ACSO
Association of Consumer Support Organisations

Reforming NHS litigation costs

The Association of Consumer Support Organisations (ACSO)

February 2022

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A message from the executive director

It is almost seven years since the government first stated its intention to introduce a system of fixed recoverable costs in clinical negligence cases in England and Wales. Since then, there has been considerable uncertainty as to when such a system will be introduced, what it will look like in practice and what the impact will be upon patients and healthcare professionals.

With the publication of its latest consultation on 31 January 2022, the government has looked to end this uncertainty. Subject to stakeholder responses – including from ACSO and its members – any changes are expected to be introduced to take effect from 2023/24. No primary legislation is required, therefore scrutiny of what is being done in patients' and taxpayers' names will be limited, making adequate scrutiny and review mechanisms all the more important.

We hope this report will aid the ongoing debate and help shape the responses different stakeholders make to the current consultation, as well as influencing how any changes are implemented and perceived.

Prevention of negligence is the most important aspect of this, and so the government's comments on this theme in its consultation document and the various initiatives underway to improve patient safety are welcome.

However, there must be adequate access to justice for those who are genuine victims, with the duty of care to them of paramount importance. Diverting funds from legal costs to frontline care is the right idea – but only on the condition that this care is of the quality which consumers rightly expect.

Thank you to all those ACSO members and others who contributed to this report, and especially to its author, Andy Tindall, trainee solicitor at Fletchers Solicitors and former ACSO secondee.

We welcome your feedback.

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About ACSO

The Association of Consumer Support Organisations (ACSO) represents the interests of consumers in the UK's civil justice systems. Its members and partners include organisations from across the legal and insurance sectors who provide the highest standards of service and support to consumers when they need it the most.

ACSO engages positively with government policymakers, regulators and the media to help ensure there is a properly functioning, competitive and effective civil justice system for all.

Executive summary

Clinical negligence litigation seeks to offer redress for those who have suffered avoidable harm following a breach of duty by a healthcare professional. These types of claims represent a substantial part of the civil justice system, with 118,677 new claim notifications over the past 10 years at a total cost to the taxpayer of just over £18bn.[1]

Since 2015, the government has stated its intention to introduce fixed recoverable costs (FRC) in cases against the National Health Service (NHS) in England and Wales, in line with Sir Rupert Jackson's overall ambitions in civil justice cases.[2] A full consultation was opened in 2017, with some respondents opposing the proposals because they could represent a substantial threat to access to justice and patient safety.[3] Nevertheless, in the summary of responses the government announced that a sub-committee of the Civil Justice Council (CJC) would undertake further work with a view to publishing recommendations in autumn 2018.[4] This group failed to reach agreement on the level of FRC, with its eventual report of October 2019 suggesting further government consultation would instead be required.[5]

In 2021, the government reiterated its intention to extend FRC to clinical negligence cases with settlements of less than £25,000 and subsequently announced its proposals to introduce a bespoke claims-handling regime.[6] The consultation on this was published on 31 January 2022, with a closing date for submissions of 24 April 2022.[7]

In order to understand better the proposed reforms and identify current government and industry thinking on FRC in clinical negligence, the Association of Consumer Support Organisations (ACSO) has produced this report.

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[1] NHS Resolution (NHSR), *Annual Report Statistics 2006/07–2020/21*, 5 November 2021.
[2] Lord Justice Jackson, *Review of civil litigation costs: final report*, Ministry of Justice, December 2009.
[3] Department of Health, *Introducing Fixed Recoverable Costs in Lower Value Clinical Negligence Claims: Consultation*, January 2017.
[4] Department of Health and Social Care, *Consultation on fixed recoverable costs in lower value clinical negligence claims: Summary of consultation responses*, February 2018.
[5] Civil Justice Council, *Fixed Recoverable Costs in Lower Value Clinical Negligence Claims*, October 2019.
[6] Health and Social Care Committee, *Call for evidence: NHS litigation reform*, 20 October 2021.
[7] Department of Health and Social Care, *Fixed recoverable costs in lower value clinical negligence claims*, January 2022.

Interviews were conducted with leading stakeholders from the civil justice system to understand the impact that FRC will have on consumers, as well as to explore alternative, industry-led models that could increase collaborative working practices between claimant and defendant representatives. Interviewees were also asked what their vision was for the sector and how it will likely evolve with future reforms.[8]

Overall, we found a number of areas of consensus between the respective parties. In particular, we identified that continued collaboration and information sharing in the pre-action stage is likely to achieve the government's aim of costs saving whilst continuing to ensure that consumers of 'lower value' claims have access to the necessary means of redress.

Key findings

- Clinical negligence litigation has received renewed calls for reform to help control the overall cost of cases against the NHS in England and Wales following the Health and Social Care Committee (HSCC) report *The Safety of Maternity Services* and NHS litigation reform inquiry.[9,10]
- Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPO) reforms have helped to reduce the average amount of legal costs for cases valued over £25,000 but similar reductions have not been seen in cases below £25,000.
- Recent years have seen the government shift its focus from claims to how patient safety and learning can be improved. In January 2022, Sajid Javid MP, Secretary of State for Health and Social Care, announced plans to establish the Health Services Safety Investigations Body, an independent, publicly-funded organisation responsible for investigating maternity incidents to improve learning to the health system.
- Widespread public support for the NHS and its staff means negligence and how it is compensated for has to be handled with sensitivity and caution, but with the rights and needs of patients put first.
- The proposed introduction of FRC in clinical negligence litigation is a complex issue. A bespoke and streamlined claims handling process is required alongside FRC owing to its heavy reliance on expert evidence.
- Collaboration between claimant representatives, panel firms and NHS Resolution (NHSR) has increased considerably in recent years, partly owing to the Covid-19 pandemic. This has resulted in the development of industry-led models and increased cost savings.

Recommendations

For ACSO members and the wider sector, and regardless of the outcomes of the ongoing consultation, we recommend the following actions:

1. Promote early rehabilitation and efforts to resolve the root causes of harm;
2. Embrace technology;
3. Continue to engage and collaborate;

[8] The list of questions posed to each organisation is available upon request.
[9] The Health and Social Care Committee, *The Safety of Maternity Services*, 6 July 2021.
[10] The Health and Social Care Committee, *NHS litigation reform: Inquiry*, 22 September 2021.

4. Improve knowledge sharing and promote learning;
5. Embrace the most suitable forms of alternative dispute resolution (ADR); and
6. Encourage closer adherence to the Pre-Action Protocol for Resolution of Clinical Disputes.

Full details of these recommendations can be found in section 7 of this report.

ACSO would like to thank the following members, supporters and stakeholders for their contribution to this report:

Interviewee	Role	Organisation
Lisa O'Dwyer	Director of Medico-Legal Services	Action against Medical Accidents (AvMA)
Georgia Briscoe	Director of Legal Strategy and Transformation	Fletchers Solicitors
Alan Mendham	Partner and Vice Chairman	Gadsby Wicks; Society of Clinical Injury Lawyers (SCIL)
Rachel Di Clemente	Chief Executive Officer	Hudgell Solicitors
Victoria Coulson	Head of Operations and Strategic Delivery	Hudgell Solicitors
Joanna Laidlaw	Partner and Group Leader (Clinical Negligence)	Lyons Davidson
Patricia Canedo	Policy and Public Affairs Manager	Medical Protection Society
Ian Cohen	Director of Practice Areas and Injury	Simpson Millar
Madeline Seibert	Technical Director	Slater and Gordon
Judith Thomas-Whittingham	Partner and Department Manager (Clinical Negligence)	Stephensons Solicitors
Richard Miller	Head of Justice	The Law Society
Kate Fox	Policy Advisor (Civil Justice)	The Law Society
Paul Balen	Director	Trust Mediation

Current NHS litigation model and reasons for reform

The initial stages of clinical negligence litigation are governed by the Pre-Action Protocol for Resolution of Clinical Disputes (the Protocol).[11] If the claim cannot be resolved within the Protocol, it will then move into proceedings where the usual rules of civil procedure will apply.

In order to establish clinical negligence, a claimant must prove that a healthcare professional has acted in a way that no responsible body of practitioners in that same field, at that time, would have condoned – the so-called *Bolam* test.[12] This means that poor or below-average care is not considered negligent. Instead, it has to have fallen below the bottom threshold of what would be considered by the profession to be acceptable. Consequently, there is a heavy reliance upon expert evidence.

In all cases, the claimant must prove that the negligence caused them injury (i.e., causation). This aspect can often be particularly complex as the claimant will usually be suffering from injury, illness or disability for which they were being treated at the time that the medical negligence occurred.

There is a considerable burden of proof for consumers to overcome and many are unaware of this until they are advised by a legal professional. It is why ACSO members who are involved in clinical negligence law reject approximately 90 per cent of cases on initial approach, as the vast majority of claims fail to reach this high threshold.

The calls for NHS reform are predominantly centred upon the following concerns:

- increases in costs;
- fear of litigation resulting in defensive medical practices and a 'blame culture'; and
- concerns that the current system fails to do enough to encourage lessons being learnt to promote patient safety.[13]

Costs

LASPO introduced reforms in April 2013 to reduce the overall cost burden on the NHS.[14] Under the changes, defendant NHS trusts are no longer required to pay the claimant's success fees under a conditional fee agreement (CFA) or an after-the-event (ATE) legal expenses insurance (LEI) premium.

LASPO has been successful in reducing the average amount of legal costs for cases valued over £25,000. However, the decline in legal costs for cases below £25,000 has not been as significant and the amount paid out in 2020/21 for these lower-value claims was close to its highest-ever average.[15] As a result, concerns have been raised by the National Audit Office

[11] The Civil Procedure Rules, *Pre-Action Protocol for the Resolution of Clinical Disputes*.
[12] *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.
[13] Health and Social Care Committee, *Call for evidence: NHS litigation reform*, 20 October 2021.
[14] *The Legal Aid, Sentencing and Punishment of Offenders Act 2012*
[15] NHS Resolution (NHSR), *Annual report and accounts 2020/21*, 15 July 2021, p.50.

(NAO) and a number of healthcare representatives that the rise in litigation costs for clinical negligence cases is unsustainable and that funds are being diverted away from front-line patient care as a result.[16,17]

The Clinical Negligence Scheme for Trusts (CNS) handles all clinical negligence claims against member NHS bodies and the costs of the scheme are met by membership contributions.[18] In 2019, the scheme was expanded to cover liabilities arising in general practice in relation to incidents from 1 April 2019.[19]

Once a claim is reported under the Protocol, it is then managed by NHS Resolution (NHSR) and/or a panel firm – a group of firms appointed to provide support to manage claims under the scheme.[20] For treatment in a non-NHS setting, claims are dealt with by private insurers depending on the particular contract between the hospital/consultant and the patient.

In 2017, the NAO estimated that by 2020/21 NHSR's expected annual spend on clinical negligence claims would be £3.2bn, and trusts' annual percentage income contribution to the CNS would be 4 per cent.[21] However, the actual figures were significantly below the NAO's estimations. The total cost of settling claims in 2020/21 was £2.26bn and, as highlighted by the table below, the average contribution to the CNS was 1.78 per cent of annual income.[22,23]

This is likely due to the impact of LASPO and the commitment from NHSR in recent years to settle claims earlier.[24] These figures should also be viewed in a wider context, with the total costs of settling claims representing 1.6 per cent of NHS England's budget for 2021/22.[25]

Trust contribution to CNS scheme

2019/20 data	Overall	Acute	Ambulance	Community	Foundation	Mental Health
Top contribution	11.21%	4.38%	0.85%	0.30%	11.21%	0.37%
Least contribution	0.01%	0.19%	0.26%	0.09%	0.01%	0.20%
Average contribution	1.78%	2.51%	0.55%	0.18%	1.83%	0.28%

[16] National Audit Office (NAO), *Managing the costs of clinical negligence in trusts*, 1 September 2017, p.6.
[17] Medical Protection Society, *The Rising Cost of Clinical Negligence. Who Pays the Price?*, June 2017, p.4.
[18] NHS Resolution (NHSR), *Clinical Negligence Scheme for Trusts*, April 2001.
[19] NHS Resolution (NHSR), *Clinical Negligence Scheme for General Practice*, May 2020.
[20] NHS Resolution (NHSR), *Panel tender appointments*, 21 January 2022.
[21] National Audit Office (NAO), *Managing the costs of clinical negligence in trusts*, 1 September 2017, p.4-6.
[22] NHS Resolution (NHSR), *Annual report and accounts 2020/21*, 15 July 2021, p.16.
[23] Weightmans LLP, *Call for evidence: NHS litigation reform*, October 2021, p.1.
[24] Helen Vernon, NHS Resolution Chief Executive to the Committee of Public Accounts, *Managing the costs of clinical negligence in hospitals*, 1 December 2017, p.38.
[25] HM Treasury, *Budget 2021*, March 2021, p.32.

Of that total settlement figure, £448.1m was paid towards claimant legal costs, a reduction of £49.4m (9.9 per cent) from the previous year.[26] This is likely to have been as a consequence of the increased collaboration between NHSR, panel firms and consumer representatives in recent years, as NHSR recognised in its *Annual report and accounts 2020/21*.[27] In comparison, £149.3m of NHS costs, including payments to panel firms, were incurred under the CNS. The methods used by ACSO members to improve collaboration between parties are discussed in section 6 of this report.

Fear of litigation

Clinical negligence claims made against a healthcare practitioner in an NHS setting are brought against the trust under which they were employed at the time of the incident. In contrast, the majority of claims against a GP or practitioner in a private setting are brought against the individual.

In a 2017 survey conducted by the British Medical Association (BMA), only 31 per cent of members felt supported by NHS management following a complaint and 20 per cent felt victimised for being a whistle-blower.[28] In addition, 88 per cent of GPs are increasingly fearful of being sued.[29] This, combined with the adversarial nature of litigation, has resulted in what is described as a 'blame culture' within the NHS and the wider healthcare system which contributes to defensive attitudes within medical treatment and litigation.[30]

Many consumers also have a fear of litigation.[31] This means they will often seek alternative forms of redress in the first instance, such as making a complaint. However, many of our interviewees said that dissatisfaction in the complaints process is common and consumers often feel forced into seeking out the assistance of a lawyer in order to achieve the answers they are looking for. This issue was recognised by NHSR in 2018.[32]

Delays, lack of involvement in the investigation and lack of independence in the complaints process can cause increased frustration for those consumers who have suffered harm. As such there is a duty on those representing the respective parties in a clinical negligence claim to guide them through the process and ensure they are aware of the purpose of this area of litigation; to compensate and not punish.

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[26] NHS Resolution (NHSR), *Annual report and accounts 2020/21*, 15 July 2021, p.43.
[27] *Ibid,* p10.
[28] British Medical Association (BMA), *Doctors' perception of support and the processes involved in complaints investigations and how these relate to welfare and defensive practice: a cross sectional survey of the UK physicians*, 21 November 2017, p.1.
[29] Medical Protection Society, *The Rising Cost of Clinical Negligence. Who Pays the Price?*, June 2017, p.5.
[30] *Ibid,* p.5; Sir Robert Francis QC, *Call for evidence: NHS litigation reform (oral evidence)*, 16 November 2021, p.20.
[31] Hodge, Jones & Allen, *UK Perceptions of the Legal and Justice System: Innovation in Law Report*, 2015, p.8.
[32] NHS Resolution (NHSR), *Behavioural insights into patient motivation to make a claim for clinical negligence*, August 2018, p.5.

Lesson learning

A growing concern for the government is that that the current system fails to encourage learning between trusts and other healthcare providers. Similarly, one of the main motivating factors for consumers bringing a claim is the wish to prevent similar harm happening to others.[33] In 2020/21, there were 83,899 complaints about NHS Hospitals and Community Health Services.[34] However, only 1 in 8 hospital trusts (<12 per cent) are compliant with statutory regulations when reporting complaints and fewer than two in five (38 per cent) make information public about the changes made in response to complaints.[35]

The majority of our interviewees emphasised that the purpose of clinical negligence litigation is to provide redress, in the form of compensation, to the individual consumer who has suffered harm as a result of negligent care. There are no requirements on healthcare providers to reflect on the care provided and implement ways to improve. Instead, lesson learning is felt to be an inconsistent by-product.

A lack of transparency is another aspect of the complaints process that causes cynicism amongst consumers and does not allow trusts to share learning among each other.[36] Fewer than 2 trusts in 10 met Healthwatch's expectation for high-level transparency in reporting on complaints.[37] Often, the main motivation for consumers bringing a complaint is that they want to avoid the same issues being experienced by somebody else. Nevertheless, the majority of our interviewees agreed that they routinely encounter common and recurring incidents resulting in harm to patients, such as birth and maternal injury, delay in cancer diagnosis and missed fractures.

These recurring incidents expose patients to increased avoidable risks which could be prevented with improved information sharing between trusts. This has been recognised by NHSR and panel firms and led to the development of products and services to assist trusts, including 'Getting It Right First Time' data packs and patient safety case studies presented at member trust forums.[38] It is therefore essential that opportunities to learn from harm to improve patient outcomes receive greater focus.

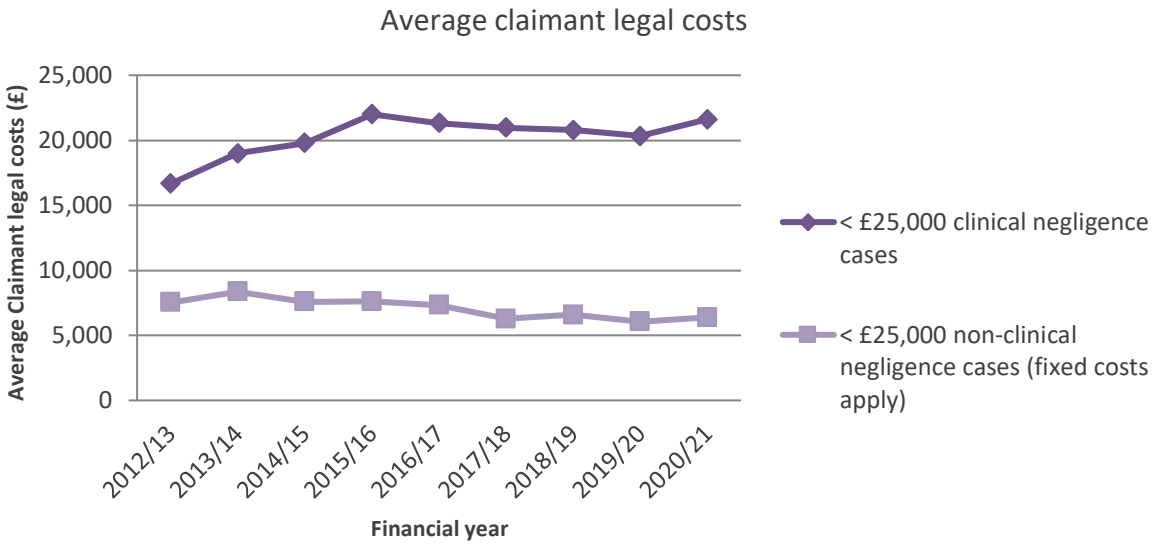
> *"The current pressure on NHS staff and lack of resources, as we are all too aware of, is simply not sustainable and consequently patients are the ones that pay the price."*
>
> **Joanna Laidlaw, Partner & Group Leader, Lyons Davidson**

[33] NHS Resolution (NHSR), *Behavioural insights into patient motivation to make a claim for clinical negligence*, August 2018, p.6.
[34] NHS Digital, *Data on Written Complaints in the NHS*, 9 July 2021.
[35] Healthwatch England, *Shifting the mindset*, January 2020, p.5.
[36] NHS Resolution (NHSR), *Behavioural insights into patient motivation to make a claim for clinical negligence*, August 2018, p.34.
[37] *Ibid,* p.9.
[38] NHS Resolution (NHSR), *Learning from Litigation Claims*, May 2021, p.10-11.

FRC proposals in clinical negligence

The proposed reforms during the government's 2017 consultation were to apply FRC to claims (i) above £1,000 and below £25,000; (ii) in the fast track or the multi-track; and (iii) against the NHS, not-for-profit and private healthcare providers in England and Wales.[39]

Based on research by Professor Paul Fenn, advisor to the CJC, 64 per cent of cases are below £25,000.[40] The NAO has estimated that the introduction of FRC could save the NHS £90m a year, or 20 per cent of the total amount paid towards claimant legal costs in 2020/21.[41] This would clearly go some way to helping achieve the aim of reducing overall costs but there is little evidence to suggest that FRC could help to improve lesson learning and alleviate fear by consumers and healthcare professionals of litigation.



(Source: NHS Resolution (NHSR), Annual report and accounts 2020/21)

The proposals follow a similar trend to reforms introduced across the 'low-value' personal injury sector over the past 10 years. However, a bespoke scheme was designed by the CJC sub-committee to improve the clinical negligence pre-issue process, with some of the key changes including:

- the introduction of a 'standard' and 'light' track for cases that do and do not require expert evidence on breach of duty and causation;
- sequential exchange of experts' reports and witness statements;
- mandatory stocktake; and
- mandatory neutral evaluation.[42]

[39] Department of Health and Social Care, *Consultation on fixed recoverable costs in lower value clinical negligence claims: Summary of consultation responses*, February 2018.
[40] Fenn, P., *Evaluating the proposed fixed costs for clinical negligence claims*, January 2017, p.8.
[41] National Audit Office (NAO), *Managing the costs of clinical negligence in trusts*, 1 September 2017, p.7.
[42] Civil Justice Council, *Fixed Recoverable Costs in Lower Value Clinical Negligence Claims*, October 2019.

In addition, it was recommended that certain categories of cases be excluded from the FRC scheme due to their complexity and sensitivity. The working group agreed on cases involving multiple defendants, more than two expert disciplines and limitation issues, yet there was disagreement on whether to include claims involving fatal accidents, secondary victims and protected parties.[43]

> *"The previous reforms suggested by the CJC need to be revisited, with a particular focus on the types of claims that should be included within the FRC regime. Fatal accident claims, for example, require a substantial amount of client care and it is vital that consumers are supported during this particularly vulnerable time."*
>
> **Madeline Seibert, Technical Director, Slater and Gordon**

At the time of the consultation, the CJC was unable to make any material progress on the level of experts' fees and ATE insurance premiums – the cost of the policy of insurance taken out by a claimant to cover the risk of losing a case. Following discussions with relevant stakeholders who were involved in the sub-committee working group, the indications were that the main issues arising from it were ATE premium levels and expert fees. There was not a substantial difference in respect of the level of FRC, as demonstrated by the tables below.

Standard Track

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

Light Track

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

(*Source: Civil Justice Council (CJC),* Fixed Recoverable Costs in Lower Value Clinical Negligence Claims)

On 31 January 2022, the Department of Health and Social Care announced a further consultation and published its proposals for a streamlined pre-issue claims process based upon the work carried out by the CJC.[44] The majority of the elements within the bespoke

[43] *Ibid,* p.33.

[44] Department of Health and Social Care, *Fixed recoverable costs in lower value clinical negligence claims*, January 2022.

scheme, set out above by the CJC, were supported by the government. Some of the key proposals included:

- the level of FRC proposed by the defendant group were preferred;
- only stillbirth and neonatal death claims to be excluded, not all fatal claims;
- claims involving protected parties would include an additional 'bolt-on' fee of £650 to reflect the additional work required;
- sequential exchange of expert evidence and witness statements was agreed, with the claimant to serve alongside the letter of claim and defendant alongside the letter of response;
- claimant to serve details of losses and an offer alongside the letter of claim;
- six-month time limit to respond to a letter of claim in the standard track and eight weeks for an FRC letter of notification in the light track;
    - in the case of the standard track, non-adherence to this time limit would result in the claim falling out of the FRC regime;
    - in the case of the light track, non-adherence would result in the claim moving into the standard track;
- scheme to apply to claims where a letter of claim/notification is submitted on or after the implementation date; and
- two new mandatory resolution stages:
    - stocktake meeting between the parties
    - neutral non-binding evaluation by a specialist barrister from an agreed panel.[45]

In addition, complete reform of the sector has also been mooted by ministers to follow a no-fault compensation scheme, such as those in Sweden, Denmark, New Zealand and some American states.[46,47] Other alternatives include compulsory mediation, more rigorous independent investigations and compensation payments for future care needs based upon NHS top-up costs rather than private provision.[48] The potential benefits and pitfalls of each of these alternative methods, amongst others, are discussed in more detail in section 6.

[45] *Ibid*.
[46] The Rt Hon Nadine Dorries MP, *Formal meeting: Safety of maternity services*, 2 February 2021, p.6.
[47] Health and Social Care Committee, *The safety of maternity services in England*, 6 July 2021, p.32.
[48] The Rt Hon Jeremy Hunt MP, *Call for evidence: NHS litigation reform (oral evidence)*, 16 November 2021, p.17.

Potential impact of FRC on consumers

Based on discussions with ACSO members, supporters and other stakeholders, the following issues were identified when considering the potential impact of FRC upon consumers in clinical negligence litigation. Each is discussed in more detail below.

Positive impacts

- Simplified process
- Speed of redress
- Certainty on costs
- Removal of secondary cost litigation

Negative impacts

- Barriers to access to justice
- Unaffordable 'screening' of cases
- Low value does not mean low complexity
- Expert input and fees
- Decrease in collaboration
- Lack of accountability

Positive impacts

Our interviewees identified areas of the current claims process that causes frustration for consumers and could be improved with the introduction of FRC at an appropriate level.

Simplified process

Alongside an FRC regime there is a need for a simplified and streamlined claims handling process to make it viable for consumers and representatives to achieve successful compliance. Removal of complex court-led costs management will help to simplify the process, unburden the courts and allow more accurate, early legal advice and certainty for consumers. This would help to improve overall consumer engagement and has the potential to encourage innovation in the market. For example, the introduction of FRC in the low-value personal injury sector has led to the development of claims management systems such as Minster Law's INK portal and Kennedy's IQ AI-powered portal assistant.[49,50]

Speed of redress

For the past five years, the average time to settle a claim under £25,000 is 1.3 years.[51] However, NHSR is usually only notified of a potential claim once a Letter of Notification or, in the majority of cases, a Letter of Claim is served.

Prior to that, consumer representatives are responsible for gathering and paginating medical records and obtaining expert evidence. As such, the average wait for a consumer is likely to be much longer.

[49] Minster Law, *INK*.
[50] Kennedys, *IQ*.
[51] NHS Resolution (NHSR), *Annual Report Statistics 2006/07–2020/21*, 5 November 2021.

Although these steps are vital to investigate a claim, most of our interviewees agreed that the current speed at which consumers are able to access vital needs - such as care provision, rehabilitation and treatment - is a major issue. In comparison, the maximum claim duration in the newly proposed FRC regime by the Department of Health and Social Care is 44 weeks.[52] Therefore, a more streamlined process to accompany FRC should, in theory, achieve quicker outcomes for consumers.

> *"From a consumer perspective, the amount of time it takes for lawyers to receive the core materials in order to bring a case is extraordinary. The system needs to provide injured parties with the necessary resources at the earliest opportunity."*
>
> **Paul Balen, Director, Trust Mediation**

Certainty on costs

The government's main justification for FRC is that they provide certainty and transparency to consumers about their potential cost liability if they were to lose the case. Indeed, the point was emphasised in the government's response to the Ministry of Justice consultation on 'Extending Fixed Recoverable Costs in Civil Cases'.[53] However, qualified one-way costs shifting (QOCS) provision in personal injury litigation means that only in limited circumstances will a costs order against a losing claimant be enforceable.[54] QOCS was introduced in 2013, alongside the LASPO reforms, to maintain consumers' access to justice.

Nevertheless, a clearly defined four-band costs structure, as suggested by Sir Rupert Jackson in 2009 and agreed by the government, is felt to promote greater discipline and certainty in controlling costs and encourage earlier settlement for consumers by offering clear costs savings.[55,56] There was, however, some concern amongst our interviewees as to whether this would translate into practice. This is discussed in more detail below.

Removal of secondary cost litigation

The introduction of FRC would remove the need for secondary cost litigation following settlement of claims. Many of our interviewees agreed that the process of costs recovery in pre-litigated cases can often be time consuming and complex, with some cases taking up to 12 months to be resolved. This, in turn, increases costs, contributes to court administrative backlogs and delays the final resolution of a claim.

Costs and delays in progress made up one in three complaints to the Legal Ombudsman Service in clinical negligence matters in 2020/21.[57] Therefore, despite consumers having minimal involvement, a clear and prompt costs-recovery process is felt to be of greater consumer benefit.

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[52] Department of Health and Social Care, *Fixed recoverable costs in lower value clinical negligence claims*, January 2022, p.14.
[53] Ministry of Justice (MOJ), *Extending Fixed Recoverable Costs in Civil Cases*, September 2021, p.8.
[54] The Civil Procedure Rules, *Part 44.13-44.16 Qualified One-Way Costs Shifting.*
[55] Lord Justice Jackson, *Review of civil litigation costs: final report*, Ministry of Justice, December 2009.
[56] Ministry of Justice (MOJ), *Extending Fixed Recoverable Costs in Civil Cases*, September 2021, p.11.
[57] Legal Ombudsman Service (LeO), *Complaints information*, 31 March 2021.

Negative impacts

Although there were felt to be areas of benefit for consumers, the majority of our interviewees agreed there was a very real possibility that FRC could fail to achieve the government's intended aims of reform. Rather, FRC are likely to conflict with consumer rights and tort law principles.

Barriers to access to justice

The main concern about the introduction of FRC, particularly among ACSO members and other representative bodies, is their potential to erode consumers' fundamental right of access to justice. Many claimant law firms stated they would be less inclined to accept 'borderline' and complex low-value cases on the basis that it would not be commercially viable for them to investigate under a FRC regime.

> *"If the amount of FRC does not enable access to skilled and experienced representation, there is a risk that a claimant may not be fully advised resulting in a potential risk to basic tort law principles. If firms do not take on as many claims that have more borderline prospects, there is a risk that these principles may be eroded for larger and larger groups of healthcare consumers."*
>
> **Vince Shore, Head of Clinical Negligence, Hudgell Solicitors**

In addition, given the complexities involved in clinical negligence litigation and the heavy reliance upon expert input, all interviewees agreed that litigants in person (LiPs) would be unable to pursue these types of cases adequately without substantial support and guidance from an experienced representative.

Lack of assistance could also impact and restrict consumer ability to finance a claim. The vast majority of claims are currently funded on behalf of consumers by way of a law firm's CFA and associated ATE policy. Therefore, the risk of being left 'out of pocket' in an unsuccessful case is borne solely by the firm and their insurers. A FRC regime combined with the effective removal of Legal Aid funding for clinical negligence cases could create a scarcity of appropriate funding options for consumers in low-value claims. It could also see an increase of cost shortfall recovery in the market - where firms charge a success fee plus any shortfall between the actual costs incurred and those recovered from the opposing party. This would then result in the need for greater consumer contribution to costs from their damages.

Unaffordable 'screening' of cases

At present, ACSO members will screen and risk assess many thousands of cases each month at no cost to the consumer. During this process, a clinical negligence lawyer will consider the circumstances of the individual case to determine prospects and advise accordingly, as well as providing reasons for their decision.

This filtering process ensures that only cases with genuine prospects are investigated and provides a form of reassurance to consumers. It also delivers a saving to the NHS and its resources by only submitting cases to the NHSR that are believed to have genuine merit.

Our interviewees were concerned that the introduction of FRC will result in this service becoming unaffordable and, in turn, result in an increase of claims from unskilled LiPs. As such, any potential savings resulting from FRC could be outweighed due to the increased costs in practice of dealing with a higher volume of unfiltered and unmeritorious claims.

Low value does not mean low complexity

FRC could see harmed consumers denied the correct level of compensation. This is because identical cases of negligence carry substantially different amounts of damages depending on the situation of the injured party – such as age, economic status, dependents, loss of earnings and the cost of any future medical procedures.

Moreover, the level of damages is not necessarily an indicator of the complexity of a case, with factual and legal complexities not always aligning proportionately to the damages claimed. The same legal costs may be incurred in proving a claim whether it is of low or high value. For instance, in a case of delayed cancer diagnosis, the same expert evidence and amount of work may be required where a patient's life expectancy has been reduced by 2 years and the award is £20,000 or where life expectancy is reduced by 50 years and the case is worth £500,000.

> *"There is a lack of understanding as to the impact that a claim, which is perceived to be minor or low value, can have on a person's life."*
>
> **Georgia Briscoe, Director of Legal Strategy and Transformation, Fletchers Solicitors**

Introducing FRC to low-value but complex work could result in cases being conducted by less experienced and qualified practitioners in order to try and keep fees to a proportionate level. However, as demonstrated above, the nature of these cases can be extremely sensitive and requires specialist involvement to assist the injured party and their families during a highly vulnerable time. It is vital that this is recognised in order to achieve better and more compassionate outcomes for consumers.

Expert input and fees

It is highly likely that expert fees will need to be limited to integrate successfully within a FRC framework. In its 2017 consultation, the Department for Health and Social Care proposed to introduce a maximum total cap of £1,200 for all expert reports on breach of duty, causation and condition and prognosis.[58] Based on feedback from ACSO interviewees who were members of the CJC working group, this figure was seemingly not based upon any appropriate or realistic data. In response to the consultation, Stephensons noted that its average expert fees for claims under £25,000 were £4,198.54.[59]

[58] Department of Health, *Introducing Fixed Recoverable Costs in Lower Value Clinical Negligence Claims: Consultation*, January 2017, p.26.
[59] Stephensons Solicitors, *Introducing Fixed Recoverable Costs in Lower Value Clinical Negligence Claims – A Consultation*, May 2017, p.7.

The lack of agreement by the CJC sub-committee means there is very little clarity on the anticipated level of medical expert fees. A cap on fees would undoubtedly reduce the amount of time that experts are able to spend on assessing potential claims and could result in a number of experts withdrawing from the market. In a survey of experts conducted by the independent charity, Action against Medical Accidents (AvMA), the majority confirmed that they could not work for claimants on a fixed-fee basis.[60] This would then lead to a reduction in the overall quality and availability of expert evidence.

> *"A restriction on the amount of experts, either due to prescribed limits entrenched in legislation or by reference to percentage recoverability of damages, will impact the ability to accurately value claims. The focus has to be on ensuring the claimant recovers the correct amount of compensation so that they are not at a loss due to the negligence."*
>
> **Judith Thomas-Whittingham, Partner & Department Manager, Stephensons Solicitors**

There was also some unease amongst interviewees that limiting the amount of recoverable expert fees could create an absence of equality of arms between the parties. It is therefore vital that consumers and their representatives are afforded equal access to appropriate expert input at necessary stages.

Decrease in collaboration

Despite the intention to create discipline and certainty by controlling costs within a clearly defined FRC structure, many of our interviewees were doubtful as to whether this would be the case in practice. Instead, an inflexible FRC regime with defined banding could create a system of 'litigate first' and a focus on withdrawal from the relevant FRC portal rather than collaboration between the parties to achieve a quicker and better resolution for the consumer.

Similarly, certain defendant behaviour may result in claimants running up legal bills that they will not be able to recover. This poses a substantial risk of undermining public trust in the justice system and leaving claimants unable to obtain effective remedy.

Lack of accountability

At the heart of clinical negligence litigation is the injured party and the medical practitioner alleged to be at fault. While redress for the injured party is the necessary purpose of a claim, it is equally vital that a medical practitioner is provided with appropriate assistance and a network of support to help them understand what went wrong. This starts with accountability.

[60] Action against Medical Accidents (AvMA), *Medical Expert Consultation 2015-16 Feedback Summary*, 2015.

Despite their potential to be of low value, cases such as delay in diagnosis of cancer, stillbirths and death of an elderly person with little or no financial dependants carry huge importance to the public. It is widely acknowledged that to ensure patient safety, incidents must be consistently reported and acted upon. As stated in the NHS *A Just Culture Guide*, "supporting staff to be open about mistakes allows valuable lessons to be learnt so the same errors can be prevented from being repeated".[61] If cases such as this became uneconomic to investigate, the ability for individual practitioners and the wider NHS to learn from mistakes would be lost.

> *"With the right learning environment, you would find that it is not an individual error that has caused harm but it is the way in which the system operates that allowed that person to make an error."*
>
> **Alan Mendham, Partner, Gadsby Wicks**

[61] NHS England, *A Just Culture Guide*, June 2019.

Alternative models

This chapter will consider the alternative models that have been proposed by stakeholders and government in order to achieve the intended aims for reform. Focus will be paid to current methods that are being trialled or are currently practiced in anticipation of FRC and comment on their effectiveness for consumers based on member and stakeholder feedback.

Effective sanctions within the current protocol

A number of our interviewees felt that the current Protocol was fit for purpose in its current form but implementation and enforcement of more effective sanctions for poor conduct was required. The current model has a number of costs-control measures in place including guideline hourly rates, case management, budgeting and the concept of proportionality (an overriding objective of the Civil Procedure Rules (CPR).[62]

The requirement to be proportionate applies across all values of clinical negligence claims, but pertains particularly to lower-value cases. Nevertheless, stricter enforcement of the Protocol, particularly para 1.7, to formalise steps actively to discourage behaviour leading to delay and avoidable issue of proceedings, with associated costs increase, was considered more likely to have a greater effect.

What can it achieve for consumers?					
Accountability	✓	Increased collaboration	✓	Lesson learning	✗

No-fault compensation schemes

A no-fault compensation scheme effectively reduces the burden of proof for consumers by removing the need to establish negligence. In Sweden and Denmark, the core test is whether the injury was 'preventable.' In New Zealand it simply needs to be established that the injury occurred during treatment. The system offers considerable benefits to consumers by delivering quicker resolution and provision of necessary support.

> *"The way in which society currently compensates children and families with severe neurological injuries is neither fair nor equitable in a civilised society as only families who are able to prove fault will receive financial compensation."*
>
> **Dr Rob Hendry, Medical Director, Medical Protection Society (MPS)**

A no-fault redress scheme was initially considered by the Department of Health (DoH) in 2003 and a further consultation was opened in 2017 with a focus on introducing a scheme for severe avoidable birth injuries.[63,64] Elements of the scheme, such as

[62] The Civil Procedure Rules, *Part 1 Overriding Objective.*
[63] Department of Health, *Making amends*, June 2003.
[64] Department of Health, *A Rapid Resolution and Redress Scheme for Severe Avoidable Birth Injury: a Consultation*, March 2017.

the ENS, were introduced but recommendations from the HSCC in its report *The Safety of Maternity Services in England* were that a scheme for maternity cases should be introduced in full based on avoidable incidents rather than negligence.[65]

The current lack of up-to-date comparable quantitative data and the different frameworks and factors involved in each international scheme make it difficult to predict whether such a model would achieve the UK government's intended aims of cost reduction, lesson learning and openness. However, economic research from 2004 estimates that the cost of implementing a Swedish-style 'avoidable harm' scheme would be £2.1bn per year.[66]

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%

(Source: Department of Health and Social Care, NHS litigation reform)

ACSO suggests that for or a no-fault scheme to be successful and beneficial for consumers, it would need to:

1. be a viable alternative to civil litigation with equivalent compensation awards;
2. extend the pool of eligible applicants by reducing the burden of proof;
3. run alongside a tort system to avoid a breach of Article 6 European Convention on Human Rights; and

[65] Health and Social Care Committee, *The Safety of Maternity Services in England*, 6 July 2021, p.32.
[66] Fenn, P., et al., *The Economics of Clinical Negligence Reform in England*, The Economic Journal, vol.114 no.496, 2004, p.17.

4. have a more robust and properly funded social care system in place to support the increase in eligible applicants.

What can it achieve for consumers?			
Quicker resolution ✓	Broader eligibility ✓	Free to access ✓	
Costs savings ?	Lesson learning ?	Accountability ?	Independence ✗

Capping private provision for future costs

Future care costs and loss of earnings make up a significant proportion of the compensation awarded to claimants in clinical negligence litigation. Proposed reforms by the HSCC have included the introduction of a cap on these losses based upon the national average wage to prevent an "unjust variability in compensation pay-outs."[67] There was concern amongst some of our interviewees that this would conflict with the tort law principle of putting the claimant in the same position they would have been in if the injury had not occurred. Additionally, it was felt some consumers will essentially be 'worse off' if this cap is introduced solely for victims of clinical negligence compared to those who have suffered another form of personal injury.

Defendant representatives have long advocated for the repeal of section 2(4) of the Law Reform Act (Personal Injuries) 1948, which allows claimants to recoup future treatment and care costs on a private paying basis.[68] However, research commissioned by the Association of Personal Injury Lawyers (APIL) concluded that private treatment is often a key factor in recovery and "access to quality treatment quickly provides reassurance to those who feel like their life has been put on pause".[69]

Furthermore, since the start of the covid-19 pandemic, the number of people waiting for NHS treatment in England has grown by a fifth, with 5.7 million people waiting to start routine treatment at the end of August 2021.[70,71] Any delay in treatment will delay the claimant's ability to return to work, meaning any loss of earnings claim will increase. Moreover, it will further erode the claimant's trust in the NHS, which is likely already to have lessened owing to the reasons they have made a clinical negligence claim, and place a further burden on already over-stretched health provision.

[67] Health and Social Care Committee, *The Safety of Maternity Services in England*, 6 July 2021, p.55.
[68] Medical Defence Union (MDU), *Six point plan to save the NHS from rising costs of clinical negligence revealed by MDU*, 23 November 2018.
[69] The Association of Personal Injury Lawyers (APIL), *The value of compensation*, January 2022, p.6.
[70] Institute for Fiscal Studies (IFS), *Could NHS waiting lists really reach 13 million?*, 8 August 2021.
[71] Binding, L., *NHS waiting lists: Backlog hits record high with nearly six million awaiting treatment in England*, Sky News, 14 October 2021.

What can it achieve for consumers?			
Costs savings	✓	Access to justice	✗
Reduced compensation	✗	Access to specialist treatment	✗

Expansion of the early notification scheme (ENS)

The ENS was introduced in 2017 and requires all member trusts to report maternity incidents that result in brain injury to the NHSR and the Healthcare Safety Investigation Branch (HSIB). Its purpose is to establish liability at an early stage and shorten the legal process. Obstetric claims account for 59 per cent of the total value of claims received by NHSR and 192 claims were recognised under the scheme last year.[72] The benefit of costs saving at an early stage in these types of cases is clear.

As a basic concept, the ENS provides great benefit for consumers and the representatives involved by providing a focus on investigating and accessing the necessary means of support for the injured parties. Despite this, some ACSO members believe that the scheme in its current form could do more to involve patients and their families by providing them with the relevant materials that have been considered as part of the investigations, such as medical records, witness statements and expert reports.

Although not part of the ENS, incidents in other areas of healthcare are also identified by trusts and NHSR is notified at an early stage leading to early admissions. This usually occurs in cases where the trust has commenced a Root Cause Analysis or Serious Untoward Incident report and identified areas of failing that have resulted in harm. This recognition and process has been welcomed by those in practice.

However, this approach is not always consistent. In some circumstances it was reported that denials would be made even when failings had been identified during internal investigations. As such, an expansion of a clearly defined framework of notification, similar to the ENS, would help to reduce the number of cases in which breach of duty needs to be investigated and focus the parties on establishing causation and associated losses.

What can it achieve for consumers?							
Costs savings	✓	Quicker resolution	✓	Accountability	✓	Transparency	✗

Increased use of alternative dispute resolution (ADR)

The NHSR Claims Mediation service is a clear example of the efforts being made to promote forms of ADR and has received positive feedback from participants.[73] However, uptake is still

[72] NHS Resolution (NHSR), *Annual report and accounts 2020/21*, 15 July 2021, p.43-47.
[73] NHS Resolution (NHSR), *Mediation in healthcare claims – an evaluation*, February 2020, p.14-16.

low. In 2020/21, out of the total of 15,397 cases that were closed by NHSR, only 299 cases were settled through mediation.[74]

Its role in the current system was felt by many to come too late in proceedings with a majority of cases being considered for ADR deep in the litigation process. Although, under the NHSR Mediation Scheme there has been a shift in recent years to mediation taking place at the pre-litigation stage. For example, in 2018 just over a quarter (27 per cent) of mediations took place at this stage, with this figure rising to 43 per cent by 2021.[75]

The question of whether ADR should be made a compulsory element within the pre-action process was met with mixed reactions from interviewees. Many felt that in order for ADR to be effective, there needs to be a genuine intention by the parties to engage with the process. A failure to do so could have a detrimental effect by increasing costs and frustration unnecessarily. Instead, a more fluid approach with active encouragement throughout and effective enforcement of cost penalties for failing to engage was felt to be of greater benefit.

An increase in the uptake of mediation, or other ADR mechanisms, may help to tackle the blame culture within the NHS. Mediation provides claimants, patients and their families with a platform to articulate concerns and enables NHS staff to listen and respond to their issues, and potentially at a reasonable cost. As such, it provides another avenue for staff learning and will therefore aid the desired move "from a blame culture to a learning culture" within the NHS.[76]

What can it achieve for consumers?		
Costs savings ✓	Quicker resolution ✓	Lesson learning ✓
Increased collaboration ✓	Accountability ✓	

Pre-litigation round table meetings (RTM)

One of the most successful models currently in use are regular virtual RTMs between NHSR, panel firms and larger claimant representatives. Each side identifies suitable cases for discussion, whether for settlement or to narrow the issues in dispute, and agrees between them a 'bulk' of cases for negotiation. For claims that are successfully resolved, similar meetings are also held to negotiate costs settlement.

These meetings have helped to promote the effective and efficient resolution of claims and increased collaboration and trust between the respective parties. They also help to achieve a clear cost saving by resolving claims before issue of proceedings. According to NHSR, over 80 per cent of claims settled in favour of the claimant where proceedings had been issued in

[74] NHS Resolution (NHSR), *Annual report and accounts 2020/21*, 15 July 2021, p.21.
[75] Trust Mediation, *8 out of 10 claims settle in first year of mediation scheme*, 27 February 2019.
[76] The Rt Hon Jeremy Hunt MP, *Speech: From a blame culture to a learning culture*, Global Patient Safety Summit, 10 March 2016.

2019/20.[77] When narrowing the issues, claimant representatives may also be able to identify potential 'weaker' cases based upon their discussions with the defendant representatives and be discouraged from issuing proceedings. As a result, there has been an increase in the amount of claims settling without proceedings with NHSR affirming its commitment to pre-litigation resolution and noting that "a spirit of co-operation in our work with claimant solicitors in response to the pandemic will also have contributed."[78]

What can it achieve for consumers?					
Costs savings	✓	Quicker resolution	✓	Lesson learning	✗
Increased collaboration	✓				

Reform of NHS complaints process

A key objective for the government in its intended reform of NHS litigation is to encourage a culture of learning from medical mistakes. The ability to achieve this through litigation can be difficult. Instead, improvements in the complaints process are felt to be best placed to achieve and promote local and more timely learning, as noted by panel firm Weightmans.[79]

Complaints provide an early opportunity to investigate, explain and resolve. By having an independent and effective complaints-handling process the number of patients who choose to litigate, particularly in the low-value category, will reduce. This potential has been recognised by the NAO, which recommend that NHSR publish detailed and more consistent complaints data to help gain further insight into the management of clinical negligence claims.[80]

> *"When consumers understand what has happened to them, especially those who have suffered what would be classified as 'less significant' injuries, they are less likely to want to go through the cost and trauma of the legal process because they will question whether it is really worth it. They simply want to be acknowledged."*
>
> **Kate Fox, Policy Advisor, The Law Society**

Patient involvement in the process and a consistent approach amongst trusts are also felt by many claimant and defendant representatives to be key factors in delivering successful reform. This is highlighted by the implementation of the legal duty of candour in 2014 – a healthcare professional's duty to be open and honest with a patient when something goes wrong with their treatment.[81] Since its introduction, there has been continued overall improvement by trusts in their inspection of the duty of candour and reporting standards, although consistency is still an issue.[82]

[77] House of Lords, *Lord Bethell to Lord Hunt of Kings Heath written answer*, 6 August 2020.
[78] NHS Resolution (NHSR), *Annual report and accounts 2020/21*, 15 July 2021, p.18.
[79] Weightmans LLP, *Call for evidence: NHS litigation reform*, October 2021, p.2.
[80] National Audit Office (NAO), *Managing the costs of clinical negligence in trusts*, 1 September 2017, p.15.
[81] The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20.
[82] Action against Medical Accidents (AvMA), *Regulating the duty of candour*, October 2018, p.3.

Our interviewees were encouraged by the impact of HSIB and its objective focus on recommendations to improve systems and processes. In January 2022, plans were announced by Sajid Javid MP, Secretary of State for Health and Social Care, to establish the Health Services Safety Investigations Body to take forward the work of HSIB.[83] As an independent public body, its focus will be to investigate maternity cases in a standardised, family-focussed manner, provide learning to the health system to improve clinical practices and support trusts to improve local investigations.

Therefore, a similar, independent regulatory body or an expansion of the HSIB with increased trust engagement is a model which should help promote lesson sharing from the outset and improve patient safety.

What can it achieve for consumers?		
Costs savings ✓	Quicker resolution ✓	Lesson learning ✓
Increased collaboration ✓	Accountability ✓	Financial compensation ✗

Better education

Clinical education around the claims process, as well as regulatory and disciplinary issues arising from it, is an area that would benefit from further review. In its guide *Learning from Litigation Claims: Getting It Right First Time*, NHSR highlighted that frontline staff were often unaware of claims within their department.[84] NHSR recognises the need for trust legal teams to increase their visibility to clinical staff at times when they are not involved in a claim as this will reduce the stigma around discussing claims to improve patient care.[85] The role of education in helping to remove the fear surrounding clinical negligence litigation and developing an open culture within the NHS, with learning at the heart of it, is vital.

What can it achieve for consumers?		
Lesson learning ✓	Increased collaboration ✓	Accountability ✓
Financial compensation ✗		

[83] House of Commons, *Sajid Javid MP Special Health Authority for Independent Maternity Investigations*, 26 January 2022.
[84] NHS Resolution (NHSR), *Learning from Litigation Claims*, May 2021, p.4.
[85] *Ibid*, p.7.

Key areas of consensus

We asked our interviewees what they believe to be the key areas of consensus that both claimant and defendant parties can work towards to help protect consumers and improve working practices. These areas of consensus form the basis of our recommendations for ACSO members, which we hope will also benefit the wider market.

1. Promote early rehabilitation and efforts to resolve the root causes of harm

Our interviewees all agreed on the main principles that are needed to improve the current clinical negligence process for consumers and the wider healthcare system. These are:

- identifying, acknowledging and learning from the causes of harm at the earliest opportunity;
- increasing transparency and creating a culture of openness;
- supporting consumers and medical practitioners involved in the process; and
- providing earlier rehabilitation.

It is essential that lessons are learned by the health system at local, regional and national level if the overall level of negligence and therefore number of claims is to be brought down. In addition, early rehabilitation results in better patient outcomes and therefore a reduction in the value of claims. Any reforms, new guidance or policy positions must have patient safety and early rehabilitation at their heart, and costs must be reduced through a reduction in the causes of claims. In addition, victims of avoidable harm in the NHS must be provided with a full and clear explanation of what went wrong and how such harm will be avoided in future.

2. Embrace technology

The outbreak of Covid-19 and the social restrictions that followed have led to a greater focus and reliance on technology in the legal sector, such as through the increased use of remote hearings.[86] Furthermore, as regulatory and legislative changes continue to alter the landscape of the civil justice system, it has become increasingly important for firms to innovate and improve consumer outcomes.

The use and success of virtual RTMs shows enthusiasm within the sector to identify innovative ways of working. Some firms and NHSR have started to incorporate artificial intelligence (AI) into their working processes to assist with pagination of records and predict future claims in order to improve patient safety.[87]

This agility and creative use of technology to help develop better solutions for injured consumers is vital and should continue to be encouraged and embraced by those working in

[86] GOV.UK, *Weekly use of remote hearing technologies in HMCTS,* 14 October 2021.
[87] NHSX, *Using AI to support NHS Resolution with negligence claims prediction*, 10 May 2021.

clinical negligence litigation. ACSO produced further guidance and recommendations to members on this in our *Technology & Innovation Report 2021*.[88]

3. Continue to engage and collaborate

The Covid-19 Clinical Negligence Protocol – a best-practice approach addressing the conduct of clinical negligence litigation during the Covid-19 pandemic – is an example of successful collaboration between multiple stakeholders within the sector.[89] All ACSO member interviewees stated that the dialogue continues to improve, and they are encouraged by the progress that has been made in developing constructive relationships to help resolve cases quickly. This was felt by all to have huge benefits for consumers and has coincided with the reduction in claimant costs over the past three years.[90]

Recent times have seen regulators, policymakers and government focus upon shifting the blame culture to a 'learning culture', which should be supported and maintained.[91,92,93] In addition, regular engagement should be conducted with healthcare professionals, charities, consumer groups and other stakeholders to understand what measures will aid the development of such a culture.

> *"Clinical negligence cases against the NHS are brought on the basis that healthcare providers and/or systems caused the injury. The NHS is also investigator and insurer of the incident and therefore it should not be solely responsible for dictating how patient safety is learned and understood. It should be done in a collaborative manner with appropriate stakeholders who can bring independent oversight, information and balance to the issues."*
>
> **Lisa O'Dwyer, Director of Medico-Legal Services, Action against Medical Accidents**

ACSO, through our Clinical Negligence Working Group, can assist members in identifying appropriate areas for collaboration and help to foster conversations between leading stakeholders, regulators and policymakers. As with the Statement of Intent for the resolution of personal injury claims, developed jointly between ACSO and the Association of British Insurers (ABI), our positive cross-market engagement has the potential to benefit the wider sector.[94]

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[88] The Association of Consumer Support Organisations (ACSO), *Technology & Innovation Report 2021*, February 2021.
[89] NHS Resolution (NHSR), Society of Clinical Injury Lawyers (SCIL) and Action Against Medical Accidents (AvMA), *Covid-19 Clinical Negligence Protocol : 2020*, 8 June 2021.
[90] NHS Resolution (NHSR), *Annual Report Statistics 2006/07–2020/21*, 5 November 2021.
[91] Health and Social Care Committee, *Oral evidence: Safety of maternity services in England*, HC 677, House of Commons, 19 January 2021.
[92] NHS England, *A Just Culture Guide*, June 2019.
[93] NHS England, *We are the NHS: People plan for 2020/21 – action for all*, 30 July 2020.
[94] The Association of Consumer Support Organisations (ACSO), *ACSO/ABI Statement of Intent for progressing claims during the Covid-19 pandemic*, 27 April 2020.

4. Improve knowledge sharing and promote learning

Those involved in clinical negligence litigation have access to unique evidence and datasets. This creates an opportunity to share knowledge to help identify areas of working practice that could be improved for the benefit of consumers and healthcare practitioners.

The need for a greater sharing of data and insights across the sector has been recognised, as evidenced by numerous pilot schemes between NHSR, panel and claimant firms.[95,96] However, this data could also be shared and analysed to benefit the wider NHS, at both local and national level. For example, the principle of informed consent has been hugely influenced by litigation following the case of *Montgomery* – a landmark Supreme Court case which shifted the approach to informed consent from a clinician-centric to a patient-centric one.[97] In addition, NHSR has used data and evidence from claims to help develop its *Faculty of Learning*, which provides educational learning products and resources to patients and staff.[98] As such, we encourage ACSO members to share their insights and experiences, utilise their claims data in a consumer-focussed manner and offer their continued support to defendant representatives.

5. Embrace the most suitable form of ADR

ADR plays a key role in providing a quicker and often more flexible form of redress for consumers. As explained by Julienne Vernon, Head of Dispute Resolution and Quality at NHSR, "[m]ediation puts the patient/claimant at the heart of the claim focussing on concerns which are very often not 'all about the money' and would otherwise not be possible to address in any other dispute resolution setting such as a meeting with just the lawyers."[99] There is a clear desire by both sides to engage with ADR and this positive momentum should be embraced. Other forms of dispute resolution – including arbitration, negotiation and various forms of online dispute resolution – should also be explored and encouraged, where appropriate.

> *"The need to consider and engage in ADR at an early stage should be an area of consensus between the parties. This is of benefit to the claimant who will want to see a swift resolution to their claim and also of benefit to the defendant who will be seeking to settle the matter without incurring significant costs."*
>
> **Dr Rob Hendry, Medical Director, Medical Protection Society**

ACSO members should ensure that they identify the most suitable and proportionate form of ADR for the individual consumer and engage with defendant representatives at an early stage.

On ADR mechanisms, ACSO will continue to facilitate and broker various levels of engagement and use our models and experiences in the personal injury sector to identify opportunities to progress ADR pilots for clinical negligence cases.

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[95] Fletchers Solicitors, *Call for evidence: NHS litigation reform*, October 2021, p.2.
[96] Hempsons Solicitors, *Call for evidence: NHS litigation reform*, October 2021, p.4.
[97] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.
[98] NHS Resolution (NHSR), *Faculty of Learning.*
[99] NHS Resolution (NHSR), *Mediation in healthcare claims – an evaluation*, February 2020, p.17.

6. Encourage closer adherence to the Protocol

From discussions with members and stakeholders, there was a belief that when the Protocol was complied with by both sides, the overall outcome for consumers was largely a positive one. It provides a clear timeframe and pathway to resolution. However, the ability to comply with the Protocol was felt by the majority of our interviewees to be dependent predominantly on file handler caseloads, expert and witness availability and case complexity. All agreed, however, that dialogue could be improved to ensure better understanding of the reasons for failing to comply with the Protocol on individual cases.

> *"It is clear from our dialogue with both sides that there are agreed ways of working within the current framework which, if most firms applied them, would improve the situation. If it was primarily expert firms dealing with them, on both sides, the process would likely be more sufficient and smoother."*
>
> **Richard Miller, Head of Justice, The Law Society**

ACSO members should adopt the best possible means of monitoring compliance with the Protocol and promote effective communication when delays occur to ensure better consumer understanding.

Future sector developments

The future of the clinical negligence sector will ultimately be shaped by the nature of the government's proposals. In September 2021, the HSCC opened a consultation to examine the case for reform of NHS litigation.[100] This built upon its report on the *Safety of Maternity Services in England*, which concluded that the clinical negligence process was failing to meet its objectives for both families and the healthcare system.[101]

Written evidence was submitted by more than 60 stakeholders, including ACSO.[102] While there were some calls for complete systemic reform, many respondents proposed improvements to the well-established tort system and, separately, identified areas for development within the NHS. A number of these proposals have been discussed in this report.

In November 2021 and January 2022, the first two sessions of oral evidence were heard, during which the committee explored the impact of litigation on families, how well the current system enables patients to seek redress, the learning that comes from it and the effectiveness of no-fault schemes in other countries.[103,104] Previous HSCC inquiries suggest a further two sessions of oral evidence will be heard before the report is published.
More importantly, the Department of Health and Social Care (DHSC) announced its much-anticipated consultation with details of its FRC regime in January 2022. The consultation is open to response until April 2022, after which the government will publish a consultation response document. If the decision is made to introduce an FRC regime, proposals will be considered by the Civil Procedure Rule Committee before being implemented by statutory instrument, potentially in April 2023. A post-implementation review will also be carried out no later than 5 years after the regime is introduced.[105]

In anticipation of future proposed reforms, our interviewees stated that business models and department structures are being adapted accordingly to ensure that lower value claims are managed by specialist teams. Moreover, case acceptance processes have become more streamlined and stricter cost monitoring has been introduced.

[100] Health and Social Care Committee, *Call for evidence: NHS litigation reform*, September 2021.
[101] Health and Social Care Committee, *The Safety of Maternity Services in England*, 6 July 2021, p.32.
[102] The Association of Consumer Support Organisations (ACSO), *Call for evidence: NHS litigation reform*, October 2021.
[103] Health and Social Care Committee, *Call for evidence (oral evidence session): NHS litigation reform*, 16 November 2021.
[104] Health and Social Care Committee, *Call for evidence (oral evidence session): NHS litigation reform*, 11 January 2022.
[105] Department of Health and Social Care, *Fixed recoverable costs in lower value clinical negligence claims*, January 2022, p.20.

Positive engagement between larger claimant firms, NHSR and panel firms is likely to continue even after any proposed reforms are implemented. The success of the Covid-19 protocol, and ongoing pilot schemes to assess various forms of ADR and case progression have highlighted that industry-led solutions can be of greater benefit for consumers than government reform. They have also contributed to the reduction in costs.

> *"We will continue to see improved collaboration between claimant and defendant lawyers with a greater focus on improving patient safety. The NHSR is constantly looking at new initiatives and engaging with their panel firms and claimant representatives. This will see the best returns on time and money."*
>
> **Ian Cohen, Director of Practice Areas & Injury, Simpson Millar**

When considering the future of the clinical negligence sector, interviewees made comparisons with the developments in the personal injury (PI) sector over recent years. Findings from IRN Research indicate that FRC and the implementation of the 2018 Civil Liability Act in 2021 – which increased the small claims limit for road traffic accident claims and placed fixed tariffs on whiplash injuries – has resulted in the PI market consolidating and increasing the divide between smaller and larger firms.[106]

If FRC are not set at an appropriate level, the clinical negligence market may see similar consolidation and smaller firms falling or stepping away from clinical negligence work as it would become uneconomical to pursue claims. Firms who continue may also invest less in the complex injury market. Each of these consequences may hinder consumer choice and access to justice.

> *"The key issue will be the level that FRC are set at. If they are set too low, then it will almost certainly lead to firms withdrawing from the market because it will no longer be economically viable to do this work."*
>
> **Richard Miller, Head of Justice, The Law Society**

Therefore, it is crucial that an FRC regime in clinical negligence is set at a reasonable and fair level to allow consumers continued access to legal expertise and expert input. In the words of Lord Wolfson QC, "uncertainty of costs hinders access to justice, while certainty of costs set at a proportionate and fair level enhances it."[107]

Until the publication of the HSCC report and DHSC consultation response document, ACSO will work with members and others to identify areas of collaboration and bring together relevant stakeholders to ensure continuing access to justice for consumers and to improve outcomes for all parties. In doing so, ACSO will help to achieve its founding mission: to ensure there is a properly functioning, competitive and sustainable justice system for consumers.

[106] IRN Research, *UK Personal Injury Market 2021*, August 2021.
[107] Ministry of Justice, *Extending Fixed Recoverable Costs in Civil Cases, The Government Response*, September 2021, p.3.

Conclusion

While the clinical negligence sector has consistently reacted well to legislative and policy changes over the years, the introduction of FRC has the potential to create considerable challenges. The reliance on expert input and the 'top heavy' nature of investigations make it a highly complex area of litigation to fit within an FRC regime. This is likely to explain why progress has yet to be made, despite the government's intention to introduce FRC since the summer of 2015.

In that time, a number of other proposals to reform clinical negligence litigation have been suggested by relevant stakeholders – some of which are likely to be more successful than others. Additionally, the considerable improvement in collaboration has led to the trialling and development of industry-led solutions which have achieved the desired outcome in reducing overall costs whilst maintaining consumers' access to justice.

It is this access which may now be under additional threat; the government will need in its response to the ongoing consultation set out in more detail what safeguards and review mechanisms it will put in place to ensure additional barriers are not put up, and especially for the most vulnerable.

Where change is appropriate it should only be undertaken with the patient as a consumer at the heart of any proposed reforms; the risk is that the government's narrow focus on costs will not aid patient safety. It is for this reason that we have based our recommendations on the areas of consensus that both claimant and defendant parties can work towards.

We hope this report and the discussions that it brings will be of lasting value to the sector and those who depend on its services.

Further information

If you require further information, please contact:

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Glossary

Access to justice
The principle that every person has an equal opportunity to seek justice under the law and the processes that provide people with the appropriate means to enforce their legal rights.

After-the-event insurance (ATE)
A type of commercially available insurance policy which provides coverage for legal costs, subject to an agreed limit of indemnity. An ATE insurance policy can provide cover for legal costs incurred in pursuing or defending legal proceedings.

Alternative dispute resolution (ADR)
A variety of ways of solving a problem without having to go to court. Types of ADR mechanisms include mediation, arbitration, online dispute resolution and other processes that can settle disputes.

Artificial intelligence (AI)
AI is intelligence demonstrated by machines, as opposed to natural intelligence displayed by animals including humans.

Breach of duty of care
A leading element of clinical negligence liability. In determining liability, as duty of care and a breach of that duty must be established. In order to prove whether the healthcare provider breached their duty of care, a claimant will need to show that what the healthcare provider did or failed to do was not supported by a responsible body of clinicians at the time and/or was not logical.

Civil Justice Council (CJC)
An advisory non-departmental public body sponsored by the Ministry of Justice. The CJC is responsible for overseeing and coordinating the modernisation of the civil justice system

Civil Procedure Rules (CPR)
The rules of civil procedure used by the Court of Appeal, High Court of Justice and County Courts in civil cases.

Clinical negligence (CN)
Occurs when a doctor or other health care professional breaches their duty of care to the patient, resulting in physical and/or mental harm and suffering and injury. Where there is negligence that causes harm, the law enables the victim to claim compensation.

Conditional fee agreement (CFA)
CFA is an agreement with a legal representative which provides for his or her fees and expenses, or any part of them, to be paid only in certain circumstances – usually only if the client wins the case.

Department of Health and Social Care (DHSC)
The DHSC is the UK government department responsible for government policy on health and adult social care matters in England, along with a few elements of the same matters which are not otherwise devolved to the Scottish government, Welsh government or Northern Ireland executive.

Duty of care
The obligation placed on healthcare practitioners to act in accordance with the relevant standard of care which is the standard expected of an ordinarily competent practitioner performing that particular task or role.

Early notification scheme (ENS)
The NHS ENS investigates serious brain injuries that happen to children at birth. Its aim is to speed up the investigation of these incidents and give families answers as soon as possible after serious injuries.

Fixed recoverable costs (FRC)
An arrangement in which the legal costs recovered by the successful party in litigation are limited according to agreed rates.

Health and Social Care Committee (HSCC)
The Health and Social Care Select Committee is a Departmental Select Committee of the British House of Commons, the lower house of the UK Parliament. It oversees the operations of the Department of Health and Social Care and its associated 29 agencies and public bodies.

Healthcare Safety Investigation Branch (HSIB)
HSIB is dedicated to improving patient safety through independent investigations into NHS-funded care across England. HSIB is funded by the Department of Health and Social Care and hosted by NHS England and NHS Improvement.

Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPO)
LASPO made a wide-ranging set of changes within various areas of the Ministry of Justice portfolio.

Legal expenses insurance (LEI)
LEI is a class of insurance which facilitates access to law and justice by providing legal advice and covering the legal costs of a dispute, regardless of whether the case is brought by or against the policyholder.

Litigants in person (LiPs)
A litigant in person is an individual, company or organisation that has rights of audience and is not represented in a court of England and Wales by a solicitor or barrister.

Mandatory neutral evaluation (MNE)
An approach to dispute resolution set out by the CJC, MNE is a mandatory evaluation of a claim to be carried out by an independent specialist barrister of a minimum level of

experience selected from a pre-agreed panel. It would apply to claims not resolved earlier in the process, and the outcome would be non-binding: claimants would be free to pursue their claim in the courts.

Multi-track cases
Defended cases in the civil courts are assigned to one of three tracks, one of which is the multi-track (the others are the fast track and the small claims track.) The multi-track is generally for very complex cases with a value of £25,000 or more. Due to their relative complexity, most clinical negligence claims under £25,000 are currently also allocated to the multi-track.

National Audit Office (NAO)
The UK's independent public spending watchdog. It supports Parliament in holding the government to account for the way it spends public money. It does this by auditing the finances of public bodies. It does not question the merits of government policies but assess whether resources have been used efficiently and effectively

National Health Service (NHS)
The NHS is the publicly funded healthcare system in England, and one of the four National Health Service systems in the United Kingdom.

NHS Resolution (NHSR)
An arm's-length body of the Department of Health and Social Care. It provides expertise to the NHS on resolving concerns and disputes fairly, sharing learning for improvement and preserving resources for patient care.

NHS Trusts
Self-governing administrative body within the NHS; usually a group of hospitals. An NHS trust provides services on behalf of the NHS in England and NHS Wales.

Qualified one-way costs shifting (QOCS)
QOCS was introduced for personal injury claims from 1 April 2013. This means that defendants will generally be ordered to pay the costs of successful claimants but, subject to certain exceptions, will not recover their own costs if they successfully defend the claim.

Small claims track
Defended cases in the civil courts are assigned to one of three tracks, one of which is the small claims track (the others are the multi-track and the fast track). The small claims track is intended to provide a simple and informal way of resolving disputes. The small claims track upper limit for personal injury claims including clinical negligence claims is currently £1,000. The £1,000 small claims track limit is due to increase to £1,500 in April 2022.