Evidence Submission to the Health and Social Care Committee Inquiry into NHS Litigation Reform*. HC 740. London, House of Commons. Accessed online at: <https://committees.parliament.uk/writtenevidence/40836/pdf/>.

<sup>26</sup> NHS Resolution (2021). *Annual Statistics (Supplementary Annual Statistics, Table 5A)*. London, NHSR. Accessed online at: <https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Supplementary-Annual-Statistics-2020-21.xlsx>.

<sup>27</sup> NHS Resolution (2021). *Annual Statistics (Supplementary Annual Statistics, Tables 11A.1 & 13A.1)*. London, NHSR. Accessed online at: <https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Supplementary-Annual-Statistics-2020-21.xlsx>

FRC scheme working with the Civil Procedure Rule Committee to ensure the smooth delivery of these reforms.

## Proportionality

Claim costs are high relative to the amount of compensation sought in the claim. This is particularly true of lower value clinical negligence claims. We know that, in 2020/21, claimant legal costs in the £1,001 to £25,000 bracket were more than twice the average amount awarded in damages (£22,124 average legal costs compared with £11,198 average damages awarded), a gap that has also steadily widened over the years.<sup>28</sup>

Our proposals set limits on these costs. We want to ensure that taxpayers (who pay for successful claims against the NHS, and for defendant fees in all cases, whether or not the claim is successful) as well as claimants, are well served by a rapid, efficient system for these claims, based on a careful assessment of the work involved and reasonable costs for that work.

## Time taken to resolve claims

Currently, too many lower value clinical negligence claims take a long time to resolve, despite progress made to reduce delays in recent years. The longer cases take to settle, the greater the risk of potential distress felt by patients and their families and the higher the costs. Ensuring a quicker resolution of claims would be beneficial to both claimants, and defendants (primarily the NHS).

This is not a new problem. In 2010, Lord Young found that: “the current system is too costly, and it takes far too long for some medical negligence cases to be resolved”.<sup>29</sup> According to the NAO's 2017 report, from 2010/11 to 2016/17, the average time taken to resolve claims rose each year, from 300 to 426 days.<sup>30</sup> We know from analysis of claims data that successful lower value (£1,001 to £25,000) claims settled in 2020/21 had an average "claim duration" (time taken from claim notification to settlement) of 1.3 years, an increase of 46% in claim duration since 2010/11<sup>31</sup>. The highest increase in average claim duration has occurred in the lower value clinical negligence claims bracket.

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<sup>28</sup> NHS Resolution (2021). *Annual Statistics (Supplementary Annual Statistics, Tables 9A & 11A.1)*. London, NHSR. Accessed online at: <https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Supplementary-Annual-Statistics-2020-21.xlsx>.

<sup>29</sup> Lord Young of Graffham (2010). *Common Sense, Common Safety: A report by Lord Young of Graffham to the Prime Minister following a Whitehall-wide review of the operation of health and safety laws and the growth of the compensation culture*. London, HMSO. Accessed online at: <https://www.gov.uk/government/publications/common-sense-common-safety-a-report-by-lord-young-of-graffham>.

<sup>30</sup> National Audit Office Comptroller and Auditor General (2017). *Managing the Costs of Clinical Negligence in Trusts*. London, NAO. p.4. Accessed online at: <https://www.nao.org.uk/report/managing-the-costs-of-clinical-negligence-in-trusts/>.

<sup>31</sup> NHS Resolution (2021). *Annual Statistics (Supplementary Annual Statistics, Table 17A)*. London, NHSR. Accessed online at: <https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Supplementary-Annual-Statistics-2020-21.xlsx>

The causes of this increase are not straightforwardly attributable to either claimants or defendants. However, it is likely that improving the current legal process and enabling increased opportunities for early agreement that is fair and reasonable to all parties, would contribute to reducing delays in resolving claims.

Our FRC proposals encourage faster resolution of claims before proceedings are issued and require that all parties meet process deadlines and engage in a mandatory evaluation (a form of alternative dispute resolution), if claims are not resolved.

Nothing in the scheme precludes parties from pursuing their claim in the courts if agreement cannot be reached within the FRC process, but the process is designed to maximise resolution prior to use of the courts, wherever possible.

For claims that are resolved within the process, the maximum claim duration for our proposed standard track is 44 weeks (308 days). Maximum claim duration for our proposed light track is 20 weeks (140 days). The maximum for a small number of light track cases requiring further evidence would be 34 weeks (238 days). Each of these maximums is lower than the average claim duration we currently see for these claims (475 days in 2020/21).<sup>32</sup>

A central objective of the streamlined process devised by the CJC is to encourage and facilitate resolution well before these maximums. Currently around 75% of lower value clinical negligence claims settle before involving the courts.<sup>33</sup> There is good reason to believe that features of the streamlined process design - the early evidence exchange and the mandatory resolution stages - would increase the proportion of claims settled in the pre-issue phase (i.e. before involving the courts, which is the period that our proposed FRC regime covers).

We believe that implementing these FRC proposals will help to reduce the average time taken to resolve lower value clinical negligence claims by at least 30%, so that claimants can achieve the justice and the compensation they deserve more quickly and at lower cost.

## **Cost reduction**

As shown, claimant legal costs for lower value claims are historically high overall and disproportionately high in relation to defendant legal costs. Our analysis indicates that the measures we propose in this consultation would reduce the cost and the time taken to

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<sup>32</sup> NHS Resolution (2021). *Annual Statistics (Supplementary Annual Statistics, Table 17A)*. London, NHSR. Accessed online at: <https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Supplementary-Annual-Statistics-2020-21.xlsx>

<sup>33</sup> Based on Professor Fenn's analyses of numbers of claims at each stage of settlement, published as Appendix B to Civil Justice Council (2019). *Fixed Recoverable Costs in Lower Value Clinical Negligence Claims*. Report of the Civil Justice Council Working Group.

process low value clinical negligence claims, while ensuring that claimants continue to be able to access justice when they believe they may have suffered negligent harm.

In summary, we estimate that these proposals would achieve cost reductions (calculated for England only) of £8 million in cashflow savings in the first year following implementation (on the assumption that this would be 2023/24), rising to an annual saving of £76 million of cashflow savings 10 years after, in 2033/34, (a total cumulative saving of £598 million up to 2033/34).<sup>34</sup> Cashflow savings expressed in net present value terms are £7 million in 2023/24 and £50 million in 2033/34 (total savings for 2023/24 to 2033/34: £454 million).<sup>35</sup> Annual expense savings expressed in net present value terms are £74 million in 2023/24 and £67 million in 2033/34 (total savings for 2023/24 to 2033/34: £765 million).<sup>36</sup> As the vast majority of clinical negligence claims relate to NHS care, this represents a significant annual saving to the NHS budget. Savings above are presented in real 2020/21 prices.

We believe that the cost savings we model as a result of our proposals will represent an important contribution towards addressing the overall rise in clinical negligence costs we have seen over the last decade and a half.

A full impact assessment for these proposals is published alongside this consultation document and sets out the projected impacts, costs and savings.

## **Patient safety and response to harm**

This consultation focuses on improving the system for legal claims when harm has occurred and on addressing the rise in the legal costs of clinical negligence.

At the same time, we are of course committed to addressing the causes of harm and improving the quality of the NHS response when harm occurs. These are vitally important issues in their own right.

Our ambition is for the NHS to be the safest healthcare system in the world. Great strides have been made towards that ambition in recent years, despite increasing demands on the system and most recently the multiple challenges of an unprecedented pandemic. Across the system, nurses, doctors and all members of health service staff work hard to deliver safe, effective, high quality care to patients. The government is proud of the NHS and all it delivers for society, and this has never been truer than over the past two years when it has worked to overcome the challenges presented by COVID-19

But we cannot ignore mistakes and we must always strive to do better. Whilst we recognise that in any system delivered and led by people errors will happen, every incident

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<sup>34</sup> DHSC internal analysis

<sup>35</sup> Ibid.

<sup>36</sup> Ibid.

of harm is one too many, and we know that the impact can be devastating to the patient, their families, friends and carers, as well as to staff.

Our long-standing commitment to safety has, over the last decade, involved a thorough overhaul of the infrastructure underpinning quality and safety, and the establishment of a comprehensive set of measures to reduce the possibility of harmful events.

The [NHS Patient Safety Strategy](#) published in July 2019 builds on this progress and aims to improve patient safety across the whole system.<sup>37</sup> The strategy sets out the safety priorities for the NHS and the programmes planned and underway to deliver on them, building on the major reset following the tragedies of Mid-Staffs and Morecambe Bay. We are redoubling our efforts to make the NHS even safer and to remove, as far as we can, the causes of error based in clinical practice that may lead to a substantial future claim. However, as the NAO found in their 2017 report, a fall in patient safety or worsening patient experience would be an “unlikely” cause of the steep rise we have seen in claim costs because “available patient safety indicators suggest that this has remained stable” and “overall patient satisfaction with hospital care has remained high”.<sup>38</sup>

Patient safety is a top priority, and we are committed to the advancement of policy and governance for the improvement of patient safety and supporting the development and progress of the NHS Patient Safety Strategy. DHSC has established a National Patient Safety Programme Board whose remit is to strengthen oversight and governance and improve and monitor patient safety across health and social care providers. The Board includes senior policy leads from across government and the NHS, and reports to DHSC ministers. In addition, the government has provided a further £9.4 million to support maternity safety pilots through the 2020 Spending Review. We are also investing £95.6 million in maternity services to target the three overarching themes identified in the first Ockenden Report: workforce numbers, training, and development programmes to support culture and leadership, and strengthening board assurance and surveillance to identify issues earlier. This is critically important to mothers and babies receiving NHS care and to our efforts to continue to strive towards better safety outcomes and avoid harm.

We are also committed to improving the NHS's response when concerns and complaints are raised and when harm has occurred. We remain focused on fostering a growing culture of learning and continual improvement in the NHS. The NHS Patient Safety Strategy is focused throughout on developing the infrastructure, data, and improvement practice within NHS organisations to deliver that culture.

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<sup>37</sup> NHS England and NHS Improvement (2019). *The NHS Patient Safety Strategy: Safer culture, safer systems, safer patients*. London, NHSEI. Accessed online at: <https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/>.

<sup>38</sup> National Audit Office Comptroller and Auditor General (2017). *Managing the Costs of Clinical Negligence in Trusts*. p28, Figure 9. London, NAO. Accessed online at: <https://www.nao.org.uk/report/managing-the-costs-of-clinical-negligence-in-trusts/>.



Similarly, NHS Resolution has developed several important measures to improve the data and learning we can gain from legal claims. NHSR's "[Being Fair: supporting a just and learning culture for staff and patients following incidents in the NHS](#)" sets out its expectations of the NHS in promoting a just culture of learning in every organisation - the kind of healthy environment in which safety improvement is maximised and people feel safe to speak up if things go wrong.<sup>39</sup>

However, we recognise that litigation, by itself, is limited in how much it can effectively drive patient safety improvement. Learning from litigation is often focussed on individual incidents and often takes place long after incidents have occurred. Instead, learning and patient safety improvement are best executed rapidly at source, through high quality investigations, taking into account local incident trends wherever possible and following a comprehensive, cohesive safety improvement plan.

The way the NHS responds to patients and families when things go wrong is also of critical importance. We have been clear in introducing the Duty of Candour that NHS organisations have a duty to tell the truth, explain what has happened and apologise to patients and families when things go wrong. NHSR has reinforced this by providing guidance on "[Saying Sorry](#)", emphasising that apologies should be made, whether or not there has been an admission of legal liability, and that apologies do not, in and of themselves, amount to such an admission.<sup>40</sup>

In all instances, the NHS should consider opportunities to offer up and provide the apologies, explanations and sensitive engagement that people need when things go wrong. It is often where these do not happen, or when they fall short, that people feel impelled towards legal action.

Though we believe that the best time to address learning, provide frank explanations and convey sincere apologies is early on, prior to any legal claim being brought, we would emphasise that if these have not occurred, NHS organisations should continue to consider and seek opportunities to provide them. This applies notwithstanding any claim process or stage we set out in our FRC proposals. We are clear that the focus of the NHS should always be on providing patients and families with the information, care and respect they are entitled to.

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<sup>39</sup> NHS Resolution (2019). Being Fair: supporting a just and learning culture for staff and patients following incidents in the NHS. London, NHSR. Accessed online at: <https://resolution.nhs.uk/resources/being-fair/>.

<sup>40</sup> NHS Resolution (2018). Saying Sorry. London, NHSR. Accessed online at: <https://resolution.nhs.uk/resources/saying-sorry/>.

### 3. Outline of consultation proposals

FRC is a mechanism by which the recoverability of legal costs by the successful party is fixed in advance by reference to a table of recoverable costs that apply to all cases within the scope of the scheme.

This does not affect the amount of compensation that a claimant can receive for their case, if successful, or the overall amount of damages awarded. It also does not set a limit on the fee arranged between the claimant and the claimant's lawyer, which is a matter of private agreement usually on the basis of a conditional fee agreement. Our proposals will only affect the amount of legal costs that one party can recover from the other following a successful claim.

The aim of our proposed FRC scheme, in common with other FRC schemes, is to encourage more claims to be resolved more quickly, at lower cost and less inconvenience to all parties, and without involving the courts where that can be avoided.

These issues have already been addressed in other areas of civil litigation. Following the principle of proportionality set out in Lord Woolf's 1996 report<sup>41</sup> and Sir Rupert Jackson's subsequent work to reform civil litigation costs, FRC schemes have already been introduced in most areas of personal injury litigation to streamline claims, lower legal costs and make costs more proportionate to damages. Clinical negligence is one of the last remaining areas of low value personal injury claims in which recoverable legal costs are not currently fixed.

This consultation seeks views on introducing a mandatory FRC system for lower value clinical negligence claims (claims valued in excess of the small claims track limit up to the value of £25,000 in damages). The scheme would only apply to England and Wales and would apply to care provided in the NHS and in the private sector.

Our proposals have at their core a streamlined pre-issue claims process, devised by the CJC. The process is designed to enable a rapid exchange of high-quality evidence in these claims so that agreement can be reached more quickly, to agreed timeframes, on:

- if the defendant is liable for the alleged negligent treatment
- the nature and extent of the injury suffered as a result of the alleged negligent treatment
- how much compensation should be awarded

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<sup>41</sup> Harry Woolf (1996) *Access to Justice: Final Report to the Lord Chancellor on the Civil Justice System in England and Wales*. London, HMSO.

Claims would be assigned either to a light track or a standard track according to their complexity and the degree to which liability is agreed from the outset.

We have also included two resolution stages within the process to encourage agreement, even in difficult-to-resolve cases, and crucially, to minimise delay, cost and distress. These are:

- a stocktake meeting between parties and
- a neutral evaluation by a barrister, to resolve as many cases as possible, even where there is significant disagreement

Key to the proposals are the fixed costs themselves, which will be mandatory for all claims falling within the scheme. Suggestions for these costs by claimant and defendant representatives were included in the CJC working group report and considered in detail by the department, informed by claims and claims cost analysis and engagement with key stakeholders, including claimant and defendant representatives. In this consultation, we propose adopting the costs suggested by the defendant group in the CJC report. The guiding principle throughout has been to ensure that the costs reflect a reasonable assessment of the work required to progress and resolve these claims.

We also set out a set of exclusions from the scheme and special arrangements for certain claims that will be subject to fixed costs but may incur extra costs.

We set out arrangements for sanctions to encourage all parties to adhere to the fixed costs regime, including the timelines to exchange evidence, reach agreement early, and take part in the specified resolution stages, where necessary.

The entire process is designed to take place before any claim is issued, thereby maximising the number of claims that can be resolved without resorting to the courts.

## **Private and not-for-profit sectors**

As the scope of the proposals set out in this consultation will cover claims arising from NHS funded or privately funded healthcare, we would welcome any relevant information from private and not-for-profit sector healthcare providers, as well as from insurers and indemnifiers of private healthcare to support our understanding of how FRC would affect claims. We would also welcome the views of claimant and defendant lawyers with an interest in clinical negligence. Any commercially sensitive data included in consultation responses should be identified as such and will be treated in confidence, subject to the department's arrangements on confidentiality. Further details on confidentiality are below at chapter 18.

## **Wales, Scotland and Northern Ireland**

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

In Wales, a parallel system for seeking clinical negligence redress in lower value cases exists alongside the usual route for bringing legal claims. The NHS Redress process for clinical negligence cases operates under Regulations made under the NHS Redress (Wales) Measure 2008 and currently applies to cases worth up to £25,000. It is a voluntary scheme and legal advice without charge is provided to patients who opt to pursue the redress process.

We have ensured that our proposals take into account the existing system in Wales and we are confident that the two systems will be able to operate alongside each other.

The Welsh Government's views will be taken into account in finalising the proposals and in implementation through changes to the Civil Procedure Rules.

## **Implementation and review**

Following this consultation, the government will carefully analyse the responses and publish a consultation response document. If it is decided to introduce an FRC scheme, any proposals would be considered and approved by the Civil Procedure Rule Committee before being implemented via statutory instrument.

A post-implementation review would be carried out not later than 5 years after implementation of any FRC scheme. The review would consider, based on the available evidence, whether:

- the overall aims of the policy have been met
- the policy has been implemented effectively
- any unintended consequences have been identified and
- the impacts and effectiveness of these proposals with specific reference to groups with protected characteristics under the Equality Act 2010

We would also review the upper claim value limit of the scheme (£25,000 in damages) to take into account the effects of claims inflation, as set out in chapter 13, below.

## 4. Summary of responses to the previous consultation

In 2017, the department published a consultation, 'Introducing Fixed Recoverable Costs in Lower Value Clinical Negligence Claims'.<sup>42</sup> The consultation sought comments on proposals to design and implement a scheme of fixed recoverable costs (FRC) for clinical negligence cases above £1,000 and up to £25,000 in England and Wales.

The aim was to support quick and more cost-effective resolution to low value clinical negligence claims and focused primarily on how an FRC scheme should be defined and implemented, how the costs should be calculated and how cases should be handled.

The responses to the consultation broadly showed that claimant solicitors were opposed to FRC, and defendant solicitors were in favour. The department also published an illustrative draft of the Civil Procedure Rules which would apply to the proposals and sought views on several key elements.

We published a summary of responses to the consultation in 2018.<sup>43</sup> Overall, there were mixed responses on the specific proposals for implementing the scheme but clear support for the importance of a bespoke streamlined process of handling claims to make the scheme viable.

Subsequent to the consultation, Sir Rupert Jackson published his report on civil litigation reform, recommending that the CJC develop a streamlined framework for a clinical negligence FRC scheme.

To take this work forward, incorporating the messages from the 2017 consultation and Sir Rupert Jackson's recommendation, the DHSC and the MoJ jointly commissioned the CJC to undertake this work in 2018. The CJC published its report in October 2019 and the proposals in our current consultation are closely aligned with them<sup>44</sup>.

The responses to the 2017 consultation also expressed concerns on a number of issues, including: the potential for an FRC scheme to drive costs; the inherent complexity of

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<sup>42</sup> Department of Health (2017). *Introducing Fixed Recoverable Costs in Lower Value Clinical Negligence Claims*. London, DHSC. Accessed online at: <https://www.gov.uk/government/consultations/fixed-recoverable-costs-for-clinical-negligence-claims>.

<sup>43</sup> Department of Health and Social Care (2018). *Consultation on Introducing Fixed Recoverable Costs in Lower Value Clinical Negligence Claims: Summary of Consultation Responses*. London, DHSC. Accessed online at: <https://www.gov.uk/government/consultations/fixed-recoverable-costs-for-clinical-negligence-claims>.

<sup>44</sup> Civil Justice Council (2019). *Fixed Recoverable Costs in Lower Value Clinical Negligence Claims. Report of the Civil Justice Council Working Group*, p.24. London, Courts and Tribunals Judiciary. Accessed online at: <https://www.judiciary.uk/related-offices-and-bodies/advisory-bodies/cjc/archive/fixed-recoverable-costs-in-lower-value-clinical-negligence-claims/>.

clinical negligence claims; potential threats to people's access to justice; and prematurity of the reforms proposed, given the then relatively recent reforms to civil litigation costs in the Legal Aid, Sentencing and Punishment of Offenders Act (LASPO) 2012.

We recognise all the concerns raised, which were considered by the CJC working party and informed their final report.

We have borne in mind the risk of increased costs in developing the structure of the scheme and the levels of fixed costs at different stages. Our impact analysis concurs with the CJC assessment that, overall, the streamlined process is likely to generate savings due to faster resolution and less avoidable use of the courts.

We recognise, as has the CJC, that clinical negligence claims can be more complex than some other civil claims. Our twin track approach addresses that complexity and tailors costs to more or less complex claims. We have also proposed a limited set of exclusions from the scheme, in part guided by a consideration of the complexity of certain claim types. We are also clear, as was the CJC report, that the streamlined processes we propose in this consultation are tailored to the specified lower value clinical negligence claims. Higher value claims, which can be much more complex and variable, and would need a separate, tailored approach, have been excluded from this FRC scheme.

We have been mindful throughout of the importance of protecting people's access to justice. Our proposals have sought to make claims more streamlined and cost-effective for all parties and we believe, with the CJC, that the processes and costs proposed in this consultation will achieve this and not pose a risk to people accessing justice. In particular, taking into account the needs of protected parties, we have proposed an extra "bolt-on" cost to protect access to justice for children and people who lack capacity.

On the timing of reform, we feel that sufficient time has now passed to understand the effects of the 2012 LASPO Act, which came into force in April 2013. Although claimant legal costs of clinical negligence claims have levelled out in the last 3 years, they remain at a high level and represent an ongoing impact on NHS budgets.

In summary, both the CJC working party and the department have considered the outputs of the 2017 consultation carefully and used these insights to inform and design these proposals. We remain convinced by the need for an FRC scheme for lower value clinical negligence claims and we are confident that our streamlined approach can achieve the aim of faster, cost-effective resolution whilst addressing the core concerns of respondents in 2017.

## 5. Our FRC proposals

Our FRC proposals closely follow the recommendations of the CJC working group which devised bespoke arrangements for low value clinical negligence claims, following Sir Rupert Jackson's 2017 recommendation.

The core elements of our FRC scheme proposals presented in this consultation document are:

### Streamlined process

- The overall definition of claims to be included in the scheme
- A two-track FRC scheme, divided into a light track and a standard track
- A streamlined process for early resolution of claims whereby there is a rapid exchange of medical evidence and a mandatory stocktake to resolve claims
- Evidentiary requirements for evidence exchanged between parties in the scheme
- Template letters and model expert report elements to be used in the initial exchange of evidence between claimants and defendants
- A mandatory neutral evaluation stage for claims that have not settled

### Fixed costs, exclusions, sanctions and implementation

- Proposed fixed costs for each stage and claims track
- Which claims should be excluded from the scheme based on complexity and sensitivity of certain claim categories
- Sanctions to encourage adherence to the rules of the scheme and incentivise resolution of claims within the scheme
- The claims the FRC scheme will apply to, at date of implementation

### Review

- Post-implementation review of the £25,000 upper limit for claims included in the scheme, to adjust for inflation in the value of claims

## Impacts

- What impacts the proposals would have on businesses in England and Wales, including small or micro businesses; and
- What impacts the proposals would have on people in groups with protected characteristics under the Equality Act, 2010.

The following chapters set out our proposals on each of these elements and ask for views.



## 6. Claims that would fall within the scheme

In our 2017 consultation on these issues, we proposed mandatory inclusion in our FRC proposals for all claims with a value up to £25,000, effectively excluding claims normally expected to be allocated to the small claims track (claims with a value of £1,000 and below). That proposal was broadly accepted and was the basis on which the CJC working group made its recommendations for FRC arrangements.

We have carried forward this definition in this consultation. Our FRC proposals would be mandatory for clinical negligence claims where the value is in excess of the small claims limit for non-road traffic accident personal injury claims,<sup>45</sup> up to £25,000, based on a final settlement or judgment value. The scheme would exclude those claims set out under the list of exclusions at chapter 11.

Although claims under the small claims track limit would generally be excluded, the scheme could include certain very complex clinical negligence claims that would not be deemed suitable for the small claims track and would not be expected to be allocated to it, due to their greater complexity. This is to avoid those claims defaulting to an inappropriately costly regime of costs. In order for such claims to be included, a clear case on grounds of complexity should be stated from the outset by the claimant.

Claims with damages expected to marginally exceed the £25,000 scheme limit should be managed prudently from the outset as if they would be subject to FRC.

Figure A of Annex C illustrates which claims would fall within the proposed scheme.

### **Question 1: Do you agree or disagree with the proposed definition for claims falling within the FRC scheme?**

- **Agree**
- **Disagree**
- **Don't know**

#### **Why?**

Please refer to 'Chapter 6: Claims that would fall within the scheme' and Figure A of Annex C in the consultation document and give any reasons for your answer.

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<sup>45</sup> The small claims track upper limit is currently £1,000 but is set to increase to £1,500 in April 2022.

## 7. A twin track approach

Following the model set out in the CJC report, we propose that there should be two separate tracks for qualifying low value clinical negligence claims, a standard track and a light track. We also propose a dedicated streamlined process for each track, reflecting the characteristics and requirements of claims on each track. Broadly speaking, the standard track is intended to apply to claims where there is not agreement on liability. Figure A of Annex C is an overview of these tracks.

### Standard track

All claims expected to settle above the small claims track limit, up to and including a value of £25,000, should be progressed on the standard track unless they meet the conditions set out below for entry on the light track or are otherwise excluded under the exclusion categories set out in chapter 11, below.

### Light track

The rationale for including a light track option is to enable swifter resolution of more straightforward cases, especially where liability is not in dispute. This supports our key policy aim of achieving faster resolution and lowering costs.

The CJC report estimated, based on analysis by Professor Paul Fenn, that up to 25% of claims currently fall into the "no dispute on liability" category.<sup>46</sup>

Claims should be progressed on the light track if:

- Parties agree no expert evidence on liability is required in respect of breach of duty of care and causation
- There is an admission of breach of duty of care (including but not limited to cases dealt with under the Welsh 'Putting Things Right' redress scheme)
- There is a "Never event"
- There is a Serious Incident Report which identifies care below a reasonable standard of care (including investigations under the Welsh 'Putting Things Right' redress scheme) or

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<sup>46</sup> Ibid. Civil Justice Council (2019). *Fixed Recoverable Costs in Lower Value Clinical Negligence Claims. Report of the Civil Justice Council Working Group*, p.24.

- There has been an inquest and the Coroner has determined either that care amounted to neglect or that death would not have occurred but for the identified neglect

**Question 2: Do you agree or disagree that the proposed scheme should incorporate a twin track approach, following the CJC model, to enable simpler, less contentious cases to progress more quickly to resolution?**

- **Agree**
- **Disagree**
- **Don't know**

**Why?**

Please refer to 'Chapter 7: A twin track approach' and Figure A of Annex C in the consultation document and give any reasons for your answer.

**Question 3: Do you agree or disagree with the proposed criteria for claims being allocated to the light track?**

- **Agree**
- **Disagree**
- **Don't know**

**Why?**

Please refer to 'Chapter 7: A twin track approach' in the consultation document and give any reasons for your answer.

## **8. Streamlined processes for standard track and light track claims**

The CJC working group report describes streamlined processes that low value clinical negligence claims within an FRC scheme would need to follow. We have closely followed the CJC's recommendations for these processes which were carefully designed to suit low value clinical negligence claims and maximise the chance of early resolution.

Accordingly, we propose two separate processes with defined timescales for the standard and light tracks. These include arrangements for a sequential exchange of evidence and then two separate stages (at stocktake or at mandatory neutral evaluation) where parties can come to agreement and resolve the claim, before any proceedings are issued. The fixed costs we propose at chapter 9 are calibrated to recognise the reasonable work required at each stage of the processes. All parties would be required to abide by these processes, requirements and timescales.

These processes are designed to facilitate a rapid exchange of evidence and to be fair to all parties, whilst remaining focussed on rapid resolution. To make this happen, claimants would need to assemble their evidence fully at the outset. Equally, defendants would be required to respond fully within the set timescale, including the evidence for their case. We agree with the view expressed in the CJC report that our FRC proposals for lower value clinical negligence claims must include a sequential exchange of evidence to discourage speculative activity by both claimants and defendants and prompt a culture change towards sensible, rapid resolution in the handling of these claims.

All parties are required to participate in the specified stages seeking rapid resolution, where that has not yet been achieved.

All the process stages, evidential requirements, timescales and consequences for breaching these rules would be set out in the Civil Procedure Rules (CPR). Any changes to these rules are implemented following detailed consideration by the CPR Committee.

For the avoidance of doubt, no provisions of the streamlined processes set out below for the standard or light tracks should prevent parties from making or accepting offers to resolve a claim, at any time.

Our proposals are set out below. Figures B, C and D of Annex C are flowcharts showing the elements of standard and light track processes, with timings.

## The proposed standard track (ST) streamlined process

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### **ST(A) - FRC letter of claim is sent: (this starts the standard track FRC process clock)**

An FRC letter of claim would be sent by the claimant to the defendant which discloses the claimant's case and is accompanied by an offer to settle. Copies of the FRC letter of claim should also be sent to the appropriate body handling claims on behalf of the defendant - in the case of the NHS in England this is NHS Resolution, in Wales this is the NHS Wales Shared Services Partnership, Legal and Risk Services. For certain other claims the letter should be forwarded to relevant insurers or indemnifiers, where these are known.

Each FRC letter of claim should include:

- medical records – to be collated, sorted and paginated by the claimant
- experts' reports on breach of duty of care and causation (limited to a maximum of 2 such liability experts in different medical disciplines)
- witness statements (limited to 2 witnesses, statements in template form, including a statement of truth)
- where applicable, any separate report on condition and prognosis
- details of losses and supporting documentation, either in the letter or in a separate schedule if required, to be supported with a statement of truth and
- an offer to settle the claim

All evidence and other documents included in the FRC letter of claim would have to be of a sufficient quality as to conform to the evidentiary rules to be set out in the CPR to allow the defendant to consider the issues and respond fully and timeously and to facilitate rapid resolution. We would welcome views on sensible requirements for these evidentiary rules.

### **ST(B) - Defendant response: (within 6 months of the letter of claim being served)**

The defendant would have to acknowledge the FRC letter of claim within 21 days. The defendant must then, within a maximum of 6 months from service of the letter of claim, choose one or more of the following options:

1. admit liability as to breach of duty of care and causation for the claim
2. accept the claimant's settlement offer

3. reject the claimant's offer and make a counteroffer to settle the claim or
4. send a response letter to the claimant, denying breach of duty of care and/or causation, disclosing the defendant's case and responding to the offer

If the defendant opts to pursue option 4), above, the defendant response letter must include:

- a reasoned denial
- experts' reports on breach of duty of care and/or causation (limited to a maximum of 2 such liability experts of different medical disciplines)
- witness statements (limited to 2 witnesses, statements in template form including a statement of truth)
- a counter-schedule of loss responding to the claimant's valuation of general damages and heads of loss to be supported with a statement of truth

All evidence and other documents included in the response letter would have to be of a sufficient quality as to conform to the evidentiary rules to be set out in the CPR to provide for a consideration of the issues and facilitate progress towards resolution. We would welcome views on sensible requirements for these evidentiary rules.

This 6-month period and the period prior to sending the letter of claim are the key points in the process where the bulk of the legal work by claimants and defendants would have to be completed, including the exchange of expert evidence. It should be emphasised that the 6-month period is a maximum time for the defendant to respond in full. In many cases it would be possible for defendants to respond within a shorter timeframe. Responses should be provided as soon as reasonably possible to enable swift resolution.

### **ST(C) - Claimant reply: (within 6 weeks of the defendant response)**

The claimant has a right to reply to the defendant's response. Within 14 days, the claimant should acknowledge receipt of the defendant's response and indicate whether the claimant wishes to exercise the right of reply. Any reply should be sent within 6 weeks of service of the defendant response letter. The purpose of this stage is to allow the claimant the chance to respond to new facts disclosed in the defendants' response. The claimant would be equally entitled to disregard this stage, make or accept an offer made by the defendant, or proceed to the mandatory stocktake stage.

If the claimant opts to reply, the reply can, where necessary, include:

- a response from the claimant to the facts presented in the defendant's letter of response;

- a further letter or report from the claimant's (previously engaged) expert(s).

**ST(D) - Mandatory stocktake: (within 4 weeks of the defendant response, if there is no claimant reply; or within 10 weeks of the defendant response if there is a claimant reply)**

A mandatory stocktake and discussion would have to take place if the case cannot be settled after the defendant response or claimant reply. This should take place within 4 weeks of the defendant response if no claimant reply is being made, or within 10 weeks of the defendant response if the claimant wishes to reply to the response (this 10-week period allows 6 weeks for the claimant to reply and then 4 weeks for both parties to prepare for stocktake).

At the stocktake, parties should examine the strength of each other's position and work towards settlement at, or shortly following, this meeting. Legal representatives at this stocktake meeting are to have full authority to settle where liability is admitted. Even where liability cannot be agreed, parties should strive, where possible to agree quantum. Even (and especially) where definitive agreement cannot be reached on liability or quantum, parties should seek to narrow issues so that progress is made.

**ST(E) - Mandatory neutral evaluation: (within 4 weeks of the mandatory stocktake)**

A mandatory neutral (but non-binding) evaluation would have to be held if the claim is not settled at the mandatory stocktake. The parties have 4 weeks from the mandatory stocktake meeting to select and commission a specialist barrister from the agreed panel. The evaluation should be a paper-only exercise as default, without routinely seeking further clarification from the parties' experts, which would add delay and costs to the process.

**ST(F) - Outcome of mandatory neutral evaluation: (to be issued no later than 4 weeks from commencement of the evaluation)**

The evaluator must forward the outcome of the evaluation to all parties simultaneously within 4 weeks. The outcome of the evaluation would not be binding, but parties should make every effort to settle at this stage.

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**Maximum length of the standard track process**

Claims adhering to the standard track process would not take longer than 44 weeks (308 days) in total to move from ST(A) claim letter to ST(F) mandatory neutral evaluation outcome.

This is a maximum. In many cases, the whole process may be significantly shorter, and many claims should be resolved well before a mandatory neutral evaluation is required. This would be a significant improvement on the average time taken to resolve claims (currently 475 days on average across all claims in the £1,001 to £25,000 bracket), a key policy aim for the FRC scheme.<sup>47</sup>

Figure B of Annex C is a flowchart setting out the proposed standard track process, with timings.

**Question 4: Do you agree or disagree with the proposals for streamlined processes in the standard track?**

- **Agree**
- **Disagree**
- **Don't know**

**Why?**

Please refer to 'Chapter 8: Streamlined processes for standard track and light track claims', and Figure B of Annex C in the consultation document and give any reasons for your answer.

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<sup>47</sup> NHS Resolution (2021). *Annual Statistics (Supplementary Annual Statistics, Table 17A)*. London, NHSR. Accessed online at: <https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Supplementary-Annual-Statistics-2020-21.xlsx>.



## The proposed light track (LT) streamlined process

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### **LT(A) - FRC claim notification letter is sent: (this starts the light track FRC process clock)**

An FRC claim notification letter should be sent from the claimant to the defendant. Copies of the FRC claim notification letter should also be sent to the appropriate body handling claims on behalf of the defendant - in the case of the NHS in England this is NHS Resolution, in Wales this is the NHS Wales Shared Services Partnership, Legal and Risk Services. For certain other claims the letter should be forwarded to relevant insurers or indemnifiers, where these are known.

The FRC claim notification letter should include:

- an explanation of the basis for the case being in the light track and any associated documents (such as a serious incident report)
- medical records – to be collated, sorted and paginated by the claimant and
- details of losses and any accompanying evidence.

All evidence and other documents included in the FRC claim notification letter would have to be of a sufficient quality as to conform to the evidentiary rules to be set out in the CPR to allow the defendant to consider the issues, respond appropriately and timeously and facilitate resolution. We would welcome views on sensible requirements for these evidentiary rules.

### **LT(B) - Defendant admission of liability: (within 8 weeks)**

The defendant must acknowledge the FRC claim notification letter within 21 days. The defendant must then respond to the FRC claim notification letter admitting full liability as to breach of duty of care and causation within 8 weeks, to ensure the claim remains in the light track. If the liability admission were not received within 8 weeks, the claim would transfer to the standard track and the clock would be reset to the standard track beginning with a claim letter being sent by the claimant in the standard track format. If the claim restarts in the standard track, costs should be recoverable for the standard track process only (there should be no separate costs recoverable for the abortive light track period).

We anticipate that it will not be possible in every instance to obtain consent from the defendant to admit liability within the 8-week period. In these cases, in order to ensure the claim remains on the light track, the defendant's indemnifier must, in place of an admission, formally agree to pay reasonable compensation, accompanied by a clear statement that this represents compensation on a full liability basis, without any deduction

for litigation risk or other factors. However, whether or not a timely admission of liability is made, the expectation of this process is that if a commitment is made to pay compensation on a full liability basis and the claim remains in the light track, then admission of liability should, wherever possible, follow as soon as possible thereafter.

**LT(C) - Mandatory stocktake: (within 4 weeks of defendant response)**

If full liability (on breach of duty and causation) were to be admitted by the defendant, (or an agreement is made by the indemnifier to pay reasonable compensation) following the claim notification letter, and the claim has therefore continued in the light track, a mandatory telephone discussion/stocktake must be held within 4 weeks of the defendant response.

Legal representatives at this stocktake meeting would have to have full authority to settle. Even (and especially) where definitive agreement cannot be reached, parties should seek to narrow issues so that progress is made.

If there was no settlement at this stage but the parties decide that no further evidence is required, the case would enter the "no further evidence" phase from LT(D)(NFE) onwards and must move into mandatory neutral evaluation within 4 weeks of the mandatory stocktake.

If at mandatory stocktake, there was no settlement and the parties decide that further evidence was required to resolve the claim, parties would then enter the "further evidence" phase below from (LT(D)(FE) onwards.

**Light track: no further evidence phase**

**LT(D)(NFE) - Mandatory neutral evaluation: (within 4 weeks of the mandatory stocktake if no further evidence is required)**

A mandatory neutral (but non-binding) evaluation would have to be held if the claim is not settled at the mandatory stocktake and no further evidence is required. This should be a paper-only exercise as default, without routinely seeking further clarification from the parties' experts, which would add delay and costs to the process. The parties would have 4 weeks from the mandatory stocktake meeting to select and commission a specialist barrister from the agreed panel.

**LT(E)(NFE) - Outcome of mandatory neutral evaluation (where no further evidence was required): (to be issued no later than 4 weeks from commencement of the evaluation)**

The evaluation must be completed, and an outcome sent to all parties simultaneously within 4 weeks of the evaluation commencement. The outcome of the evaluation would not be binding, but parties should make every effort to settle at this stage.

### **Light track: further evidence phase**

We anticipate that only a very small percentage of claims would require a further evidence phase. Although this phase would potentially add a number of weeks to the light track process, it would be necessary to provide for the minority of non-liability cases that have not come to agreement and are deemed to require further evidence at mandatory stocktake.

#### **LT(D)(FE) - Further evidence (decision and instruction): (within 6 weeks of the stocktake)**

If at stocktake there is no settlement and further evidence is required, the parties must decide within 2 weeks of the mandatory stocktake whether a condition and prognosis report and a claimant witness statement dealing with the factual background and quantification of damages are required.

If a condition and prognosis report was needed, the parties should agree a joint expert (limited to 1 expert), within 4 weeks of the mandatory stocktake discussion and should send instructions within 2 weeks of that agreement.

If a claimant witness statement was needed setting out any continuing injuries for consideration by the expert, this should be provided within 4 weeks of the mandatory stocktake.

#### **LT(E)(FE) - Further evidence (joint expert report/assessment): (6 weeks (if no assessment) or 10 weeks (if assessment is required))**

The expert should provide a paper-only report as the default position, unless they indicate they need to assess the claimant. The joint expert must indicate within 4 weeks of instruction if an assessment is required. If no assessment were required, the joint expert should provide the report within 6 weeks of instruction. If an assessment were required, the joint expert should arrange an assessment within 8 weeks of instruction and should provide the report within 2 weeks of the assessment. The joint expert should be instructed to adhere to these time limits.

#### **LT(F)(FE) - Further evidence stocktake: (within a maximum of 14 weeks of mandatory stocktake (if no claimant assessment) or within a maximum of 18 weeks (if assessment is required))**

If further evidence were to be agreed and sought following the mandatory stocktake, parties must hold a "further evidence stocktake" discussion with the aim of resolving the claim informed by the joint evidence. The further evidence stocktake must be held within a maximum of 14 weeks (if no claimant assessment) or a maximum of 18 weeks (if an assessment is required) following the mandatory stocktake (LT(C)). Legal representatives at this stocktake meeting would have full authority to settle. Even (and especially) where

definitive agreement cannot be reached, parties should seek to narrow issues so that progress is made.

**LT(G)(FE) - Mandatory neutral evaluation (following further evidence): (within 4 weeks of the further evidence stocktake)**

A mandatory neutral (but non-binding) evaluation must be held if the claim is not settled at the further evidence stocktake. The parties would have 4 weeks from the further evidence stocktake meeting to select and commission a specialist barrister from the agreed panel. The evaluation should be a paper-only exercise by default.

**LT(H)(FE) - Outcome of mandatory neutral evaluation (following further evidence): (to be issued no later than 4 weeks from commencement of the evaluation)**

The evaluation must be completed, and an outcome sent to all parties within 4 weeks of the evaluation commencement. The outcome of the evaluation would not be binding, but parties should make every effort to settle at this stage.

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**Maximum length of the light track process**

**Light track with no further evidence phase**

Claims adhering to this process would not take longer than 20 weeks (140 days) in total, where no further evidence were required, to move from LT(A) - (claim notification letter), to LT(E)(NFE) - (MNE outcome (no further evidence required)).

**Light track with further evidence phase**

Where further evidence was required in a small percentage of claims, claims adhering to the light track process would not take longer than 34 weeks (238 days) in total; (or 38 weeks (266 days) in total, if a claimant assessment was also required) to move from LT(A) - (FRC claim notification letter) - LT(H)(FE) - (MNE outcome following further evidence)

These are maximums. In many cases, the whole process should be significantly shorter, and many claims should be resolved well before a mandatory neutral evaluation is required. In particular, the expectation is that use of the light track further evidence phase would only be necessary in a very small percentage of cases. The light track process would enable a much quicker turnaround for claims where liability is not at issue and should therefore contribute to lowering the average time taken to resolve claims, a key policy aim for the FRC scheme.

Figures C and D of Annex C are flowcharts setting out the proposed light track process with timings. Figure C shows the light track process without further evidence phase. Figure D shows the light track process with further evidence phase.

**Question 5: Do you agree or disagree with the proposals for streamlined processes in the light track?**

- **Agree**
- **Disagree**
- **Don't know**

**Why?**

Please refer to 'Chapter 8: Streamlined processes for standard track and light track claims', and Figures C and D of Annex C in the consultation document and give any reasons for your answer.

**Question 6: What are your views on the evidentiary requirements applying to both standard and light track claims, that should be set out in the Civil Procedure Rules to support this FRC scheme?**

Please refer to 'Chapter 8: Streamlined processes for standard track and light track claims', in the consultation document, with particular regard to stages ST(A), ST(B), (LT(A) and LT(B), when answering.

## Template letters

We agree with the CJC working group that template letters should be used in the standard and light track processes (FRC letter of claim (standard track) and FRC claim notification letter (light track)). We also agree that expert report model elements should be used for standard track claims and (where applicable), for light track claims. The aim is to help simplify the process, increase speed and efficiency and ensure that all parties adhere to the requirements of the scheme.

We therefore propose the use of template letters and expert report model elements in the streamlined FRC scheme. Examples of template letters and expert report elements are included at Annex B. These are based on templates suggested in the CJC report, and there was significant agreement on them from claimant and defendant groups involved in the CJC process.

We consider the proposed template examples and the expert report model elements to be sensible and workable tools reflecting the aims of the standard and light track processes to facilitate early resolution.

Should the FRC scheme be implemented, the letter templates will be finalised prior to implementation for both the standard and light tracks, ensuring they include the components set out within the streamlined process for the FRC letter of claim (standard track) and FRC claim notification letter (light track), closely aligning with the consensus achieved as part of the CJC process and taking into account responses to this consultation.

**Question 7: Do you agree or disagree in principle that template letters and expert report model elements should be used as part of the streamlined processes in both the standard and light tracks?**

- **Agree**
- **Disagree**
- **Don't know**

**Why?**

Please refer to the 'Template letters' section of 'Chapter 8' and to Annex B in the consultation document, giving any reasons for your answer, and providing any views or suggestions you may have for the format and content of the letter templates or expert reports.

## 9. Fixed Costs

A fixed recoverable costs scheme operates by fixing the maximum amount that lawyers can recover in costs from the losing party. In clinical negligence cases it will most often be the NHS, and in fewer cases other healthcare providers, who must pay these costs for successful claims. FRC does not affect the amount that claimants can and will, if successful, receive in compensation.

The level at which the fixed recoverable costs are set is a critical decision in ensuring that an FRC scheme is viable and sustainable. In devising these proposals, we have focussed on ensuring that our proposed costs:

- a) will support continued access to justice for clinical negligence claimants
- b) reflect a reasonable assessment of the work lawyers must do to bring lower value clinical negligence claims to resolution and serve their clients' best interests
- c) are tailored to match each stage of the process designed by the CJC
- d) effectively control costs of lower value clinical negligence claims
- e) address the growing disproportionality of legal costs of lower value clinical negligence claims relative to compensation achieved and
- f) will support faster, fair resolution of claims.

The CJC report suggested two versions of the grids of costs, one proposed by members of the working group representing the claimant perspective, the other by members representing the defendant perspective (the two sets of costs are below at Annex A and have both been considered in the accompanying Impact Assessment). The CJC report did not express a view as to which of these versions was more reasonable, accurate or in any other way preferable.

Following the publication of the report, the department has engaged with representatives of both claimant and defendant groups and with other interested parties on the work involved in bringing and processing claims and on the suitability of the fixed costs proposed.

We have considered in detail the relative merits of the costs proposed by the claimant group and the defendant group. We have also examined the work on reasonable costs conducted by Professor Paul Fenn to inform the CJC working group and conducted further analysis of claims, claims costs and of the potential cost reductions under a fixed costs regime.

It is our considered view that the costs proposed by the defendant group represent the most reasonable assessment of the work involved at each stage of the streamlined

processes designed by the CJC, whilst protecting the access to justice of claimants and furthering the common goal of rapid resolution.

We believe adopting these costs will best drive the culture change, behaviours and systems that the CJC report identified as critical to successful reform of low value clinical negligence claims so that they are handled more quickly, efficiently and proportionately in the future.

We also agree with the CJC working group that these proposed fixed costs must only apply to claims expected to settle between the small claims track limit and £25,000 (though the scheme may include certain unusually complex claims below this limit). Our analysis has been guided by this principle and our proposed costs were selected with this value band only, in mind.

The costs proposed for each stage of the streamlined processes have been tailored to the expectations and requirements of the work involved within each claims track. This means, in particular, that the greatest cost maximums apply to the beginning of the processes, where claimant lawyers are asked to undertake significant work upfront to prepare the claim and defendant lawyers are required to respond fully and quickly. Subsequent lower cost maximums reflect the fact that the most onerous work in processing the claim will have been completed by these stages.

In setting these costs, we recognise that there are some cases which incur extra costs, in cases involving protected parties (children under the age of 18 and people lacking mental capacity). These costs include the legal work involved in preparing court documents, liaising with clients and attending a hearing as well as the cost of obtaining advice from Counsel. MoJ is considering the way forward on this issue as part of its work and recent consultation on extending Fixed Recoverable Costs in other areas and we will ensure this work is taken into account in any next steps for lower value clinical negligence claims. Subject to that, one option to account for these costs, is to have an additional, 'bolt-on' fee of £650 for these cases. This bolt-on amount is based on claim cost estimates from defendant representatives and is informed by similar existing costs within the FRC scheme for road traffic accident claims, as well as by the views of claimant representatives and the experience of using bolt-on costs for protected party cases in the 'Putting Things Right' scheme in Wales. We would welcome views on the level of this bolt-on cost which we will take into account prior to implementation.

Our proposed costs, which reflect the CJC defendant group position, are set out in the table below (all figures are exclusive of VAT and legal disbursements).



## Proposed grids of costs

These costs are based on defendant group costs suggested as part of the CJC working group process. Claimant and defendant group suggested costs are set out for comparison at Annex A.

**Table 1: Grid of costs - standard track**

Stage	Costs	Description of activity within FRC streamlined processes and maximum timeframe
<b>Stage 1 (ST(A) to ST(D))</b>	£5,500 plus 20% of damages agreed	All steps up to and including stocktake (the standard track process specifies this is a maximum period of 38 weeks from FRC letter of claim)
<b>Stage 2 (ST(E) to ST(F))</b>	£500 in addition to standard track stage 1	From stocktake up to and including neutral evaluation (the standard track process specifies this is a maximum period of 8 weeks)

**Table 2: Grid of costs - light track**

Stage	Costs	Description of activity within FRC streamlined processes and maximum timeframe
<b>Stage 1 (LT(A) to LT(B))</b>	£1,000 plus 10% of damages agreed	All steps up to 21 days after letter of response is due (the light track specifies this is a maximum period of 11 weeks from FRC claim notification letter)
<b>Stage 2a (LT(B) to LT(C))</b>	£500 in addition to light track stage 1	From 21 days after letter of response up to and including stocktake (the light track process specifies this is a maximum period of 1 week)
<b>Stage 2b (LT(D)(NFE) to LT(E)(NFE)); or (LT(D)(FE) to LT(H)(FE))</b>	£500 in addition to light track stages 1 and 2a	From stocktake up to and including neutral evaluation (the light track specifies this is a maximum period of 8 weeks if no further evidence is required following stocktake; or 24 weeks if further (non-liability) evidence is required.)

**Table 3: Protected party claims in standard or light tracks**

Stage	Costs	Description of activity
<b>Suggested bolt-on cost (Protected party claims only)</b>	£650 in addition to above stages	In recognition of extra work required in claims involving protected parties. Not applicable to non-protected party claims.

**Question 8: Do you agree or disagree with the proposed fixed costs framework based on the CJC Working Group 'defendant group' costs proposals, including the suggested bolt-on cost for protected party claims?**

- **Agree**
- **Disagree**
- **Don't know**

**Why?**

Please refer to 'Chapter 9: Fixed costs' and Tables 1 to 3 in the consultation document and give any reasons for your answer.

## 10. Mandatory neutral evaluation

The CJC set out a proposal for mandatory neutral evaluation (MNE), an evaluation of the claim to be carried out by an independent specialist barrister of a minimum level of experience selected from a pre-agreed panel. This is based on the expectation that a) the majority of claims will be settled at an earlier stage, including at the mandatory stocktake stage; and b) that there will always be a minority of cases in which agreement is difficult to reach in the pre-issue stage.

We agree with the CJC that in order to facilitate as many claims as possible to settle within the FRC scheme, there should be some form of neutral dispute resolution, capable of addressing all points at issue in a claim, and that this step must be mandatory and fair to all parties. At the same time, we agree it is important that the outcome of the evaluation should be non-binding so as not to preclude either party from accessing justice in the courts.

Although this is a new approach to resolution of clinical negligence claims, there is precedent for this approach in other areas of law, notably in the frequent use of family dispute resolution in the family courts.

We believe that the CJC's proposals on MNE support our aims to ensure as many claims as possible can settle fairly within the FRC process, and without the delay and disproportionate costs involved with claims that extend into the courts, though use of the courts will still be possible.

Our proposal, in line with the CJC report, is that if claims are not resolved at the mandatory stocktake stage of the process (or the further evidence stocktake stage in a minority of light track claims) there should be a mandatory, paper-only evaluation, with the evaluator providing a written opinion on their assessment of the likely outcome on liability, quantum or both aspects of a claim, as needed. In doing so, the evaluator will need to record and analyse the relevant parts of the evidence and to give reasons for their conclusions. This evaluation would then be provided to both parties within a 4-week period.

However, in most cases that progress to the evaluation stage, we expect the focus of any dispute to be on liability rather than quantum, as quantum can typically be addressed through negotiation.

In certain cases, it may be necessary for evaluators to move beyond the paper-only process and seek clarification from experts. However, if this were permitted in all cases, it would undermine the speed and cost effectiveness of MNE. We propose setting out, prior to implementation, criteria governing when this is permitted, so it is strictly limited to only the most complex of claims.

## Evaluator fees

We propose that the evaluator’s fees are shared equally at the outset by claimant and defendants who, having failed to agree a settlement at the mandatory stocktake stage, decide to take this further step. Evaluators will be paid a fixed fee for an evaluation, the amount to vary depending on whether the evaluation is on liability issues only, quantum only, or liability and quantum.

The CJC report included two sets of indicative evaluator fees proposed by the Bar group (with claimant approval) and the defendant group.

In line with the CJC report’s suggestion, we propose opting for the Bar Council version of fees for “liability and quantum” and “liability only” determinations but for the defendant suggestion for “quantum only”, which we believe better reflects the work involved in quantum only cases. These are as follows:

### Evaluator Fees

Type	Fee
Liability and quantum	£2,000
Liability only	£1,500
Quantum only	£750

Opting for the more generous Bar Council version, where more complex liability questions are at issue, recognises the novel nature of MNE in this area and seeks to be high enough to encourage barristers to take part.

To deter unnecessarily invoking the evaluation step (and therefore to encourage resolution at mandatory stocktake or earlier), we propose that in the event that the evaluator were to decide in favour of the claimant on liability, then the defendant should pay the entirety of the evaluator's fees. Similarly, where quantum is at issue, if the claimant were to beat the defendant's final (pre-evaluation) offer of damages, the defendant should pay the entirety of the evaluator's fees. If the claimant were to lose on liability at evaluation or fail to beat the defendant's final offer on quantum, evaluation costs should be shared equally between claimant and defendant.

For the avoidance of doubt, for claims within this FRC scheme, it will not be permissible for claimants to recover the cost of any portion of an 'after the event' insurance premium that relates to the cost of this type of evaluation. This is consistent with current practice on the recoverability of 'after the event' insurance premiums in clinical negligence cases, which is restricted to that part of a premium that relates to the cost of expert reports.

## Implementation of the mandatory neutral evaluation stage

The proposal to incorporate a neutral evaluation stage into the FRC processes is a novel solution designed specifically for clinical negligence claims in order to encourage as many claims as possible to settle prior to proceedings being issued.

Prior to proposed implementation we would put in place a number of logistical arrangements to facilitate and evaluate the new system. We propose:

- establishing a dedicated panel of specialist barristers to call upon to conduct the evaluations. This will include eligibility criteria for inclusion on the panel
- putting in place a method of random selection from the panel to ensure selection is fair and minimises delays. One veto per party would be permitted
- agreeing criteria governing where evaluators can go beyond a paper-only evaluation to interrogate expert evidence in a limited set of circumstances
- putting in place mechanisms specifically to evaluate the effectiveness of MNE, including an assessment of the proportion of cases that settle at MNE, to be considered in the post-implementation review of the FRC scheme.

**Question 9: Do you agree or disagree with the proposed arrangements for mandatory neutral evaluation, including the costs framework for evaluations and how these are funded?**

- **Agree**
- **Disagree**
- **Don't know**

**Why?**

Please refer to 'Chapter 10: Mandatory neutral evaluation' in the consultation document and give any reasons for your answer.

## 11. Excluded claims

Our proposed overarching definition of claims to be included in the FRC scheme is those claims for clinical negligence that have a value (based on value at settlement) in excess of the small claims track limit but not exceeding £25,000. Certain highly complex claims expected to be valued below the small claims track limit, but which would not be expected to be allocated to it due to their complexity may be included in the scheme. Claims with damages expected to marginally exceed the £25,000 band should be managed prudently from the outset as if they will be subject to FRC.

This section of the consultation sets out our proposals for special exceptions to this definition.

We recognise that certain types of cases are not suitable for inclusion in the FRC scheme. The CJC working group identified a number of exclusion categories that could be considered in the scheme design and claimant and defendant representatives contributed to these suggestions. Primarily the categories discussed in the CJC report involve a greater degree of complexity, sensitivity or special additional costs.

Our approach to exclusions is to consider where there may be exceptional complexity in certain clinical negligence claims which can involve more legal work and more time to achieve fair resolution. In addition, where claims necessarily entail discrete, unavoidable expenditures, we have considered whether they should be excluded from the scheme, or alternatively, whether the extra costs can be incorporated into the scheme. Our overarching intention is to ensure that the known complexity and variety of claims is fairly taken into account in the scheme design, whilst keeping exclusion categories straightforward and comprehensible to all.

Below is the list of claim categories that are excluded from the scheme.

### **Claims requiring more than 2 liability experts to be excluded**

We consider that claims requiring more than two liability experts on breach of duty of care and causation are likely to have an exceptional degree of complexity and should be excluded. Robust justifications for any further liability experts should be supplied at the point of notification of a claim. Parties should be prepared to present these justifications, should the claim progress to court, and account for any decision to seek more than two liability experts.

## **Claims with genuine multiple defendants (where allegations against each defendant are different) to be excluded**

We consider that claims involving more than one defendant can involve more complexity and workload in processing the claim. However, in order to be excluded from FRC, such claims must demonstrate that there are multiple defendants and that the allegations against each are distinct and different, and therefore genuinely complex.

Robust justifications explaining the genuine differences between allegations against different defendants must be supplied when a claim is notified. Parties should be prepared to present these justifications, should the claim progress to court.

## **Claims involving stillbirths or neonatal deaths to be excluded**

We consider that claims involving stillbirths or neonatal deaths are particularly sensitive in nature. The loss of a baby is, of course, particularly devastating to all those affected and can have long-term traumatising effects. We recognise that these families, in particular, are likely to require more support through the legal process and that these claims can often be highly complex in nature. These claims should be excluded from FRC on that basis.

The claimant position in the CJC working group was to exclude all fatal claims. Through our analysis and engagement with claimant and defendant representatives on this issue, we have concluded that fatal claims (other than stillbirths or neonatal deaths) are not categorically more complex or time consuming than other claims (except where there are costs associated with an inquest) and should not be excluded on that basis. However, the costs of an inquest in any fatal case should not be included in the fixed costs regime and should be recoverable where that is appropriate, as in the current system. Where an individual fatal claim is more complex because there are multiple liability experts or multiple defendants, it would of course be excluded on that basis.

## **Claims where limitation is raised by the defendant as an issue, to be excluded**

If, within 21 days of an FRC letter of claim (standard track) or an FRC claim notification letter (light track), limitation is raised as an issue by the defendant, we propose that the claim will drop out of the FRC scheme, in recognition of the likely complexity of these claims.

In addition, we agree with the recommendation of the CJC working group that there should be a formal suspension to the limitation period relating to any claim entering the FRC scheme. As the streamlined processes set out, this should be the case unless the defendant raises limitation as an issue within 21 days of service of the FRC letter of claim

in the standard track or the FRC claim notification letter in the light track. Limitation would then remain suspended until 8 weeks after exit from the FRC scheme. This proposal was agreed by the claimant and defendant groups within the CJC working group.

## **Protected parties to remain in the FRC scheme with an additional bolt-on cost**

We propose that all claims on behalf of protected parties (for example, children or people who lack mental capacity) should *remain in the fixed costs scheme* with a suggested additional bolt-on cost of £650 applied, to recognise the extra work involved in these claims (namely, preparing documents for court, attending a hearing in cases involving children or where mental capacity is an issue, obtaining advice from Counsel, and providing for extra time for legal support for these parties) (also see grid of costs in chapter 9.) In order to ensure consistency with MoJ's wider proposals in this area, we would welcome views on this approach, including on the level of the proposed bolt-on cost.

**Question 10: Do you agree or disagree with the proposals on claims to be excluded from the FRC scheme and on the approach to protected party claims?**

- **Agree**
- **Disagree**
- **Don't know**

**Why?**

Please refer to 'Chapter 11: Excluded claims' in the consultation document and give any reasons for your answer.



## 12. Sanctions to encourage adherence to the scheme

Our FRC proposals rely on all parties following the requirements of the streamlined processes and seeking rapid progress towards resolution. To ensure we incentivise all parties to work constructively within the processes set out and abide by the rules, we propose several sanctions to apply at different stages.

### **Timely defendant response**

Ensuring the defendant's response to the FRC letter of claim or FRC claim notification letter and bundle of evidence is received within the timelines set out for the standard and fast tracks

We propose strict adherence to time limits as follows. Deadlines set out in the streamlined processes must be adhered to. This is particularly important in the exchange of evidence at the beginning of the processes. A fair, timely and fulsome exchange at this point enables the possibility of rapid resolution. It is therefore imperative that the defendant responds in full to the claimant's FRC letter of claim within 6 months in the standard track. Similarly, the defendant must respond to the FRC claim notification letter in the light track within 8 weeks (indicating whether or not liability as to breach of duty of care and/or causation is admitted).

If these deadlines are not met, a standard track claim would fall out of the clinical negligence FRC scheme and will be processed according to the same arrangements made for clinical negligence claims above the upper limit for the scheme (£25,000). A light track claim will, if the deadlines are not met, recommence in the standard track (with an FRC letter of claim) and costs will be recoverable only for the standard track process (this is to ensure that claims are not inappropriately initiated in the light track).

Given the higher costs involved if a claim were to fall out of the scheme, (recovered from the defendant if the claimant succeeds), this sanction is intended to incentivise efficient and timely responses from defendants and their indemnifiers/insurers.

Non-adherence to other deadlines in the streamlined processes would not result in the claim dropping out of the FRC scheme. However, any instance of non-adherence to deadlines or undue delay should be detailed by either party and, in the event that the claim progresses to the court, may be included in the papers presented to the court in its consideration of costs.

We will seek to reflect in the Civil Procedure Rules (CPR) that failures to adhere to FRC process deadlines can be considered a conduct issue with potential cost consequences.

We think the most appropriate way to deal with non-adherence in these circumstances is to have a fixed percentage uplift to avoid unnecessary litigation. While we will need to consider this issue in the context of MoJ's wider work on extending fixed recoverable costs, we would welcome views on a proposed 50% reduction to the costs the claimant is able to recover from the defendant in the case of claimant delays. If a claim subsequently exited the FRC scheme, the 50% cost reduction would be either to FRC scheme costs or to standard costs, whichever results in a lower amount, following the reduction. For defendant delays, we would propose a 50% uplift to the damages claimants are entitled to recover from the defendant. Any penalties would apply to the relevant stage(s) in which non-adherence occurred.

## **Evidence quality**

**Ensuring the claimant's initial FRC letter of claim or FRC claim notification letter and bundle of evidence accords with rules of evidence set out in the Civil Procedure Rules (CPR) and is sufficiently detailed for the defendant to respond to the issues raised**

Parties must provide high quality, detailed, well organised bundles of evidence at the outset in order to enable rapid resolution. This is especially important in the initial exchange of evidence from the claimant to the defendant. If the claim letter and accompanying evidence are not sufficient to allow the defendant to understand the issues or to respond to the evidence and points of claim, the defendant could be placed at an unfair disadvantage or be at risk of not meeting the response deadlines. We will seek to reflect in the CPR the evidentiary requirements for evidence exchanged in the FRC process.

To guard against this, if the defendant is unable to respond in full due to a lack of sufficient and relevant information in the claimant's evidence bundle, we propose that the defendant is entitled to include in the response a formal explanatory statement setting out how any deficiency in the claimant's bundle has hindered a full response. The defendant must nevertheless respond within the allotted deadline.

Should the claim progress to court, any such explanatory statement by the defendant may be included in the evidence considered by a judge in the consideration of costs. We will seek to reflect in the CPR that failures to provide sufficiently detailed evidence at the outset of the FRC process can be considered a conduct issue with potential cost consequences in terms of limitations to the costs the claimant is able to recover from the defendant. This would mean a 50% reduction to the costs the claimant is able to recover from the defendant. If a claim subsequently exited the FRC scheme, the 50% cost reduction would be either to FRC scheme costs or to standard costs, whichever results in

a lower amount, following the reduction. Any penalties would apply to the relevant stage in which non-adherence occurred.

## **Mandatory neutral evaluation**

**Ensuring that parties are fairly and reasonably incentivised to come to agreement following the outcome of a mandatory neutral evaluation**

Our overall policy intent is to maximise the number of claims that achieve early resolution. The streamlined FRC processes we have set out have been designed to encourage resolution of a significant percentage of claims early in the process, without requiring a Mandatory Neutral Evaluation.

However, for difficult-to-resolve cases, the option of an evaluation will be open to parties and our aim is that as many as possible of those claims can settle following the evaluation outcome. It will be the case however, that the evaluation outcome is not binding on parties - parties will not be precluded from progressing the claim in the courts if they cannot come to agreement at that stage, or if they do not agree with the evaluator's recommendation.

To encourage resolution and avoid unnecessary use of the courts, we propose introducing a number of further sanction and safeguard elements.

Due to qualified one-way costs shifting, defendants in clinical negligence cases are liable to pay claimants' costs if they lose, whereas claimants are not liable to pay defence costs if they lose. There is already, therefore, a substantial financial risk and disincentive to the defendant of continuing to contest the claim in the courts. Some of the options we set out below apply to the claimant only, because we believe there is already sufficient disincentive to guard against defendants seeking to pursue issues in the courts unnecessarily.

These would include the following scenarios and applicable measures:

### **A. Presentation of evidence**

#### **Evidence presented should be consistent at evaluation and in court**

That a trial judge should consider the evidence exchanged pre-issue as presented to the evaluator, together with such additional oral or written evidence as the court permits, not different evidence.

This is to ensure genuine engagement with the evaluation by all parties and to guard against the risk of parties mounting one presentation of evidence at evaluation and then, if this were not to be successful, a different presentation in court. This prospect, if unaddressed, would undermine the FRC process and encourage unnecessary litigation.

Nothing in this proposal should prevent details of undue delays or of inadequate evidence, occurring at earlier stages of the FRC streamlined process as set out above, from being submitted to the court in its consideration of costs, where that is appropriate.

## **B. Claimant liability non-acceptance**

### **Claimant not accepting the evaluation recommendation on liability, then proceeding to court and losing, pays evaluation costs in full**

In the event that a claimant does not accept the evaluation recommendation on liability, proceeds to court and loses, the claimant would be liable to pay for the cost of the evaluation (rather than sharing the cost with the defendant, or the defendant bearing the full cost).

The purpose of this measure is to ensure there is a risk of further cost for a claimant in deciding to pursue the claim further in court following the evaluation, thereby incentivising engagement with the evaluation, serious consideration of the evaluator's recommendation and disincentivising unnecessary litigation and delay.

## **C. Claimant quantum non-acceptance i)**

### **Claimant not accepting the evaluation recommendation on quantum, then proceeding to court and failing to beat the recommendation by a sufficient margin, pays evaluation costs in full**

In the event that a claimant does not accept the evaluation recommendation on quantum, proceeds to court, and does not beat the recommendation by 20%, the claimant would be liable to pay for the cost of the evaluation (rather than sharing the cost with the defendant, or the defendant bearing the full cost).

As with scenario "B", the purpose of this measure is to ensure there is a risk of further cost for a Claimant in deciding to pursue the claim further in court following the evaluation, thereby incentivising engagement with the evaluation, serious consideration of the evaluator's recommendation and disincentivising unnecessary litigation and delay.

## **D. Claimant quantum non-acceptance ii)**

### **Claimant not accepting the evaluation recommendation on quantum, proceeding to court and failing to beat the evaluation recommendation by a sufficient margin, faces risk of limitations on cost recovery from defendant**

If a claimant rejects an evaluator's recommendation on issues of quantum and proceeds to court but fails to beat the evaluator's recommendation by 20%, it would be permissible to share the evaluation with the judge at the point when issues of costs are being decided, and the judge will consider whether there will be a 50% reduction to the amount the claimant can recover in costs from the defendant on grounds that the claimant rejected a reasonable quantum settlement.

The purpose of this measure is to introduce a risk of limited recovery of costs from the defendant if a claim is pursued in the courts on issues of quantum where there is little prospect of improvement. This is intended to incentivise resolution within the FRC scheme and avoid unnecessary litigation and delay.

Where a claim involving a protected party requires court approval, as is the case with children under the age of 18, use of the courts for those purposes would not invoke any of the above sanction provisions.

## Evaluating the effectiveness of the FRC scheme

Should the FRC scheme be implemented, as part of the monitoring and evaluation of the scheme in its first years of operation, the government will assess the effectiveness of any sanctions put into effect in the CPR to drive adherence to the rules of the scheme, achieve early resolution and minimise unnecessary use of the courts.

We will consider the outcomes of this evaluation in determining whether further or different sanctions are needed, including whether there should be costs consequences accompanied by a limited exception to qualified one-way costs shifting, in cases where an evaluator's recommendation is rejected by a party who subsequently loses at trial or fails to beat the evaluator's recommendation on quantum by a set percentage.

We will also consider, following evaluation, whether the clinical negligence fixed costs regime should be extended to activity taking place in the post-issue phase (once proceedings have been issued in the courts.)

### **Question 11: Do you agree or disagree with the proposals on sanctions to be considered and implemented by changes to the Civil Procedure Rules?**

- **Agree**
- **Disagree**
- **Don't know**

#### **Why?**

Please refer to 'Chapter 12: Sanctions to encourage adherence to the scheme' in the consultation document and give any reasons for your answer.

## 13. Implementing the FRC scheme

We have also considered the question of how to implement these proposals. The government's previous consultation on an FRC system for clinical negligence claims sought views on different options for implementing FRC a) by date of claim notification (the preferred option) or b) by date of incident. Under a), the FRC scheme would apply to all cases in which the FRC letter of claim (or FRC claim notification letter) is sent on or after the implementation date. Under b), FRC would apply to all incidents occurring after the implementation date. Views on these options were mixed, with a slightly higher number of respondents favouring b).

Our guiding principle in considering this issue has been to ensure that the changes we seek to make will lead to greater certainty and smoother implementation and will begin to deliver savings early.

We have taken on board concerns that date of incident implementation would mean a potentially substantial delay in the benefits of the scheme being felt by claimants and defendants. We also note the difficulties around establishing the date of incident in some cases, compared to the simplicity of a notification date. At the same time, we have noted concerns that date of notification implementation would apply to cases in which the lawyer and client have already entered into an agreement about fees and costs, and that costs may already have been incurred.

The balance we have sought is between ensuring that parties are able to be sufficiently prepared for the application of the FRC regime, but that the parameters of the scheme, including which claims should be included at implementation, can be readily identified and understood by all parties.

Accordingly, we propose that our FRC scheme will apply to claims included in the scheme where an FRC letter of claim (or FRC claim notification letter in the light track) were submitted on or after the implementation date.

**Question 12: Do you agree or disagree that the proposals on FRC should apply to claims where the FRC letter of claim (or FRC claim notification letter) was submitted on or after the implementation date of the scheme?**

- **Agree**
- **Disagree**
- **Don't know**

**Why?**

Please refer to 'Chapter 13: Implementing the FRC scheme' in the consultation document and give any reasons for your answer.

## 14. Reviewing the upper limit for claims

The £25,000 limit we are proposing for the FRC scheme functions to ensure that lower value clinical negligence claims representing a significant proportion of overall claims, are settled more quickly and at lower cost.

However, we know that currently the value of claims is rising faster than the volume of claims. Over time, this means that an increasingly large proportion of claims will be settled above £25,000 and would therefore be excluded from the FRC scheme.

To ensure this effect does not negate the benefits of our proposed FRC scheme and the proportion of claims included in it, we will review the £25,000 limit either as part of the wider post-implementation review stage or sooner, depending on how rapidly damages inflation has increased, with a view to preserving the proportion of overall claims included. The review would only consider an increase to the limit that reflects the rate of claim value inflation over the period in question. Thereafter, we will review the limit at regular intervals.

**Question 13: Do you agree or disagree that the £25,000 upper limit for scheme claims should be reviewed post-implementation, and at regular intervals thereafter, specifically to take account of the effects of claims inflation?**

- **Agree**
- **Disagree**
- **Don't know**

**Why?**

Please refer to 'Chapter 14: Reviewing the upper limit for claims' in the consultation document and give any reasons for your answer.

## 15. Impact on businesses, including small and micro businesses

Our proposals articulate a new way of handling and processing claims in order to achieve faster, more cost-effective resolution. Some elements of the processes we set out are novel, such as the mandatory neutral evaluation stage and are likely to require all parties to learn and adapt. Supporting other elements, such as the requirement to prepare and exchange evidence early, may involve changes to existing ways of working and the way resources are allocated.

Claimant legal firms, defendant panel firms, and in certain cases, indemnifiers or insurers, including NHS Resolution, will all need to consider whether they will need to adapt their operations to support the streamlined processes and mandated elements set out in these proposals, and if so, how best this can be achieved. Healthcare providers, including providers in the private or not for profit sectors may also want to consider how best they can support these processes.

As part of this consultation, we want to understand what those considerations, adaptations and impacts on businesses may be, so these can be taken into account in taking these proposals forward.

As well as generalised impacts, we are seeking views on whether small and micro businesses – in particular, law firms that are also small or micro businesses – could be disproportionately affected by the new scheme.

The department carried out analysis of data available on the Law Society website to understand the composition of the clinical negligence market. We do not have access to employee numbers but have considered the number of solicitors in each firm as an appropriate proxy. If the manual census results are representative, 20% of small firms active in the clinical negligence market might rely on clinical negligence work as a key revenue source.

We would therefore welcome any views from small or micro business law firms, or other small businesses on how these proposals might affect them and if there are differential or disproportionate impacts.

If implemented, we would continue to evaluate these impacts and the effectiveness of these proposals with specific reference to small and micro businesses.



**Question 14: What are your views on how the proposals in this consultation might impact businesses involved in handling and processing lower value clinical negligence claims?**

Please refer to 'Chapter 15: Impact on businesses, including small and micro businesses' in the consultation document, when answering.

**Question 15: What are your views on how the proposals in this consultation might differentially or disproportionately impact small and micro businesses such as:**

- **law firms**
- **other small or micro businesses involved in supporting the handling or processing of lower value clinical negligence claims?**

Please refer to 'Chapter 15: Impact on businesses, including small and micro businesses' in the consultation document, when answering.

## 16. Equalities impact

It is fundamental to the policymaking process to undertake a robust consideration of health disparities and to assess and understand how different groups are impacted differently or disproportionately by the policies we implement.

Throughout the development of these proposals, we have placed a high importance on taking equalities into consideration, including the impact of these changes on different groups, particularly those with protected characteristics under the Equality Act 2010.

The department carried out analysis of demographic information relating to groups with protected characteristics under the Equality Act 2010. This includes analysis of the age, race and disability protected characteristics, for which there was available data. We also considered income as a factor although this is not a protected characteristic. There is no data available relating to certain protected characteristics (of religion or belief, gender reassignment, sexual orientation, pregnancy and marriage or civil partnership). For the characteristics assessed, the analysis concluded that the scheme is unlikely to have a direct negative impact on any group. Further information on impact on groups with protected characteristics is sought in this consultation. The consultation responses will be analysed and will inform decisions taken on the proposals.

The existing data suggests that the scheme could have a disproportionate indirect impact (but there was not evidence for a negative impact) on people with certain characteristics, including disability and age. The reason for this indirect impact is that people in these groups have more frequent interactions with the healthcare system and, as a result, increased likelihood of experiencing an incident. We would expect individuals from these groups to continue to experience and claim for adverse events at slightly higher rates, regardless of the introduction of the FRC scheme. According to the policy intent of the proposals in this consultation, all groups, including older people and people with disabilities, should benefit from the faster resolution of claims facilitated by the scheme.

Responses to the 2017 consultation on introducing an FRC scheme highlighted as a potential risk that the scheme may prevent individuals with lower incomes from accessing justice to the same extent as higher earners. The reasoning given was that people with a lower income may receive comparatively less compensation for loss of earnings, one of the potential heads of loss in a damages assessment. There was insufficient data available to draw conclusions from an analysis of income levels. However, our analysts were able to make assumptions based on related protected characteristics including sex, disability and age which may correlate with lower income. These were analysed and no groups with protected characteristics were found to be directly impacted by the introduction of the scheme. It should also be emphasised that our FRC proposals fix legal costs, not compensation levels. There should be no direct effect of the FRC scheme on the amount of damages people receive in compensation.

Employment status was also analysed to make assumptions about income. We concluded that the scheme would not have a direct effect on the unemployed, as the proportion of unemployed individuals in the £1,000 to £25,000 claim value bracket did not differ significantly from the proportion in the overall claims sample. There is a higher proportion of retired individuals in the £1,000 to £25,000 claim value bracket compared to the overall sample. This correlation is likely to be due to the fact that this group is predominantly comprised of older people who tend to have more frequent contact with the healthcare system and are more likely to experience an adverse incident. As previously discussed, we expect this group to continue to make claims regardless of the introduction of an FRC scheme.

We believe that the proposals set out in this consultation will have a beneficial effect on all relevant claimants and their families, predominantly because the focus is on achieving faster resolution of legal claims and reducing the costs, delay and distress involved with protracted legal action, compared with the current system. This means that everyone making a claim should have more certainty, more quickly and that people who have been harmed and have a meritorious claim should receive their compensation sooner.

We have been mindful of the potential impacts on people's access to justice. We have carefully assessed our proposals to ensure that these risks are minimised, in particular, by calibrating the processes and associated fixed costs to support claimants' rights to bring a claim, obtain legal representation and pursue justice in the courts, if needed.

We have also ensured the proposals take account of the needs of vulnerable groups. We have excluded from the proposed FRC scheme, claims involving a stillbirth or neonatal death, in recognition of the special sensitivities around these claims and the support needs of the families.

We have suggested and are seeking views on a separate bolt-on cost of £650 for claims involving protected parties (children or people lacking mental capacity) in recognition of discrete activity and costs associated with those claims (for example applying to a judge for a decision on cases involving children or where mental capacity is an issue, obtaining Counsel's advice and providing for extra time for legal support for these parties) and to ensure protected party claimants can access justice and benefit from rapid resolution within the FRC scheme. The level of this bolt-on cost would be kept under review post-implementation to ensure it continues to support these aims and takes into consideration wider work on bolt-on costs being taken forward by the Ministry of Justice.

We are seeking further views in this consultation on how any groups with protected characteristics may be impacted by these proposals. If implemented we would continue to evaluate the impacts and effectiveness of these proposals with specific reference to groups with protected characteristics under the Equality Act 2010, including an assessment of the effectiveness of the proposals in taking into account the needs of vulnerable people.

**Question 16: What are your views on how the proposals in this consultation might impact:**

- **people with protected characteristics as defined under the Equality Act 2010**
- **health disparities or**
- **vulnerable groups?**

Please refer to 'Chapter 16: Equalities impact' in the consultation document and the accompanying 'Equalities Impact Assessment', when answering.

# 17. Summary of consultation questions

The following is a list of all the questions we are seeking views on in this consultation.

**Question 1: Do you agree or disagree with the proposed definition for claims falling within the FRC scheme?**

- **Agree**
- **Disagree**
- **Don't know**

**Why?**

Please refer to 'Chapter 6: Claims that would fall within the scheme' and Figure A of Annex C in the consultation document and give any reasons for your answer.

**Question 2: Do you agree or disagree that the proposed scheme should incorporate a twin track approach, following the CJC model, to enable simpler, less contentious cases to progress more quickly to resolution?**

- **Agree**
- **Disagree**
- **Don't know**

**Why?**

Please refer to 'Chapter 7: A twin track approach' and Figure A of Annex C in the consultation document and give any reasons for your answer.

**Question 3: Do you agree or disagree with the proposed criteria for claims being allocated to the light track?**

- **Agree**
- **Disagree**
- **Don't know**

**Why?**

Please refer to 'Chapter 7: A twin track approach' in the consultation document and give any reasons for your answer.

**Question 4: Do you agree or disagree with the proposals for streamlined processes in the standard track?**

- **Agree**
- **Disagree**

- **Don't know**

**Why?**

Please refer to 'Chapter 8: Streamlined processes for standard track and light track claims', and Figure B of Annex C in the consultation document and give any reasons for your answer.

**Question 5: Do you agree or disagree with the proposals for streamlined processes in the light track?**

- **Agree**
- **Disagree**
- **Don't know**

**Why?**

Please refer to 'Chapter 8: Streamlined processes for standard track and light track claims', and Figures C and D of Annex C in the consultation document and give any reasons for your answer.

**Question 6: What are your views on the evidentiary requirements applying to both standard and light track claims, that should be set out in the Civil Procedure Rules to support this FRC scheme?**

Please refer to 'Chapter 8: Streamlined processes for standard track and light track claims', in the consultation document, with particular regard to stages ST(A), ST(B), (LT(A) and LT(B), when answering.

**Question 7: Do you agree or disagree in principle that template letters and expert report model elements should be used as part of the streamlined processes in both the standard and light tracks?**

- **Agree**
- **Disagree**
- **Don't know**

**Why?**

Please refer to the 'Template letters' section of 'Chapter 8' and Annex B in the consultation document, giving any reasons for your answer, and providing any views or suggestions you may have for the format and content of the letter templates or expert reports.

**Question 8: Do you agree or disagree with the proposed fixed costs framework based on the CJC Working Group 'defendant group' costs proposals, including the suggested bolt-on cost for protected party claims?**

- **Agree**
- **Disagree**
- **Don't know**

### Why?

Please refer to 'Chapter 9: Fixed costs' and Tables 1 to 3 in the consultation document and give any reasons for your answer.

**Question 9: Do you agree or disagree with the proposed arrangements for mandatory neutral evaluation, including the costs framework for evaluations and how these are funded?**

- **Agree**
- **Disagree**
- **Don't know**

### Why?

Please refer to 'Chapter 10: Mandatory neutral evaluation' in the consultation document and give any reasons for your answer.

**Question 10: Do you agree or disagree with the proposals on claims to be excluded from the FRC scheme and on the approach to protected party claims?**

- **Agree**
- **Disagree**
- **Don't know**

### Why?

Please refer to 'Chapter 11: Excluded claims' in the consultation document and give any reasons for your answer.

**Question 11: Do you agree or disagree with the proposals on sanctions to be considered and implemented by changes to the Civil Procedure Rules?**

- **Agree**
- **Disagree**
- **Don't know**

### Why?

Please refer to 'Chapter 12: Sanctions to encourage adherence to the scheme' in the consultation document and give any reasons for your answer.

**Question 12: Do you agree or disagree that the proposals on FRC should apply to claims where the FRC letter of claim (or FRC claim notification letter) was submitted on or after the implementation date of the scheme?**

- **Agree**
- **Disagree**

- **Don't know**

**Why?**

Please refer to 'Chapter 13: Implementing the FRC scheme' in the consultation document and give any reasons for your answer.

**Question 13: Do you agree or disagree that the £25,000 upper limit for scheme claims should be reviewed post-implementation, and at regular intervals thereafter, specifically to take account of the effects of claims inflation?**

- **Agree**
- **Disagree**
- **Don't know**

**Why?**

Please refer to 'Chapter 14: Reviewing the upper limit for claims' in the consultation document and give any reasons for your answer.

**Question 14: What are your views on how the proposals in this consultation might impact businesses involved in handling and processing lower value clinical negligence claims?**

Please refer to 'Chapter 15: Impact on businesses, including small and micro businesses' in the consultation document, when answering.

**Question 15: What are your views on how the proposals in this consultation might differentially or disproportionately impact small and micro businesses such as:**

- **law firms**
- **other small or micro businesses involved in supporting the handling or processing of lower value clinical negligence claims?**

Please refer to 'Chapter 15: Impact on businesses, including small and micro businesses' in the consultation document, when answering.

**Question 16: What are your views on how the proposals in this consultation might impact:**

- **people with protected characteristics as defined under the Equality Act 2010**
- **health disparities or**
- **vulnerable groups?**

Please refer to 'Chapter 16: Equalities impact' in the consultation document and the accompanying 'Equalities Impact Assessment', when answering.



## 18. How to respond

Comments on these proposals can be submitted:

- Via the [online survey](#)
- By post to: Clinical Negligence FRC Consultation, NHS Policy and Performance, Department of Health and Social Care, 39 Victoria Street; London SW1H 0EU
- By email to [FRCconsultation@dhsc.gov.uk](mailto:FRCconsultation@dhsc.gov.uk)

The consultation will close at 11:45pm on 24 April 2022.

### Confidentiality

The department will manage the information you provide in response to this consultation in accordance with the department's Personal Information Charter.

The department will process your personal data in accordance with the Data Protection Act 2018 (DPA), and in most circumstances, this will mean that your personal data will not be disclosed to third parties.

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

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply, including obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided, as confidential. If the department receives a request for disclosure of the information, we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the department.

## 19. Conclusion

Making the legal process around lower value clinical negligence claims more efficient and streamlined is a goal shared by all. It was this shared endeavour that motivated participants in the Civil Justice Council working group to come to consensus on so many issues when developing the report recommendations.

We believe the proposals we set out in this consultation, if implemented, will make it possible for more claimants to access justice and compensation more quickly and at lower cost. The cost savings we project as a result of these reforms would be an important contribution towards addressing the unsustainable rises in clinical negligence costs we have seen over recent years.

Ultimately, we want to foster a system where people are compensated fairly and cost-effectively so that less of the money we give to the NHS is diverted from the work to support and improve frontline healthcare services, including the improvements we are continuing to make to patient safety in the NHS.

At the same time, we know that, as with any FRC scheme or other mandated legal reform, the changes we are proposing may necessitate adjustments to the way claims are prepared and managed. All parties will need to consider how best they can support the requirements of the processes set out in these proposals and, if necessary, improve the efficiency of their claims handling. Claimant and defendant solicitors, as well as others, will need to ensure their systems, resources and internal processes are fit for purpose to meet the requirements of the FRC scheme so that people who want to bring a claim for clinical negligence can benefit from faster resolution.

We are confident that these proposals are achievable by all and that they will represent a step change in the speed and efficiency of lower value claim handling, which will be of benefit to claimants, defendants and taxpayers alike.

We welcome your views on the proposals we set out in this consultation and their impacts.

# Glossary

Term	Definition
<b>Access to justice</b>	The principle that every person has an equal opportunity to seek justice under the law and the processes that provide people with the appropriate means to enforce their legal rights.
<b>Adverse incidents</b>	An event that causes, or has the potential to cause, unexpected or unwanted effects involving the safety of patients or other persons.
<b>After the event insurance (ATE)</b>	A type of commercially available insurance policy which provides coverage for legal costs, subject to an agreed limit of indemnity. An ATE insurance policy can provide cover for legal costs incurred in pursuing or defending legal proceedings.
<b>Alternative dispute resolution (ADR)</b>	A variety of ways of solving a problem without having to go to court. NHS Resolutions claims mediation service has been designed to support patients, families and NHS staff in working together towards the resolution of incidents, complaints, legal claims and costs disputes – avoiding the unnecessary expense, time, stress and potential emotional distress of going to court.
<b>Breach of duty of care</b>	A key element of clinical negligence liability. In determining liability, a duty of care and a breach of that duty must be established. In order to prove whether the healthcare provider breached their duty of care, a claimant will need to show that what the healthcare provider did or failed to do was not supported by a responsible body of clinicians at the time and / or was not logical.
<b>Causation</b>	A key element of clinical negligence liability. Having established a breach of duty, the claimant must also demonstrate that the breach resulted in some injury or damage. This is usually done with reference to the 'but for' and balance of probabilities test – i.e., but for the breach of duty, was it more likely than not (more than 50%) that the injury would have been avoided.
<b>Civil Procedure Rules (CPR)</b>	The rules of civil procedure used by the Court of Appeal, High Court of Justice, and County Courts in civil cases.
<b>Civil Procedure Rule Committee (CPRC)</b>	Set up under the Civil Procedure Act 1997 to make rules ("the Civil Procedure Rules") of court for the Civil Division of the Court of Appeal, the High Court and the County Court. The CPRC is an advisory non-departmental public body of the Ministry of Justice. The Civil Procedure Rules set out the practice and procedure to be followed in civil justice cases, including personal injury cases.
<b>Clinical negligence</b>	Occurs when a doctor or other health care professional breaches their duty of care to the patient, resulting in physical and/or mental harm and

	suffering and injury. Where there is negligence that causes harm, the law enables the victim to claim compensation.
<b>Clinical Negligence Scheme for Trusts (CNST)</b>	An indemnity scheme providing cover for NHS bodies including NHS Trusts, Foundation Trusts, and Clinical Commissioning Groups as well as some independent sector providers of NHS services for claims for incidents occurring on or after 1 April 1995.
<b>Clinical Negligence Scheme for General Practice (CNSGP)</b>	An indemnity scheme operated by NHS Resolution to cover clinical negligence claims for incidents occurring in general practice on, or after, 1 April 2019.
<b>Civil Justice Council (CJC)</b>	An advisory non-departmental public body sponsored by the Ministry of Justice. The Civil Justice Council (CJC) is responsible for overseeing and co-ordinating the modernisation of the civil justice system.
<b>Compensation</b>	Monetary, or sometimes non-monetary benefits, awarded to someone in recognition of loss, suffering, or injury.
<b>Conditional fee agreement (CFA)</b>	A funding arrangement between a claimant and their lawyers where lawyers agree to act on a 'no win, no fee basis'. If the claimant wins their case, the lawyers are paid their base costs along with a success fee. The claimant will usually recover the base legal costs payable from the defendant. If the case is lost, the claimant will generally not have to pay their legal fees. A CFA may be entered into alongside insurance arrangements which reduce or eliminate the other costs (such as for medical reports or defendant's costs) for which a claimant may be liable.
<b>Damages</b>	A sum of money claimed or awarded in compensation for a loss or an injury.
<b>DHSC</b>	Department of Health and Social Care
<b>Duty of care</b>	The obligation placed on healthcare practitioners to act in accordance with the relevant standard of care which is the standard expected of an ordinarily competent practitioner performing that particular task or role.
<b>Duty of Candour</b>	This is the legal duty of NHS organisations to inform and apologise to patients where something unexpected or unintended happens that causes, or could cause moderate or severe harm, death or prolonged psychological harm.
<b>Expert evidence</b>	This is provided by experts (medical and non-medical) and can cover whether negligence has occurred, whether the negligence caused injury or financial loss, and on the value of the losses claimed. Whilst they are usually instructed by the claimant and/or the defendant, they owe their duties to the court. This "overriding duty to the court" means they must provide their complete opinion on matters within their expertise. Their duty is to inform the court of their entire opinion even if it harms the position of the party instructing them.

<b>Existing Liabilities Scheme for General Practice (ELSGP)</b>	An indemnity scheme operated by NHS Resolution for NHS clinical negligence claims made against current and former GP members of medical defence organisations (MDOs) in respect of liabilities incurred before 1 April 2019. This applies where terms have been agreed between the government and the MDO in question.
<b>Equality Act 2010</b>	Legally protects people from discrimination in the workplace and in wider society.
<b>Fast track cases</b>	Defended cases in the civil courts are assigned to one of 3 tracks, one of which is the fast track (the others are the multi-track and the small claims track. The fast track is generally for claims with a value of between the small claims track limit and £25,000. Due to their relative complexity, most clinical negligence claims under £25,000 are currently allocated to the multi-track rather than the fast track.
<b>Fixed recoverable costs (FRC)</b>	An arrangement in which the legal costs recovered by the successful party in litigation are limited according to agreed rates. This does not, in itself, affect the sum a lawyer charges a client, which is matter of private agreement. Nor does it affect the amount of compensation awarded to the claimant (although increased damages may be payable based on penalties applied to the defendant). It solely affects the legal costs that a claimant can recover from the defendant following a successful claim.
<b>General damages</b>	Compensation following a tort for non-financial (non-pecuniary) losses, including pain, suffering and loss of amenity (PSLA).
<b>Indemnity</b>	Cover provided to healthcare staff and their employers for expenses arising from clinical negligence claims.
<b>Liability</b>	Legal responsibility – for example for an act of negligence resulting in personal injury.
<b>Light track claims (Clinical negligence FRC)</b>	Claims falling under our proposals in this consultation, which are considered more straightforward, especially where liability is not in dispute.
<b>Mandatory neutral evaluation (MNE)</b>	An approach to dispute resolution set out by the CJC, MNE is a mandatory evaluation of a claim to be carried out by an independent specialist barrister of a minimum level of experience selected from a pre-agreed panel. It would apply to claims not resolved earlier in the process, and the outcome would be non-binding: claimants would be free to pursue their claim in the Courts.
<b>Medical Defence Organisations (MDOs)</b>	Mutual non-profit organisations owned and funded by their members. Their primary purpose is to indemnify healthcare professionals for incidents arising from their clinical care of patients and provide their members 24-hour access to advice on medico-legal issues arising from practice. The 3 main MDOs are the Medical Defence Union (MDU), the

	Medical Protection Society (MPS) and the Medical and Dental Defence Union of Scotland (MDDUS).
<b>Multi-track cases</b>	Defended cases in the civil courts are assigned to one of 3 tracks, one of which is the multi-track (the others are the fast track and the small claims track.) The multi-track is generally for very complex cases with a value of £25,000 or more. Due to their relative complexity, most clinical negligence claims under £25,000 are currently also allocated to the multi-track.
<b>National Audit Office (NAO)</b>	The UK's independent public spending watchdog. They support Parliament in holding the government to account for the way it spends public money. They do this by auditing the finances of public bodies. They do not question the merits of government policies but assess whether resources have been used efficiently and effectively.
<b>Never event</b>	"Never events" are defined by NHS England and Improvement (NHSE&I) as "Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers". NHSE&I's policy on never events and list of never event incident types are available online at: <a href="https://improvement.nhs.uk/resources/never-events-policy-and-framework">https://improvement.nhs.uk/resources/never-events-policy-and-framework</a> .
<b>NHS Resolution (NHSR)</b>	An arm's-length body of the DHSC (the operating name of NHS Litigation Authority from April 2017).
<b>NHS Trusts</b>	Self-governing administrative body within the NHS; usually a group of hospitals. An NHS trust provides services on behalf of the NHS in England and NHS Wales.
<b>NHS Wales Shared Service Partnership (NWSSP)</b>	An independent organisation owned and directed by NHS Wales. NWSSP supports NHS Wales through the provision of a comprehensive range of high quality, customer focused support functions and services.
<b>Particulars of claim</b>	Sets out the facts that the claimant relies upon in their claim, including allegations made against the defendant. Served upon the defendant at the same time as, or shortly after, serving the Claim Form.
<b>NHS Patient Safety Strategy</b>	Published by NHS England and Improvement in 2019 the strategy sets out plans for how safety will be improved over the next decade. The strategy focuses on fostering a safety culture underpinned by learning, developing safer national systems, and improving localised capability to embed safety into how healthcare professionals think and act.
<b>Qualified one-way cost shifting (QOCS)</b>	Regulation introduced for personal injury claims from April 2013. This means that defendants will generally be ordered to pay the costs of successful claimants but subject to certain exceptions, will not recover their own costs if they successfully defend the claim.

<b>Quantum</b>	See 'Damages'.
<b>Settled claims</b>	Claims where damages have been agreed or successfully defended.
<b>Small and micro businesses</b>	Small businesses are defined as those employing between 10 and 49 full-time equivalent (FTE) employees. Microbusinesses are those employing between one and 9 employees. Small and micro businesses include voluntary and community bodies (also known as civil society organisations).
<b>Small claims track</b>	Defended cases in the civil courts are assigned to one of 3 tracks, one of which is the small claims track (the others are the multi-track and the fast track). The small claims track is intended to provide a simple and informal way of resolving disputes. The small claims track upper limit for personal injury claims including clinical negligence claims is currently £1,000. The £1,000 small claims track limit is due to increase to £1,500 in April 2022.
<b>Standard track claims (Clinical negligence FRC)</b>	Claims falling within our proposals in this consultation (where the value is estimated to be in excess of the small claims limit for non-road traffic accident, personal injury claims (currently £1,000) up to and including £25,000) should be progressed on the FRC standard track unless they meet the conditions set out for entry on the FRC light track or are otherwise excluded under the exclusion categories. Certain unusually complex claims with an expected settlement value at below the small claims limit may also be progressed on the FRC standard or light tracks.

## Citation

References in this document are cited in citation style: Harvard (University of Southampton)

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# Annex A: Civil Justice Council Working Group – suggested grids of fixed recoverable costs

Included in the Civil Justice Council Working Group report, "[Fixed Recoverable Costs in Lower Value Clinical Negligence Claims](#)", including claimant group and defendant group proposals.

## Standard track

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

## Light track

Stage	Description	Claimant group proposal	Defendant group proposal
1	All steps up to 21 days after letter of response is due	£2,500 plus 25% of damages agreed	£1,000 plus 10% of damages agreed
2a	From 21 days after letter of response up to and including stocktake	£1,500 plus further 5% of damages agreed, in addition to stage 1	£500 in addition to stage 1
2b	From stocktake up to and including neutral evaluation	£500 in addition to stages 1 and 2a	£500 in addition to stages 1 and 2a



## Annex B: Template letters

### Fixed recoverable costs letter of claim (suggested template)

To Defendant

Dear Sirs,

#### Fixed recoverable costs letter of claim

**[Claimant's name] –v- [Defendant's Name]**

We have been instructed to act on behalf of [claimant's name] in relation to treatment carried out/care provided at [name of hospital, GP or treatment centre] by [name of clinician(s) if known] on [insert date(s)]. Please let us know if you do not believe that you are the appropriate defendant or if you are aware of any other potential defendants.

#### Address for service of particulars of claim

Unless you advise to the contrary, we will use the following address and details to effect service of the particulars of claim:

[Details of healthcare provider's address for service.]

#### Claimant's details

Full name, date of birth, address, NHS Number, national insurance number and details of all NHS hospitals attended as a result of the alleged injury.

#### Limitation

On the application of limitation principles, a claim must be brought within 3 years of the date of injury or date of knowledge. For the purposes of limitation, we calculate that any proceedings will need to be issued on or before [date]. However, limitation is suspended on entry to the scheme by service of an FRC letter of claim and remains suspended until 8 weeks after exit from the scheme. In the first 21 days after service of the FRC letter of claim the defendant can expressly raise limitation as an issue in writing and if this was to occur then the limitation waiver would cease 28 days from this notice (as the case would exit the scheme).

#### Dates of allegedly negligent treatment/ events giving rise to the claim

- no detailed chronology required

- include brief summary of key facts on relevant dates, including details of other relevant treatments by other healthcare providers.

### **Light track [delete if not applicable]**

Based on the information currently available to us, it is our view that this case meets the criteria for the Light Track and as such we do not intend to produce expert medical evidence. We have set out the allegations of negligence and brief details on how this case meets the criteria referred to. You should notify us within 21 days if you disagree with this approach, otherwise we are entitled to assume that you do not disagree with this approach and will continue to conduct this claim in accordance with the Light Track Rules.

### **Allegation of breach of duty of care and where applicable details of the how the light track criteria have been met.**

- A concise outline of each of the allegations of breach of duty said to have caused damage, injury or loss, or reference to paragraphs [XYZ] of the appended medical report in simpler cases if preferred
- We enclose:
  - a copy of supportive witness statement of fact, if any, limited to maximum of 2 witnesses [name], dated [date]. [Note: subject to clarification as to cases where no factual witness evidence is required]
  - a copy of supportive expert evidence [name, field of expertise] dated [date]. [Note: subject to clarification as to cases where no expert evidence is needed on breach of duty]

### **Allegation of causation**

- An outline of the causal link between each of the corresponding allegations of breach of duty above and the injuries complained of, or reference to paragraphs XYZ of the appended medical report in simpler cases if preferred;
- We enclose:
  - a copy of supportive expert evidence [name, field of expertise] dated [date] [subject to clarification as to cases where no expert evidence is needed on causation]

### **Conditions and prognosis:**

- Details of the claimant's injuries and prognosis.

- Suggestions for rehabilitation and/or future treatment;
- We enclose a copy of supportive expert report [name, field of expertise] dated [date] [subject to clarification as to cases where no expert evidence on quantum is required];

**Damages (set out below or enclose schedule of loss)**

(i) General damages (by reference to relevant JCB guidelines and any relevant case law);

(ii) Details of the claimant's special damages are calculated as follows:

- Past care – estimate of amount of care provided, by whom and for how long etc together with hourly rate sought
- Loss of earnings – details of any statutory sick pay; loss of bonus etc
- Travel expenses to and from hospital – copies of any receipts available enclosed

(iii) Total estimated value of the claimant's claim: (i) + (ii) above

We enclose relevant documents relating to quantum for example wage slips, P60, receipts.

**Clinical records**

We enclose an index of all the relevant records that we hold and copies of core medical documents.

**Offer**

[An offer to settle the claim.]

[The offer should state whether it is net or gross of CRU and whether the claimant has a copy of the current CRU certificate and the value on it, if any, or if they believe the value of the CRU to be nil.]

**Funding**

- Confirmation fixed costs case
- Confirmation of conditional fee agreement (CFA) and 'after the event' (ATE) insurance (if applicable) [Please note that we have entered into a CFA with our client dated xxx in relation to this claim and that our client has taken out a policy of after the event insurance dated xxx with provider xxx under policy number xxx with a level of cover of £xxx. Please note that we shall seek to recover part of the ATE insurance premium from your client at the conclusion of the claim if successful.]

- Alternatively, confirmation of LSC, BTE or DBA funding (if appropriate).

We enclose a further copy of this letter for you to pass to your insurer, Defence organization or NHS Resolution as appropriate.

We look forward to receiving an acknowledgment of this letter within 21 days and your letter of response within 6 months of the date on which this letter was received. We calculate the date for receipt of your letter of response to be [date].

We look forward to hearing from you.

Yours faithfully.

## **Letter of response (suggested template)**

### **To Claimant**

**Dear Sirs**

**[Claimant's name] –v- [Defendant's Name]**

We have been instructed to act on behalf of [defendant] in relation to treatment carried out/care provided to [claimant] at [name of hospital or treatment centre] by [name of clinician(s) if known] on [insert date(s)].

### **Parties**

It is accepted that [defendant] had a duty of care towards [claimant] in respect of [details if required] treatment/care provided to [claimant] at [location] on [date(s)]. However, [defendant] is not responsible for [details] care/treatment provided to [claimant] at [location] on [date(s)] by [name of clinician if known].

[If the defendant believes the claim should be addressed to an alternative defendant, that defendant should be specified].

### **Records and documents**

We hold the following records:

[List all records defendant holds for the claimant and provide copies of updated records i.e. any that post-date those previously provided to the claimant]

We enclose the following documents:

[Provide copies of any relevant documents including protocols/guidelines, complaint files, SUI roles or duty of candour documents]

We require copies of the following records:

### **Comments on events and/or chronology**

We [agree the chronology enclosed with the FRC letter of claim] [or set out a revised chronology of events (it is not sufficient to say the claimant's chronology is agreed insofar as it accords with the records, any dispute should be set out)].

## **Liability**

In respect of the specific allegations raised by the claimant, the defendant [has obtained an expert opinion and] responds as follows:

[Each allegation should be addressed separately. The defendant should explain which (if any) of the allegations of breach of duty and/or causation are admitted and why. The defendant should also make clear which allegations are denied and why. The defendant must set out its case on causation – it is not acceptable to state that causation is not being investigated because breach of duty is denied]

Where liability is denied, the defendant must include:

- a reasoned denial
- experts' reports on breach of duty and causation (limited to a maximum of 2 such liability experts of different medical disciplines)
- witness statements (limited to 2 witnesses, statements in template form including a statement of truth)

## **Quantum**

[The defendant must state if quantum is agreed. If it is not, the defendant must provide a counter schedule and valuation of general damages together with any supporting witness evidence (where appropriate), JC Guidelines, case law and any other documents]

## **Resolving the claim**

[If liability is admitted but quantum is not agreed, the defendant should make an offer of settlement. If liability is denied the defendant may either: make a counteroffer or propose resolving the case at a stocktake discussion].

The claimant is requested to acknowledge receipt within 21 days.

Yours faithfully.

## **Agreed-upon expert report model elements to be present in claimant and defendant expert reports.**

Expert report elements agreed as part of the CJC Working Group process include the following:

1. Name of claimant
2. Name of defendant
3. Expert's name
4. Area of expertise
5. Details of any expert accreditation
6. Expert's contact details
7. Party's details and reference number
8. Documentation considered
9. Key date chronology
10. Opinion on breach of duty and/or causation
11. Range of professional opinion, where this exists
12. Details of any relevant texts/literature
13. Expert declaration

# Annex C: FRC process flowcharts

Figure A: FRC process overview

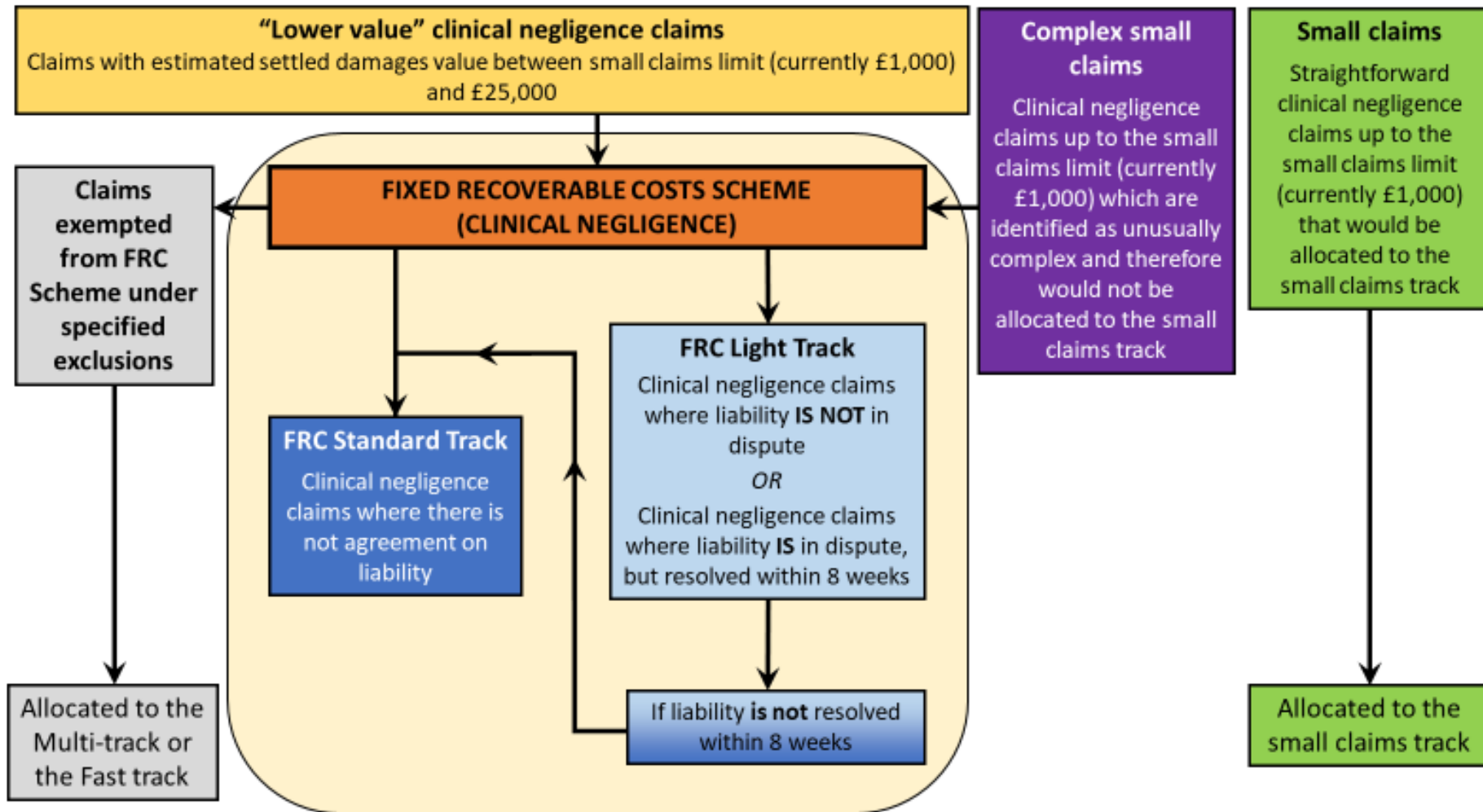




Figure B: Standard track process flowchart

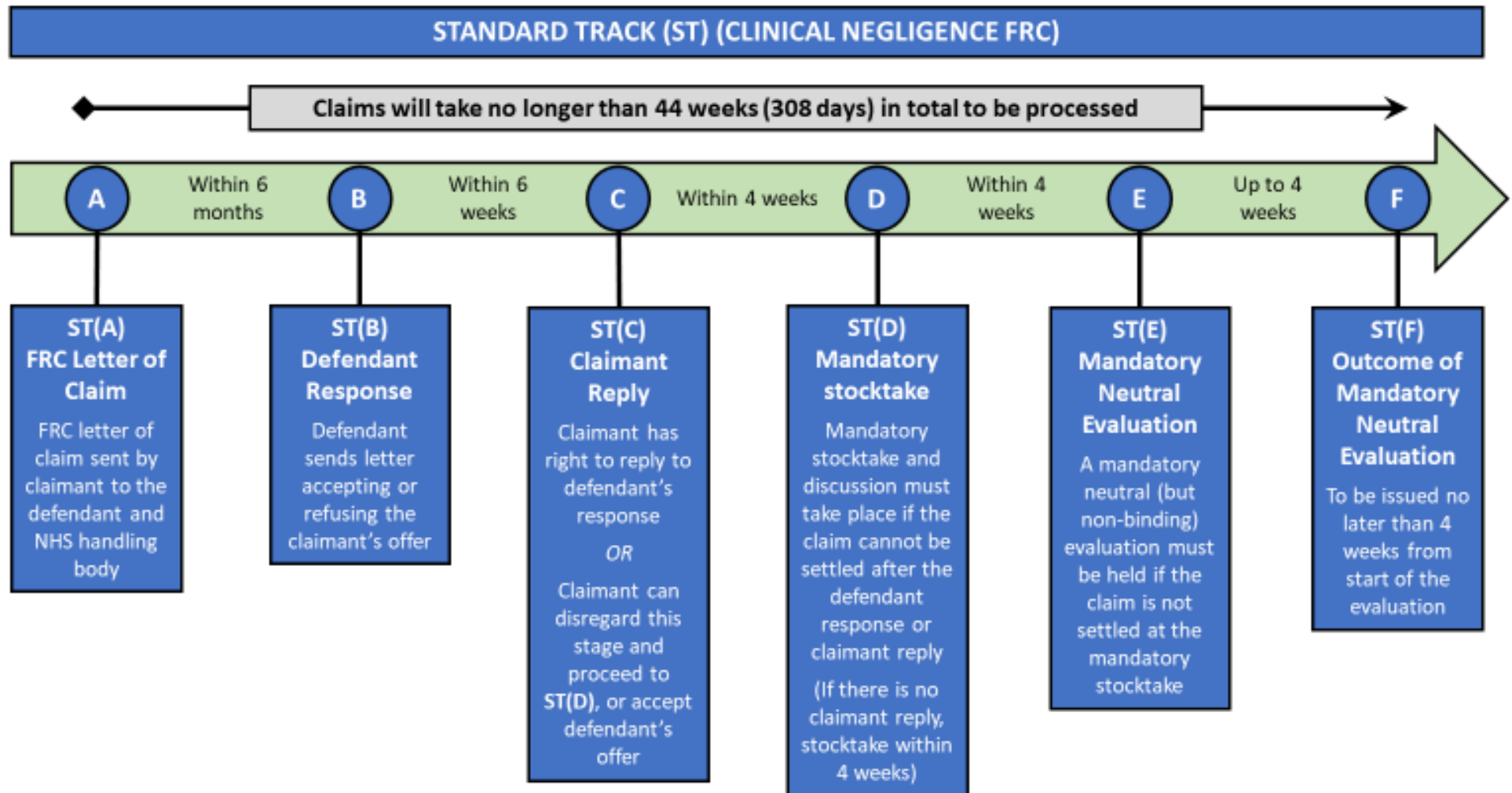


Figure C: Light track (no further evidence) process flowchart

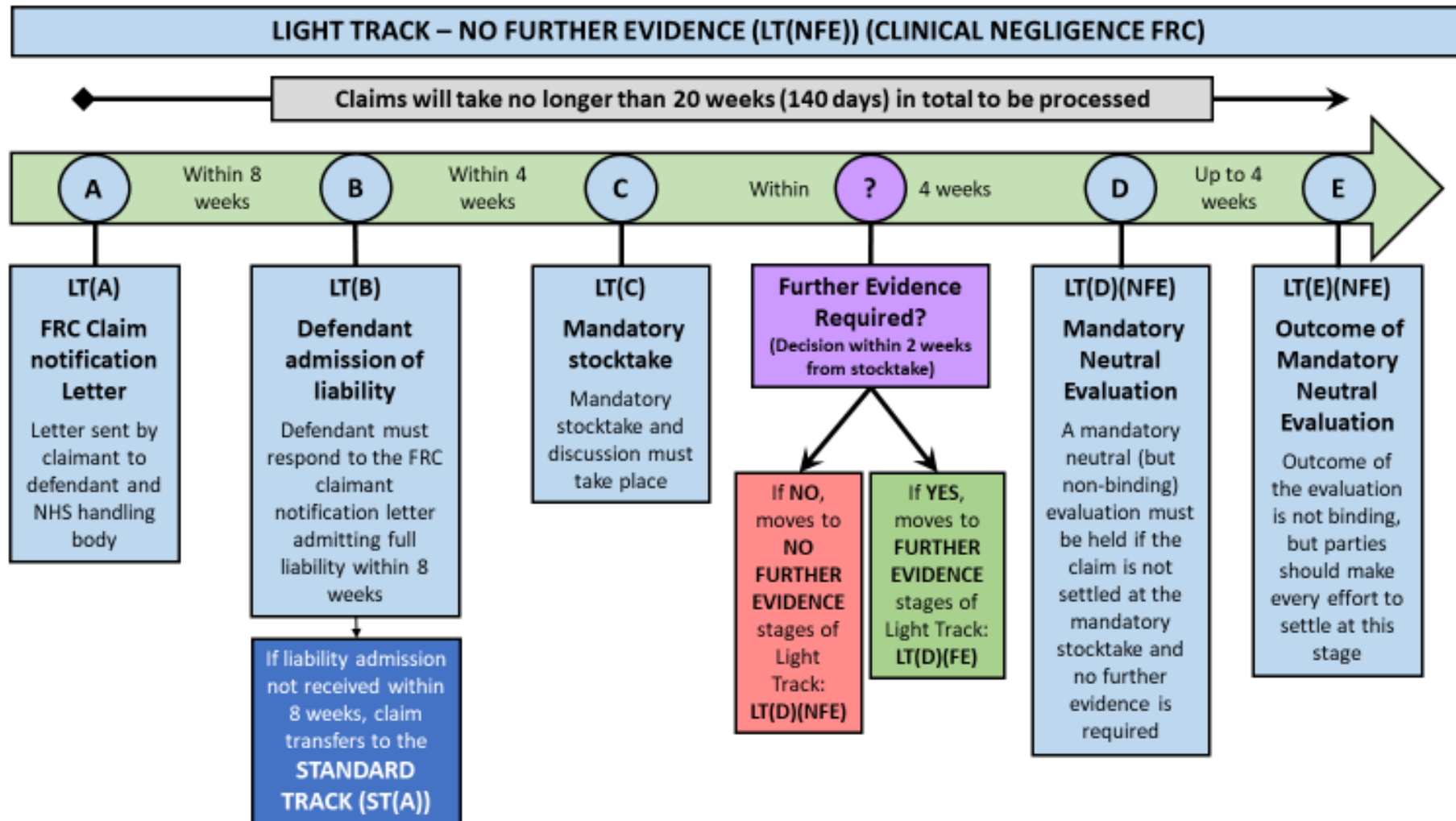
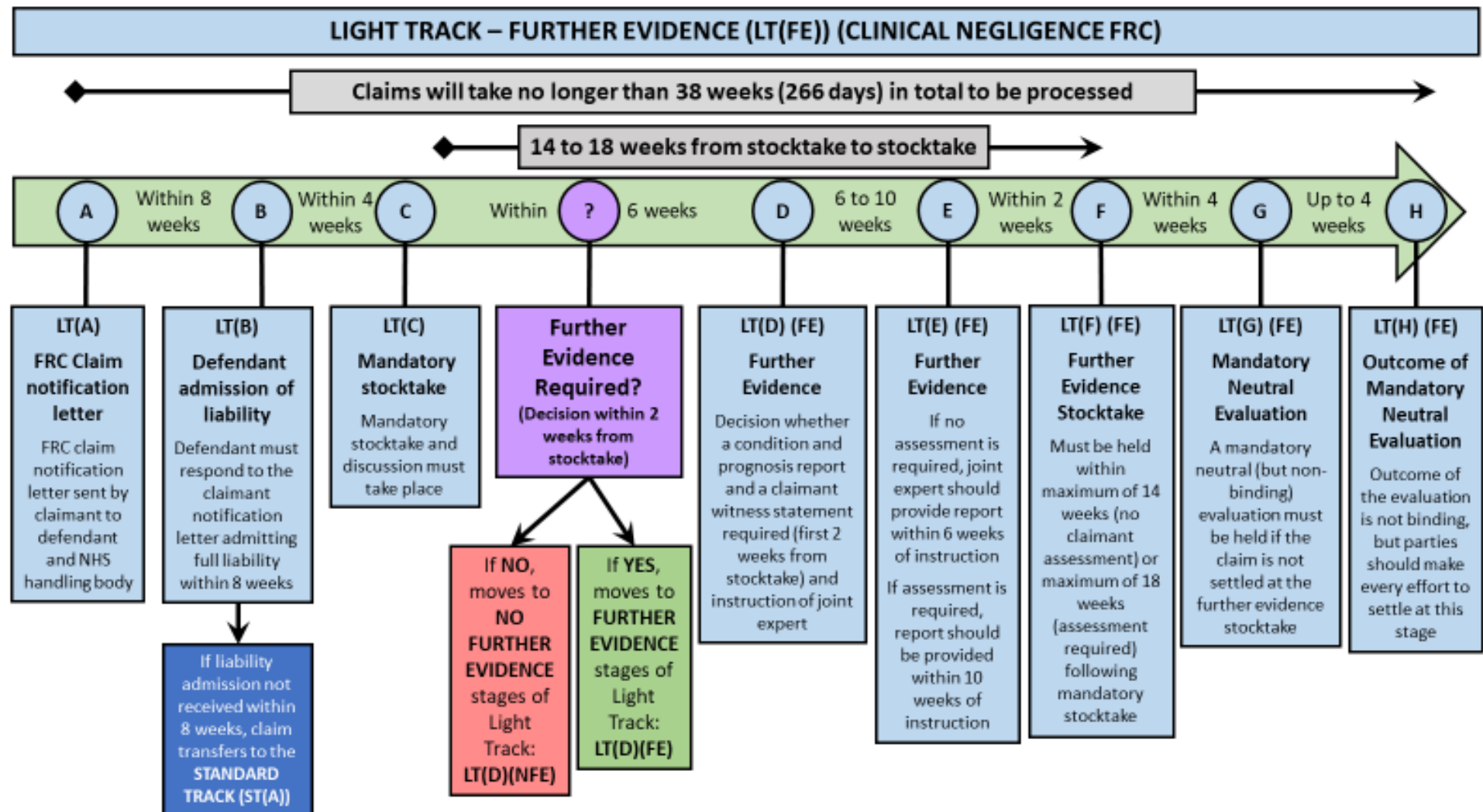


Figure D: Light track (further evidence) process flowchart



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NHS Group/Clinical Negligence Team

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