Department of Health & Social Care

Consultation on Introducing Fixed Recoverable Costs in Lower Value Clinical Negligence Claims

Summary of Consultation Responses

February 2018

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Author: Patient Experience, Resolution and Maternity Team, Acute Care & Quality Directorate Cost Centre: 13620
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Contents

1. Introduction

This document sets out a summary of the views provided in response to the consultation paper, 'Introducing Fixed Recoverable Costs in Lower Value Clinical Negligence Claims' published on 30 January 2017.

It will cover:

- the background to the consultation;
- a summary of the responses to the consultation;
- a detailed response to the specific questions raised in the consultation;
- the next steps following this consultation.

Further copies of this report and the consultation paper can be obtained by contacting:

Patient Experience, Resolution and Maternity Team

Acute Care and Policy Directorate, Department of Health

Quarry House,

Quarry Hill,

Leeds

LS2 7UE

Email: FRC-Consultation@dh.gsi.gov.uk

Alternative format versions of this publication can be requested from the above address.

Complaints or comments

If you have any complaints or comments about the consultation process you should contact the Department of Health at the above address.

2. Background

The consultation paper 'Introducing Fixed Recoverable Costs in Lower Value Clinical Negligence Claims' was published by the Department of Health on 30 January 2017. It invited comments on how 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. Alongside this document the Department also published an Impact Assessment, a draft of the Revised Civil Procedure Rules and an independent evaluation of the proposals and indicative costs by Paul Fenn, Emeritus Professor at Nottingham University Business School.

The consultation explained that the proposals to introduce fixed costs are a key strand in the Government's programme to improve patient care and patient experience, and the efficiency and cost-effectiveness of clinical negligence claims. These proposals would support quick and more cost effective resolution to low value clinical negligence claims brought against the NHS, while ensuring that learning and safer clinical practice results from incidents of harm.

The proposals focused on a number of key issues:

- How should such a scheme be implemented? Should a fixed cost scheme be introduced on a mandatory basis? Should all cases above £1,000 and up to £25,000 be included?
- How should the rates be calculated? Is it best to base the costs allowed on an estimate of the time taken to run a case or on current cost data? Should fees include a percentage of damages? Should there be a reduction in the fees allowed in cases where there is an early admission of liability?
- How should we account for other costs? Is it appropriate to introduce a cap on the expert witness costs? We also sought views on the possibility of introducing a single joint expert.
- How should cases be run under a fixed cost scheme? Should there be an early exchange of evidence? Are there any types of cases that should be automatically exempt from the scheme?
- What would be the equalities impact of the proposals?

The consultation closed on 2 May and this report summaries the responses.

A list of respondents is included at Annex A.

Alongside the consultation the Department asked Professor Fenn to collect further data and produce revised cost estimates. This report has been published alongside the consultation response and is summarised at Annex B.

3. Summary of responses

Demographics

The Department is very grateful to those individuals and organisations that took the time to respond to the consultation.

A total of 167 responses were received. The largest proportion of responses (64) came from law firms although there were also responses from individual solicitors and barristers. Of those respondents who are currently practising law nearly 90% represent the claimant-side or both claimants and defendants.

Responses were also received from representative bodies (24), other types of organisation (17), healthcare providers (9) and health insurance organisations (5).

Headlines

The results show a somewhat complex picture where different groups of stakeholders hold different views on the proposals for the introduction of FRC (see table below). The majority of responses provided are from individuals and organisations from a legal background (i.e. individuals or organisations such as solicitors, barristers, law firms, legal representative bodies, professional bodies etc.) and most of those are from practising law professionals.

When asked whether they agree that Fixed Recoverable Costs for lower value clinical negligence claims should be introduced on a mandatory basis, the table below shows a slight majority disagreed with the proposals overall (58%) with more variation within key stakeholder groups.

Do you agree that Fixed Recoverable Costs for lower value clinical negligence claims should be introduced on a mandatory basis?	Yes	No
Overall	42%	58%
Practising Law Professionals Representing Claimants	15%	85%
Practising Law Professionals Representing Claimants and Defendants	60%	40%
Practising Law Professionals Representing Defendants	86%	14%

For example, the responses show those currently practising law and representing the claimant side (37% of total responses to the consultation) most strongly oppose FRC (85% above). However, there was variance of opinion within this group, reflecting a breadth of knowledge and expertise in representing the claimant side.

In comparison, practising law professionals representing the defendant side appeared to strongly support the proposals (86% above) overall, while those representing both the claimant and defendant side appeared to be more evenly split (approx. 60% support, 40% oppose). However, it should be noted that the samples are much smaller for these two groups (18% and 8% of total responses to the consultation) than for those representing the claimant side; therefore these results should be treated with caution.

To add to the complexity, a range of additional feedback was provided around the proposed design and implementation of FRC. This suggests most respondents - whether they support or oppose FRC - have identified specific aspects of the proposal that they would like to consider further.

This was evident in the responses with details such as the most appropriate methodology for setting rates, the method for implementation, and most of the eight constituent parts of the Civil Procedure Rules all garnering no overall agreement or disagreement from those responding.

There were also frequent calls for a working party to be established to more fully consider how FRC could work in practice if introduced. This is something that the Department has agreed to take forward as the most appropriate mechanism to engage all stakeholder groups in the design of a potential FRC scheme.

Arguments against

The main arguments made against the introduction of any fixed cost scheme to clinical negligence cases were:

- Potential to drive cost - it was argued that fixing costs may actually drive cost elsewhere in the claims process. Examples given included that under a fixed cost regime claimant firms may not be able to afford to properly sift cases. Respondents argued this would lead to an increase in the number of cases being brought and although a higher proportion of these cases would be meritless they would still need to be investigated and processed by the defendant side. On the issue of single joint experts 10% of respondents said that this could lead to disputes in choosing experts leading to satellite litigation which would increase costs.
- Access to justice - respondents repeatedly noted that the proposals put at risk injured patients' access to justice, redress and appropriate compensation. This is because in the view of some respondents, claimants may not be able to find a solicitor prepared to work within a fixed fee arrangement. Concerns were registered particularly for claimants from vulnerable groups, such as the elderly or bereaved, who, due to the nature of the damages awarded to such claimants, may find it particularly difficult to find legal representation. When discussing access to justice it was also often noted that the protection of this principle requires that claimants have access to specialist legal advice. Under a fixed cost regime experienced claimant firms may choose to exit the market. This could leave injured patients with inexperienced legal advice or as litigants in person. This was not seen as a satisfactory outcome for vulnerable patients and it was also suggested it has the potential to drive cost elsewhere in the system.
- Complexity of clinical negligence - it was generally accepted by most respondents that clinical negligence is more complex than other forms of personal injury; that clinical negligence cases are rarely 'typical' and that certain costs are incurred regardless of the ultimate level of damages awarded. It was argued therefore that it is inappropriate to apply a 'one-size fits all' approach to recoverable costs to clinical negligence.
- Proportionality - some went further and made the case that it is misguided to compare damages with recoverable costs, or claimant costs with defence costs and that pursuing greater proportionality is ill-judged. Respondents noted that there are irreducible costs to bringing a clinical negligence claim and that these costs apply regardless of the damages

ultimately awarded. It was also argued similarly that it costs more to establish a claim than to defend one.

- Premature - a great number of responses noted their belief that the proposals in the consultation were premature. Generally there were two main arguments cited - the first concerns the fact that the extent of the savings due from the Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPO) are still largely unknown in terms of clinical negligence. This is because clinical negligence cases tend to take some time to settle and therefore there is only a small sample of such cases which have been brought and settled post-LASPO. The second line of argument here is that the proposals were published before Lord Justice Jackson's Review of Civil Litigation Costs (LJJ Review) or the NAO review had time to present their findings.
- Patient safety - some respondents believe that the proposals risk patient safety. They argued that if access to justice is impeded and cases with merit are not brought then the NHS cannot benefit from learning generated by this incident of harm. In addition, many respondents argued that the Department should first focus its efforts on improving patient safety so that incidents of harm do not occur in the first place. It was noted that in many ways launching a civil suit is an action of last resort for injured patients and that most are not seeking compensation but rather want acknowledgement and adequate explanation and an apology. It follows therefore that efforts should be made to improve patient experience, complaints handling and investigations to reflect this.
- Suspicion of the Department - some respondents added to their critique of the scheme their unease that these proposals were being brought forward by the party who would benefit most from the implementation of fixed costs in clinical negligence cases.

Arguments for

Those respondents who were supportive of the proposals appreciated that as a publicly funded service, the NHS has to account for how funds are spent and ensure that public funds paid towards legal costs are not disproportionate or unreasonable. There is a general view amongst those who supported the FRC scheme proposals that costs associated with claims up to £25,000 are now often disproportionate and there is a desire to make savings on cost and protect scarce NHS resources for frontline care.

The main arguments made for the introduction of any fixed cost scheme to clinical negligence cases were that;

- It would change defendant/claimant lawyers behaviours and deliver cost savings - throughout the responses a main theme was that defendants and claimant lawyers needed to change behaviours. Those that supported the proposals said that the proposed scheme will incentivise both defendants and claimant solicitors to make speedy resolutions to individual cases as the ability for both sides to build up disproportionate legal costs wouldn’t be available. This would save costs as a result.
- It would benefit any successful claimant - it was recognised that the aim of these proposals was to ensure that those patients unfortunately harmed as a result of negligent treatment

whilst receiving NHS care, can receive compensation. Respondents felt that these proposals would allow patients who did suffer harm to potentially achieve resolution of their case much faster and in a much less stressful way than at present.

- Defendant solicitors have for some years undertaken work on a fixed fee basis - it was pointed out by some respondents that defendant solicitors successfully defend many cases to trial, within the parameters of a fixed recoverable costs scheme so respondents thought it wasn't unreasonable to expect claimant lawyers to work under similar limits.

There were however two distinct thoughts on what value of cases should fall within any FRC Scheme:

- Support for the scheme to apply to cases between £1,000-£25,000 only - many respondents were content that the FRC scheme could be introduced to non-complex, low value clinical negligence cases up to £25,000, where the issues were straightforward and that there were suitable exemptions for complex or unusual cases such as for the elderly, still births or people with disabilities.
- Support for the scheme to apply to cases beyond the £25,000 limit. Some respondents believed the proposed cap of £25,000 for the FRC scheme is too low and should be extended. Various suggested caps were mentioned ranging from a limit of £50,000, £100,000 and £250,000. The reason given for this was that with changes to the Discount Rate, a £25,000 upper limit would mean that the number of cases that would fall within the scope of our FRC proposals would be limited and deliver minimal savings. There was also a suggestion that some claimants may seek to inflate the value of claims in order to exit the FRC regime proposed and that the higher limit would prevent this.

Nearly all respondents who were in favour did however express some caution about the proposed scheme. The overriding theme from those who were supportive of the proposals wanted to ensure that any new costs regime for clinical negligence prioritised improving patient care by ensuring effective learning of lessons from incidents, with the ultimate aim of reducing harm and therefore instances of clinical negligence. Respondents were concerned that the Department needed to remember that many clinical negligence cases do have value other than financial, deaths of the elderly and still births are two examples given, and that any scheme introduced should include provision for exceptions for complex cases.

There were also concerns that although supportive of the principle of FRC the costs needed to be set to a reasonable level and updated regularly to take into account inflationary costs.

Throughout the responses there were repeated calls from both sides for the Government to set up a working group to examine the process through which low value clinical negligence cases are managed and alongside a new fixed costs scheme.

4. Responses to specific questions

4.1 Implementation

Question One: Do you agree that Fixed Recoverable Costs for lower value clinical negligence claims should be introduced on a mandatory basis?

Table One: Should FRC be introduced on a mandatory basis?	
Yes	64 (42%)
No	89 (58%)
Not answered	14

Just over half of respondents (58%) did not want to see fixed recoverable costs introduced, with just under half (42%) supporting implementation.

The additional responses showed some respondents displayed strong feelings towards FRC. For this reason further analysis was conducted on the demographic breakdown of responses to this question to locate any variations between specific groups.

The results show that of the 153 respondents who answered this question, three-quarters (75%) were from a legal background (i.e. individuals or organisations such as solicitors, barristers, law firms, legal representative bodies, professional bodies etc.). Of these 106 respondents are currently practising law - 58% represent the claimant side, 28% represent both claimants and defendants and 13% represent defendants only.

While it must be noted that the sample is relatively small overall, the results show almost nine out of ten (85%) respondents currently practising law and representing the claimant side oppose fixed recoverable costs. In comparison, 14% of those practising law and representing defendants oppose FRC. Within the group of practising professionals who represent both claimants and defendants the response is fairly evenly split (approx. 60% support fixed recoverable costs, 40% oppose).

In short, fixed recoverable costs are most strongly opposed by practising law professionals representing the claimant side. This demographic analysis provides additional context for the more detailed explanations provided by respondents.

Within the small majority of respondents (58%) who did not want to see fixed recoverable costs for clinical negligence introduced on a mandatory basis, 83% are from a legal background (solicitors, barristers, law firms, legal representative bodies, professional bodies etc.) with the majority (72%) of those currently practising law representing the claimant side.

Many who held this view were also opposed to the introduction of fixed recoverable costs in any form in principle, and used this question as an opportunity to rehearse arguments against the introduction of fixed costs in clinical negligence at all.

The main arguments given against the introduction of fixed recoverable costs on a mandatory basis centred on the risk that under fixed costs patients will find it more difficult to find a solicitor willing to represent them and this will mean that access to justice is impeded. Respondents also noted that this possible effect on access to justice has the potential to disproportionally impact those from vulnerable groups - for example the elderly or unemployed. It was also advised that

patient safety will suffer if there is a restriction in the cases that are being brought against the NHS and other healthcare providers.

The consultation document noted that applying fixed costs to clinical negligence is an extension of similar schemes that already apply in other forms of personal injury. However, those respondents who disagree with this extension in principle noted that clinical negligence cases are significantly more complex, and therefore more costly, to litigate.

A number of these respondents outlined their belief that the proposals are premature given that the full effect of the LASPO reforms is yet to be known. Also, at the time the consultation proposals were launched, the Lord Justice Jackson review and the NAO report 'Managing the costs of clinical negligence in trusts' had yet to be published.

Arguments were also made that the Department should focus its efforts on encouraging a culture of learning within the NHS and reducing incidents of harm alongside work to improve patient experience and complaints handling; and that these interventions would improve the health service for patients and would have the secondary impact of reducing the cost of clinical negligence cases.

Amongst these responses there was also some criticism of defendants and the suggestion that poor claim handling by defendants and a culture of 'deny, delay and defend' is responsible for a large proportion of increased claimant legal costs.

The remaining 42% of respondents agreed that fixed recoverable costs should be introduced on a mandatory basis.

Within this group just under two-thirds (64%) are from a legal background (solicitors, barristers, law firms, legal representative bodies, professional bodies etc.). Around a quarter (22%) of those currently practising law represent the claimant side, with a further 39% representing both claimants and defendants and 24% representing defendants only.

Within the group of respondents who indicated that a fixed cost regime should be mandatory there was some doubt about whether a voluntary fixed costs regime could work; how would participation in such a scheme be incentivised, given that there would be such a strong disincentive for claimant solicitors to operate their cases within the cost constraints of a voluntary scheme?

Respondents in support of mandating the scheme also noted that caution should be exercised around how a fixed cost regime fits with creating a good learning culture in the system and satisfactory redress for patients.

There were repeated calls for a working group to be set up to look at what improvements can be made to the claim process and how to incentivise better claims-handling and behaviours on both sides. This working group would also examine a new fixed cost structure within a new process.

Question Two: which cases should fixed recoverable costs apply to?

Table Two: Do you agree that Fixed Recoverable Costs should apply in clinical negligence claims:	
Option A: above £1,000 and below £25,000	49 (35%)
Option B: another proposal	91 (65%)
Not answered	27

The Department's preferred option was that cases be included in fixed recoverable costs based on final settlement value; the proposed threshold for inclusion was claims worth over £1,000 and up to £25,000.

A majority of respondents (65%) suggested that another proposal was preferable. Three-quarters (74%) of this group were responding from a legal background and the majority (61%) are practising professionals representing the claimant side.

There were various other suggestions both around the value thresholds and whether claim value is the most appropriate criteria through which to determine inclusion in fixed recoverable costs.

Just over a third (35%) of respondents agreed with the preferred option. Again this group was mainly comprised of respondents from a legal background (73%) but the majority of the group were practising professionals representing both claimants and defendants (35%). Approximately 20% of those agreeing with the Department's preferred option were practising professionals representing claimants.

Similarly to question 1, a significant proportion of respondents - around a fifth - outlined their opposition to the introduction of fixed recoverable costs in clinical negligence and used this question to provide evidence to support this position. The themes were broadly similar to those already outlined in previous sections.

Of those who agreed with the premise that case value should be used to determine entry into a fixed cost scheme there was some disagreement about the appropriate thresholds. Those on the claimant-side who agreed that case value is the most sensible criteria to determine inclusion in fixed costs tended to argue that the upper threshold of £25,000 was appropriate or that it should be reduced. Some noted pleasure in the fact that this upper ceiling had been scaled back based on the pre-consultation exercise. Responses from the defendant side – that is NHS providers, the Medical Defence Organisations and defendant lawyers - were more likely to suggest that the threshold for inclusion in a fixed cost scheme be higher than the upper ceiling proposed. A number of responses advocated an upper cap of up to £250,000 or indicated that the scheme could initially start with cases up to £25,000 and be extended later.

Of those who proposed alternative criteria there was broad agreement that case value is a poor proxy for complexity in clinical negligence and therefore not an appropriate criteria against which to fix claimant-side costs. Respondents generally wanted any scheme to reflect this complexity. It was suggested that it might be more appropriate for fixed costs to apply to 'simpler' cases – a number of responses suggested that a scheme could work if it applied to fast-track cases only or to those in which liability was admitted.

There was broad agreement that whatever the criteria for inclusion it would be important for the fee structure to be appropriate and that exemptions would be needed in order to preserve access to justice.

Question Three: how should fixed recoverable costs be introduced?

Table Three: which option for implementation do you agree with?	
Option 1: all cases in which the letter of claim is sent on or after the proposed implementation date	36 (25%)
Option 2: all adverse incidents after the date of implementation	47 (32%)
Another proposal	62 (43%)
Not answered	22

In the consultation document the Department outlined two proposed implementation options; the preferred option was that fixed costs apply to all cases in which a letter of claim is sent after the implementation date. Under this proposal there was some allowance made for the need of transitional arrangements. The second option was that fixed costs apply based on the date of the incident of harm.

There was no clear agreement amongst respondents on the method of implementation. Around a quarter (25%) of respondents agreed that fixed recoverable costs should apply based on the date of the letter of claim; however more respondents - just under a third (32%) - were in support of implementation based on the date of the adverse incident. More still, just under half (43%) of responses outlined an alternative proposal. As with the responses to other questions, the theme of opposition to the introduction of fixed recoverable costs for lower value clinical negligence was present in these responses.

Those who were in support of implementation based on the letter of claim date believe that this approach would lead to greater certainty, smoother implementation and deliver savings earlier than other approaches.

The critique of this approach included that it would apply to cases in which the lawyer and client have already entered into an agreement about fees - possibly a conditional fee arrangement - and in which investigatory work, and therefore cost, has already been incurred. Without an appropriate transition this approach would apply retrospectively. Over a quarter of all responses raised this issue.

Similarly, some argued that basing inclusion in fixed recoverable costs on the date of the letter of claim would lead to a spike in claims as solicitors rush to complete investigatory work and prepare letters of claim, therefore getting cases started under standard cost-budgeting rather than any new fixed cost approach. It is possible not just that there is an increased volume of cases but also that these are of poorer quality. The argument was made that there is an associated risk of increased satellite litigation around what is and isn't an appropriate letter of claim with this implementation option.

Respondents in support of implementation based on date of incident noted that this is a fairer approach in that it would avoid fixed costs being applied to cases that are already underway. However it was also noted that introducing fixed costs on this basis would mean that it would take a longer time to implement as there would be a 'long tail' of cases being processed under the previous cost budgeting system and that this could be seen as too generous to the claimant-

side. This would mean that the savings possible from introducing fixed costs would take longer to materialise. The difficulty of establishing the date of incident was also commented upon.

Of those respondents who outlined other implementation options around a fifth of respondents suggested to fix costs based on when the harmed patient entered into an arrangement with a claimant firm - the date of retainer. The arguments given in support of this new approach are that 'date of retainer' represents a midpoint between date of incident and letter of claim and that this would hopefully avoid a spike in claims or a long implementation phase.

A number of respondents advocated a transition period.

4.2 Setting the rates

Question Four: how should the rates be set?

Table Four: looking at the approach, do you prefer:	
Option 1: staged flat fee arrangement	18 (14%)
Option 2: staged flat fee arrangement plus % of damages awarded	5 (4%)
Option 3: early admission of liability arrangement	22 (17%)
Option 4: cost analysis approach	28 (21%)
Option 5: another proposal	58 (44%)
Not Answered	36

The consultation document set out a number of potential rate setting methodologies and illustrative figures. There were two proposals on which to base the rate; either work by an NHS LA advisory group on the time taken to progress a case or analysis by Professor Paul Fenn concerning the current costs incurred. Both approaches assume an efficiency based on the more streamlined process proposed in the draft rules that accompanied the consultation.

The Department also sought views on three variants of these; a staged flat fee in which the recoverable amount depends on the stage of which the claim is settled, irrespective of settlement value, including an additional recoverable amount to reflect settlement value; in the form of a percentage of damages; and finally an early admission of liability arrangement whereby recoverable fees are reduced by a percentage if the defendant accepts liability and proposes settlement within a defined period.

The Department did not have a preferred methodology. If a FRC scheme is introduced, whatever methodology is employed to set the rate, it is important that patients continue to have the option of taking legal action where something has gone wrong with their care. The level at which the rates may be set will be very important in guaranteeing this - through ensuring that claimant lawyers are not deterred from taking on these cases, balanced with the need to consider delivering savings, and protect scarce NHS resources for frontline delivery. In addition, any FRC scheme could seek to incentivise parties on all sides to work towards earlier resolution and create a less adversarial climate.

Responses on all the fees options showed there is opposition to the introduction of fixed recoverable costs for lower value clinical negligence, for reasons which have been discussed earlier. A number of respondents said they selected an option because it was ‘least worst’ of all the proposals.

Effectively this showed that aside from the clear disapproval for Option 2, the only real clarity provided by the results for this question is that respondents are unclear on the most appropriate methodology for setting rates. There was no unanimous support even for the most popular of the four options presented - Option 4 'cost analysis approach'- and even the most popular response overall - Option 5 'another proposal' - generated more negativity towards fixed recoverable costs in general than an agreed alternative methodology for setting rates.

The most appropriate methodology for setting rates may be considered a key topic for further discussions and consultation to design the structure of fixed recoverable costs.

Many respondents failed to note that the figures included in the consultation document were illustrative only, and included to demonstrate what the different costs basis and variants could mean to rates. There were many respondents who noted that the fees quoted were too low for the level of expertise that is required and would not cover claimant costs in full.

Respondents pointed out that claimant lawyers usually work under Conditional Fee Agreements, which means that the profit in the cases they win subsidise the costs in the cases they lose. If we were to introduce a system which minimised these profits it may mean that as cases they lost could be no longer subsidised by winning ones it would make no economic sense to take on that case affecting peoples access to justice.

We did receive a number of suggestions on how the process could be improved overall, and there was a strong feeling that some sort of incentive should be introduced to encourage parties to deal with individual cases as quickly as possible as this would save costs and reduce stress for claimants.

Many of the respondents suggested a working party of interested parties should be formed to discuss how best any potential scheme should be implemented. This included looking at the processes involved in cases as well as the fees paid.

Option One: time-analysis approach, staged flat-fee

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

18 respondents preferred this approach. Many preferred this option because it included a staged flat fee. They recognised that lower value claims often needed the same amount of work as a higher value claim, therefore it is only fair it should attract the same fee. Respondents who preferred this option also expressed concerns about the other proposals. Many felt that any costs proposal which allows a percentage for damages awarded will discriminate against patients with lower value claims. This was because it was felt it may discourage claimant lawyers from taking on the lowest value claims as the costs awarded wouldn't be as high, and may therefore deprive some injured claimants with legitimate but low value claims of access to justice.

While agreeing with this proposal some respondents said that the proposed fees were too low and unworkable in practice. Others suggested that we form a working party of interested stakeholders to identify savings as fixed recoverable costs are not appropriate in anything other than fast-track claims.

Option Two: time-analysis approach, staged flat-fee plus a percentage of damages

Under this option, a lower fixed sum (the base cost) is offered than Option One but an additional amount would be calculated as a percentage of the final damages awarded, and would then be added to the base cost.

There was very little support for this option; only five respondents preferred this approach. Overall, respondents did agree that a staged flat fee plus a percentage of damages was a better option that Option One as it more accurately reflects the costs involved in bringing clinical negligence cases and the fact that beyond a rump of irreducible cost it costs more money to pursue cases at the upper end of the £25,000 threshold. However all respondents suggested the fees we were proposing were too low and offered suggestions on changes required.

Option Three: time-analysis approach, staged flat-fee with an early admission of liability arrangement

In this option the flat fee rates used for Option One are reduced in cases where a defendant accepts liability within a defined period and proposes settlement.

22 respondents preferred this option. Half of those agreed that this option is the most likely option to influence behaviours of both claimants and defendants to secure appropriate early admission and resolution (where appropriate) in cases of low value. This approach would benefit claimants and avoid the need for them to deal with a long running and stressful legal dispute. Other respondents have said it would also encourage efficiencies in the way cases are run.

We received suggestions as to how the level of fees are set. Some respondents did suggest that we set a higher base fee to allow the reduction for early settlement to be more, say 25% as this would be a bigger incentive to settle earlier (if appropriate). Others did suggest that the level of fees set needed to be higher as they were not enough to cover the work involved in clinical negligence cases.

There were a small number of respondents who objected to this proposal as they felt it would offer no benefit for the claimant. This was because the work involved in preparing such cases was the same even if the defendant made an admission of liability after disclosure.

Option Four: cost-analysis approach

This option is based on a proposal from Professor Paul Fenn of Nottingham University Business School using the same methodology for calculating rates that is used in other fixed recoverable costs schemes. It bases the rates on evidence of current costs.

28 respondents agreed with this proposal and of the four proposals put forward this was the most popular. Many respondents said that this option most accurately reflected the costs of clinical negligence cases, and is firmly based on available data. However many commented that the specific figures set out in Option Four appeared too low for the level of expertise that is required for a claim worth below £25,000. It was commented that they are not indicative of the complexity of the issues and needed to be increased to reflect costs. There was also a danger, if these proposals were introduced, of claimant firms not being able to operate in the below £25,000 clinical negligence claims market, which would prevent access to justice.

It was noted that triage costs incurred by firms have not been incorporated into this proposal, and should be included before any cost approach is selected. The vast majority of initial clinical negligence cases are screened out at the triage stage, meaning that there are a number of hidden costs for claimant firms.

Some respondents disagreed with this approach as they felt it did not encourage the greater efficiencies in case management that will be required to reduce legal costs, which they felt options 1, 2 and 3 did.

Further cost analysis work

Following an initial proposal for FRC rates which were used in the consultation, we commissioned Professor Paul Fenn from Nottingham University Business School to undertake further work on FRC rates using a matrix derived from average actual base cost to calculate proposed new rates of FRC. Professor Fenn reported back to the Department in June 2017 and

this further work has resulted in the Department re-estimating the savings from our FRC proposals will be approximately £40 million per annum, down from £45 million per annum as estimated in our consultation.

Option Five: another proposal

58 respondents selected the ‘another proposal’ option. The majority of responses used this as an opportunity to express their general disapproval of the proposals rather than suggest additional methodologies for setting the rates and incentivising earlier resolution.

The suggestions that were made included that:

Fixed costs should apply only to cases where an admission of liability has been made.

There needs to be an incentive for defendants to settle early (where appropriate).

Some procedural changes to how notification/claim are issued would be beneficial, with IT enhancements introduced to speed up the process.

There should be a financial penalty for the defendant side - in the form of a fixed uplift in recoverable costs - in the event of settlement close to trial. This could encourage early settlement of cases.

Have a fixed /predictable uplift on recoverable costs in the event of settlement in the pre final stages before trial to promote early engagement from all sides with the resolution processes.

18 respondents suggested that a working party of interested stakeholders should be formed to identify costs savings that can be made and to avoid any unintended consequences.

4.3 Other costs

Question Five: should there be a cap on expert witness costs?

Table Five: do you believe that there should be a maximum cap of £1,200 applied to recoverable expert fees for both defendant and claimant lawyers?	
Yes	34 (23%)
No	115 (77%)
Not answered	18

As part of setting appropriate rates for recoverable fees in lower value clinical negligence cases, the Department sought views on whether or not to set a standard sum for recoverable expert fees. The consultation document included a proposed maximum recoverable fee of £1,200.

Of those who answered this question over three-quarters (77%) did not want to see a cap on expert fees. Of these almost all said that experts wouldn't work for the suggested fees and would need to be much higher to attract them to the work. It was suggested that the proposed changes would leave claimants with a reduced pool of experts and may leave claimants unable to obtain appropriate expert evidence to allow them to properly pursue their claim.

Many were concerned that these proposals did not take in to account the complexity of work for clinical negligence claims. Around a quarter of respondents suggested that fixing expert fees was a false economy and could actually push fees up due to poor quality experts and reports actually making the litigation process more complicated.

About a third of those responding no also cited concerns about access to justice and that it would create an uneven playing field against claimants. The main concern raised was that a claimant may struggle to find an expert willing to work for this fee – which could potentially deny them justice. It was also suggested that as the NHS has huge buying power, it could negotiate lower rates with experts, something that a claimant lawyer could not do, giving a potential unfair advantage to defence teams.

Around a fifth of respondents supported the introduction of fixed costs for expert witnesses. The reasons given were it was reasonable, would give value for money for the tax payer and suggested that the fixed fees could encourage a culture change as both sides would need to streamline their processes to work within the new fees structure.

Question Six: what is you view on the introduction of a Single Joint Expert?

Table Six: should there be a presumption of a single joint expert?	
Yes	32 (21%)
No	118 (79%)
Not answered	17

In our pre-consultation exercise a number of parties suggested that the resolution of claims could be made more efficient if both claimant and defendant sides agreed to use a single set of experts. The Department therefore sought views as to whether this would be appropriate for breach of duty and causation and how this might work in practice.

Similarly to question 5, over three-quarters (79%) of respondents who answered this question opposed the introduction of a single joint expert. Many respondents were concerned about the fairness of using a single joint expert. Some said that it is important that both parties are properly and independently represented, and that joint experts would not allow this. Claimants in particular would feel disadvantaged. Others stated that it would give too much reliance on the opinion of one expert. Around a quarter of all respondents (for all yes and no responses) stated that there was a concern that a single joint expert could be seen to be the judge of an individual case.

Respondents also raised concerns about how the system would operate. A fifth of those who disagreed said that choosing an expert would be problematic as it would be difficult for parties to agree. Around the same number said that clinical negligence claims were too complicated to have a single joint expert and needed a suitable number of experts on both sides to ensure fairness. A number of examples were quoted to back up these concerns.

Respondents also expressed concerns that single joint experts are not allowed to meet or speak with one party alone. It was suggested that this could cause issues in the preparation of cases because experts are not lawyers and usually their initial reports usually require clarification and discussion to fully address the relevant legal tests and burden of proof, which potentially couldn't be done with a single joint expert.

Around a fifth of respondents (21%) said that they would be in favour of a single joint expert, however many of those were cautious on its introduction. It was suggested that choosing an expert would be difficult, therefore respondents instead suggested setting up a panel of experts. Many of those who agreed also said that there could be concern that a single joint expert could be seen to be the judge of an individual case. It was also pointed out that it would be difficult to implement and that because of the complexity of clinical negligence cases provision should be made to allow more than one expert if required.

4.4 Running the scheme

Question Seven: should there be an early exchange of evidence?

Table Seven: do you agree with the concept of an early exchange of evidence?	
Yes	96 (66%)
No	50 (34%)
Not answered	21

It is important that clinical negligence cases are processed with due speed and efficiency; this is better for patients unfortunately harmed by NHS care and ensures that the system can learn from such incidents and implement improvements. More efficient processing of cases would lead to savings. As such the Department sought views on whether an early exchange of evidence would make the claims process more efficient.

Two thirds of respondents (66%) supported the concept of early exchange of evidence. Many of those that agreed with the proposal did not give a reason for supporting, but of those that did, 23 respondents made suggestions as to how this policy could be implemented, with some suggesting that expert reports obtained must be in a 'disclosable' form at an early stage.

Others who agreed with an early exchange of evidence said that this proposal may work in certain circumstances, that it should be encouraged and that it may lead to improvements which would reduce costs.

Around a third of respondents (34%) disagreed with the proposal. Of these over half said that the proposal will not work as it does not take into account the complex nature of clinical negligence claims. The complexity of clinical negligence claims was also the reason cited by 20 respondents who said that its introduction would be a false economy and could actually lead to increased litigation costs. Others said it could be seen to be unfair for the claimant.

However, of those that disagreed, around a third suggested that we set up a working party with interested groups to look for a workable solution.

Question Eight: review of the draft protocol and rules

Table Eight: do you agree with the proposals in relation to:			
	Yes	No	Not answered
Trial costs	42 (38%)	67 (62%)	58
Multiple claimants	56 (52%)	53 (48%)	58
Exit points	45 (44%)	57 (56%)	65
Technical exemptions	57 (55%)	46 (45%)	64
Number of experts	77 (71%)	32 (29%)	58
Child fatalities	84 (79%)	22 (21%)	61
Interim applications	50 (48%)	54 (52%)	63
London weighting	62 (58%)	44 (42%)	61

Alongside the consultation, the Department published an illustrative draft of the Civil Procedure Rules and sought views on various constituent parts. The aim was to ensure that the amended rules were similar to those that operate for other personal injury FRC schemes. The Department sought views on a number of key elements of the draft rules.

Overall, there was little agreement from respondents on most of the eight constituent parts. Considering those who answered the questions, proposals for the number of experts (71% agreed) and child fatalities (79% agreed) received a significant majority of support from respondents.

A smaller majority of 62% did not support proposed trial costs, but for the other five constituent parts respondents were undecided, with none receiving any more than 58% of the responses provided. This suggests that aside from the proposals for the number of experts and child fatalities, stakeholders are unsure of the best approach for the remaining constituent parts.

Trial Costs

The Department proposed a rising scale of fast track trial costs which the court may award. These proposed rates should also apply to multi-track cases as well as fast track cases.

Almost two-thirds (62%) of respondents did not support our proposals for limits on trial costs. Many of these respondents highlighted the point that clinical negligence claims were complex and that the fees proposed were too low for the work involved in a typical case.

Over a third (38%) of respondents supported the proposal. However, many of those who provided a written response did express some concern that the proposed fees may only work in a limited number of cases and if it was introduced fully, the fees for a complex case appeared to be a little low. A small number gave suggestions on how the policy could be implemented.

Multiple Claims

The Department proposed where two or more potential claimants instruct the same legal representation, the intention would be that FRC will apply in relation to each claimant.

Just over half (52%) of respondents supported our proposals for introducing FRC for multiple claimants. Many respondents did not provide any comments to support their response but of those that did there were a few suggestions as to how the policy may work including what exemptions should apply.

The remaining half (48%) did not support our proposals for multiple claimants. Many of those responding 'No' to the question said that the proposals were unfair and did not take into account the complexity of multiple claims and that victims of the same negligent incident can have totally different injuries which would need a separate investigation. It was pointed out that limiting the legal representation an individual claimant can have could have the potential to limit their access to justice.

Exit Points

The existing fixed cost rules allow a court the potential to award an amount of costs greater than the applicable FRC, but only if it considers that there are exceptional circumstances making it appropriate to do so. This consultation proposed that exit points in exceptional circumstances in the context of a typical negligence claim should apply.

Respondents were split on this proposal. Just over half (56%) of those who answered the question disagreed with this proposal on exit points. Respondents again voiced concerns that clinical negligence claims were complex and cannot be dealt with in the same way as other types of fast track claims. Around a fifth of those responding 'no' were concerned that we hadn't set out what would count as 'Exceptional Circumstances' so found it difficult to comment fully. Others said that this term is open to interpretation and could lead to satellite litigation regarding what qualifies as an 'exceptional circumstance' which would push up costs. Around a fifth of those responding suggested what could count as a potential exit point, however, in all cases the suggestions would mean that a large number of clinical negligence claims would be excluded from FRC.

Just under half (44%) of respondents agreed with our proposals on exit points. Many respondents did not supply comments to support their response, but of those that did a small number suggested ways to implement the policy. This included suggestions on the level of the threshold test, what would count as an exceptional circumstance, and that sanctions should apply to sides for conduct outside the spirit of FRC.

Technical Exemptions

The Department looked at whether to have any automatic exemptions to a proposed FRC scheme for clinical negligence claims which apply to other similar FRC schemes.

Just over half (55%) of respondents agreed with this proposal. Of those that responded many made suggestions on extra technical exemptions to include as well as those proposed. These included young adults, people lacking mental capacity and people with a disability. Still births and all fatal claims were also requested to be included as a technical exemption. Respondents argued that including this type of case is essential as they are all very sensitive cases and generally involve issues of public interest and raise access to justice concerns.

Other respondents requested that the list of technical exemptions should be expanded but did not give any specific examples.

Just under half of respondents did not agree with our proposals for technical exemptions. As with those who responded 'yes' to this question many of the comments that were received suggested extra technical exemptions to include as well as those proposed. This list also included fatal claims and protected parties. We did have a small number of respondents who suggested the list of technical exemptions should be less than proposed as the exemptions listed currently may have the potential to dilute the proposed FRC scheme.

Over a third of respondents did not answer this question.

Number of Experts

We proposed an exemption from FRC for claims where the number of experts reasonably required by both sides on issues of breach and causation exceeds two per party. This exemption was designed to ensure access to justice for those with complex clinical negligence claims.

A majority of 71% of respondents agreed with this proposal. All those who responded raised the point that not all lower value claims are simple and straightforward, and that they agreed with our proposal that if a case required more than two experts it should not be processed under FRC to ensure fairness and to allow claimants to get access to justice.

Just under a third (29%) of respondents did not agree with the proposal. A small number commented that the number of experts per party should be no more than one before the exemption to remove a case from FRC applies. Others suggested that we should increase the number of experts per side before the exemption applies.

Child Fatalities

The Department recognised that child fatalities can be complex cases of an emotive nature, and following concerns received about these cases being included, we considered an exemption for child fatalities arising from clinical negligence claims.

Of those answering the question a large majority of respondents (79%) agreed with this proposal; however the overriding comment we received from all respondents was that this exemption should be extended to include all fatal claims. Many respondents said that there are many other type of cases that do not attract high value and that it would be wrong to restrict the ability of families to find expert representation.

Interim applications

The Department considered the control of the use of interim applications and how best this is achieved.

Respondents were very evenly split in terms of support for this proposal. Half (48%) of those answering the question agreed with this proposal. Of the comments received a small number made suggestions as to how the policy could be introduced. This included suggestions on the removal from FRC if an interim application uncovers poor behaviour on a particular side, to imposing financial penalties for incomplete disclosure which may alleviate the need for many interim applications. Other suggestions included parties be allowed greater freedom to agree

changes to the directions timetables without having to pursue an application to the court and to only allow interim applications in a limited number of circumstances.

The remaining half (52%) disagreed with our proposals for interim applications. Many commented that interim applications were needed and should not be restricted. Respondents then gave examples of how interim applications were used by claimants to compel the NHS and other healthcare providers to disclose the claimant's medical records and to apply to the court for interim payments of damages where the defendant Trust has refused to make payments voluntarily. Defendants also use interim applications to apply for extensions of time when they cannot meet timetables set by the court, or to ask the court to force claimants to comply with timescales set by the court. There were also concerns that the control of interim applications in complex cases allocated to the Multi Track is not appropriate and would affect access to justice.

London Weighting

The Department looked at introducing a London weighting for FRC for claimants or defendants who live or work in the Greater London area and whose solicitor also practices in the area. In these instances we propose an additional 12.5% to be added to the FRC figures set out in table 4 of the consultation excluding VAT.

Respondents were once again fairly evenly split over support for this proposal. Just over half (58%) agreed with our proposals for a London weighting. Many said that it was an industry norm which was needed to reflect the higher costs in London.

Just under half (42%) did not agree with our proposals for a London weighting. Respondents highlighted that with the availability of modern communication technology, there is no reason why any case needs to be managed from any specific location. Others expressed concern that the London Weighting proposed was not high enough, and we did have comments that there were other expensive areas of the country to operate in and that a weighting should be considered for those areas too.

Question Nine: what else could be done to encourage less adversarial behaviours?

This question asked if there are any further incentives or mechanisms that could be included in the Civil Procedure Rules or pre-action protocol to encourage less adversarial behaviours on the part of all parties involved in the litigation process.

There were 130 contributions in this section.

35 respondents said that a fundamental change in behaviour is required when approaching lower value clinical negligence claims which needed to be less adversarial. Defendant behaviour was specifically questioned by 15 respondents who said the NHS defended cases it shouldn't and made the legal process for each case more complicated than it needed to be. A further 16 respondents said that the NHS needed to admit liability sooner (when appropriate) as they had a tendency not to want to admit failures. 6 respondents also said that the NHS needed to be more open and honest about safety.

Almost all of the respondents agreed that the focus for parties must be on early and cost effective resolution. 34 respondents suggested that Alternative Dispute Resolution (ADR) should be considered more often to settle claims and a further 8 suggested some other means of mediation. 24 respondents said that there should be a positive requirement to show why ADR is not suitable for a given case, rather than simply expecting parties to consider it. Financial penalties were suggested for any party which refused to enter ADR, examples given were that a successful claimant could be penalised by not receiving costs after the date of their refusal and that an unsuccessful Defendant could be penalised by payment of indemnity costs from the date of their refusal.

Other comments included 3 respondents suggesting that there needs to be an incentive for both sides to reach an early settlement thus avoiding lengthy legal cases. There were also 3 suggestions on how to improve delays with disclosure of records with one respondent suggesting an IT system where documents could be shared securely online.

4.5 Question 10: further evidence

The Department is grateful to those individuals and organisations that provided additional information in order to aid policy development either through the consultation or through the cost analysis work by Professor Fenn. This is particularly important as in crafting the original proposals the Department was by necessity, heavily dependent on data and expertise from NHS Resolution. Through the consultation and stakeholder engagement we have developed a broader evidence base; one that includes information from primary care defendants, as well as claimant-side and others, through which to examine fixed costs.

Like the responses to other questions, many respondents used their additional submissions and Question Ten to provide further evidence against the introduction of fixed recoverable costs in any shape or form. The arguments made against introducing fixed costs - and the often lengthy evidence provided - expounded on themes already discussed, including;

the risk that introducing a fixed cost scheme drives cost elsewhere in the claims process,

the possible threat to ongoing access to justice,

concerns about the complexity of clinical negligence,

arguments that the pursuit of proportionality in lower value clinical negligence is misguided,

and that the proposals risk patient safety.

There were repeated calls for a working party to be established to examine claims process and what efficiencies can realistically be made before seeking to implement the proposed fixed costs regime.

Specific areas

It was noted that the proposals outlined in the consultation document to introduce fixed recoverable costs would apply to all clinical negligence cases where the value of the damages is above £1,000 and up to £25,000 in England and Wales. This means primary care as well as secondary care and incidents that occur in the private sector.

Through the course of our consultation and engagement exercise it has become clearer that there are specific circumstances in Wales, primary care and the private sector that should be acknowledged in thinking about FRC proposals.

General Practice

In general practice, clinical negligence indemnity is purchased by individual GPs and provided in the most part by private sector organisations called Medical Defence Organisations (MDOs). This is contrast to secondary care where individual practitioners are covered for clinical negligence by the hospital trust they are employed by.

This is significant in the first instance because in producing the original savings estimate the Department only had access to secondary care data. However any action to reduce the cost of clinical negligence – including introducing fixed recoverable costs – would also deliver savings in primary care clinical negligence costs as well.

As might be expected the MDOs were broadly supportive of the proposals to fix costs as outlined in the consultation document, indeed they suggested that the scheme as proposed should extend to cases worth up to £250,000 and that the scope for exemptions should be limited. However there was also some acknowledgement that there is potentially more that

could be done to improve the claims handling process to make it more efficient and better for claimants.

The point was also made that introducing fixed costs should only be one part of a whole package of legal reforms aimed at tackling the rising cost of clinical negligence claims. Since the consultation closed two of the MDOs have launched specific campaigns to lobby for wider tort reform, and the Secretary of State has announced that the Department of Health is planning, subject to examination of the relevant issues, to develop a state-backed indemnity scheme for general practice in England.

Wales

Introducing fixed recoverable costs would require an amendment to the Civil Procedure Rules. These apply in England and Wales. However the wider health context is somewhat different in Wales.

In 2011 NHS Wales introduced a redress scheme. This set up a voluntary and alternative route to the court process through which those patients unfortunately harmed as a result of negligent treatment whilst receiving Welsh NHS care, can receive compensation as well as an explanation of what went wrong with their care and an apology. The aim is to be patient centred and to try to resolve matters swiftly without recourse to the courts.

Specialist clinical negligence solicitors, whose fees are capped, represent patients who opt to pursue the redress arrangements, the solicitors' fees are paid for by the NHS. Patients are eligible for the redress scheme based on case value. Redress currently only applies to those cases worth up to £25,000.

The fixed cost proposals in the consultation document would therefore apply to the same cohort of cases as redress. As is the case in Wales now, patients can choose whether to enter redress or pursue a claim through the courts. If a patient opts to pursue redress, the rules applicable to the redress scheme will apply: the NHS in Wales will pay the Claimant's fixed legal costs. If a patient accepts an offer of settlement under the redress process, they are precluded from seeking compensation through the courts in respect of the same incident. However, if the redress process does not result in a settlement, or if a patient opts not to follow the redress process, a patient is free to litigate his or her case in the normal way. In such a scenario, if a patient is ultimately successful in their litigated case, the NHS will be responsible for paying the Claimant's reasonable legal costs associated with the litigation.

If fixed costs were introduced, the difference would be that, unlike now where litigation costs are based on the Guideline Hourly Rate and the courts frequently decide to depart from these in awarding costs, there would be a fixed rate at which costs were awarded in litigated cases where the damages awarded were between £1,000 and £25,000.

Respondents in Wales expressed strongly that the principles behind redress; that of putting the patient at the centre of any process and focusing on what can be learnt from an incident in order to prevent future similar incidents was very important and were critical of what they saw as the narrow cost-reducing focus of the FRC proposals. It was also noted that a by-product of shifting the focus onto the patient and creating a culture of learning has been to produce savings because patients do not feel the need to litigate. Finally, there was some disappointment expressed that the Department did not consider using the NHS Redress Act of 2006 to establish a redress scheme in England.

Private and not-for-profit sectors

Cases brought against private healthcare providers under £25,000 would also fall into the FRC scheme as proposed. Again the context of delivering healthcare in a private setting is somewhat different to providing secondary care within the NHS; principally because clinical negligence cover in this sector is typically provided by commercial insurers which means there are high excesses and also those working in private healthcare typically do so with practising privileges on a contractor/self-employed basis.

Given the FRC proposals were presented primarily as a cost-saving measure respondents from the private sector were interested in whether savings would be felt in private healthcare through reduced insurance premiums.

5. Equalities, Health Inequalities and the Family Test

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

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

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

Question 11 of the consultation asks for information, both quantitative and qualitative, to support the final stage assessment. The Government will be working with NHS resolution to understand more fully the impact of the proposed reforms on the claimant demography. The final assessment will be used as the baseline for the post-implementation review if the FRC scheme is introduced.

With regards to the proposals, many respondents expressed concerns that the scheme will impact disproportionally on lower income groups or those with no incomes as the damages would be small due to no or little loss of earnings. As a result a claim would not be seen profitable for claimant lawyers to run and potentially as a result, they would not be as willing to take on this type of case. This would affect an individual's access to justice as it was pointed out that individuals in these groups would not be able to afford the sums they would need to pay their lawyers to bring a claim.

Respondents gave details of a number of groups which they felt would fall into the lower/no incomes bracket. They are: Children, the Elderly, Women, Ethnic Minorities, the disabled and people with long term conditions.

Only a very small number of those responding felt that the proposals will not have any particular impact on claimants of any particular age, gender, disability, race, religion or belief, sexual orientation or have a negative effect on health inequalities and family issues. It was noted that these respondents pointed out that no such equalities issues have arisen from the FRC regime already in place for Personal Injury cases.

6. Next steps

Since the consultation was launched, there have been a number of other developments which are relevant to this policy development. They are:

The change in the personal injury discount rate

In February the Lord Chancellor announced a change in the personal injury discount rate (PIDR). The rate was previously 2.5% and was moved to minus 0.75%. This change significantly increases the cost of clinical negligence claims. The MoJ has consulted on how the PIDR should be set in future and published its response on 7 September 2017.

Lord Justice Jackson's 'Review of Civil Litigation Costs: Supplemental Report'

On the 31 July the Right Honourable Lord Justice Jackson published his recommendations on the extension of fixed recoverable costs across personal injury, in 'Review of Civil Litigation Costs: Supplemental Report'.

Although lower value clinical negligence was originally out-of-scope for this review, LJ Jackson made a number of observations that are relevant to our ongoing policy development. The comment that costs and procedure must be linked chimed with many consultation responses who remarked on the difficulty of imposing a new system of fixed costs without addressing wholesale the claims process. He also noted that the Civil Justice Council (CJC) have had some success recently in bringing together claimant and defendant representatives to agree a new process for noise induced hearing loss (NIHL) claims alongside a specific grid of fixed recoverable costs.

In his concluding remarks on clinical negligence, Jackson makes the following recommendation:

'I recommend that the Civil Justice Council should in conjunction with the Department of Health set up a working party, including both claimant and defendant representatives, to develop a bespoke process for clinical negligence claims initially up to £25,000 together with a grid of FRC for such cases.'

In the consultation responses too there were repeated calls for a working group to be set up to consider improvements to the clinical negligence process.

The Government is considering all of LJ Jackson's proposals and the Lord Chancellor will announce the next steps in due course. However, The Secretary of State for Health has accepted the proposal to set up a working group to develop a bespoke process for clinical negligence claims and a grid of costs, and work has already begun with the CJC to establish this working group.

As noted in the consultation document, in 2011/12 NHS Resolution, (the operating name of the NHSLA) held discussions with organisations representing the claimant side to examine the claims process and identify specific improvements that could be made to ensure that harmed patients who are due compensation receive it promptly and to agree a schedule of fixed costs that would apply in these cases. This group made good progress however there remained a

number of objections to the introduction of this scheme; not least the focus on case value to define the scope of a fixed cost scheme, disagreements about the level of cost allowed for at various stages in the process and the voluntary nature of the scheme.

The Department intends that the CJC working group will build on this work and on further progress made through this FRC consultation and the independent cost analysis work by Professor Fenn. It is significant that whilst acknowledging there is further work to be done, LJ Jackson is broadly supportive of the application of fixed costs in clinical negligence and in the process of his work found a number of legal experts, both claimant and defendant who were optimistic. Unlike in 2011/12 this group will be convened and chaired by a neutral party - a member of the CJC - and mediation will be employed in areas of specific disagreement. LJ Jackson has offered to adjudicate if necessary.

Preliminary work has already been completed with the CJC, including agreeing the draft terms of reference for the working group, appointing a Chair and Deputy Chair and seeking members to ensure that the relevant expertise is engaged and all sides are represented.

It is important that general practice representatives are included on the defendant side as well as representatives from NHSR which deals with secondary care negligence claims.

Similarly, any new process would apply to incidents of harm occurring in the private sector and so this needs to be considered by the working group. Finally, any amendments to the claims process in clinical negligence will apply to cases brought in Wales; against Welsh primary care practitioners, secondary care and in private practice. This means that particular thought needs to be given to the interaction between the Welsh ADR Redress and an improved claims process.

We expect that the CJC working group will be in a position to publish recommendations in Autumn 2018, which will be considered as quickly as possible by the Government.

Annex A: list of respondents

Table 1: Type of Respondents

Type Of respondent	Number of Responses	% of responses
A Law firm	64	39%
A health care provider	9	5%
A health insurance or Medical Defence organisation	5	3%
A representative body	24	14%
Another type of organisation	17	10%
Not answered	48	29%
Total	167	100%

Table 2: Type of Law Firm

Law Firm Mainly represents	Number of Responses	% of responses
Defendants	10	16%
Claimants	47	73%
Both	5	8%
Not answered	2	3%
Total	64	100%

Annex B: Summary of Professor Fenn Report

Paul Fenn is an Emeritus Professor at the Industrial Economics and Finance Division of Nottingham University Business School, and Senior Visiting Fellow, Health Economics Research Centre, University of Oxford. Professor Fenn was an assessor for Lord Justice Jackson's reviews on FRC for civil litigation.

In October 2015, the Government asked Professor Fenn to review independently the methodology and data provided from NHS LA to generate the proposed FRC options. Professor Fenn's report gave his perspective on the introduction of Fixed Recoverable Costs in personal injury claims and how it could apply to clinical negligence. Professor Fenn accepts that the work undertaken by the DH to underpin the FRC rates has been thorough and informative.

Professor Fenn recommended using a matrix derived from average base costs to calculate the rates of FRC (the same approach taken in other FRC schemes), and options to reduce the fixed cost where there is an early admission of liability, which we refer to as the cost analysis approach.

Alongside the consultation the Department also commissioned further independent work on the cost analysis approach by Professor Fenn. This further work was carried out during the consultation period to enable it to be considered alongside the consultation responses and feed into the Government response.