Written evidence submitted by the Department of Health and Social Care (NLR0070)

An updated version of this submission has now been published as (NLR0072)

Introduction

1. NHS care is usually very good, and most people do not experience any problems. But occasionally things can go wrong. When this happens, it is vital that the NHS learns from incidents to reduce the chances of the same thing happening again, and people harmed by the NHS as a result of clinical negligence are able to obtain appropriate compensation. The Government remains committed to the continuous improvement of patient safety and embedding a learning culture across the NHS.

2. However, the costs of clinical negligence claims are rising at an unsustainable rate; annual cash payments have quadrupled in the past 15 years to £2.2billion in 2020-21,[1] equivalent to 1.5% of the NHS budget. In addition, claimant legal costs are frequently disproportionate to the level of damages (compensation) awarded, particularly in lower value claims. Given these factors, the Department of Health and Social Care (the Department) welcomes this inquiry.

3. The Committee has called for written evidence on the case for reform of 'NHS litigation'. Litigation against the NHS takes many forms including employer's liability, but because the predominant increases are in clinical negligence claims and given the scope of the Inquiry's questions, this is where we are focusing our evidence. Most of our data refers to all clinical claims resolved by NHS Resolution and covers compensation awards and legal costs.

4. We address each of the Committee's questions in the call for evidence in four sections: the cost and impact of clinical negligence, addressing the rising cost of clinical negligence, developing a learning culture in the NHS, and improving claim resolution. This evidence has been prepared by the Department with contributions from NHS Resolution (NHSR*)*, NHS England and NHS Improvement (NHSEI), the Ministry of Justice, HM Treasury, and Cabinet Office.

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

Responses to the Committee's questions

Section 1: The cost and impact of clinical negligence

Q1) What is the impact of the current cost of litigation on the financial sustainability of the NHS and the provision of patient care?

Overview

5. Patients may bring a legal claim for clinical negligence against their healthcare provider if they believe they have been injured as a result of negligent medical treatment. The Government fully supports patients' entitlement to compensation if negligence is established and recognises the importance of maintaining access to justice, including access to legal advice and representation for all, as a fundamental principle of justice. However, the cost to the NHS of financing clinical negligence claims has risen at a rate far higher than Health and Social Care spend,[2] the wider economy or inflation metrics over the past 15 years (see Figure A).[3]

6. Despite increased funding to the NHS and a clear strategy for increasing safety and reducing harm, in recent years the NHS has been spending a growing proportion of its resource budget (otherwise available for patient care) on claims, and significantly more than some other countries (see Table A). It is worth noting that this growth in the cost of claims is primarily driven by payments for compensation, not the number of claims, particularly in recent years, and we are not aware of evidence that patient safety has been deteriorating.

7. The NAO found that "the increasing costs of clinical negligence are adding to the significant financial pressures already faced by many trusts" and "there are indications that financial stress faced by trusts has an impact on patients' access to services and quality of care".[4] In 2018, Niall Dickson, Chief Executive of NHS Confederation, and heads of other healthcare bodies including the British Medical Association wrote to the Lord Chancellor stating that "the rising cost of clinical negligence is unsustainable and means that vast amounts of resource which could be used more effectively have to be diverted elsewhere".[5]

How the cost of clinical negligence claims has grown

8. Annual cash payments for claims against NHS providers increased four-fold between 2006-07 and 2019-20 from £0.6billion to £2.3billion (see Figure A),[6] the equivalent to 1.8% of the

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[2] Total clinical negligence payments have risen at an average of 11% per year between 2006/07 and 2019/20. NHS funding has increased at an average of 4.4% per year over the same period.
[3] Inflation metrics such as GDP and CPI have averaged at around 2% since 2006/07.
[4] National Audit Office Comptroller and Auditor General (2017). *Managing the Costs of Clinical Negligence in Trusts*. (p6). London, NAO. Available online at: https://www.nao.org.uk/wp-content/uploads/2017/09/Managing-the-costs-of-clinical-negligence-in-trusts.pdf.
[5] Letter from Niall Dickson, Chief Executive of NHS Confederation, to the then Lord Chancellor, Rt Hon David Gauke MP (2018).
[6] NHS Resolution (2021). *Annual Statistics (Supplementary Annual Statistics, Table 1.A)*. London, NHSR. Available online at: https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Supplementary-Annual-Statistics-2020-21.xlsx.

NHS resource budget.[7] In 2020-21, the year of the pandemic, this figure nevertheless remained stable at £2.2billion.[8]

9. Total liabilities for clinical negligence claims, the amount the NHS estimates it will have to pay in the future as a result of incidents across all clinical schemes, has increased from £9billion at 31 March 2007 to £83.8billion at 31 March 2020 (see Figure B).[9] By 31 March 2021, this had slightly decreased to £82.4billion.[10]

10. Our projections within the Clinical Negligence Scheme for Trusts (CNST)[11] indicate that by 2029-30, annual cash payments could nearly double to £4.3billion (see Figure C) and total liabilities could increase to £155billion (see Figure D). CNST, the largest clinical negligence scheme, accounted for £2.1billion out of a total of £2.2billion of cash payments for clinical schemes in 2019-20.[12]

11. The following graphs set out how both annual cash payments (including compensation and legal costs breakdown) and total liabilities for claims have increased over the past 15 years, and their projections over the next decade.

Explanatory notes on the way these figures are calculated are provided in the spreadsheet.

[7] HMT (2021). *Public Expenditure Statistical Analyses 2021. "NHS England - Departmental Expenditure Limits, 2016-17 to 2021-22".* (p18, paragraph 1.31). London, HMT. Available online at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1003755/CCS207_CCS0621818186-001_PESA_ARA_2021_Web_Accessible.pdf.

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

[9] **NHS Litigation Authority/NHS Resolution. (2007/08–2019/20). *Annual Report and Accounts 2007/8 to 2019/20*. London, NHSR/NHSLA.**

[10] NHS Resolution. (2021). *Annual Report and Accounts 2020/21*. (p143). London, NHSR. Available online at: https://resolution.nhs.uk/wp-content/uploads/2021/07/Annual-report-and-accounts-2020-21-web.pdf.

[11] CNST is an indemnity scheme providing cover for NHS bodies and some independent sector providers of NHS services.

[12] NHS Resolution (2021). *Annual Statistics (Supplementary Annual Statistics, Table 1.A and Table 1.B).* London, NHSR. Available online at: https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Supplementary-Annual-Statistics-2020-21.xlsx.

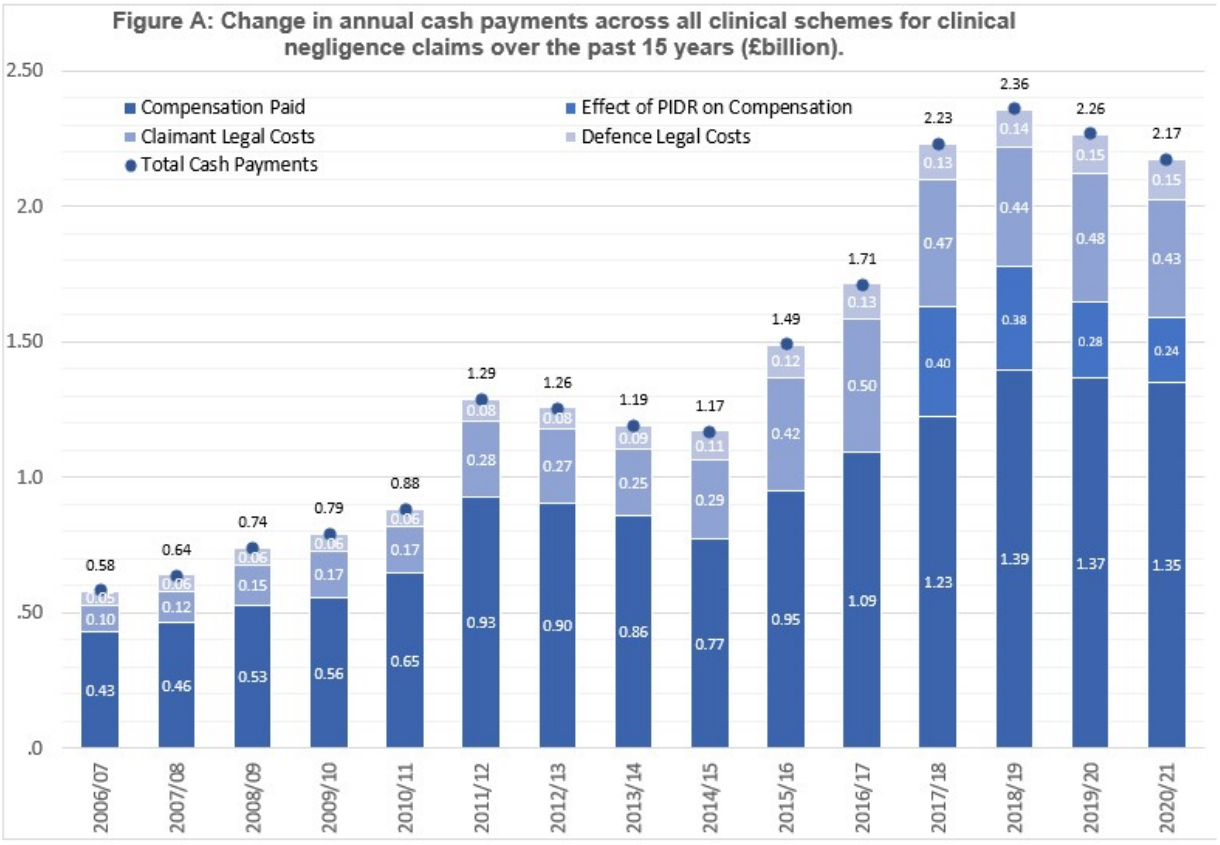

Figure A shows the change in annual cash payments across all clinical schemes for clinical negligence claims between 2006/07 and 2020/21 including a breakdown of compensation paid, the effect of the Personal Injury Discount Rate (PIDR) change in 2017 on the amount of compensation paid, defendant legal costs and claimant legal costs. Annual cash payments for claims increased from £0.6billion to £1.3billion between 2006/07 to 2011/12 before slightly decreasing to £1.2billion in 2014/15. Annual cash payments then increased steeply up until 2018/19 to £2.4billion, before slightly decreasing to £2.2billion by 2020/21.

Figure reference: NHS Litigation Authority/NHS Resolution. (2007/08–2020/21). Annual Report and Accounts 2007/08 to 2020/21. London, NHSR/NHSLA.

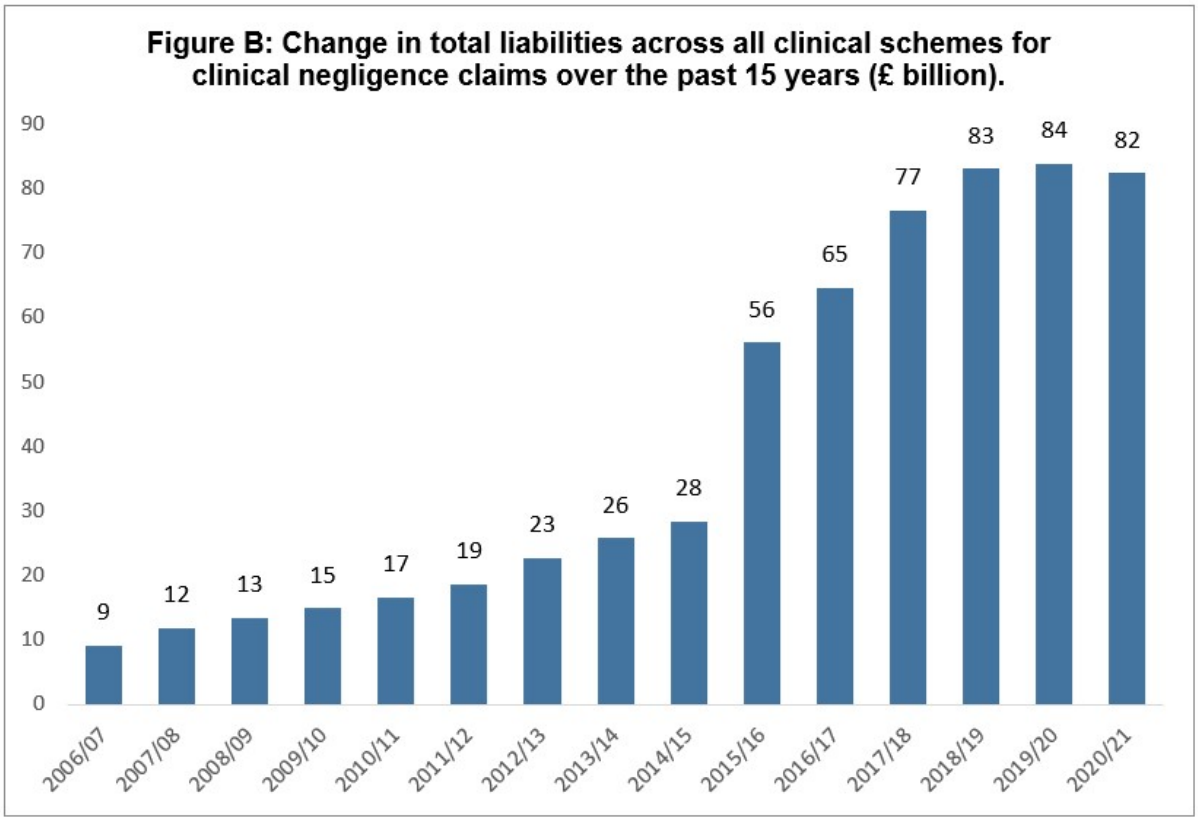

Figure B shows the change in total liabilities across all clinical schemes for clinical negligence claims over the past 15 years. Between 2006/07 and 2014/15, total liabilities increased steadily from £9billion to £28billion. They increased to £56billion in 2015/16 due to a change in the Treasury-prescribed discount rate for valuing liabilities and continued to increase to £83billion in 2019/20, before decreasing slightly to £82billion in 2020/21.

Figure reference: NHS Litigation Authority/NHS Resolution. (2007/08–2020/21). Annual Report and Accounts 2007/08 to 2020/21. London, NHSR/NHSLA.

Figure C: Annual cash payments for clinical negligence claims up to 2030/31 (CNST only, excluding the impacts of COVID-19)

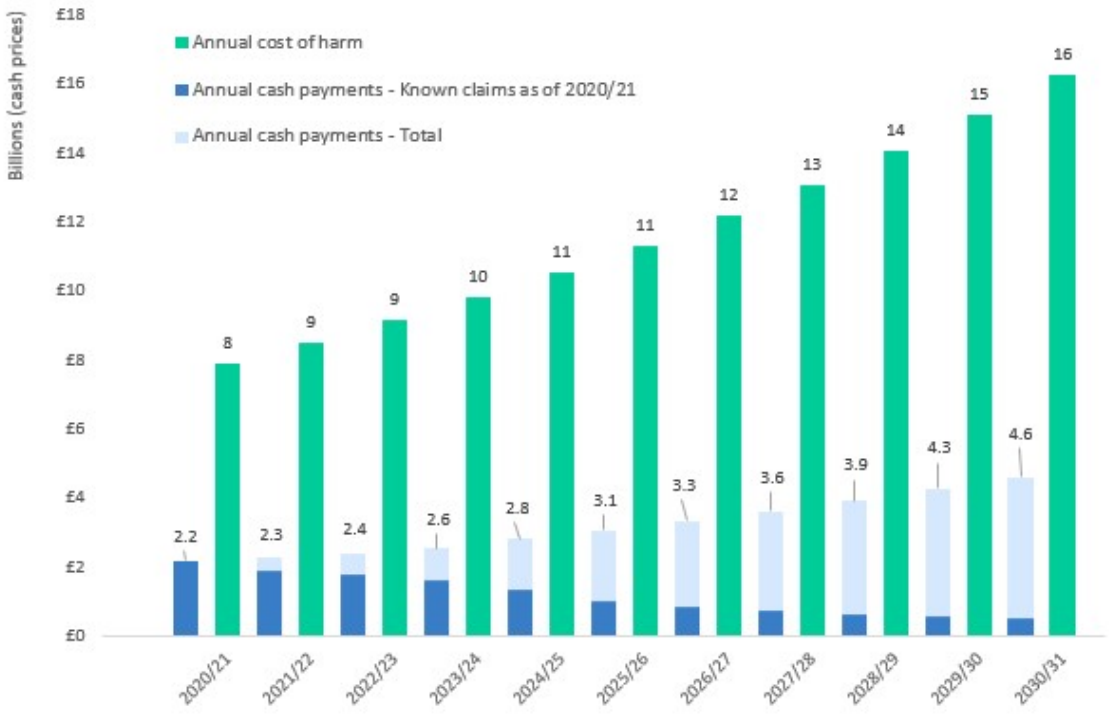

Figure C shows our projections, informed by NHSR's provisioning models, assumptions, and the Government Actuary's Department (GAD) advice, of how annual cash payments for clinical negligence claims under CNST may change over the next decade. They exclude the impact of the pandemic. The graph shows total annual payments increasing from £2.2billion in 2020/21 to £4.6billion in 2030/31. The annual cost of harm increases from £8billion to £16billion over the same period. The annual cost of harm includes an actuarial estimate of the lump sum and future periodic payments and all legal costs payments for incidents that occurred in that year, whether or not they have already been notified to NHSR.

Figure references: NHS Resolution (2021). Annual Report and Accounts 2020/21. (p18). London, NHSR. Available online at: https://resolution.nhs.uk/wp-content/uploads/2021/07/Annual-report-and-accounts-2020-2021-WEB-1.pdf; NHS Resolution. (2021). Annual Statistics (Supplementary Annual Statistics, Table 2.A). London, NHSR. Available online at: https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Supplementary-Annual-Statistics-2020-21.xlsx; DHSC projections for all other years using GAD assumptions.

Figure D: Projections for total provisions for clinical negligence claims up to 2030-31 (CNST only, excluding the impacts of COVID-19.

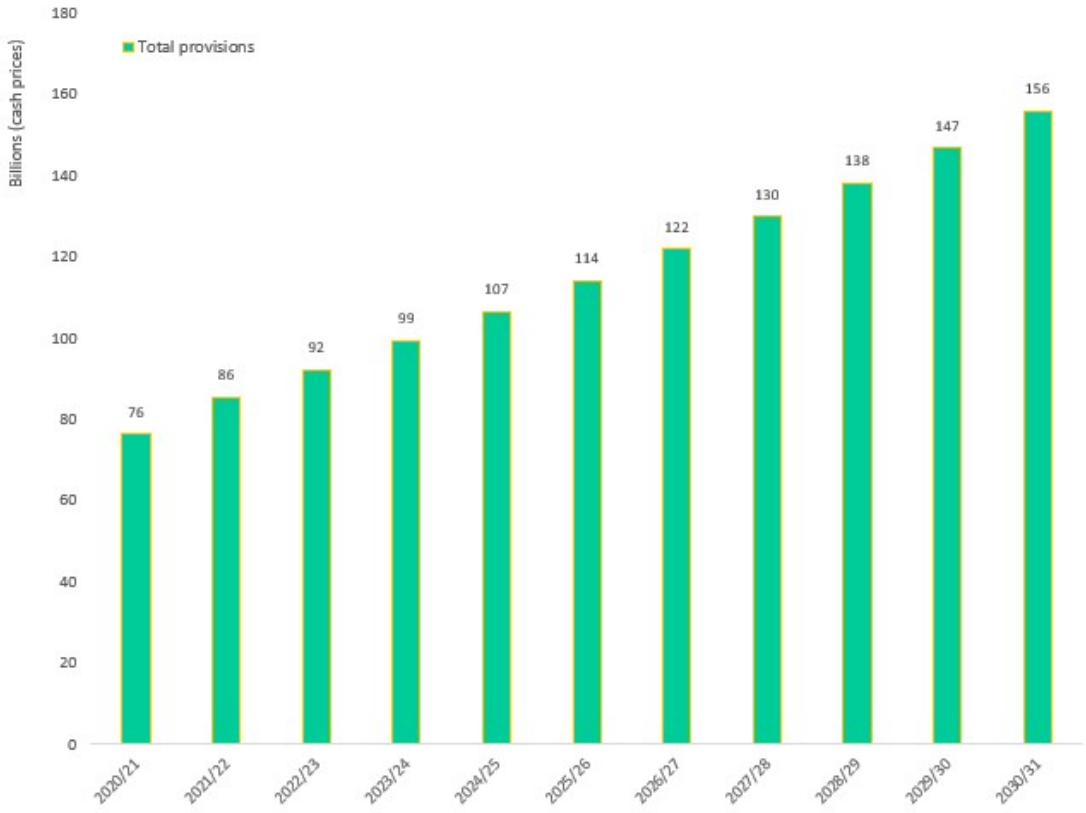

Figure D shows our projections, informed by NHSR's provisioning models, assumptions, and GAD advice, for total provisions for clinical negligence claims under CNST over the next decade. They exclude the impact of the pandemic. The graph shows total liabilities increasing from £76billion in 2020/21 to £156billion by 2030/31.

Figure references: NHS Resolution (2021). *Annual Statistics (Annual Report Statistics, Table F.2). London,* NHSR. Available online at: https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Annual-Report-Statistics-2020-21.xlsx; DHSC projections for all other years using GAD assumptions.

Why the cost of clinical negligence claims has grown

12. The 2017 NAO report 'Managing the Costs of Clinical Negligence in Trusts' identified three key drivers of clinical negligence costs over the previous decade: compensation awards, claimant legal costs, and, the largest at that time, claim volume.[13] However, the landscape of clinical negligence claims has since changed: claim volume has levelled out from 2013-14 as has claimant legal costs, another significant contributor, from 2016-17.

13. Meanwhile, overall costs have continued to rise steeply, driven by rising payments for compensation, accounting for 73% of annual payments for claims by 2020-21.[14] Higher-value awards, mainly for maternity claims, make up a large proportion of the overall amount

[13] National Audit Office Comptroller and Auditor General (2017). *Managing the Costs of Clinical Negligence in Trusts*. London, NAO. Available online at: https://www.nao.org.uk/wp-content/uploads/2017/09/Managing-the-costs-of-clinical-negligence-in-trusts.pdf.
[14] NHS Resolution (2021). *Annual Statistics (Supplementary Annual Statistics, Table 1.A and Table 3.A.3)*. London, NHSR. Available online at: https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Supplementary-Annual-Statistics-2020-21.xlsx.

paid in compensation and are growing at rates significantly higher than inflation. Patients who have suffered obstetric injuries often require significant social care support. Compensation is awarded under various heads of loss, of which social-care is the highest-cost element. We provide a breakdown of compensation by Head of Loss in Annex A.

14. Several factors have influenced the growth in the cost of these higher-value claims, including increased use of Periodic Payment Orders (PPOs), the 2017 reduction in the Personal Injury Discount Rate (PIDR), as well as external factors such as the rising cost of social care and increasing life expectancy. However, together these factors alone cannot fully explain their steep rise. It appears that a proportion of the rise may be due to precedent setting in the Courts.

15. We expand on our analysis of current drivers in Annex B.

International comparisons

16. Systems for managing clinical negligence claims vary internationally. We have looked at a limited set of other countries to understand if they have faced similar issues with rising clinical negligence costs. Using available data from previous years, Table A below provides a breakdown of claims and costs data between various countries of interest. This snapshot shows the overall cost of claims against the NHS being significantly higher than in some other countries.

17. Making direct comparisons between countries is difficult due to many factors including differences in healthcare systems, state provision of services and legal systems. While Scotland, Australia and Canada have tort law systems more comparable to this country, Sweden, Denmark and New Zealand have adopted compensation schemes. Tort law systems can be seen as more adversarial, with claims negotiated between claimant and defendant solicitors. If there is no agreement on liability and/or the amount of compensation to be awarded, they will ultimately go to trial in the courts. In comparison, compensation schemes are more inquisitorial with claims generally taken to an administrative body which decides on eligibility and compensation, with much-reduced use of the courts and legal representation.

Table A: Clinical negligence claims and costs data across jurisdictions.[15]

[15] Year referenced in each column reflects where data was readily available across all jurisdictions. Department of Health and Social Care (2021). Internal DHSC analysis.

System	Country	Population (2018, million)	Claims/ 100,000 (2018/19)	Average cash per successful claim (£m) (2016/17)	Cost per capita (£) (2016/17)	% of GDP (2016/17)	% of Health Spend (2016/17)
Tort law	England	56	19	0.22	29.1	0.08%	1.3% (1.9% by 2019/20)
	Wales (2017 data)	3.2	14	-	21.9	0.1%	0.9%
	Scotland	5.4	10	0.32	10.2	0.03%	0.41%
	Australia (2016 data)	24	4	0.13	4.4	0.012%	0.062%
	Canada (2016 data)	36	3	0.08	0.1	0.0002%	0.0007%
'Avoidable harm' compensation scheme	Sweden	10	157	0.01	5.5	0.015%	0.99%
	Denmark	6	183	-	-	-	-
'No-fault' compensation scheme	New Zealand	4.9	239	0.07	136	0.49%	3.9%

18. Sweden, Denmark and New Zealand also have a wider eligibility for compensation. While in this country it needs to be established that the claimant was injured as a result of negligent medical treatment, Sweden and Denmark have 'avoidable harm' systems meaning that once the injury is established to have been caused by a decision, act or omission of the heath care provider, the core test is whether the injury was preventable. In the New Zealand 'no-fault' scheme, there is no need to prove a breach of duty of care by the healthcare provider, just that the injury occurred during treatment. Consequently, a higher proportion of harmed patients are eligible for compensation in these countries than here, seen by the higher claims per 100,000 people rates set out in Table A.

19. However, neither the Government's own enquiries nor the published literature have yet yielded a full explanation as to why spending in this country is significantly higher than in these other countries. While average cash per successful claim in England was £220,000 (in 2016), in Canada this was £80,000 (2016), Australia was £130,000 (2016) and Sweden was £10,000 (2016). The exception is New Zealand, where the per capita cost of clinical negligence in 2016 was four and a half times larger than in England.[16] We welcome evidence from stakeholders to help explain these differences.

Section 2: Addressing the rising cost of clinical negligence

[16] Department of Health and Social Care (2021). Internal DHSC analysis.

20. The Government is focused on addressing the rising cost of clinical negligence such as through its work on Fixed Recoverable Costs (FRC).

> **Q2) What are the key changes the Government should consider as part of its review of clinical negligence litigation?**
>
> **Q2e) The Government has reiterated its intention to extend fixed recoverable costs, which limit the amount that can be paid out to meet legal costs, to clinical negligence cases with settlements of less than £25,000. At what level should these fixed recoverable costs be set, and are there any circumstances in which they should not apply to low value clinical negligence cases?**
>
> **Q7) What legislative changes would be required to support these changes?**

Improving safety and response to harm

21. The Government remains committed to the continuous improvement of patient safety across the NHS. Patients trust the people and organisations caring for them in their most vulnerable moments to provide them with safe, high-quality care, every time. When patient safety incidents do happen, the effects can be devastating, which is why the Government is re-doubling its efforts to make the NHS as safe as possible.

22. Comprehensive safety systems, highly trained staff and empowered regulators are in place to promote a high standard of patient care. Significant measures have been introduced to promote a safety and learning culture and improve transparency across the NHS in the last decade, and these are detailed in Section 2 and Annex C.

23. Our particular focus on improving maternity safety is important not only in its own right, but also because obstetric incidents make up a large proportion of clinical negligence costs. The Government is committed to improving outcomes for mothers and babies, and good progress is being made towards the Government's National Maternity Safety Ambition. More detail is provided in Annex D.

24. Every patient in the NHS should expect the people and organisations caring for them to make their safety a priority. However, harm caused by healthcare affects every health system in the world. The factors underpinning this are systemic, cultural, contextual and human in nature. While the reasons for harm in healthcare are complex, multifaceted and difficult to eradicate, their persistence is cause for significant concern across all health systems.

25. When harm does occur, the NHS should ensure patients' needs are met. We also understand that a good response from the NHS to incidents of harm, such as a clear explanation and apology (as required by the duty of candour) and thorough work to understand what has happened and why, can reduce the need that some patients feel to resort to legal routes to obtain answers and/or an apology.[17]

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[17] NHS Resolution (2018*). Behavioural insights into patient motivation to make a claim for clinical negligence.* London, NHSR. Available online at: https://resolution.nhs.uk/wp-content/uploads/2018/10/Behavioural-insights-into-patient-motivation-to-make-a-claim-for-clinical-negligence.pdf.

26. But however safe NHS treatment is, we cannot assume that reductions in harm would necessarily drive a similar reduction in numbers and costs of claims. We do not believe any measurable decline in safety is driving the long-term rise in the cost of clinical negligence claims – we have found no evidence to suggest this while the NAO found this "unlikely".[18] There has been a decline in the number of settled high-value maternity claims (specifically obstetric cerebral palsy and brain injury claims) in recent years. Costs are rising because payments for compensation and, until recently, claimant legal costs have been growing at rates far above inflation.

Claim process improvements

27. The Department and NHSR continue to consider how current arrangements for claimants and NHS staff could be improved. In the current system for compensation, claims are resolved between the claimant and defendant through negotiation, or if they cannot agree, in the courts at trial. We recognise there is scope for improvement including simplification, time to resolution, and support. Current action taken in this area is set out in Section 4.

Learning from other countries on systems for compensation

28. Systems of compensation in other parts of the world provide learning opportunities on addressing the rising cost of clinical negligence claims, patient safety and claimant experience. Some stakeholders believe the adoption of an 'avoidable harm' or no-fault' compensation scheme as exists in some Nordic nations and New Zealand could lead to improvements in these areas.

29. While it is possible to construct an argument that adopting an 'avoidable harm' or 'no-fault' compensation scheme could bring about some benefit in terms of patient safety (e.g. through removing a disincentive to disclosure) or claimant experience, we cannot say this with any certainty, considering the limited evidence available and the inevitable difficulties in translating findings across different health systems. Some of these benefits are being achieved in this country through different means. We are also not aware of direct evidence that fear of the current claims process is discouraging NHS staff from disclosing incidents.

30. There is also uncertainty over how many additional claims may be brought if these alternative schemes were introduced. As set out in Table A, New Zealand, Sweden and Denmark have all experienced higher claim volumes. Notably, in 2016, New Zealand had a claim volume rate over 12 times that of England and spent over four times more per person addressing clinical harm. Adopting these alternative schemes, particularly a no-fault scheme, could potentially lead to an increase in costs for the NHS. We welcome further evidence from stakeholders as part of this inquiry process on these and other compensation approaches used in different countries.

Legal costs

[18] National Audit Office Comptroller and Auditor General (2017). *Managing the Costs of Clinical Negligence in Trusts*. (p28, Figure 9). London, NAO. Available online at: https://www.nao.org.uk/wp-content/uploads/2017/09/Managing-the-costs-of-clinical-negligence-in-trusts.pdf.

31. Legal costs represent a sizeable proportion of the overall rise in clinical negligence costs, and the proportion has been growing with legal costs exceeding claimant awards in 74% of clinical negligence settlements below £50,000.[19] Most disproportionate are claimant legal costs associated with lower-value awards between £1,001 - £25,000. For lower value claims, the average claimant legal cost per claim doubled from £10,121 in 2006/07 to £22,124 by 2020/21[20] and average claimant legal costs in 2019/20 were *five* times those of defendant legal costs.[21]

32. Following on from our consultation on FRC in 2017, we commissioned the Civil Justice Council (CJC) to develop proposals for FRC which would set recoverable legal costs for lower-value claims at a fair and proportionate rate. The CJC proposed a bespoke, streamlined system for handling claims and put forward grids of fixed costs.

33. The Department is considering the CJC proposals in detail and will consult on any next steps. This work takes place in the context of a number of reforms in recent years to extend FRC in civil cases.

Legislation

34. Government is committed to addressing the rising cost of clinical negligence claims. We have been working intensively to understand the drivers of clinical negligence costs. As part of this work, we are considering what legislative changes would be required under various options. In the 2020 Spending Review, the Government committed to publishing a consultation on this issue.

Section 3: Developing a learning culture in the NHS

2a) What changes should be made to the way that compensation is awarded in clinical negligence claims in order to promote learning and avoid the same problem being repeated elsewhere in the system?

(3) To what extent does the adversarial nature of the current clinical negligence system create a "blame culture" which affects medical advice and decision making?

(4) How important is it that any clinical negligence system encourages lesson learning and commitment to change as the result of any action?

(5) What changes should be made to clinical negligence claims to enable a move away from a blame culture and towards a learning culture in the NHS?

(6) How can the Healthcare Safety Investigation Branch work to improve short term responses to patient safety incidences and therefore reduce the number of those who are forced to pursue litigation as a means of obtaining non-financial remedies?

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[19] NHS Resolution (2021). NHSR internal analysis.

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

[21] NHS Resolution (2021). *Annual Statistics (Supplementary Annual Statistics, Table 11.A and Table 13.A)*. London, NHSR. Available online at: https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Supplementary-Annual-Statistics-2020-21.xlsx.

35. Improving safety through developing a learning culture in the NHS is a priority for the Government. Within this, we are strengthening learning from clinical negligence claims.

Learning from claims

36. It is vital that we examine patient safety incidents to identify what actions might be taken to reduce future risks. Alongside other reporting routes, claims data can be a rich source of information for learning and change, and this is a feature of NHSR's strategy and work. However, claims are not the primary source of learning for the NHS, which is best undertaken at source and as close in time to the event as possible so that rapid action can be taken to prevent further harm. Time lags between incident and claim may curtail the scope for many individual claims to have much impact on system-wide learning.

37. NHSR now routinely shares intelligence with others to drive system-wide improvement. This is done through several initiatives including developing and disseminating thematic reviews, sharing learning from the Early Notification (EN) Scheme across the system (this scheme is described in more detail in Section 4), and collaborating with stakeholders. For example, NHSR undertakes thematic reviews across a range of topics (such as the 2017 report *Five years of cerebral palsy claims*[22]), delivering in-depth insights in priority areas and working with stakeholders to identify issues and possible solutions.

38. NHSR has also collaborated with the Getting It Right First Time (GIRFT) programme to co-produce a best practice guide to help trusts learn more from NHS negligence claims in order to drive patient safety. Throughout, NHSR aims to share data to help the CNST members better understand their claims and risk profiles so they can prioritise their safety activity.

Current clinical negligence system and blame cultures

39. We recognise blame cultures can exist in the health sector and the harmful impacts they can have on staff behaviour. We need environments in which staff feel comfortable to disclose information on safety issues to enable learning to take place.

40. We recognise that being the clinician or team at the centre of a clinical negligence claim can be stressful and upsetting for the clinicians involved. However, we have seen little evidence to date that the litigation system is a major contributing factor to blame cultures. For NHS staff, their healthcare provider is almost always vicariously liable for their actions. Clinicians are also very rarely cross-examined in court: in 2019-20, fewer than 60 clinical negligence claims handled by NHS Resolution resulted in a trial, and clinicians were only required to account for their actions in person in some of those claims.[23] Clinicians are held to account by their professional regulators which review their fitness to practice.

41. Several other factors could be just as influential. Clinicians talk about a range of fear factors including disciplinary action, regulatory action, complaints, investigations, press reporting, reputational damage and the opinion of colleagues and peers. We want to continue to work

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[22] Magro, M., & Fellow, D. (2017). *Five years of cerebral palsy claims: A thematic review of NHS Resolution data*. London, NHSR. Available online at: https://resolution.nhs.uk/resources/five-years-of-cerebral-palsy-claims/.

[23] NHS Resolution (2021). NHSR internal analysis.

with clinicians, healthcare professionals and NHS employers to tackle blame cultures, continuing the focus set out in the NHS Patient Safety Strategy. NHSR's Advice function is developing a training initiative named 'Compassionate Conversations' for NHS Managers to help them to have compassionate conversations with their staff.

42. We welcome views and evidence from stakeholders in this area during this Inquiry.

Learning promotion

43. We know that the best way to reduce patient harm in healthcare is for providers to fully embrace a culture of learning. Following the tragedy at Mid-Staffordshire and other concerning cases, the Government has overhauled the infrastructure underpinning safety and quality in the past decade to promote a safety and learning culture and improve transparency across the NHS. These systems apply regardless of whether or not the affected patient later decides to bring a legal claim, and typically operate within days or weeks of the incident happening.

44. The Health and Safety Investigation Branch (HSIB) conducts independent investigations of patient safety concerns and incidents in NHS-funded care across England, with a specific focus on system-wide learning and improvement. Its work contributes both directly and indirectly to improving short-term local responses to patient safety incidents, with potential implications for reducing the number of patients who feel they need to pursue litigation to obtain answers.

45. We describe some of the measures introduced to promote learning and prevention within our healthcare system, including the NHS Patient Safety Strategy and the work of the HSIB, in Annex C.

Section 4: Improving claim resolution

2b) How can clinical negligence processes be simplified so that patients can receive redress more quickly?

2c) How can collaboration between legal advisors be strengthened to encourage early and constructive engagement between parties?

2d) What role could an expanded Early Notification scheme play in improving transparency and efficiency system-wide?

46. The Department and NHSR have worked to simplify the experience for patients of making a clinical negligence claim and help them receive redress more quickly.

How the current claim resolution process works

47. We recognise that current legal processes prescribed for bringing and settling claims do not always serve claimants or NHS staff well. The system is complex and can often take years to reach a conclusion. However, the majority of claims resolve without formal court proceedings, and very few claims ultimately go to trial.

48. It is important to bear in mind that a desire for speedy resolution and a smooth claimant experience must neither cut across access to justice and appropriate redress for claimants nor dilute the requirement to ensure value for money for the NHS and the taxpayer. For example, injuries need to be allowed time to stabilise before experts can advise on their impact and an appropriate settlement can be finalised. An important element of NHSR's role is to challenge claims that may lack merit or include legal costs or compensation elements that cannot be justified.

49. We are interested in views from stakeholders on how the claim resolution process works for them.

Initiatives to improve claims processes

50. As well as addressing disproportionate legal costs, the CJC's FRC proposals would look to improve the claims experience of both claimants and defendants by streamlining the process for all parties and minimising the number of cases that need to enter court proceedings. The Department will consult on any next steps.

51. Since 2017, NHSR has year-on-year reduced the number of cases entering formal legal proceedings. In 2020/21, NHSR resolved the majority of claims in-year without formal proceedings (74%, compared to 71% in 2019/20).[24] These were resolved via correspondence, at settlement meetings or via forms of dispute resolution, including formal mediation. The use of mediation in particular has sharply increased, becoming a regular feature in health claims.

52. NHSR have led on a new, more collaborative approach with claimant solicitors to resolving clinical negligence claims, as set out in their 2019-22 strategy 'Delivering fair resolution and learning from harm'.[25] Under this approach, NHSR have worked with claimant law firms and their own panel firms on a number of pilots exploring various innovative dispute resolution techniques focused on improving resolution meetings and changes to process..

53. The EN scheme, established by NHSR in 2017, is a national programme for the early reporting of babies born with a potential severe brain injury following pre-term labour, with a focus on intrapartum hypoxic ischaemic encephalopathy. The scheme requires NHSR's CNST members to notify NHSR, via the HSIB, of these maternity incidents. Its purpose is to contribute to improvements in the safety of maternity care, while also responding to the needs of families where clinical negligence is identified, including the early admission of liability or breach of duty where appropriate.

54. Although in its early years, the EN scheme has already reduced the time between an incident occurring, an investigation into eligibility for compensation being initiated and admissions of liability being made. Seeking earlier notification of incidents means not only that NHSR can proactively investigate liability, but also that trusts are encouraged to be open about

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[24] NHS Resolution (2021). *Annual Report and Accounts 2020/21*. (p56). London, NHSR. Available online at: https://resolution.nhs.uk/wp-content/uploads/2021/07/Annual-report-and-accounts-2020-21-web.pdf.

[25] NHS Resolution (2017). *Delivering fair resolution and learning from harm: Our strategy to 2022*. London. NHSR. Available online at: https://resolution.nhs.uk/wp-content/uploads/2020/06/NHS-Resolution-Our-Strategy-to-2022.pdf.

incidents, be candid with families and maximize opportunities to learn from them. The early notification approach has already led to rapid learning and recommendations for safety improvement which have been implemented by maternity units to prevent a recurrence. While there are no plans at present to expand the scheme beyond its current remit, NHSR is currently considering how to improve and maximise the effectiveness of the existing scheme.

55. The scheme also aims to improve the process of obtaining compensation for families, meeting needs in real time where possible and ensuring support is in place early. In claims involving babies, it is typically necessary for the child to have reached a certain level of development, several years after an incident, before a clinical assessment can predict their future needs effectively. This means there is often an element of unavoidable delay in resolving those cases. The scheme helps to offset this problem by addressing the known factors that delay resolution in this group of claims and getting help to patients and families much quicker than previously.

56. More information about NHSR's work to improve claim resolution can be found in Annex E.

Response to harm and concerns

57. The initial response by the NHS to adverse incidents or concerns raised by patients is vitally important – transparency and candour with patients is critical. We know that poor handling when an incident or other issue occurs can be distressing for patients and families at a time when they are vulnerable. There is also evidence that poor handling, including the lack of a timely apology or explanation, can exacerbate frustrations felt by patients and could be a factor influencing patients' motivation to claim.[26] Such research supports NHSR's more 'upstream' approach, which means being responsive before patients seek legal advice.

58. The Government has taken significant steps to help the NHS improve the response to patients who are harmed and their families and to reduce patient harm. These include involving patients, their families and carers, if they wish, in investigations into patient safety incidents; where appropriate, apologies and disclosure of information from the investigation should be provided in an open, timely, compassionate and effective manner. More initiatives are set out in Annex C.

Conclusion

59. The rising cost of clinical negligence claims is an issue with implications for the NHS and society more generally. Clinical negligence claims are funded from the core NHS budget and use resources that could otherwise have been spent on patient care. We welcome the Committee's focus on this important issue and look forward to considering evidence from the various interested parties and the Committee's conclusions.

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[26] Gray, A. & Fenn, P. et al. (2017). "Changing experience of adverse medical events in the National Health Service: Comparison of two population surveys in 2001 and 2013." *Social Science & Medicine*, vol 195, pp83-89. Available online at: https://doi.org/10.1016/j.socscimed.2017.11.016.
NHS Resolution (2018). *Behavioural insights into patient motivation to make a claim for clinical negligence*. London, NHSR. Available online at: https://resolution.nhs.uk/resources/behavioural-insights-into-patient-motivation-to-make-a-claim-for-clinical-negligence/

60. The Government has taken and continues to take significant steps to improve patient safety and the response from the NHS when patients are harmed, facilitate smoother claim resolution, and work up proposals to lower legal costs. We are continuing to work intensively across Government to address these issues. In the 2020 Spending Review, the Government committed to bringing forward a consultation to address the rising costs of clinical negligence claims.

Annex A: Compensation by head of loss

Table B: Compensation by head of loss in 2018/19 (estimates).

Heads of Loss	Head of Loss Breakdown by Aggregated Bands				
	£1-£100k	£100k-£1m	£1m-£3.5m	£3.5m+	Grand Total
General Damages	57%	21%	7%	2%	7%
Social Care	10%	26%	37%	58%	51%
Accommodation	0%	4%	13%	10%	10%
Loss of Earnings	9%	15%	13%	6%	7%
Miscellaneous and other HoLs	16%	20%	11%	3%	6%
Case management	0%	1%	3%	5%	4%
Deputyship	0%	2%	2%	4%	4%
Therapy and treatment	5%	5%	4%	3%	4%
Equipment	1%	3%	5%	3%	3%
Travel/transport	1%	2%	3%	2%	2%
Holidays	0%	0%	2%	2%	2%
Education	0%	0%	0%	0%	0%

Table B shows compensation by Head of Loss in 2018/19 (compensation is awarded under several heads of loss). The highest-cost element was social care which accounted for 51% of total compensation, including 58% of compensation for awards above £3.5million.

The table uses estimates based on a sample of claims used to study the distribution of compensation awards across Heads of Loss. As these are estimates based on a sample, the actual spend on each head of loss could differ.

Reference: Department of Health and Social Care (2021). Internal DHSC analysis.

Annex B: Why the cost of clinical negligence claims has grown

Claim volume

1. The NAO found in their 2017 report that one of the main drivers of overall costs by that stage was an increase in the annual number of new claims. These more than doubled from 5,426 to 11,945 between 2006-07 and 2013-14 (see blue line in Figure E).[27]

2. This increase in new claims has since levelled out, not rising above these levels until 2020-21. (The change between 2019-20 and 2020-21 reflected the inclusion of General Practice claims into NHSR-managed schemes following the introduction of the state indemnity schemes for General Practice).

3. Another important consideration regarding claim volume as a driver of overall costs is the observed time between 'notified' claims that come into the system (see blue line in Figure E), and when they are settled (see red line in Figure E), the latter being when compensation is typically paid. While total successful claims across all claim types increased from 2006/07 before peaking in 2016/17,[28] the volume of successful obstetric cerebral palsy and brain injury claims, which are typically high-value claims that have historically accounted for around 40% of annual cash payments for claims (see compensation awards section), fell over this period, continuing into 2020-21 (see Figure E).[29]

[27] NHS Resolution (2021). *Annual Statistics (Annual Report Statistics, Table A.1).* London, NHSR. Available online at: https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Annual-Report-Statistics-2020-21.xlsx.
[28] NHS Resolution (2021). *Annual Statistics (Annual Report Statistics, Table C.1).* London, NHSR. Available online at: https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Annual-Report-Statistics-2020-21.xlsx.
[29] NHS Resolution (2021). *Annual Statistics (Annual Report Statistics, Table D.1). London,* NHSR. Available online at: https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Annual-Report-Statistics-2020-21.xlsx.
NHS Resolution. (2021). *Annual Statistics (Supplementary Annual Statistics, Table 2.A).* London, NHSR. Available online at: https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Supplementary-Annual-Statistics-2020-21.xlsx.

Figure E: Index of new claims and successful claims (claims settled with compensation) across all schemes between 2006-07 and 2020-21.

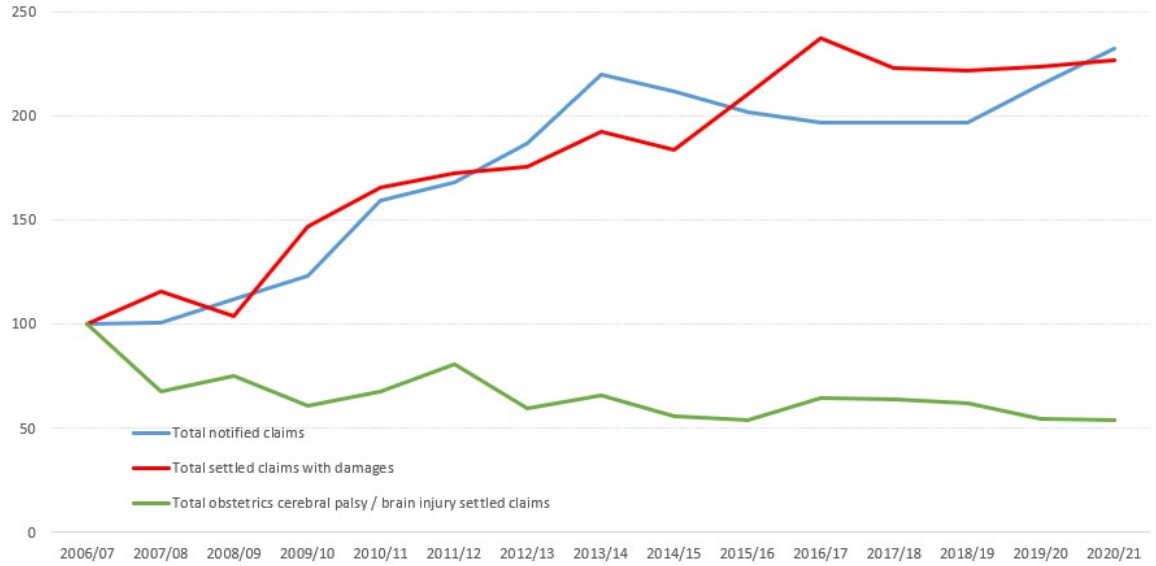

Figure E uses an index to demonstrate the relative growth over time of volumes that have significantly different orders of magnitude in absolute terms. Each line represents the relative growth in volumes (e.g. total notified claims) using 2006/07 as a base year (i.e. where the index is equal to 100). As an example, 'Total notified claims' are almost 2.5 times as large in 2020/21 as they were in 2006/07.

References: NHS Resolution (2021). Annual Statistics (Annual Report Statistics, Tables A.1, C.1, D.1). London, NHSR. Available online at: https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Annual-Report-Statistics-2020-21.xlsx.

4. Meanwhile, annual cash payments for claims more than doubled between 2006-07 and 2013-14 and doubled again between 2013-14 and 2019-20 (see Figure A). Whilst some of these increases are partially explained by the increase in settled claims in aggregate, this has levelled out since 2016-17, and for some of the highest-value claims in the system, there has been a reduction in settled claims. In conclusion, it does not appear, at least in recent years, that the overall rise in cost can be explained by claim volume.

5. While the number of claims increased between 2006-07 and 2013-14, we do not have evidence to suggest that a change in safety or patient experience contributed to the rise in claims between 2006-07 and 2013-14. In their report, the NAO found a fall in patient safety or worsening patient experience would be an "unlikely" cause because "available patient safety indicators suggest that this has remained stable" and "overall patient satisfaction with hospital care has remained high".[30]

6. Improving patient safety and reducing levels of harm are objectives in their own right and must remain a top priority for the NHS. As explained in Sections 2 and 3, in the last decade the Government has introduced significant measures to improve patient safety, the response to harm and NHS learning from things that go wrong.

7. In their report, the NAO considered patient access to legal services to be a "likely" contributing factor to the volume increase.[31] Some of the changes in legal services

[30] National Audit Office Comptroller and Auditor General (2017). *Managing the Costs of Clinical Negligence in Trusts*. (p28, Figure 9). London, NAO. Available online at: https://www.nao.org.uk/wp-content/uploads/2017/09/Managing-the-costs-of-clinical-negligence-in-trusts.pdf.
[31] National Audit Office Comptroller and Auditor General (2017). *Managing the Costs of Clinical*

highlighted by the NAO were the introduction of 'no-win-no-fee' agreements, the growth of claim management companies, the introduction of fixed legal costs for road traffic accident injury claims, and the reforms brought into force by the Legal Aid, Sentencing and Punishment of Offenders (LASPO) Act 2012. We agree with the NAO that these factors may help explain the rise, up to the peak of claim volume in 2013-14.

8. Which and how many claims claimant solicitor law firms decide to take on would also likely influence claim volume. Firms draw in potential claims through a number of routes, including advertising or word of mouth. We understand that they may then filter out many of these on the grounds that they lack merit, are not profitable to pursue, or that they do not otherwise meet their business needs (for example, the firm does not have capacity to take on more claims).

Compensation awards

9. A further driver identified by the NAO was an increase in compensation awards. Payments for compensation increased four-fold from £0.4billion to £1.6billion between 2006-07 and 2019-20 where they accounted for 60% of payments for claims (see Figure B above – excluding PIDR).[32] In 2020-21, the year of the pandemic, payments for compensation remained stable at £1.6billion. Given claims volume has levelled out, compensation awards are now the main driver of overall costs.

10. The largest component and driver of the size of compensation awards is higher-value claims, defined in this response as those that settled at £3.25million and above. In 2019-20, these awards accounted for 58% of payments for compensation, and 48% of total costs across all claims.[33] Typically, awards in higher-value claims have Periodical Payment Orders (PPOs) attached to them. Our analysis suggests the average compensation within CNST for these claims, including future PPO payments, has risen at an average rate of 7% to 8% per year over the last decade.[34]

11. While we can currently assess the proportion of compensation awards accounted by higher-value claims by looking at those above £3.25million, when comparing claims over time, obstetrics claims are a better measure for how compensation for like-for-like injuries has changed over time. Claims relating to obstetrics comprise an estimated 79% of total compensation for these high value claims settled in 2020/21, with cerebral palsy and brain injury (CP/BI) roughly 74% of these high value claims. Figure F shows how average compensation for CP/BI claims increased steadily from £2.5million in 2006/07 to £5.4million in 2016/17, rising steeply up to £10.2million in 2018/19 (accounting for PIDR change) before decreasing to £8.9million by 2020/21.[35] Figure F also shows that average compensation,

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Negligence in Trusts. (p28, Figure 9). London, NAO. Available online at: https://www.nao.org.uk/wp-content/uploads/2017/09/Managing-the-costs-of-clinical-negligence-in-trusts.pdf.

[32] NHS Resolution. (2021). *Annual Statistics (Supplementary Annual Statistics, Table 1.A, 3.A.1).* London, NHSR. Available online at: https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Supplementary-Annual-Statistics-2020-21.xlsx.

[33] NHS Resolution (2021). *Annual Statistics (Supplementary Annual Statistics, Table 1.A.1, 3.A.1).* London, NHSR. Available online at: https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Supplementary-Annual-Statistics-2020-21.xlsx.

[34] Department of Health and Social Care. (2021). Internal DHSC analysis.

[35] NHS Resolution (2021 *Annual Statistics (Supplementary Annual Statistics, Table 10.A).* London,

once rises in wages for care workers (Annual Survey of Hours & Earnings) are accounted for, follows a similar trend.

12. Meanwhile, the absolute volume of settled CP/BI claims has fallen steadily since 2006/07 and growth in numbers of claims across maternity claims more broadly has been considerably lower than total claims. This underlines the point that for these claim types, volume has not been the key driver of cost rises. Considering there is no evidence that the severity of injuries has worsened, this suggests that compensation for a harmed patient 15 years ago. However, we remain committed to making progress in improving maternity safety.

Figure F: Index value of obstetrics (cerebral palsy and brain injury) claims using 2006/07 as a base year up to 2020/21.

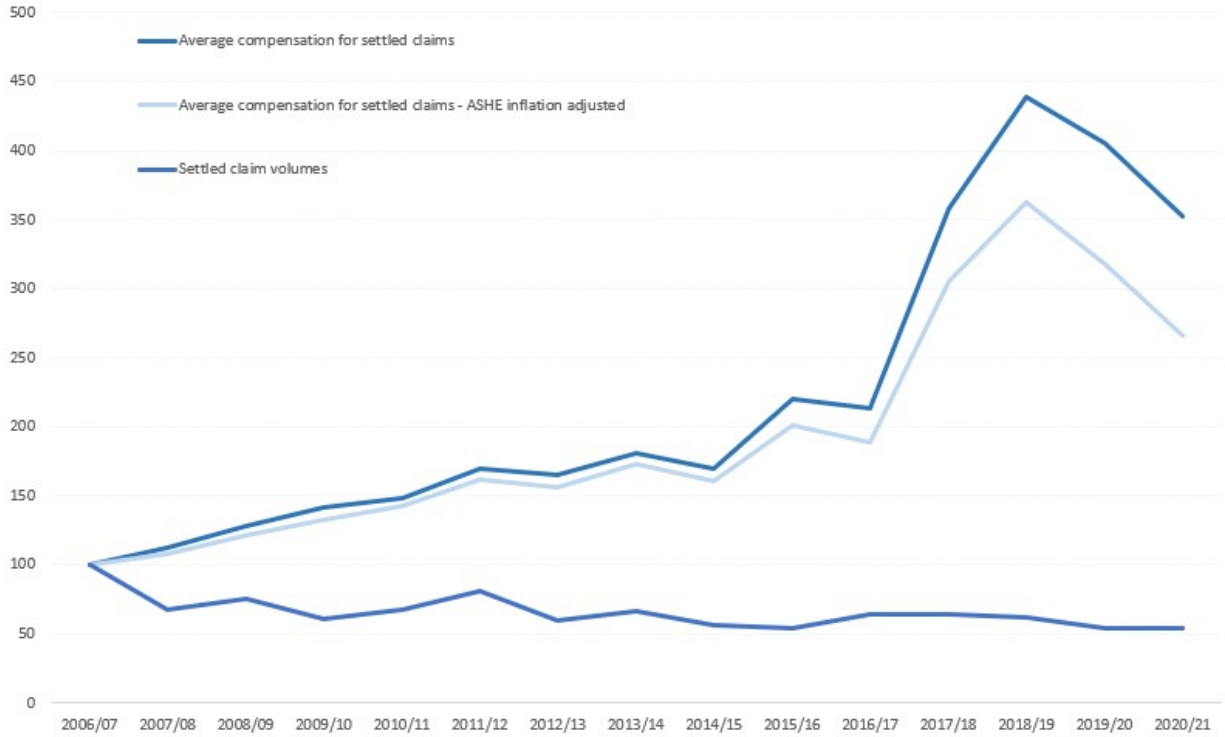

Figure F uses an index to demonstrate the relative growth over time of volumes that have significantly different orders of magnitude in absolute terms. Each line represents the relative growth in volumes using 2006/07 as a base year (i.e. where the index is equal to 100).

References: NHS Resolution (2021). Annual Statistics (Annual Report Statistics, Table C.1). London, NHSR. Available online at: https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Annual-Report-Statistics-2020-21.xlsx.

13. Several factors have influenced the increase in the liabilities represented by these higher-value claims including:

    - **Changes made to the way payments are made**: PPOs account for an increasing proportion of payments for compensation. This means that every year, rather than being paid up-front, additional liabilities are added to be paid in future years.

NHSR. Available online at: https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Supplementary-Annual-Statistics-2020-21.xlsx.

- **Personal Injury Discount Rate**: The reduction in the PIDR in 2017 added £786million to lump-sum payments for compensation (i.e. those not settled as PPOs) between 2017-19.[36] Though the rate, and the basis for setting it in the future, was changed again in 2019, this has only partially reversed the impact of the earlier change.

- **External factors**: such as the rising cost of social care and increasing life expectancy.

14. However, together these factors do not fully explain the steep rise in the cost of payments for compensation. Even when focussing only on lump sum payments to avoid the cumulative effect of PPOs and removing the PIDR effect, we still observe high nominal growth in annual payments for compensation from £738million in 2013-14 to £1.1billion in 2019-20 of around 7% per year.[37] In 2020-21, annual payments for lump sums excluding the PIDR effect were £1billion.[38] We welcome evidence from stakeholders as part of this inquiry process on drivers of the size of compensation awards.

Precedent-setting

15. Compensation for personal injury claims is awarded in line with the full compensation principle. The objective of this principle is for compensation, as far as reasonably possible, to put the claimant back into the same position as they would have been if they had not suffered harm. Interpretation of what constitutes meeting the full compensation principle changes over time as societal expectations and technology develop.

16. Alongside these factors above, it is possible that a proportion of the rise in payments for compensation is due to precedent-setting leading to higher compensation awards in court. Court decisions may raise expectations of what sums can be recovered in future claims. Claimants may reject offers which previously would have been acceptable, and defendants may be inclined to offer more in compensation in order to avoid the costs of proceeding to trial and significant costs penalties at court.

Uncertainty in calculating future components of compensation awards

17. Most compensation awards are made on a once-and-for-all basis.[39] This means the courts need to consider a claimant's lifetime needs from assessment at a single point in time. There can be considerable uncertainty in making an accurate assessment because the claimant's conditions and needs can change. This is particularly the case for those whose disabilities resulting from proven clinical negligence are severe enough to require long-term social care, and these are generally the highest-value claims. There are approximately 300-350 claims currently settled per year in England for claimants who have these requirements; approximately half of these would have been children at the time of the incident.[40]

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[36] NHS Resolution. (2021). *Annual Statistics (Supplementary Annual Statistics, Table 3.A.2).* London, NHSR. Available online at: https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Supplementary-Annual-Statistics-2020-21.xlsx.

[37] Department of Health and Social Care (2021). Internal DHSC analysis.

[38] Ibid.

[39] **In rare and quite specific situations, the claimant may be entitled to an award of provisional compensation.**

[40] NHS Resolution (2021). NHSR internal analysis. Claims settled with total compensation value of

18. The more complex the injury and the longer the claimant's life expectancy, the greater the degree of uncertainty in accurately predicting what degree of funding would adequately restore them to the same position as they would have been in but for the negligence. This is a highly specialised task often requiring the opinions of multiple experts, who may reach different conclusions. Therefore, there are risks of either over- or under-compensating, and there is no data to help us understand to what extent either could currently be occurring.

19. Given that growth in compensation awards for higher-value claims are now the largest driver of total claims costs, it is possible that factors linked to uncertainties in assessing and calculating future needs may be contributing to the growth in payments for compensation.

Double recovery

20. Double recovery can take place where a claimant receives funding or provision from more than one source for the same requirement. For example, if they receive compensation for a given service or item and then access state services for the same need. There is the potential for double recovery within several heads of loss, including social care, treatment and therapy (healthcare), education provision, some Department for Work and Pension benefits, and equipment and aids.

    a. For treatment and therapy, section 2(4) of 'The Law Reform (Personal Injuries) Act 1948' provides that the court "shall disregard the availability of NHS care when considering whether any expenses claimed are reasonable".[41] This means claimants can be provided with compensation that will enable them to fund the treatment and therapy privately. Double recovery could then take place if they were to go on to obtain the same treatment from the NHS.

    b. For social care, double recovery can occur because under The Care and Support (Charging and Assessment of Resources) Regulations 2014,[42] compensation awards held in a trust fund are exempt from local authority 'means-testing'. This means there is the potential for claimants to access local authority services without paying for the provision, even when their compensation award has been calculated to fully meet their needs arising from the negligence.

21. Beyond anecdotal evidence of individual cases where compensation award recipients have sought their entitlements for social care with local authorities, there is no data on the extent to which double recovery occurs. Treatment and therapy costs account for a small proportion of payments for compensation (see Table B in Annex A), and so the cost impact of any double recovery for healthcare is likely to be small in the context of overall costs. In contrast, social care is a much larger head of loss, and for that reason it is possible that double recovery has a larger impact on total costs. However, we have no evidence that the

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£1m or more.

[41] Law Reform (Personal Injuries) Act 1948. 1948 c. 41 (Regnal. 11_and_12_Geo_6). (s 2.). Available online at: https://www.legislation.gov.uk/ukpga/Geo6/11-12/41/section/2.

[42] The Care and Support (Charging and Assessment of Resources) Regulations 2014. 2014. SI:2014/2672. Available online at: https://www.legislation.gov.uk/uksi/2014/2672/made#f00061.

level of double recovery has increased, and we therefore do not think it is likely to be a significant driver behind the growth in the cost of payments for compensation.

Legal costs

22. The third driver of overall costs highlighted by the NAO was rising claimant legal costs. Between 2006-07 and 2016-17, these rose fivefold from £98million to £496million.[43] Since 2016-17, we observe that claimant legal costs have levelled out, reducing slightly to £433million in 2020/21.[44] However, in 2020/21 they remained at a high level relative to 2006/07, accounting for 20% of annual cash payments for claims.[45]

23. Claimant legal costs accounted for 77% of total legal costs (including defendant legal costs) in 2019-20 and this proportion has been growing.[46] Over this period, average claimant legal costs per claim grew from double to quadruple the size of average defendant legal costs per claim.[47]

24. The NAO considered that an underlying factor of the increase in claimant legal costs was a rise in lower and medium-value claims funded by 'no-win-no-fee' agreements.[48] We agree with the NAO conclusion that the rise in claimant legal costs in recent years is "closely associated with legal reforms and market developments in legal services". We discuss here how current arrangements for bringing claims could be contributing to the long-term rise in claimant legal costs.

25. The availability of Conditional-Fee Agreements (CFAs), After-the-event (ATE) insurance and the application of Qualified One-Way-Cost-Shifting (QOCS) have minimised the financial risk borne by claimants bringing clinical negligence claims. As claimants are not exposed to the legal costs that different legal firms charge, they are not incentivised to consider differences in legal costs charged when choosing a firm to bring their case, and this may reduce the incentives of firms to keep their fees low. However, guideline hourly rates, which are periodically updated, are used as a starting point in negotiation between claimant and defendants as to claimant legal representatives' hourly rates for each claim, and legal costs in general can be reviewed by the court.

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[43] NHS Resolution (2021). *Annual Statistics (Supplementary Annual Statistics, Table 5.A).* London, NHSR. Available online at: https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Supplementary-Annual-Statistics-2020-21.xlsx.

[44] NHS Resolution (2021). *Annual Statistics (Supplementary Annual Statistics, Table 5.A).* London, NHSR. Available online at: https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Supplementary-Annual-Statistics-2020-21.xlsx.

[45] NHS Resolution (2021). *Annual Statistics (Supplementary Annual Statistics, Table 1.A and Table 5.A).* London, NHSR. Available online at: https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Supplementary-Annual-Statistics-2020-21.xlsx.

[46] NHS Resolution (2021). *Annual Statistics (Supplementary Annual Statistics, Table 5.A and Table 7.A).* London, NHSR. Available online at: https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Supplementary-Annual-Statistics-2020-21.xlsx.

[47] NHS Resolution (2021). *Annual Statistics (Supplementary Annual Statistics, Table 11.A.1 and Table 13.A.1).* London, NHSR. Available online at: https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Supplementary-Annual-Statistics-2020-21.xlsx.

[48] National Audit Office Comptroller and Auditor General (2017). *Managing the Costs of Clinical Negligence in Trusts*. (p9). London, NAO. Available online at: https://www.nao.org.uk/wp-content/uploads/2017/09/Managing-the-costs-of-clinical-negligence-in-trusts.pdf.

26. There are no caps on the amount of claimant legal costs that can be recovered for clinical negligence claims. While costs are limited in most other areas of personal injury such as road traffic accident injuries, clinical negligence claims have been excluded from these reforms.

27. However, the 'Legal Aid, Sentencing and Punishment of Offenders Act' (LASPO) reforms of 2012 may have created some offsetting reductions in claimant costs between 2016/17 and 2019/20 by removing the recoverability of success fees and some aspects of the premiums paid for ATE insurance from the defendant. ATE premiums for clinical negligence expert reports remain recoverable. This means that claimants do not have to pay upfront for the (often sizeable) costs of reports relating to causation and liability, and this burden falls on the defendant (in this case the NHS) if a claim is successful.

28. Though extensive filtering takes place, we acknowledge the financial risk that claimant legal firms take when they pursue a claim for clinical negligence; they only recover fees from the defendant when their claim is successful, and many firms will not receive payment until after the settlement of the case which may take many years. Claimant solicitors may seek to cover claimant firms' costs in unsuccessful claims through the fees they charge for successful claims. At the same time, QOCS means defendants now cannot generally recover legal fees from the claimant.

Impact of the pandemic

29. During 2020-21, there was a slight decrease in claim volume, payments for compensation and legal costs (see Figure A). This is likely to be due, at least in part, to the coronavirus pandemic resulting in disruption to normal patterns of bringing, handling and settling claims.[49] The full impact of the pandemic on claims will emerge over time, and NHSR is keeping this under close review.

30. In addition, a new indemnity scheme, the 'Clinical Negligence Scheme for Coronavirus' (CNSC), was launched to meet liabilities arising from the special healthcare arrangements being put in place in response to the coronavirus outbreak which are not covered elsewhere. At the end of 2020-21, there were only 7 reported incidents.[50]

Annex C: Measures to improve patient safety, response to harm and learning within our healthcare system

1. The **NHS Patient Safety Strategy** was published by NHSEI in 2019 and updated in 2021. It sets out an ambitious programme of work to continuously improve patient safety across the NHS, alongside the NHS Long Term Plan. The Strategy committed to building on the foundations of a good patient safety culture and patient safety systems.

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[49] NHS Resolution (2021). *Annual Report and Accounts 2020/21*. (p40). London, NHSR. Available online at: https://resolution.nhs.uk/wp-content/uploads/2021/07/Annual-report-and-accounts-2020-21-web.pdf.

[50] NHS Resolution (2021). *Annual Report and Accounts 2020/21*. (p18). London, NHSR. Available online at: https://resolution.nhs.uk/wp-content/uploads/2021/07/Annual-report-and-accounts-2020-2021-WEB-1.pdf.

2. Despite the challenges of the pandemic, NHSEI and the NHS have made significant progress in implementing the Strategy. This includes:

    - a new **Learn from patient safety events** service which will replace the ageing National Reporting and Learning System as an improved central service for recording and analysing patient safety events;
    - a **Patient Safety Incident Response Framework** which has been piloted ahead of rollout in 2022 in order to improve local responses to, and investigations of, incidents involving patient safety;
    - the first **NHS Patient Safety Syllabus**, making available training and education in patient safety to all NHS staff;
    - identifying over 700 **Patient Safety Specialists** in almost every NHS organisation to oversee and support patient safety activities across their organisation;
    - a new Framework for Involving Patients in Patient Safety has been published to support patients to contribute to their own safety.
    - the ongoing focus on **maternity and neonatal safety** with significant new investment; and
    - programmes focussing on **medication safety** and **mental health safety**.

3. A **National Patient Safety Alerts Committee** has also been delivered as part of the NHS Patient Safety Strategy. The role of the Committee is to deliver a new accreditation and approval process to ensure that providers implement National Patient Safety Alerts effectively in order to reduce the risk of death and disability. The NHS has a very good track record for reporting and learning from patient safety incidents. Every year, over 2.2 million incidents are reported by healthcare staff (the majority (86% in 2020/21) are reported as causing no or low harm). Reporting drives local action to reduce risks, as well as enabling national action to identify new and under-recognised risks to be identified and where possible acted on.

4. NHSEI has published a **Just Culture** guide to support consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents.[51] NHSR has highlighted the need for a just learning culture in its report *Being Fair* and created a *Just and Learning Culture Charter* for organisations to adapt and adopt based on real-world examples of good practice.[52]

5. Further measures to promote a safety and learning culture and improve transparency across the NHS include:

    - Establishing in 2017 the **HSIB** - with a programme to improve maternity safety - to conduct independent investigations into serious patient safety incidents in NHS-

[51] NHS England and Improvement (2019). *A Just Culture Guide*. London, NHSEI. Available online at: https://www.england.nhs.uk/patient-safety/a-just-culture-guide/.
[52] NHS Resolution (2019). *Being Fair: Supporting a just and learning culture for staff and patients following incidents in the NHS*. London, NHSR. Available online at: https://resolution.nhs.uk/resources/being-fair/.

funded care and promote system-wide learning across the NHS. The Health and Care Bill, which is currently going through Parliament, would establish the **Health Services Safety Investigation Body** (HSSIB) as a new independent Arm's-Length Body to continue the work of the HSIB. This would create a "safe space" within which patients, families and staff can provide information to the HSSIB in confidence so that the causes and system factors that underpin incidents are identified. This enables effective and sustainable actions to be taken to reduce risks and further support learning and a safety and improvement culture within the NHS and the independent sector. The Bill keeps options open for NHS England or any other public body to carry out maternity investigations in the future. Further work by HSIB can be found within their evidence submission to this Inquiry.

- Implementing **medical examiners** across the NHS as a critical reform so that all non-coronial deaths are scrutinised by an independent medical practitioner and bereaved families have a point of contact to ask questions or raise concerns. The Bill would allow NHS bodies, rather than Local Authorities, to appoint medical practitioners as medical examiners.

- Legislating in the Medicines and Medical Devices Act 2021 to establish a new **Patient Safety Commissioner** whose role will be to promote the safety of patients and the importance of their views in relation to medicines and medical devices. Subject to secondary legislation, the Commissioner will be appointed in 2022.

- The **Duty of Candour** law for NHS organisations which has been in place since 2014 and is regulated by the Care Quality Commission (CQC). It means Trusts must tell patients if they have been involved in a patient safety incident leading to moderate harm or worse and apologise, something which is vital to learning, and enhancing an open and transparent culture. The CQC now look at poor culture and duty of candour when reviewing NHS Trusts, and in 2020, they successfully prosecuted a Trust for the first time for failure to comply with regulations concerning the duty of candour.

- Giving more protections to *whistle-blowers* when they raise concerns, supported by **Freedom to Speak Up Guardians** in all Trusts, and the **National Guardian**.

6. The Government is clear that Patient Safety must remain a top priority for the NHS. Our new cross-government **National Patient Safety Programme Board** reports to the Department's Secretary of State and provides new coordination and monitoring of patient safety and response to harm across the NHS.

7. NHSR's **Maternity Incentive Scheme** provides financial incentives within CNST for Trusts to improve maternity safety.

Annex D: Maternity safety

1. The Government is committed to making the NHS the best place in the world to give birth through personalised, high-quality support.[53] The **National Maternity Safety Ambition** is to

[53] Department of Health and Social Care. (2020). *Evidence Submission for the Health and Social*

halve the 2010 rates of stillbirths, neonatal and maternal deaths and brain injuries occurring during or soon after birth by 2025, with an interim ambition of a 20% reduction in these rates by 2020. The original ambition was to halve these rates by 2030 but it was re-set on 28 November 2017 following the provision of additional funding and support.[54] An additional ambition to reduce the pre-term birth rate from 8% to 6% was also introduced in 2017.

2. To date we have seen good progress in reducing perinatal mortality rates but slower progress with other elements of the ambition.[55] Since 2010, there has been a 25% reduction in the stillbirth rate and a 29% reduction in the neonatal mortality rate for babies born over the 24-week gestational age of viability. The maternal mortality rate in 2016-18 had dropped by 9% from 2009-11 levels. The pre-term birth rate reduced from 8.1% in 2017, to 7.9% in 2019. The overall rate of brain injuries occurring during or soon after birth is variable but shows no trend downwards: having risen from 4.2 to 4.7 per 1000 live births between 2012 and 2014, brain injury rates had fallen to 4.2 in 2019.[56] We are committed to doing more to meet the challenges set in the Maternity Ambition, especially on brain injury. There is no room for complacency.

3. Reviews of perinatal and maternal mortality and intrapartum brain injury cases undertaken by Royal College of Obstetricians and Gynaecologists' **Each Baby Counts Programme**[57] and by MBRRACE-UK confidential enquiries[58] have highlighted the multifaceted nature of safety incidents – there is not one solitary factor that leads to a negative outcome. There is, however, evidence of improved outcomes associated with the implementation of safety interventions. An evaluation of the Saving Babies Lives Care Bundle showed that stillbirths fell by a fifth at maternity units where implementation of the care bundle was evaluated over the two years to April 2017,[59] equivalent to an estimated 600 fewer stillbirths a year nationally.

Care Committee Inquiry - Safety of Maternity Services in England. (p8). Available online at: https://committees.parliament.uk/writtenevidence/11114/pdf/

[54] Department of Health (2017). *Safer Maternity Care - The National Maternity Safety Strategy - Progress and Next Steps*. London, DH. Available online at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/662969/Safer_maternity_care_-_progress_and_next_steps.pdf.

[55] Department of Health and Social Care (2021). *The Government's response to the Health and Social Care Committee report*. London. DHSC. Available online at: https://committees.parliament.uk/publications/7404/documents/77572/default/.

[56] However, the rate of infants born with a particular type of brain injury, Hypoxic Ischemic Encephalopathy, fell 15% between 2014 and 2019.

[57] Royal College of Obstetricians and Gynaecologists (2021). *Each Baby Counts: 2020 Final Progress Report*. London, RCOG. Available online at: https://www.rcog.org.uk/en/guidelines-research-services/audit-quality-improvement/each-baby-counts/reports-updates/2020-report/.

[58] Knight M, Bunch K, Tuffnell D, Shakespeare J, Kotnis R, Kenyon S, Kurinczuk JJ (Eds.) on behalf of MBRRACE-UK (2020). *Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18*. Oxford: National Perinatal Epidemiology Unit, University of Oxford. Available online at: https://www.hqip.org.uk/resource/maternal-newborn-and-infant-programme-saving-lives-improving-mothers-care-2020-report/#.YYVYBPrP2Uk.

[59] Widdows K, Roberts SA, Camacho EM, Heazell AEP (2018). *Evaluation of the implementation of the Saving Babies' Lives Care Bundle in early adopter NHS Trusts in England*. Maternal and Fetal Health Research Centre, University of Manchester, Manchester. Available online as: https://www.e-lfh.org.uk/wp-content/uploads/2020/02/SPiRE-evaluation.pdf.

4. In the 2020 Spending Review, we announced £9.4million to improve maternity safety. This is in addition to the £95million we are investing 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.

Annex E: NHS Resolution initiatives to improve claim process

1. NHSR's claims mediation service and use of alternative dispute resolution (ADR) is designed to support patients, families and NHS staff in working together towards the resolution of incidents, legal claims, costs disputes, and to avoid the potential emotional stress and expense of going to court.[60] Mediation can also provide a forum for claimants and their families to articulate concerns directly to healthcare providers who can provide face-to-face explanations and apologies – this is not ordinarily the case in other forms of dispute resolution.

2. Since NHSR's mediation scheme was first launched on 5 December 2016, over 1,200 claims have been mediated up to 31 March 2021.[61] This has helped to change the way in which mediation is viewed in clinical negligence as the benefits for claimants are seen. Mediation is not the only form of ADR utilised by NHSR. They have been testing a wide range of dispute resolution techniques in addition to mediation, such as:

    - 'Resolution meetings': this process allows parties to identify and discuss claims where there has been limited progress, or the claim is about to enter formal court proceedings.[62]

    - 'Stock-take': this procedure involves scheduling formal meetings with lawyers acting for claimants at key, fixed stages during a claim.[63] At these fixed stages the parties can identify the risks with their respective claims, narrow issues, and avoid the issue of court proceedings if possible.

3. For each year since NHSR's 'Delivering fair resolution' strategy was launched, with its emphasis on collaboration and alternative resolution, the percentage of cases for which court proceedings are issued has reduced to a new low and now stands at 26%.[64] NHSR is continuing to expand and evaluate ADR offers in claims management.[65] It is also currently re-procuring its own legal panel and reviewing its own claims operating model, both of which seek to drive reduced litigation .

4. Early in the pandemic, NHSR agreed an innovative protocol with the legal market in recognition of the particular pressures placed on healthcare staff at that time who might be

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[60] NHS Resolution (2021). *Annual Report and Accounts 2020/21*. London, NHSR. Available online at: https://resolution.nhs.uk/wp-content/uploads/2021/07/Annual-report-and-accounts-2020-21-web.pdf.
[61] NHS Resolution (2021). NHSR internal analysis
[62] Ibid. (p58).
[63] Ibid. (pp21 & 58).
[64] NHS Resolution (2021). *Annual Report and Accounts 2020/21*. (p56). London, NHSR. Available online at: https://resolution.nhs.uk/wp-content/uploads/2021/07/Annual-report-and-accounts-2020-21-web.pdf.
[65] NHS Resolution (2021). *Business plan 2021/22.* London, NHSR. Available online at: https://resolution.nhs.uk/wp-content/uploads/2021/06/Business-plan-2021_22.pdf.

unable to contribute to the investigation of a claim as well as the pressures on the court system and individual legal firms.[66] The protocol has appeared to be an effective model of collaboration in which early and constructive engagement achieved progress in the interests of claimants and the NHS. It has allowed clinicians to focus on frontline care while protecting the legal position on active cases, reducing the number of claims progressing into litigation and creating the space for parties to work together to achieve a resolution. In future, NHSR aims to build on the best features of the protocol and work with the market to preserve increased collaboration.

[66] NHS Resolution (2020). *The COVID-19 Clinical Negligence Protocol between NHS Resolution, Action Against Medical Accidents (AvMA) and the Society of Clinical Injury Lawyers (SCIL).* London, NHSR. Available online at: https://resolution.nhs.uk/wp-content/uploads/2021/06/Covid-19-Clinical-Negligence-Protocol-2020.pdf.