



Department
of Health

Triennial Review of the NHS Litigation Authority

Review Report

July 2015

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Review Report

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Executive summary

The NHS Litigation Authority (NHS LA) is a Special Health Authority operating under direction from the Secretary of State for Health. The NHS LA operates at arm's length from the Department of Health.

The NHS LA's main functions are to provide a litigation service through which all NHS hospital provision in England has indemnity cover against clinical negligence and non-clinical employers', public and professional liabilities. The NHS LA also enables and supports learning from claims to help the NHS (and other providers of NHS care) to better manage their risks in a way that helps to reduce the number and severity of claims.

A significant challenge to the NHS LA in managing litigation on behalf of the NHS is the rising growth in clinical negligence claims. The financial implications of litigation for NHS providers is stark, with the cost of indemnifying organisations against claims substantial. For this reason, there is a need to rethink the approach to reducing the incidence and cost of claims to the NHS.

To address the challenge, decisions need to be taken and the NHS Litigation Authority as a Special Health Authority is well placed to do this, having the benefit of being both a NHS body whilst working at close arm's length to the Department. This provides assurance for NHS organisations and the Department, the NHS LA will ultimately act in the interests of fairness to patients, staff and the public, whilst having regard to protecting the public purse.

Main findings

Overall, the review considered the NHS LA was meeting the objectives set for it; was well led and operationally efficient providing NHS providers with a cost effective service. The review recommends that the NHS LA's current form is suitable for its current purpose.

However, the review found an environment of claims growth, particularly clinical negligence claims resulting in liabilities of over £26.1 billion. The review also received evidence of the potential for a relatively small number of policy changes to realise significant savings on the negligence bill, through both local and national action. These measures are outlined in this report and whilst further work is needed, they could realise up to £400 million per year.

Improving patient safety to reduce avoidable harm is the main route to reducing complaints and claims on NHS bodies. The review considered the system wide push for improved patient safety, recognising reductions in avoidable harm but also greater candour with patients and families when things go wrong, will lead to fewer claims.

As a result, the review reinforces measures now outlined in *Hard Truths One Year On* and Government response *Culture Change in the NHS: Applying the lessons of the Francis Inquiries*, the Parliamentary and Health Service Ombudsman's vision for good complaints handling *My Expectations for raising concerns and complaints*. This review has highlighted the need to go further and faster on local access to mediation that will complement efforts underway to improve local handling of complaints. In the later stages, the review also took note of the Public Administration Select Committee inquiry on NHS complaints and clinical failure.

Next steps

Section 2 sets out nine review recommendations in detail. These will lead to longer term action. In the first instance, the Department will work with the NHS LA to set a clear narrative on the NHS LA role, functions and objectives, as well as provide a framework within which the regulations governing NHS LA functions can be rationalised. The review also recommends an intensive period of development in the months following publication of this report through a series of recommendations that will require the Department, the NHS LA, other governmental bodies, NHS organisations and other experts to combine efforts to:

- Reinforce improvements in patient safety, through sharing trends in claims data and supporting campaigns such as ‘Sign up to Safety’ working with other health and care system bodies to incentivise better quality care and acting to improve patient safety;
- Enhance the local handling of concerns and complaints that lead to litigation using the leverage of the Duty of Candour as set out in Hard Truths, One Year On, but also supporting organisations by providing improved access to mediation
- To use the claims database to analyse and feedback to NHS providers patterns of litigation for safety and learning purposes
- Promote high impact measures that could improve patient safety, for example increasing the use of fetal heart monitoring in line with NICE guidelines
- Work with other governmental bodies and expert stakeholders to review the regulatory framework and where appropriate, make the case for law reform, to reduce the costs of claims so those savings can be released to frontline NHS services
- Consider the impact of integration and emerging models of care to ensure a more flexible offer is available to meet the changing needs of the health and care system.

1. Introduction and background

Public Bodies Reform

- 1.1 Public bodies need to be responsive to an ever changing landscape. They need to be efficient, they need to be effective and they need to be accountable. Any duplication of activity needs to be removed and activities and functions no longer needed should be stopped. For those which remain, the public have a right to be assured they are as effective, efficient and well governed as they can be. Regular challenge and review provides this assurance and so is central to the reform agenda.
- 1.2 Health and social care system reform set out in the Health and Social Care Act 2012 and the Care Act 2014 resulted in the devolution of functions and powers away from the Department of Health to arm's length bodies and local health and care organisations.
- 1.3 Triennial Reviews provide a systematic approach for the regular review of public bodies operating at arm's length to government departments.
- 1.4 As steward of this evolving system, the Department of Health (the Department) is using Triennial Reviews to provide assurance that the system, and the new and reformed bodies within it, are fit for purpose. For this reason, the Department's programme of Triennial Reviews extends to all Executive Non-Departmental Public Bodies (ENDPBs), Advisory Non-Departmental Bodies (ANDPBs), Executive Agencies and Special Health Authorities (SpHAs).
- 1.5 Triennial reviews have two main stages:
 - The first tests the continuing need for the body, both in terms of the functions it performs and the model and approach in which they are delivered.
 - The second considers the body's governance, performance and capability as well as exploring opportunities for efficiencies.
- 1.6 In reviewing the NHS Litigation Authority (NHS LA) the two stages were combined.

NHS Litigation Authority Triennial Review

- 1.7 The review was conducted by Lorraine Thomas, lead reviewer assisted by a multi-disciplinary team drawn from across the Department of Health and Cabinet Office (see Annex H) working under direction of Andrew Baigent, the Senior Review Sponsor.
- 1.8 Evidence was gathered through a variety of means, including desk review, submitted evidence, workshops and interviews with NHS LA stakeholders and interviews with NHS LA Board members and Department of Health officials. A public 'Call for Evidence' was run between 16 October and 12 November 2014.

2. Recommendations

Purpose of the NHS Litigation Authority

2.1 As a result of health and social care system reform and the introduction of a clearer role for the NHS LA in promoting safety, the review found a need to reinforce the scope and purpose of the NHS LA. The review found differing perceptions and mixed views on whether the priority is for the NHS LA to concentrate on providing a more streamlined claims management service, or one which focuses on added-value client services for members. The NHS LA is operating in an environment of changing and rapidly rising claims. It needs the authority and it needs to remain fair in providing redress to those harmed. Using the levers it has, NHS LA should better incentivise a sharper focus on better care in the health and care system complementing wider work to drive up care standards. NHS LA's functions and priorities are currently underpinned by a regulatory framework that is dated and piecemeal and in need of re-purposing. The functions are broadly right and at the time of review the evidence showed no tangible benefit in altering the current corporate form, however this should be revisited in future work to consider the organisational purpose of NHS LA. It is recommended that:

- **Recommendation 1. The main NHS LA functions, namely the Clinical Negligence Scheme for Trusts, the Risk Pooling Scheme for Trusts (Liabilities to Third Parties Scheme) and the Safety and Learning Service, should continue to be delivered through the NHS LA as a Special Health Authority**
- **Recommendation 2. The Department of Health should lead work with NHS LA to review and articulate the role of NHS LA. The outputs should include a single narrative on scope, purpose and objectives, including the NHS LA role in promoting safety and sharing data that the Board should use to consider whether any further changes to its composition are required. The results of the work should be shared with stakeholders by 31 October 2015.**
- **Recommendation 3. Following this review and by 30 November 2015, the NHS LA Board should develop and agree with the Department a set of Key Performance Indicators (KPIs) which are a balance between quantitative and qualitative metrics – qualitative metrics should include regular member satisfaction surveys.**

Organisation and Management of the NHS Litigation Authority

2.2 The review considered the key efficiency metrics for the NHS LA and concluded that against the available metrics, the NHS LA performed well closing 15,384 claims in 2013/2014 against a background of rapid claims growth. Whilst there are no specific recommendations on operational efficiency, there is merit in NHS LA continuing to benchmark itself against comparator organisations and between claims teams.

Policy, Incentives and Cost Drivers

2.3 There are a number of items which drive up the costs of litigation and level of damages currently managed by the NHS LA. Stakeholders highlighted a number of areas, both within and outside the control of the NHS LA which would benefit from detailed work to identify action to reduce the overall cost of litigation to the NHS. It is recommended that:

- **Recommendation 4.** *By 31 October 2015 the Department of Health reviews options to appropriately limit claimant legal costs. In particular, the Department should consider how it can work with NHS LA, Ministry of Justice and others in government to review the potential to introduce fixed costs for clinical negligence, and the recoverability of After the Event Insurance costs from NHS LA.*
- **Recommendation 5.** *Further work should be led by the Department with the NHS LA, Ministry of Justice and others in government, by 31 January 2016, on the level of settlements to identify the main items which would lead to more effective and equitable awards.*

Responding to Change

2.4 Health and care services are becoming more integrated and organised around the patient pathway with new models of care being developed that cut across traditional organisational boundaries. NHS LA has the additional challenge of a more litigious environment with increasing claims and increasing numbers of claimant firms new to the health and care sector. NHS LA should work with members to consider cost efficient, alternative and complementary models for handling smaller claims. There is evidence to support NHS LA allowing some local member legal teams to handle small claims through locally delegated authority and to direct the use of mediation as part of a range of options for complainants and claimants to find timely, appropriate and fair resolution.

- **Recommendation 6.** *The Department should support NHS LA to consider and take account of the impact of health and social care integration on indemnity cover and by 31 October 2015, identify what additional flexibilities are needed to NHS LA functions so they can provide services across the new models of care described in the NHS Five Year Forward View.*
- **Recommendation 7.** *By 31 December 2015, NHS LA should lead work with a cross section of members, the Department and other stakeholders to evaluate whether i) an extended programme of local delegated authority and ii) arrangements for local voluntary excesses could work.*
- **Recommendation 8.** *NHS LA should evaluate its pilot mediation programme by 31 October 2015 and at an early stage enter wider discussion with members and external partners on the evaluation results and the roll out of mediation as a less adversarial, mainstream model of redress.*

Information and Safety

2.5 NHS LA has nearly 20 years' worth of claims data likely representing one of the most comprehensive claims database available in any sector. There is potential for better analysis and use of this data to identify themes and through the safety and learning service promote the root cause of incidents leading to claims and ultimately improve the quality of care and the safety of patients. However, there are barriers to the NHS LA sharing this data more widely; specifically, rules on data protection. It is recommended that:

- **Recommendation 9.** *NHS LA supported by the Department should establish a data project by 31 December 2015 in partnership with scheme members and information experts to develop ways of improving the quality, analysis and access to claims data. Particular focus should be given to the viability of matching claims data with complaints and incident data.*

Stage one report

Report on the considerations of NHS Litigation Authority's

- Functions
- Delivery Model and Corporate Form

Including

- Context within which the functions are delivered

3. Functions and activity of the NHS LA

Legal and policy framework

- 3.1 The NHS Litigation Authority (NHS LA) is a Special Health Authority operating under direction from the Secretary of State for Health. NHS LA operates at arm's length from the Department as a semi-autonomous body.
- 3.2 NHS LA was first established by the National Health Service Litigation Authority (Establishment and Constitution) Order 1995, S.I. 1995/2800. The order was made under section 11 and paragraph 9 of schedule 5 to the National Health Service Act 1977. Following consolidation, this order now has effect as if made under the National Health Service Act 2006. Subsequent amendments have been made and the list of establishment legislation is set out in Annex D to this report.
- 3.3 The legislative and policy framework within which the NHS LA works has been developed and adapted over time and there are a number of regulations and directions from which it draws its authority to act. The wider policy framework is owned by Department of Health, but the regulatory framework which governs the claims functions, as access to redress, is owned by Ministry of Justice.

The NHS Litigation Authority was established in 1995 as a Special Health Authority (National Health Service Act 2006). Its role is to administer risk based schemes through which NHS bodies (and NHS contractor bodies) can post the cost of liabilities to third parties for loss, damage or injury arising from the carrying out of their functions. The majority of these relate to clinical negligence however there are additional risk pools within the NHS LA for property and third party liabilities – public and employers' liability.

Clinical and non-clinical indemnity Schemes

- 3.4 The NHS LA runs a number of risk pooling schemes on behalf of the Secretary of State for Health. These indemnify all NHS hospital provision in England against clinical negligence and non-clinical employers', public and professional liabilities. The NHS LA is required to pay proven claims promptly and fairly and to defend unproven claims robustly. It also enables and supports learning from claims to help the NHS (and other providers of NHS care) to better manage their risks in a way that helps to reduce the number and severity of claims - over time this will result in improved patient, staff and public safety.
- 3.5 Membership of the NHS LA schemes is optional for NHS Foundation Trust (NHS FT) and Independent Sector members free to take out alternative cover against their risk. Currently, all NHS FTs and all but one independent sector providers are indemnified through NHS LA.
- 3.6 The main functions being considered in this review are the provision of litigation services through clinical and non-clinical negligence indemnity schemes centrally administered by NHS LA as a national function. They operate on a membership basis for local of providers of NHS services. The schemes are:

- Non Clinical Risk Pooling Schemes for Trusts (RPST) which comprises two schemes covering non-clinical risks, the Liabilities to Third Parties Scheme (LTPS) and the Property Expenses Scheme (PES). LTPS covers employers' and public liability claims.
- Clinical Negligence Scheme for Trusts (CNST) that covers all clinical negligence claims against member NHS bodies where the incident in question took place on or after 1 April 1995 (or when the body joined the scheme, if that is later).
- Existing Liabilities Scheme (ELS) which is centrally funded by the Department of Health and covers all clinical negligence claims against member NHS bodies where the incident in question took place before 1 April 1995.

3.7 With the exception of ELS, the costs of the schemes are met by membership contributions. The cost of claims is assessed in advance each year and contributions are calculated to meet the total forecast expenditure. The schemes are supported by a safety and learning service that helps the NHS identify and address the root cause of claims.

Safety and learning function

- 3.8 A function of NHS LA is supporting the NHS to learn from claims to improve patient, staff and public safety. NHS LA indemnity contributions reflect organisational levels of risk by ensuring that organisations with fewer claims have lower contributions, and similarly organisations with higher levels of claims pay accordingly. NHS LA supports members to reduce their claims by providing detailed, real time access to claims information and learning through a secure extranet and local learning activity.
- 3.9 Support is provided through geographically organised safety and learning leads working with local and regional member networks. The primary role of the safety and learning service is to support members in learning from claims, identifying areas for local improvement in patient, staff and public safety, and acting to help members reduce avoidable harm.

Other functions

3.10 The NHS LA has other responsibilities which include advising the NHS on:

- Human Rights Law
- Age Discrimination and Equal Pay claims
- appeals from pharmacies, dentists and ophthalmologists against decisions made by primary care commissioners
- providing the National Clinical Assessment Service which helps improve patient safety by resolving concerns about the professional practice of doctors, dentists and pharmacists in the UK and overseas.

3.11 These are outside the scope of this review although where evidence was received, it was considered as context.

Evidence and consideration of NHS Litigation Authority functions

- 3.12 Indemnity or insurance cover is a statutory requirement for NHS provider bodies. The indemnity offer of the NHS LA provides a cost effective option for pooling risks and resources across the health system, achieving economies of scale in claims handling and legal representation. In carrying out the functions at national level, NHS LA helps reduce the burden and cost to the NHS front-line services.
- 3.13 This provides evidence of the continued need for the main functions. This was strongly supported by members and other stakeholders responding to the Call for Evidence and in individual and workshop discussions.
- 3.14 Since the NHS LA was first established as a Special Health Authority, there has been an iterative approach to the regulations that provide direction to the Authority. These have resulted in a number of functions being added over time.

It is recommended that:

- ***The main NHS LA functions namely the Clinical Negligence Scheme for Trusts, the Risk Pooling Scheme for Trusts (Liabilities to Third Parties Scheme) and the Safety and Learning Service should continue to be delivered through the NHS LA as a Special Health Authority [Recommendation 1].***
- ***The Department of Health should lead work with NHS LA to review and articulate the role of NHS LA. The outputs should include a single narrative on scope, purpose and objectives, including the NHS LA role in promoting safety and sharing data that the Board should use to consider whether any further changes to its composition are required. The results of the work should be shared with stakeholders by 31 October 2015 [Recommendation 2].***

4. Context to the review of functions and delivery model

Building on the 2011 Industry Review

- 4.1 In 2011, the Department of Health commissioned Marsh Ltd to conduct an “Industry Review” into the role and remit of the NHS LA. The purpose of the review was to establish whether the organisation was achieving optimal performance and whether there was scope to replicate commercial best practice. The key areas of the review identified in the scope and purpose were:
- whether the NHS LA achieves optimum performance in delivery of its risk pooling functions
 - any opportunities to introduce greater commercial management and practice to improve the efficiency
 - whether any sup-optimal performance by the NHS LA is responsible for the upward trends in scheme liabilities.
- 4.2 The 2011 Industry Review supported the retention of the NHS LA and its main role of indemnifying NHS bodies and managing litigation involving them; it produced 40 recommendations to improve the NHS LA’s role, its performance and its efficiency, of which 36 were accepted in the Department’s 2012 response.
- 4.3 The 2011 Industry Review also highlighted the different models of cover offered by the NHS LA and commercial insurers in managing claims. However, whilst all compensators are driven to respond quickly to claims, the NHS LA public duties include:
- promoting patient care and a safe working environment for NHS staff
 - paying proven claims promptly
 - defending unmeritorious claims robustly
 - sharing learning from claims with the wider NHS.
- 4.4 This is a significant driver that differs from more commercial drivers of cost effectiveness, reduced financial impact to business, profit, and providing sufficient information for business decisions.
- 4.5 In June 2014, the NHS LA produced a report outlining its progress in implementing the recommendations. Of the 36 accepted, seven were not progressed due to the changed strategic direction, resulting in the move away from the Risk Management Standards and assessment process to a more outcome focused safety and learning service. Until April 2014, a major part of the operation of the clinical and non-clinical indemnity schemes centred on the risk management standards and assessment. The decision making around this change and the evidence used was considered as part of this review. Other 2011 Industry Review recommendations have been implemented or significant progress had been made. The Department’s Senior Departmental Sponsor acknowledged the progress made by NHS LA in his foreword to the NHS LA’s report.
- 4.6 This review has not considered in detail those recommendations which NHS LA has implemented, but where evidence or specific observations on progress has been found, it has been taken into account and where appropriate, noted in this report.

The changing market environment

Market growth

4.7 NHS LA is operating within both an evolving health and care system and against a background of changes to the indemnity and claims market environment. 'Market growth' has resulted in a significant but steady rise in claims over the past five years, with particular increases in clinical negligence claims. Despite almost half of all clinical negligence claims being repudiated i.e. challenged and dismissed without award, there remains a continued increase in the provisions for claims and legal expenses associated with such claims.

4.8 Responding to this rising growth in claims is a substantial financial challenge for the NHS

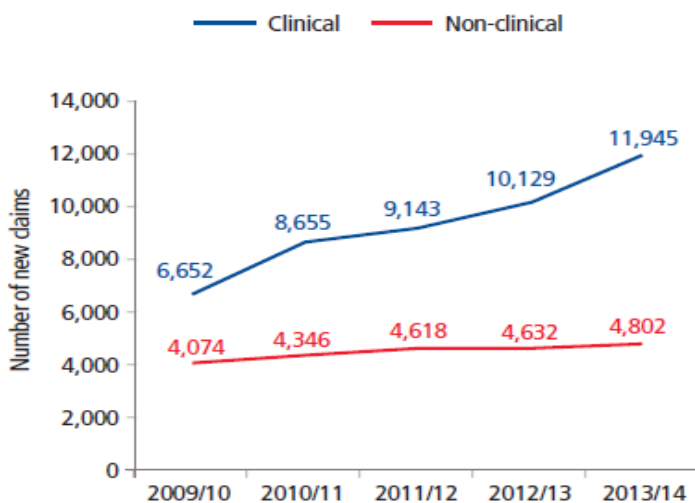


Figure 1: Number of new claims reported (clinical and non-clinical, all members)

4.9 A number of factors are reportedly driving this growth including:

- The NHS is treating more patients than ever before.
- Health and care provision is increasingly complex, and this is driven by a number of factors, including the need to respond to the requirements of a demographically diverse and ageing population.
- A generally more litigious society (compensation culture) resulting from societal changes and economic pressures.
- Changes to the legal market, including the emergence of 'non-specialist' lawyers, moving into the clinical negligence arena from personal injury work (such as motor personal injury).
- Greater awareness and willingness to litigate as a means of redress.
- Greater transparency and awareness of high profile failures resulting in a loss of confidence in health and care services.

4.10 The growth of claims and an increase in the cost of claims that has taken place over the past few years has resulted in over £26.1 billion being set aside as a provision for meeting those claims.

The expenditure estimates for clinical negligence claims for the next three years show an increase in expenditure (see table below).

Spending round forecasts calculated with assistance of the NHS LA's actuaries submitted to the Department for Clinical Negligence Scheme for Trusts (CNST) in 2015/2016 show £1,554m. Agreed position for 2015/2016 is £1,418m, a 35% increase. Future expenditure forecasts shared with the Department for CNST are:

	2016/2017	2017/2018	2018/2019
	£'000	£'000	£'000
CNST Expenditure	1,775,000	1,973,000	2,190,000

Table 1: Estimates of clinical negligence growth

4.11 The CNST provisions are an actuarial calculation that includes an estimated value for:

- Known claims reported to the NHS LA but yet to be resolved. Of the £6bn of known claims at 31 March 2014, just over half relate to obstetric claims with 75% of the total relating to incidents occurring before 31 March 2010. The delay between the incident occurring and the claim being reported to NHS LA is an average of 2.7 years; this is longer for the obstetric claims.
- Periodic Payment Orders (PPs or PPOs) – these are court orders that are comprised of a lump sum payment followed by regular payments over the life of the patient for future care. These orders are index linked. PPO settlements are most appropriate to those patients requiring lifetime care as a result of avoidable harm. These settlements do offer a short term cash flow benefit to the NHS compared to a single lump sum award more popular in the commercial environment, however they also provide longer term security to the patient and their family.
- IBNR (incurred but not reported) is an actuarial estimate of the value of claims which have yet to be formally lodged, but may be brought in the future.

4.12 Without significant policy development there will be limited scope for affecting change to the growth in expenditure on clinical and non-clinical litigation. Overall, the Clinical Negligence Scheme for Trusts (CNST) is by far the larger proportion of the overall spend on claims, and has experienced the greatest growth in claims. CNST provisions have increased from £11.3bn in 2008/2009 to £23bn in 2013/2014. The majority of this relates to the £14.6 billion estimated value of 'incurred but not reported' (IBNR) claims. Increases in IBNR provisions are driven by both claims activity i.e. increased claims reporting patterns and overall total value of anticipated claims increased. An example of this is that since the Mid Staffordshire NHS Trust failures, there has been an NHS-wide growth in claims relating to negligent care of the frail and elderly; although generally of lower value, the growth patterns have resulted in revisions of the longer term forecasts of the claims portfolio.

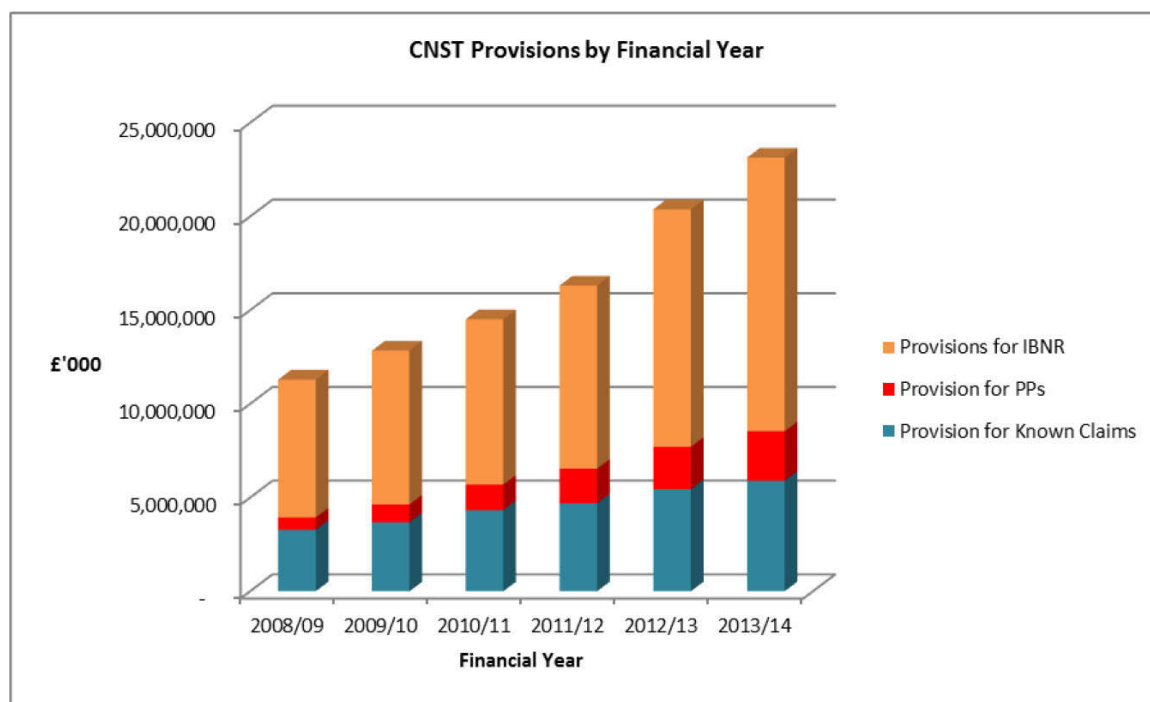


Figure 3: CNST provisions by financial year (since 2008/2009)

Legislative basis for the rise in claims

- 4.13 There is evidence to support the assertion that changes in the legal environment contributed to an increase in claims during 2013/2014 which has continued into 2014/2015. In part, this is considered a result of intensive marketing by claimant lawyers prior to the 1 April 2013 enactment of the Legal Aid Sentencing and Punishment of Offenders Act 2012 (LASPO). LASPO changed the rules on conditional fee arrangements (no-win, no-fee agreements) which restricted claimant lawyers' uplifts on their costs in agreements signed after 1 April 2013 which, prior to LASPO, were routinely charged at 100% of the level of base costs.
- 4.14 Additional legislative limitations placed on the use of 'after the event' (ATE) insurance have resulted in claimants being unable to recover the costs of insurance against an unsuccessful claim from defendants. The exception is clinical negligence where claimants are still able to recover the costs of insurance for the cost of expert reports in recognition that these costs might make pursuing clinical negligence claim seem prohibitive to some claimants.

Claimant legal costs

- 4.15 The total legal claimant costs are reportedly 22% of clinical negligence expenditure and 38% of non-clinical negligence expenditure. Claimant legal costs are disproportionately and increasingly high. This is particularly the case for lower value claims where legal costs are disproportionate to the amount of compensation being claimed as illustrated in Figure 4 below.

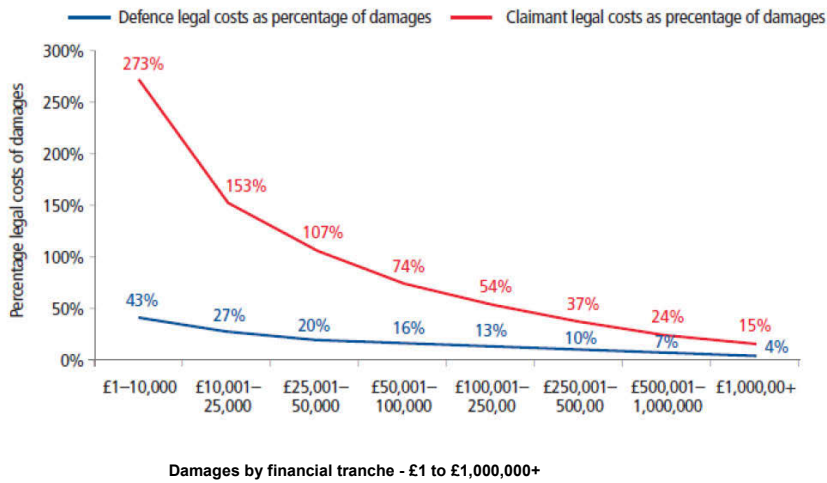


Figure 4: Clinical claims legal costs as a percentage of damages paid for claims closed in 2013/2014

- 4.16 The introduction of low fixed fees in other areas of personal injury work such as motor claims has led to increasing number of non-specialist claimant firms entering the clinical negligence market. Evidence suggests many of these firms often work to high volume low value claims, rather than adopting a more targeted strategy.
- 4.17 NHS LA has taken action to actively manage these costs through a mixture of challenge and improving the claims process. There is some evidence to suggest there is likely value in wider work to develop a fixed cost recovery scheme for claimant lawyers for claims between £1,000 and £100,000. Such a change could increase transparency for the public as well as defendants and potentially generate significant savings in the health sector.
- 4.18 As a result of the NHS LA's work in targeting excessive claimant costs, they report savings in 2013/2014 of over £74 million (both schemes). NHS LA's action in this area needs to continue, and there is value in considering how this could be better publicised. In addition to cross-government action to review the underpinning legislative framework impacting on these costs, learning from what has worked should continue to be shared across claims teams and the Legal Panel. There is also value in NHS LA ensuring learning from this work is shared with scheme members.

Cost of claims

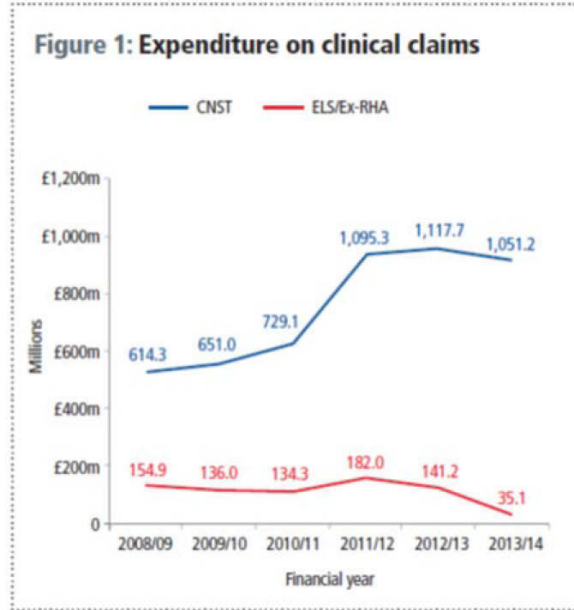
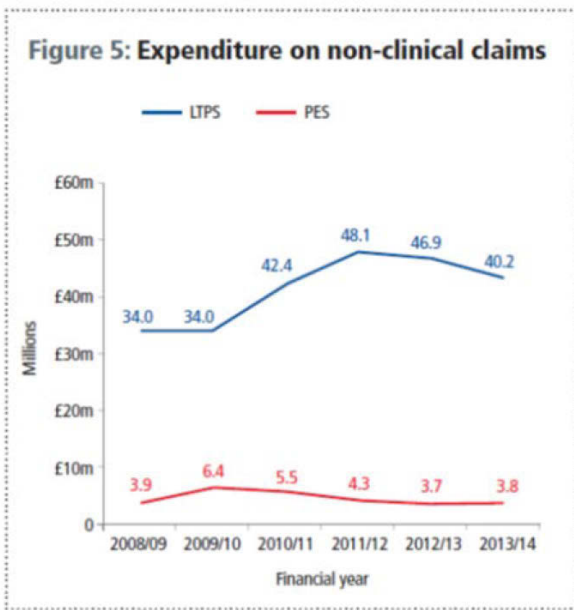


Figure 5: Expenditure on non-clinical claims and expenditure on clinical claims (including interim payments 2013/2014) (£'m)

4.19 NHS LA is addressing the cost of claims and whilst the number of claims received by the NHS has increased significantly in recent years so too has the volume of claims resolved by the NHS LA with no payment of damages. In 2013/2014, 79% of these cases which went to trial were successfully defended and in the same period, 44% of claims – some 3114 claims - were closed without any damages paid.

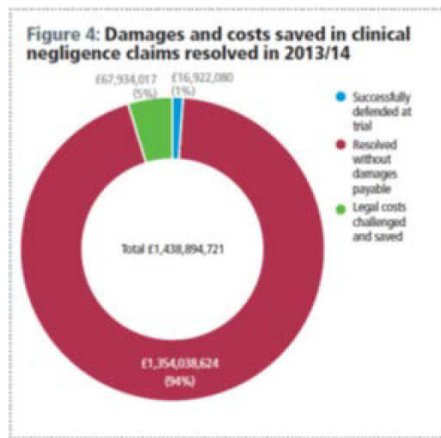
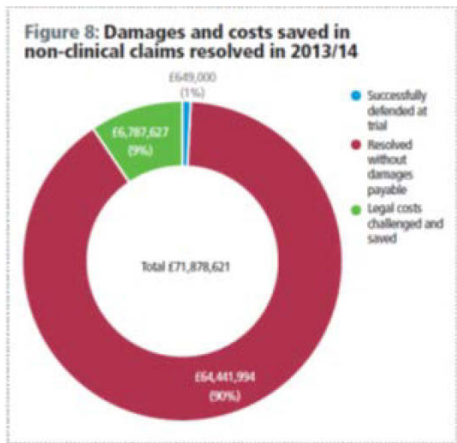


Figure 6: Damages and costs saved (clinical and non-clinical claims)

It is recommended:

- ***By 31 October 2015 the Department of Health reviews options to appropriately limit claimant legal costs. In particular, the Department should consider how it can work with NHS LA, Ministry of Justice and others in government to review the potential to introduce fixed costs for clinical negligence, and the recoverability of After the Event Insurance costs from NHS LA. [Recommendation 4].***
- ***Further work should be led by the Department with the NHS LA, Ministry of Justice and others in government, by 31 January 2016, on the level of settlements to identify the main items which would lead to more effective and equitable awards. [Recommendation 5].***

5. Delivery model and corporate vehicle

- 6.1 The NHS LA has a number of functions, the most significant of which is to indemnify and manage litigation for providers of NHS care. In carrying out these functions NHS LA makes provisions in three areas:
- Known claims: Claims that the NHS LA are aware of, but have not yet resolved.
 - Estimated costs of future Periodical Payment Orders (PPOs): PPOs are orders made by the court, where the claim is resolved by way of lump sum payment, together with regular payments for the rest of the claimant's life in order to meet their ongoing care needs – the NHS LA are reportedly the most regular users of these.
 - Claims which may be brought in the future but which have not been reported: The NHS LA estimates the value of claims which may be brought based on incidents and current claims trends. These are referred to as incurred but not yet reported (IBNR).
- 6.2 The 2011 Industry Review supported the retention of the NHS LA and the use of risk pooling schemes as the mechanism for indemnifying NHS bodies and managing litigation involving them. In conducting this Triennial Review, evidence was considered on the appropriateness of the delivery model for the main NHS LA functions and as part of that, further consideration was given to whether Special Health Authority is the most appropriate corporate vehicle for the delivery model.
- 6.3 Section 4 of this report sets the context within which NHS LA delivers its functions. It sets out the scale of the provisions and the environment of increasing claims and claims costs. The action needed to reduce the provisions to slow the growth in claims, and the cost of claims is predicated on which corporate vehicle will offer most appropriate balance of opportunity, influence, stability and sustainability. Any action will need political will and public understanding to dispassionately take action to bring to a halt the steep rise in claimant costs, the level of damages and the rates charged for legal representation of claimants.
- 6.4 The main four areas that could be pursued are:
- mandatory fixed costs for clinical negligence claims (with damages up to £100,000)
 - increase in the court discount rate
 - removing recovery of After the Event Insurance costs from clinical negligence claims
 - changing the assessment and cost of long term care
- 6.5 Pursuing these options is possible, and NHS LA together with the Department has had early discussions with the Ministry of Justice and others to start the dialogue on delivering policy and regulatory change. This change will ultimately require cross-government agreement and joint action. Section 9 outlines the potential improvement in quality and savings which amount to an estimated £400 million per year from this action. Effecting the changes needed to generate these savings will require regulatory and legal change. The following assessments of appropriate delivery models take into account the savings potential and most effective corporate form to secure cross government agreement.

Option 1: Functions delivered by Department of Health

6.6 Consideration was given to bringing all or some of the NHS LA's functions fully into the Department of Health. The Department does have the necessary leverage to influence central government departments in securing wider action to make savings. However, given the specifically technical nature of the main functions and the 'membership' approach of the risk pooling schemes, the review considers that the functions of the NHS LA are best delivered by a single, focused NHS branded organisation with the necessary independence and specialist expertise.

Option 2: Functions delivered by the commercial or social enterprise sector

6.7 Consideration was given to transferring NHS LA's provision of indemnity cover to the private sector management. NHS LA's Annual Report for 2013/2014 sets out the NHS LA's valuation of outstanding claims and estimates of potential future expenditure on claims (the provisions) as being approximately £26.1 billion.

6.8 The extent of these provisions means that any transfer to the private sector would either come at significant cost or would require government guarantees to be provided. As a result, there is no benefit to patients and the public of transferring the NHS LA's functions to the private sector whilst the £26.1 billion provisions remain on the government accounts.

6.9 Assuming the NHS LA's £26.1 billion provision for existing claims (including IBNR and PPOs) remains within the public sector, the Review considered alternative delivery models for new claims with the provisions for existing claims to be run off by the NHS LA (or another body). In this scenario, there would be costs for NHS bodies to fund NHS LA (or another body) to run off those existing claims. This will include paying for the cost of known periodic payment orders (PPOs).

Option 3: Delivery of functions by a mutual

6.10 Consideration was given to the benefits of the NHS LA becoming a mutual (community interest or fully commercial model). The evidence reviewed, included policy research of the financial, governance and legal requirements of mutuals. Consideration of the evidence identified a number of disadvantages in formally mutualising the NHS LA, these included additional tax liabilities. There was no evidence a mutual would provide greater efficiency to the current delivery model and the added complexity and cost of setting up a mutual was unlikely to represent value for money.

Option 4: Outsourcing of the functions

6.11 The review also considered outsourcing to the private sector some of the NHS LA's functions, namely the administration of the relevant risk pooling schemes and the management of legal services. These functions require technical expertise (e.g. managing and conducting clinical negligence claims) or are not commercially motivated (e.g. providing fair access to justice for patients). Moving these functions wholesale to the private sector would present risks including the need to explicitly write public interest requirements into the constitution or articles of association.

6.12 There is no clear evidence a private sector organisation would be any more efficient than NHS LA with its recent focus on increasing operational efficiency. There are additional costs that transfer of functions might attract for example VAT, unless the company was held within the health tax group, as NHS LA is now. It is not possible to determine whether insurance tax would be levied on such a company. However, there is scope for longer term exploration of establishing NHS LA as a NHS company.

Option 5: Functions delivered wholly through commercial insurance market provision

6.13 Consideration was given to requiring NHS bodies and independent sector providers of NHS care (who currently obtain indemnity cover from the NHS LA) to obtain cover for new claims from the commercial insurance market, with existing claims run-off by the NHS LA (or another body).

6.14 The pricing of the NHS LA's indemnity cover is significantly cheaper than the price offered by the commercial insurance market. This price differential between the NHS LA and the commercial insurance market remains a factor in NHS LA retaining its NHS members in the open market and, since April 2013, over 50 independent sector providers took the opportunity to join CNST. The clear price difference exists for a variety of reasons including:

- No Insurance Premium Tax (IPT) is payable by members on their contributions to the NHS LA while IPT (currently 6%) would be charged on any insurance policy;
- NHS LA schemes are non-profit making risk-pooling mechanisms while commercial insurers' premiums will include profit for the insurer and the cost of capital.

6.15 The pay-as-you-go basis for the NHS LA's schemes also means that, unlike with the commercial insurance market, NHS funds do not have to be used to pay upfront for claims that will be settled in future years. There are a number of other factors mitigating against wider use of the commercial insurance market for indemnity cover including:

- Public interest requirement involves balancing protection of the public purse with the need to provide fair access to justice. Commercial insurers do not have a comparable remit to provide fair access to justice.
- Concerns that insurers could, in practice, limit the clinical specialities and types of work covered i.e. by making insurance cover unaffordable and not in the patient interest, particularly in an environment of an ageing population with co-morbidities.
- Multiple providers would struggle to identify and co-ordinate any issues which impact (or could have impacts) across the NHS, so such issues are dealt with in a consistent and cost-effective manner.
- The NHS LA is ultimately underwritten by the government and, therefore, claims settled by Periodic Payment Orders have the financial security of the government.

Option 6: Local responsibility for delivery of the functions

6.16 Consideration was given to whether the NHS LA's functions could move outside central government and be delivered at a local level by NHS bodies (i.e. the members of the NHS LA's schemes). Prior to the creation of the NHS LA, claims were handled by individual NHS bodies with locally contracted legal support.

6.17 The benefits to having a specialised central management function for claims against NHS bodies include:

- ability to secure consistent and competitive rates from a small number of high quality law firms (the Legal Panel)
- economies of scale from centralising the management of claims against NHS bodies;
- ability to identify and coordinate similar claims from different geographical locations, ensuring such claims are dealt with in a consistent and cost-effective manner

- positioned to bring collective influence to dialogue with other national bodies on potential areas for reform (e.g. clinical negligence costs) and control precedent setting litigation across the NHS.

6.18 Although there is some recognition of the benefits of retaining centralised functions, there are some advantages to introducing greater involvement and control at a local level (see Section 9).

Option 7: Other public sector delivery options

6.19 Consideration was given to delivery of the NHS LA's functions by an Executive Non-Departmental Public Body (ENDPB). The evidence suggests, at this point enabling a new body would be lengthy in terms of time and potentially cost due to the need for primary legislation.

6.20 The possibility of merging the NHS LA with another body was considered. A number of other governmental Arm's Length Bodies (ALBs) have an alignment with the functions of NHS LA and consideration was given to whether there were any natural options for merger or joint enterprise. There are a number of risk pooling schemes across the public sector of varying scope and scale. The review considered the value of NHS LA entering arrangements with other risk pooling schemes, or, forming a hub for the management of risk pooling schemes. It was considered, at this point, there was scope for greater efficiency by NHS LA focusing on providing indemnity cover to providers of NHS care.

6.21 During the course of this review, Scheme members expressed a preference for a single organisation within the 'family' of the NHS, that provided economies of scale, and the flexibility for services to be tailored to member needs.

6.22 The challenge of responding to the health and care system post reform and in particular, the emerging integrated networks for health and care provision represents a challenge that a NHS body can most effectively meet by offering a good quality service for patients, good value for members and over time, reducing the cost to the public purse.

Evidence and consideration of NHS LA delivery model / corporate form

6.23 Consideration was given to the various delivery models for the main NHS LA functions. The review of alternative delivery models did not conclude any would deliver significantly greater benefits than the NHS LA's current Special Health Authority status. Some of the core functions of the NHS LA either required technical expertise or were not commercially motivated. As such, an alternative of moving its functions to the private sector or a different/new part of government could present a risk to the patient and public interest.

6.24 Special Health Authority Status (SpHA) provides a degree of flexibility for NHS LA as well as the Department of Health. The benefit of SpHA status is that the organisation remains within the NHS family (and VAT code). It reflects the nature of the organisation; it is essentially a membership body, and to some extent, a mutual due to the risk pooling schemes as the main models of delivery. The status affords a degree of independence and is particularly appropriate for handling large operational activities relating to the NHS on a national basis. SpHA status also gives Secretary of State the power to direct NHS LA about delivery of its functions, allowing the organisation to be responsive to wider health and care system needs. Recommendation 1 above confirms there should be no change to the NHS LA corporate form.

6.25 In relation to the delivery model, the review concluded that:

- The risk pooling schemes are an effective method of managing the liabilities of NHS bodies

- None of the alternative models considered would deliver significantly greater benefits than the NHS LA's current Special Health Authority status.
- It is very likely that the costs of implementing a different delivery model would outweigh the benefits of doing so.

Stage one conclusion

Consideration was given to the evidence on the need for the functions taking account of the requirement for employer and public liability indemnity/insurance cover, plus the need for the NHS as a publicly funded service to offer fair access to redress where patients or the public have suffered avoidable or negligent harm. On this basis, the review found the functions of NHS LA were needed. On confirmation the functions are still needed, the evidence was considered on the delivery model for the functions.

Consideration of the delivery model was based on the evidence on the changing market environment, including the £26.1 billion provisions and the level of claims growth, and the unique factors impacting on the speed of growth in the clinical negligence market. This, together with the ‘how’ and ‘who’, can take action to address the growth in claims and claims costs, and help frame the consideration of the delivery model.

The financial implications of handling claims for NHS providers should not be underestimated. Individual contributions from NHS organisations are substantial and, for that reason, decisions are best taken by the NHS for the NHS. Special Health Authority status meets that need, being an NHS body, having the confidence of the NHS whilst working at close arm’s length to the Department, albeit still at arm’s length. The NHS LA’s status provides assurance for NHS organisations and the Department that it will ultimately act in the interests of fairness to patients, staff and the public, whilst having regard to protecting the public purse.

Decisions are best taken by the NHS for the NHS and this requires a specific body that can take those decisions with confidence. Special Health Authority Status provides a degree of assurance for both NHS organisations and the Department that the body will act in the interests of patients and the public, whilst having regard to the cost to the public purse.

In considering the various models of delivery, there was no compelling evidence of the benefit of NHS LA functions being delivered outside the public sector, be that in cost savings, other efficiencies or better quality service. The review concluded Special Health Authority status provides the right degree of controls and flexibility for the Department to work with NHS LA to engage others in government and beyond on the immediate action needed to begin to reduce the provisions and drive down the cost of claims.

This review finds Special Health Authority status to be the correct corporate form for delivery of the Schemes and safety and learning functions.

Stage two

With confirmation of the continuing need for the functions and the most appropriate delivery model, the review went on to consider evidence on:

- governance and relationships
- performance and capability
- operational efficiency
- adapting to the challenge.

6. Governance and relationships

Governance of NHS Litigation Authority

- 6.1 Good corporate governance is central to the effective and efficient running of all public bodies. The NHS LA complies with the principles of good governance set out in *Managing Public Money* and as agreed in the Framework Agreement with the Department.
- 6.2 NHS LA has an independent Chair, four other independent non-executive board members, and a complement of executive board members, led by the CEO. The responsibilities of the CEO as Accounting Officer are set out in the Standing Orders. The CEO is directly accountable to Parliament and the public for ensuring proper stewardship of public funds and assets, plus has an accountability line to the Department's Principal Accounting Officer. The CEO is also held to account by the NHS LA Chair for the day-to-day operation and management of NHS LA, and for ensuring the organisation meets the standards required (in terms of governance, decision-making and financial management) set out in *Managing Public Money*.
- 6.3 The Board hold regular meetings, with part open to the public. NHS LA has a unified Board which is appropriate, but there is scope for greater distinction between the Executive Director role and that of the Non-Executive Directors (NEDs). The rolling appointment of NEDs presents the opportunity to continually refresh and strengthen the Board to reflect the current organisational need; however there is a need to ensure strong NHS experience is replaced by similar experience within the NED cohort.
- 6.4 A named NED has specific patient interest remit, a recommendation from the 2011 Industry Review. The role would make a greater impact upon NHS LA operations if there was clear organisational support for the role. Patient interest should usefully inform the development of the safety and learning service and bring insight that could help the NHS LA be more responsive to members.
- 6.5 There is evidence of some disconnect with the operational priorities and culture of the wider health and care system. Whilst this is not necessary for day-to-day decision making on NHS LA business, it does impact on the ability of NHS LA to identify and respond to health and care system challenges or development of system-wide solutions.
- 6.6 This mainly presents itself in the views of members that suggest NHS LA has been detached (see section 7) but the appointment of a new Chair in April 2014 provides an opportunity for further organisational development to address these challenges. NHS LA Board composition will be

Principles of Good Corporate Governance

Good corporate governance is central to the effective operation of all public bodies. As part of the review process, therefore, as an Arm's Length Body (Special Health Authority) of the Department of Health, the governance arrangements in place in NHS LA should be reviewed. As a minimum, the controls, processes and safeguards in place in the ALB should be assessed against the principles and policies set out in this guidance. These reflect best practice in the public and private sectors and, in particular, draw from the principles and approach set out in the **Corporate Governance in Central Government Departments: Code of Good Practice**.

considered in developing a single narrative on the role, purpose and objectives of NHS LA as set out in recommendation 2.

NHS Litigation Authority relationship with the wider health and care system

Member relations

- 6.7 NHS LA is, for its main functions, a membership organisation. Consideration was given to evidence of engagement of members by the CEO. Despite this, a repeated theme of evidence received from members was of limited engagement and a perception of detachment of NHS LA from members.
- 6.8 The tripartite arrangements between NHS LA, the Legal Panel and the member contributes to a perception that NHS LA is less customer focused than commercial alternatives. The perception appears to be borne from some interaction being routed by the Legal Panel, rather than directly from NHS LA. Members suggested a void exists during the claims process and, although there is evidence of some members receiving progress updates from claims handlers, the general view was this was an exception rather than part of any protocol. Steps have been taken to address this through the claims portal and members were positive about the development. In considering member relations, it has to be recognised the continued high volumes of claims will act against claims handlers having the capacity to engage members in the way in which they would prefer. NHS LA would benefit from a stakeholder strategy and member services approach.

Relationship with the Department of Health

- 6.9 The Department is the steward of the system and acts as sponsor for all its arm's length bodies. NHS LA has a senior departmental sponsor who leads the overall departmental sponsor function, with a senior civil servant led team providing day to day sponsorship. Sponsors are supported by sponsorship standards and a sponsor guide, and all sponsors receive induction. The NHS LA relationship is centred on these sponsorship arrangements. There are differing opinions on the relationship with the Department, both from within the NHS LA and DH. As a whole, the Department's general awareness of the NHS LA and the challenges it faces is limited. Responsibility for this lack of understanding does not solely rest with the sponsor team although they could help increase awareness using sponsorship networks.
- 6.10 The senior departmental sponsor relationship is considered a valuable part of the sponsor arrangements and NHS LA consistently reported this role as being demonstrably responsive to the organisation's needs. Consideration was given to whether the senior departmental sponsor could better leverage wider system engagement in NHS LA challenges, observing he is also the sponsor for NHS England, Monitor and the NHS Trust Development Authority so is well placed to use those relationships in support of NHS LA.
- 6.11 There is evidence of a slight disconnect in the stewardship of ALBs in terms of the Department's relationships with the NEDs. ALBs are responsible for the induction of new NEDs, rather than there being a central offer and limited evidence was found of arrangements for Chairs (or other non-executive directors) to systematically feedback on their experiences. Chairs are appraised by the senior departmental sponsor and so there is an opportunity for a degree of feedback to the Department.
- 6.12 The approach of focusing the Department/NHS LA relations through the sponsorship prism reduces the potential for more wide-ranging relationships. NHS LA Chair and other non-executive directors

have engaged in the Department of Health hosted NED events which provide an opportunity to be informed about system wide issues. These events are considered of value however, beyond this, there is limited opportunity for NEDs to systematically feed back into the Department on their experiences and the events are not formal meetings in a way that could help the non-executive community in national health and care system partner organisations to understand the system wide challenge of addressing the £26.1 billion provisions, or agree how best to work together to reduce claims and improve patient safety.

Relationship with other health and care system leaders

- 6.13 There is evidence of NHS LA being slightly adrift from the core national health and care system leader groupings. This results in NHS LA having to work harder to be heard. In strategic and policy development, there is not always recognition of the cost of indemnity cover, and therefore the need to engage NHS LA so cover can be streamlined and provided in the most cost efficient way. Engagement with other national health and care system organisations is not systematic. NHS LA is not a member of a number of fora that would enable collective agreement on local as well as national action to improve patient safety and reduce claims in a sustainable way. The review observed NHS LA structure does not include a designated policy role common in many arm's length bodies; such a role could free up Board member time, allowing them to focus on building national alliances.
- 6.14 The Department, in its role of system steward, has the opportunity to better support the challenges faced by NHS LA to slow claims growth and address the outstanding provisions by providing space at national fora to engage other leaders on the issues. The review observed NHS LA are not members of the health and care system leaders' forum or the associated common purpose activities and believe there would be value in the Department extending an invitation to NHS LA.

Responding to a changing health and care system

- 6.15 The 2014 NHS Five Year Forward View set the direction for a more integrated health and care system in England. This changing, integrated health and care landscape will be underpinned by pooled funding streams.
- 6.16 The new, locally determined models of care that will emerge across traditional boundaries acting as networks of care, rather than single organisations, will remove the boundaries that allow for fixed oversight and management of the negligence schemes. The potential risk to the health and care system is one of poor value indemnity or cover that is restrictive to practice, inadequate or inappropriate. In addition, there is the challenge of overlapping indemnity and gaps in indemnity cover.
- 6.17 The reality of integration presents both a challenge and an opportunity for the NHS LA. The NHS LA are well placed to bring technical expertise to this changing system and will need to ensure in-house and member claims teams, together with the Legal Panel, are appropriately prepared for an initial upsurge in co-litigation. The Department are well placed to ensure NHS LA are gaining cross-system buy-in to the need for, and efficiency of, appropriate and streamlined indemnity or insurance cover for the new integrated entities.
- 6.18 In considering the evidence, an observation was made that, without clear accountable or corporate body for the emerging local networks, there is a need for member's involvement as innovations are designed.

It is recommended that:

- ***The Department should support NHS LA to consider and take account of the impact of health and social care integration on indemnity cover and by 31 October 2015, identify what additional flexibilities are needed to NHS LA functions so they can provide services across the new models of care described in the NHS Five Year Forward View. [Recommendation 6]***

7. Performance and capability

Operational performance

- 7.1 The NHS LA is well led and operationally efficient. Since 2011, the NHS LA has taken forward a number of change programmes aimed at strengthening operational performance. Resource has been invested in developing a comprehensive system for measuring and assuring performance at each level of the organisation through a series of local KPIs.
- 7.2 There is a systematic process for reporting operational performance through to the Board, and the indicators contribute to how the Board draws its assurance on performance.
- 7.3 The NHS LA operates to a comprehensive set of indicators which are underpinned by local claims team metrics, with a wider range of indicators drawn from across the organisation covering all aspects of NHS LA work. For claims functions within NHS LA and the Legal Panel, this is supplemented by sample testing or 'internal audits' of claims files. The results of the audit are fed back to claims handlers and team leaders; there is scope for sharing the learning from these audits with members.



Figure 8: Claims closed (all) 2013/2014

- 7.4 The 2011 Industry Review was able to draw comparisons on the non-clinical employer and public liability indemnity schemes, drawing comparisons with insurers and loss adjusters to suggest an optimum caseload of 250 cases. NHS LA is currently averaging 348 claims per claims handler. The NHS LA has made progress in reducing the number of clinical claims managed per handler; however delays in recruitment and the increasing number of claims have prevented the NHS LA fully achieving this objective.
- 7.5 There would be benefit in improving consistency and quality through introducing a broader quality indicator.
- 7.6 The overall good staff retention rate during the period of increasing claims volumes was noted as being helpful in maintaining good operational efficiency.

It is recommended:

- ***Following this review and by 31 October 2015, the NHS LA Board should develop and agree with the Department a set of Key Performance Indicators (KPIs) which are a balance between quantitative and qualitative metrics – qualitative metrics should include regular member satisfaction surveys. [Recommendation 3]***

Safety and learning service

Learning from claims

- 7.7 A primary role of the safety and learning service will be to support members in learning from claims, identifying areas for local improvement, improving patient, staff and visitor safety, and acting to reduce avoidable harm.
- 7.8 At the time of the review, the safety and learning service was still being developed as a replacement to the risk management standards assessment process. It currently offers members:
- information and analysis of organisation claims via the extranet
 - a library of best practice guidance including case studies
 - snapshot analysis of national claims
 - thematic guidance
 - development of local networks.
- 7.9 There is evidence of further work, in the planning stages, including root cause analysis of high risk areas such as maternity and surgery, development of further networks, and a newsletter.
- 7.10 Claims data can be used as an indicator of risk in an individual organisation or, taken collectively, can show patterns of risk across the provider landscape and thus may be used to identify more systematic issues. Whilst there are some limits on the use of claims data (with, typically, significant time lags between incidents and resolution) there is real potential for greater use of closed claims data for learning.
- 7.11 NHS LA has nearly 20 years' worth of claims data most, likely representing one of the most comprehensive claims databases available in any sector. This could, potentially, be mined more rigorously to provide a better analysis of the contributory and root cause of incidents leading to claims. Through the safety and learning leads, work has begun to systematically feedback organisation level claims data, but further investment and more proactive and systematic engagement with members and external information experts would represent a step change. As part of this, the safety and learning function could also act as a conduit for sharing analysis and best practice amongst members.
- 7.12 The sharing of learning is important to helping reduce the root cause of claims by improving patient, staff and public safety. NHS LA has analysed the higher value cases settled by court approved periodical payment orders over a ten year period to identify the most common causes. It was found the most frequent cause of the most costly and arguably the highest human impact harm was brain damage suffered by babies during delivery. This usually results in cerebral palsy. The analysis identified the most frequent cause of this harm is failure to effectively monitor and/or appropriately

respond to a change in fetal heart rate. If the NHS were to invest specifically in fetal heart rate monitoring and training, there is potential to significantly reduce the number of those harmed.

Electronic fetal monitoring (EFM) is when the healthcare practitioner uses a Doppler ultrasound machine to monitor the baby's heart rate while simultaneously using a pressure sensor to monitor the mother's contractions. Both of these sensors are linked to a recording machine, which shows a print-out or computer screen of the baby's heart rate and the mother's contractions. There are 2 types of EFM: continuous and intermittent. However, just because the monitoring is continuous does not mean that a clinician is continuously watching the monitor. Most of the time, a clinician determines and evaluates the fetal heart rate every 30 minutes during the active stage of first stage labour (when the mother is dilated 5-10 cm) and every 15 minutes during the active pushing phase of labour. However, if the mother is high risk, or if she is being induced, then this may be done more frequently. Intermittent electronic fetal monitoring generally means that you have to wear the machine sensors for 20-30 minutes of every hour.

Intermittent auscultation is when the healthcare practitioner listens to the baby's heart rate for about 60 seconds using a fetal stethoscope (fetoscope or Pinard) or a hand-held Doppler ultrasound device. While listening, the healthcare practitioner also palpates the mother's contractions by placing a hand on the abdomen. Most guidelines agree that intermittent auscultation should be done every 15-30 minutes during the active phase of the first stage of labour (from 5-10 cm dilation) and every 5-15 minutes during the pushing phase of the second stage of labour.

What is the purpose of using these tests?

The purpose of monitoring the baby's heart rate during labour is to identify oxygen problems in the baby so that the healthcare practitioner can intervene and prevent complications such as cerebral palsy, brain damage, newborn seizures, or death.

Table 2: Explanation of electronic foetal monitoring (see also NICE guidance on the use of electronic fetal monitoring)

- 7.13 The extranet is a major NHS LA development, providing all members with access to data and some limited benchmarking data. By turning claims data into more widely available information NHS LA could support valuable local learning, identify national trends and, in turn, improve patient safety and care, potentially incentivising the reducing of incidents of avoidable harm.
- 7.14 Members were keen to make the data more accessible in a form that would allow a wider range of people, including clinicians, to have conversations about reducing harm at local level. There would be benefit in NHS LA developing a pilot data project, with relevant health and care system partners, to match claims data with incident and complaints to identify trends, improve learning and ultimately improve patient safety and avoid harm. There are however barriers to increased data sharing by the NHS LA, and any project would need to be preceded by examination by the Department as to how these might be reduced.

Barriers to exit

- 7.15 The 2011 Industry Review recommended that exit barriers to the Clinical Negligence Scheme for Trusts (CNST) should be reviewed to allow greater competition from commercial insurers.
- 7.16 The most significant consideration for a trust is the financial implication on exit, arising from the type of indemnity scheme operated at NHS LA.
- 7.17 The CNST operates as a risk pool, with the contribution levels for trusts being calculated on a 'claims paid' basis rather than 'claims made' as would be the case with commercial insurers. With the 'claims paid' scheme, the claims are paid by the scheme on behalf of the trust if the trust is a member of the scheme, both when the incident occurred and the claim paid. However, with a "claims made" scheme, the claim is paid on behalf of the member if they are a member of the

scheme when the incident occurred and is reported. The settlement date of the claim is not a factor with the commercial model.

- 7.18 As a result of this difference, the members of the CNST scheme have not yet contributed to the costs of claims yet to be settled. These future costs relate to the payments yet to be made on incidents which have already been notified to the NHS LA, in addition to payments which are reasonably expected to be incurred from incidents which have occurred during the period of cover, but have not yet been reported.
- 7.19 For any trust leaving the CNST, these future claims are potentially significant. They would need to be accounted for within their accounts, and would need to be funded.
- 7.20 There are a number of potential options available to trusts. For example, these liabilities could be paid in full as a lump sum payment on exit, or run-off cover could be arranged to administer and pay future claims. Both of these options could have significant affordability implications on trust finances.
- 7.21 Another available option for reducing exit barriers would be for the NHS LA to alter the scheme type to 'claims made', and align with the commercial insurers. Again, the future claims of the whole scheme would need to be funded. With total NHS LA provisions amounting to £26.1 billion as at 31 March 2014, this option is not practical. See also Section 8.
- 7.22 A second area considered by NHS LA in reducing the barriers to exit is in regards to the notice period which is required to be given by members. Members have previously needed to provide the NHS LA with 12 months' notice of their intention to leave the scheme. Following on from the 2011 Industry Review, changes have been made and the notice period has now been reduced to seven months.
- 7.23 Whilst NHS LA have made improvements in this area with both the notice period and the flexibility of arrangements available for funding exit liabilities, the most significant barrier remains. As detailed in Section 8 of this report, the funding mechanism for the NHS LA results in a significant value of unfunded liabilities. If the current market trends continue and the funding mechanism remains unchanged, the cost of exiting the scheme will continue to increase and be prohibitive.
- 7.24 As there was separate detailed work on the pricing methodology being undertaken during the course of this review, this report makes no recommendations on this area.

Member views

- 7.25 In addition to routine claims management dialogue, there was evidence of NHS LA engagement of Scheme members both face-to-face and, more routinely through the extranet. However, there is mixed opinion on how involved and engaged members are at the 'ground level' e.g. claims and risk management teams.
- 7.26 There was universal acknowledgement of the expertise within NHS LA, particularly that within the Technical Claims Unit. Day-to-day relationships between members and NHS LA focused on routine claims management interactions with some early, limited engagement with the safety and learning leads.
- 7.27 The safety and learning team are making significant inroads into building more direct bridges to members which should support a greater sense of connection. However, there is only limited evidence of a strategic approach to this, and the potential for these relationships to drive

engagement in a broader sense does not yet seem to have been fully explored. Whilst there is evidence of members being surveyed, both NHS LA and members would likely benefit if a more systematic approach were adopted; the potential for this forming part of NHS LA performance metrics is outlined above.

- 7.28 More generally, members were unable to identify how members are able to routinely feedback on the NHS LA offer, or for involvement in significant decision making – for example the removal of the standards and assessment process. However, it is noted that the NHS LA undertook an extensive customer survey at this time to explore member views both at claims/risk manager and board level on the standards and assessment process.
- 7.29 In addition, during 2012/2013 the NHS LA commissioned its Scheme managers, Det Norske Veritas, to review the viability of the risk management standards and assessment approach, reviewing and mapping the standards against other health care standards and accreditation systems. The 2012/2013 review concluded there was benefit in replacing the pricing structure which provided discounts for risk management as determined by the standards and assessments, with a simpler, more explicit claims history based pricing model. The aim of this change was to encourage members to focus on reducing claims and to use learning from claims to identify areas to improve patient and staff safety and reduce avoidable harm.
- 7.30 Consideration has been given to both the rationale for this move and the approach, finding evidence that, despite NHS LA's engagement efforts (including a member survey and presentations around the country by the NHS LA senior team) some members did not feel included or engaged in the decision making process and/or did not understand the full implications of the changes or the way the changes would take effect, prior to their being implemented. The introduction of the changes also meant some members felt financially disadvantaged both due to the investment made in the risk process to secure discounts that were attached as part of the past pricing model, as well as the effect of a model of pricing based only on claims history risk.
- 7.31 There was evidence of a culture of 'separateness' between the local environment where risks are realised or managed, and the NHS LA. Collaborative working and the exploitation of the expertise and experience held within the membership base will be essential if the health and care system is to drive down claims and fully achieve the ambition for improving patient safety and reducing avoidable harm.
- 7.32 These observations suggest a need for NHS LA to refocus on relationships with members as a way of improving quality. There would be value in NHS LA developing a strategy for engaging members and other stakeholders more systematically at all levels.

Policy support

- 7.33 NHS LA is engaged in a number of health and care specific policy developments. Consideration was given to this work, particularly the work flowing from the Dalton and Williams Review, in the form of the Duty of Candour and the Secretary of State initiated, cross-cutting 'Sign Up to Safety' campaign.
- 7.34 Although these high profile policy activities are considered an appropriate and valid use of NHS LA's expertise, the review observed there was scope for the Department to better plan for NHS LA involvement in policy and programme development. The Departmental sponsor team should work

with NHS LA to ensure draws on NHS LA resource are managed and planned appropriately so as not to distract from operational activities.

7.35 NHS LA are called on to provide ad hoc information or support for policy development; this is potentially powerful in raising the NHS LA profile and building networks across the Department and, in the course of this line of enquiry, the review received positive feedback on NHS LA's involvements.

It is recommended:

- ***NHS LA supported by the Department should establish a data project by 31 December 2015 in partnership with scheme members and information experts to develop ways of improving the quality, analysis and access to claims data. Particular focus should be given to the viability of matching claims data with complaints and incident data. [Recommendation 9]***

8. Efficiency

Use of resources

- 8.1 Overall, NHS LA is an operationally efficient, well led and run organisation. The review has considered wide evidence from NHS LA, comparators and member and stakeholders on the administrative and wider efficiencies within NHS LA.
- 8.2 The average administrative cost of managing a claim has reduced to £406 per claim in 2013/2014, with administration spend being 0.89% of the total claims expenditure. With operational costs being such small parts of the overall spend, the focus of this review has not been on the administrative efficiency of NHS LA but rather the wider opportunities to reduce costs and respond to the ever evolving health and care system.

Scheme budget and accounting

- 8.3 The NHS LA schemes CNST, covering clinical claims, LTPS and PES, for non-clinical claims, are all run on a 'claims paid' basis. The costs of meeting claims are met through the contributions on a pay-as-you-go basis.
- 8.4 Figure 9 shows the contributions collected from members over the past five years from 2009/2010 to 2013/2014:

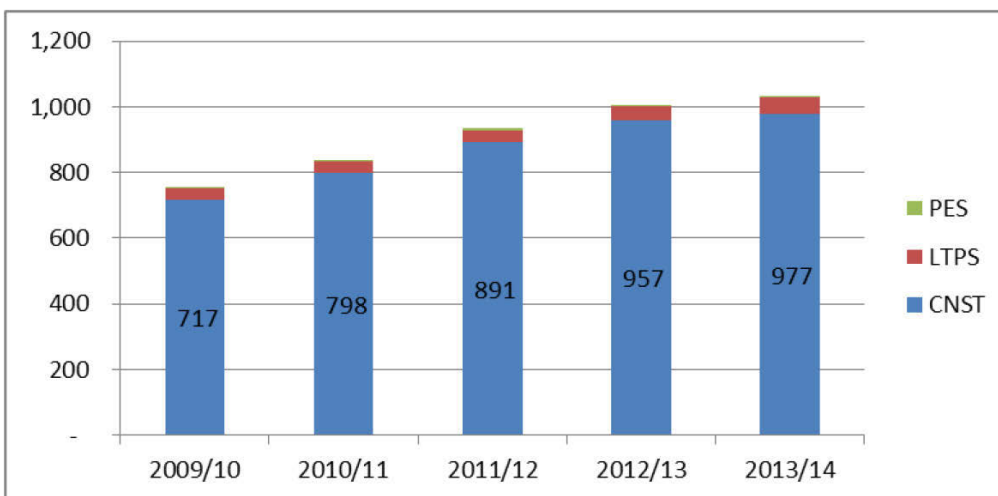


Figure 9: Contributions collected by NHS LA (£'m)

8.5 The claims paid by NHS LA over the same period are shown in Figure 10 below:

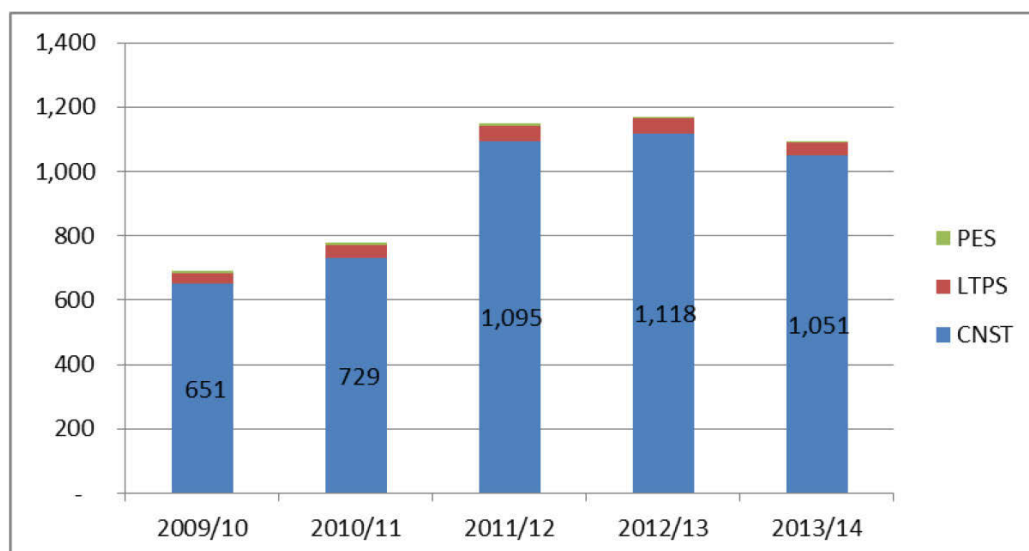


Figure 10: Claims paid by NHS LA – CNST/LTPS/PES (£'m)

8.6 And the growth in the provisions for claims arising in these schemes is shown in Figure 11:

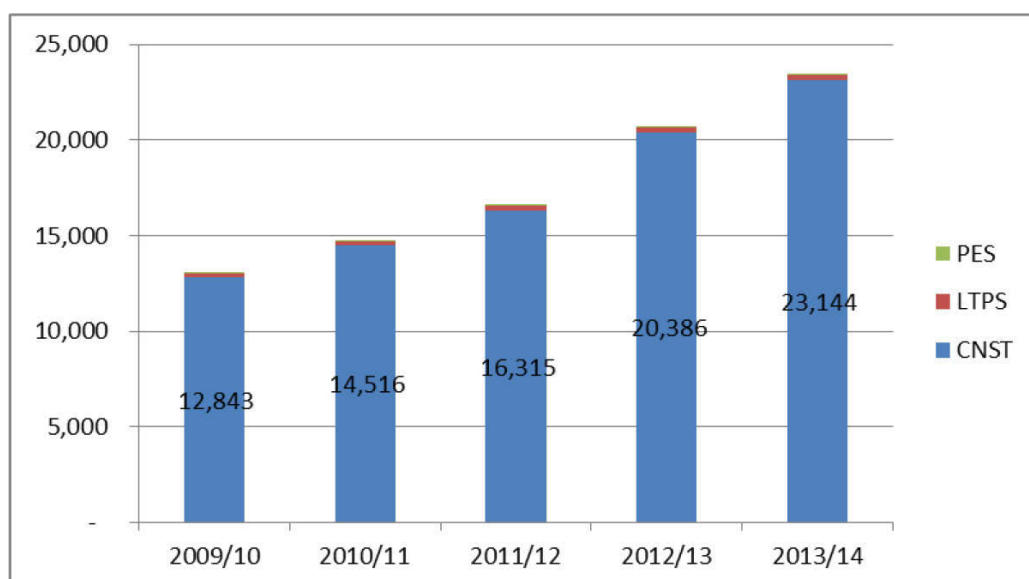


Figure 11: Provision for known claims and IBNR - CNST/LTPS/PES (£'m)

8.7 Over the period 2009/2010 to 2013/2014, the overall CNST provisions have increased by 80% from £12.8 billion to £23.1 billion. The most significant element of this provision relates to the estimated value of claims incurred but not yet reported (IBNR). This element reflects the fact that there is a time delay between an incident occurring which will give rise to a claim, and that claim being reported. Due to the nature of clinical negligence claims, in some cases this delay may be many years. As NHS LA are not yet aware of these claims, actuarial assumptions and judgements are

used to estimate the value of the projected future payments arising from such incidents in each year. This provision for IBNR over the same period rose from £8.2 billion to £14.6 billion.

- 8.8 Section 5 of the report highlights the pressures which the NHS LA faces under the current market and legal environments. All indications are that both the volumes and costs of claims will continue to rise in the current environment. Under current circumstances this will result in ever higher provisions to be recorded by NHS LA.
- 8.9 Under the current accounting arrangements, the schemes operate on a pay-as-you-go basis. The total amount to be collected from members is estimated to cover expected payments in the following year. Under these arrangements claims payments for future years will remain unfunded, and the contributions collected in future years will need to increase accordingly.
- 8.10 Consideration has been given to whether the current accounting arrangements are appropriate, and whether the NHS LA could change from a 'claims paid' to a 'claims made' basis. As previously noted (Section 6), the main impact of this change would be the need to fund the liability for future claims, which currently totals £23.1 billion for CNST/LTPS/PES (see Figure 11). Taking into account all schemes, the total provision for known claims and IBNR was £26.1 billion at 31 March 2014.
- 8.11 There are obvious cost implications to this option. In addition to the issue of funding the current claims provision of £26.1 billion, future contributions from all members would need to increase. Under a 'claims made' scheme the contributions collected each year would not only cover the expected cost of payments in the forthcoming year, but also include a contribution for future expected claims. Under the principles of Managing Public Money it is not considered good value for money to pay for services in advance of need. This would divert resources from current priorities, with the additional contributions held in reserve for future claims.
- 8.12 Although the current claims environment is resulting in significant increases to the provisions for known claims and IBNR, and the current pattern will see significant increases in member contributions, changing to a 'claims made' scheme does not appear to be an affordable option.

Tendering and contract efficiencies

- 8.13 At the time when the 2011 Industry review was conducted, the current scheme actuaries had been in place since 1995, although NHS LA had undertaken retendering processes during this time. Subsequently NHS LA has retendered this contract and the Government Actuaries Department (GAD) has been appointed as the new actuaries, with effect from June 2014.
- 8.14 Also, the NHS LA has undertaken a tender process for the procurement of legal services. This has led to a central contract being available from May 2013, with beneficial rates and value added services. It is noted that this new framework is also available to the Department and its ALBs and was a finalist for a National Procurement award
- 8.15 The performance of the legal panel is monitored via a comprehensive set of performance indicators on a monthly basis.

Claims efficiencies

- 8.16 The NHS LA indemnifies the NHS in England. Changes have been made to the regulations so that from April 2013 independent sector organisations providing NHS care may also join.
- 8.17 As shown previously, the environment in which NHS LA is operating has changed rapidly in recent years. The last five years has seen a large growth in the number of claims and significant rises in costs.

8.18 The figures below illustrate this:

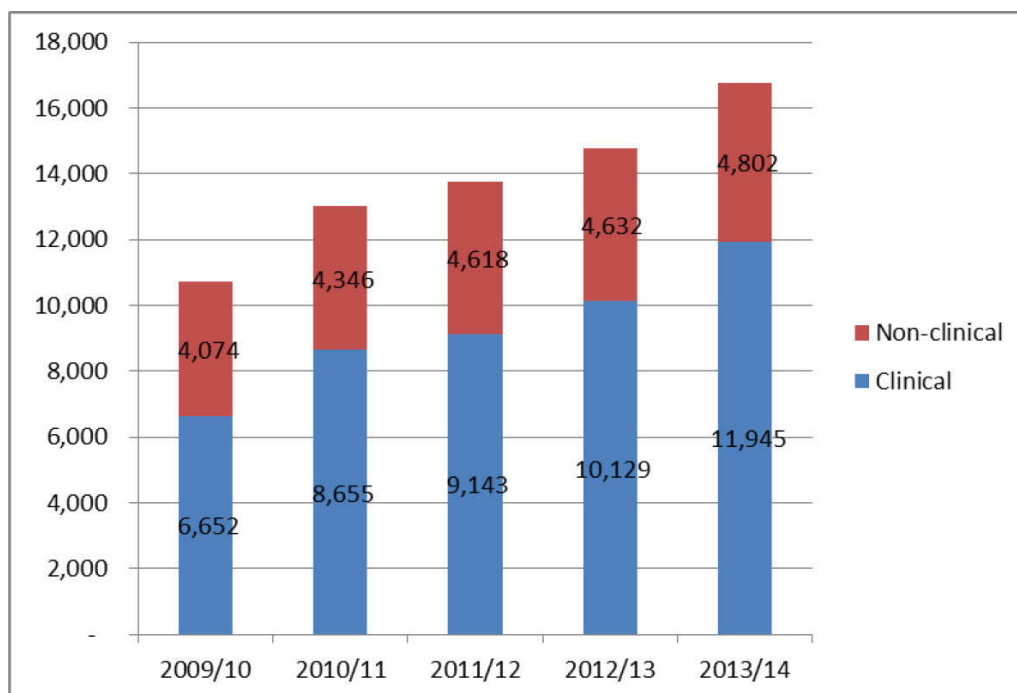


Figure 12: Claims volumes - reported in year (number)

8.19 Whilst the volumes of non-clinical claims have increased by 17.8 % to 4,802 in the last five years, there has been a corresponding increase of 80% in the number of clinical claims reported to NHS LA, with 11,945 clinical claims reported in 2013/2014.

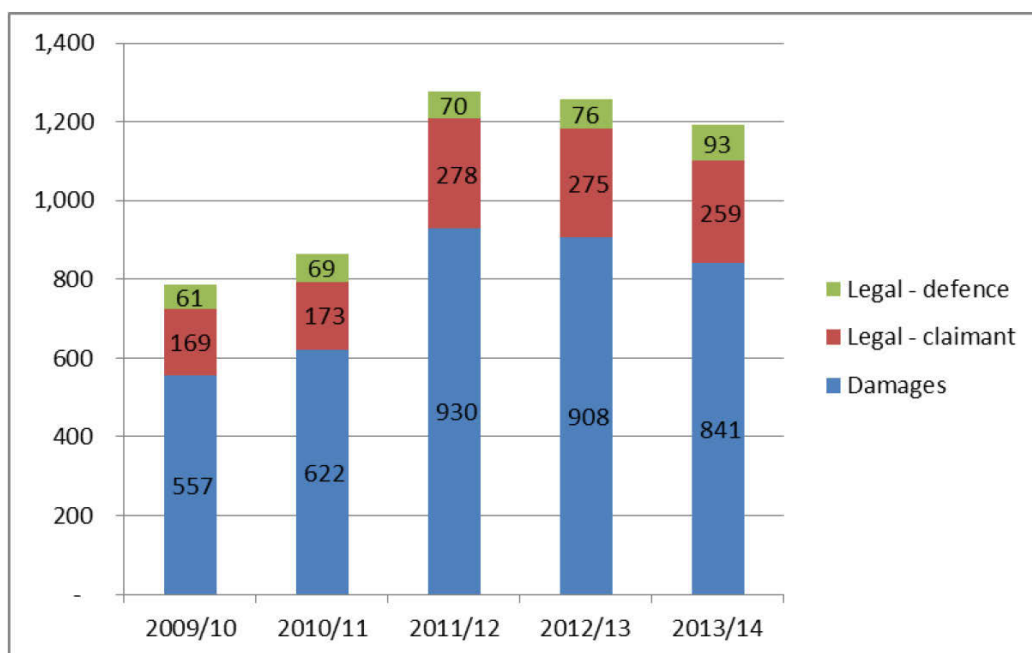


Figure 13: Clinical Negligence Expenditure - CNST/ELS/Ex-RHA/DH Clinical (£'m)

8.20 There were a number of recommendations made by the 2011 Industry Review in relation to claims efficiencies within NHS LA:

Team structures and caseload

- 8.21 There are two main claims teams within NHS LA headed by the Director of Claims, dealing with clinical or non-clinical claims. In addition, there is a Technical Claims Unit (TCU) which supports these teams with high level technical assistance. [Organisation charts are set out in Annex C].
- 8.22 The 2011 Industry Review recommended an optimum caseload per case handler was 250. This was to avoid inconsistencies in service level and the unnecessary transfer of work to Panel solicitors. Measures have been taken to address this, but progress to reduce volumes has been constrained by claims growth.
- 8.23 To address the additional pressures, NHS LA has recruited to the clinical claims teams with a view to expanding the teams further, to reduce the caseload to 250. NHS LA has been operating a flexible approach to case management, developing a mixed clinical and non-clinical team.

Claims settlement culture

- 8.24 The context within which NHS LA operates, as outlined above, is one of increasing numbers of claims, increasing awards from damages and increasing claimant legal costs.
- 8.25 The decision points on a claim pathway are many and complex, and all affect the overall outcome and potential total costs.
- 8.26 The current claims key performance indicators (KPIs) are a mixture of measures that do recognise handling claims in a timely matter is cost efficient. However, there is potential for revisiting the KPIs with a view to claims cost reduction and inclusion of a broader range of qualitative metrics supported by greater member input to performance measures. Best practice should be shared amongst teams to promote best outcomes. This could include 'softer' measures such as member satisfaction with services; reporting of recommendations that are explored in Section 7. There might also be benefit in internal benchmarking of claims teams to support both learning and consistency.
- 8.27 Examples of where NHS LA is working to achieve efficiencies include reducing the proportion of claims which lead to payment by defending claims which lack merit. In 2013/14, 44% of clinical claims were dealt with by NHS LA with no payment made for damages. NHS LA also regularly challenges claimant solicitor costs. This has resulted in savings, with some costs being settled at around 50% of original value.

Shared services

- 8.28 The central government approach is to implement a shared service solution to drive efficiencies and enable savings across back office functions. Managing NHS LA operational costs can provide only limited efficiency savings compared to the overall spend on litigation; there has been demonstrable commitment to the principles of shared services including shared buildings, use of health and care system internal audit functions, transferring actuarial services to the Government Actuaries Department, and the advantageous rates negotiated through the Legal Panel contract arrangements have been made available to other health and care national system partners.

Fraud error and debt

- 8.29 NHS LA have invested in fraud protocols and training. Led by the TCU, all claims teams receive fraud training. It is widely recognised there is greater scope for fraud in LTPS, particularly employer and public liability, and patterns of claims are being identified using emerging techniques and technology.
- 8.30 NHS LA has been subject to a wider assessment of its fraud and losses arrangements through the Department's Assurance Division and NHS Protect. This comprehensive process of assurance will report shortly after this review concludes.

Economies of scale – class action efficiencies

- 8.31 As the NHS LA is a central body which indemnifies the NHS in England, they are in a strong position to identify any national trends and cases which may develop into class actions (group claims). The TCU oversees all of these cases which are, by their nature, high profile.
- 8.32 There are a number of benefits to undertaking class actions; these include streamlining the claims process which results in administrative efficiencies. Also, agreeing protocols with claimant firms can result in financial savings in the areas of fees and damages. This use of Alternative Dispute Resolution (ADR) has many benefits, and the 2011 Industry Review recognised that the NHS LA's use of ADR for managing complex group claims is a good example of where the NHS LA adds value to the NHS.

Commercialisation and increasing revenues

- 8.33 The Review considered how the NHS LA could take full advantage of commercial opportunities in order to increase its revenues.

Increasing membership

- 8.34 Since revised regulations on CNST came into effect in April 2013, over 50 independent sector providers have joined CNST. The Review identified the wider benefit of this and suggests NHS LA continue to encourage new independent sector providers of NHS care to join CNST.

Running other public sector risk pooling schemes

- 8.35 The NHS LA is widely recognised as having considerable technical expertise in running risk pooling schemes and handling claims.
- 8.36 There are a number of other risk pooling schemes in the public sector of varying size and scope. Given its expertise and long experience, the NHS LA could bid for and, if successful in any competitive tender process, run other risk pooling schemes, potentially becoming a hub for the management of such schemes across the public sector. The NHS LA could, in running other risk pooling schemes and handling claims, significantly increase its revenues. This could result in wider benefits, creating economies of scale across the public sector and also bringing the NHS LA's expertise to other parts of the public sector.
- 8.37 The review concluded that, while it would be technically possible for the NHS LA to run other risk pooling schemes and thereby generate additional revenues, there is a risk that the NHS LA would lose focus. Indeed, a significant minority of members have expressed concern that any diversification of the NHS LA's functions could reduce the quality of its NHS-focused risk pooling schemes.

8.38 The Review suggests that the option of running other risk pooling schemes should be kept under review by the Department of Health and the NHS LA in consultation with members of the NHS LA's schemes.

Patient safety services

- 8.39 The NHS LA's Safety and Learning service commenced operation during 2014. The service replaces, in part, the standards and assessment approach to reducing avoidable harm by investigating and analysing claims to discover how and when things have gone wrong, thereby identifying areas for patient safety improvement. The service seeks to help members learn from claims and reduce harm to patients by providing them with information, analysis and practical support, including via the safety and learning library on the NHS LA's Extranet. The NHS LA's Safety and Learning Team of experts were recruited in 2014.
- 8.40 The review considers that these patient safety services represent an unexploited commercial opportunity; the NHS LA could generate revenue from these patient safety services with interest in purchasing such services potentially coming from, amongst others, private healthcare providers. The Review observes NHS LA could, subject to direction from the Department, explore opportunities to generate revenues from these patient safety services and, longer term, there is an opportunity for NHS LA to develop commercial opportunities as part of these functions.

Benchmarking and other comparator data

- 8.41 The 2011 Industry report undertook extensive benchmarking of NHS LA operational performance. At the time, that was right and proper in order to challenge NHS LA on its efficiency and value for money compared to other providers of indemnity services. That report concluded that risk pooling was a valid concept and the NHS LA performance was comparable to others in the indemnity and insurance services. As a result, this report does not seek to re-visit the detail of the 2011 report, although there has been some verification of action against the recommendations at that point. In June 2014, NHS LA produced its own report of progress as part of its annual account and reports, and three year plan package.
- 8.42 In seeking to benchmark NHS LA wider performance, we have asked what is the purpose of comparing performance and how can it help NHS LA going forward? We have considered a range of evidence drawn from NHS LA, Legal Panel and Scheme members on how quickly NHS LA makes financial redress to resolve meritorious claims, taking account of a point of how NHS LA provides fair access to justice balanced against wider management of the public purse.
- 8.43 The Review has considered benchmarking the NHS LA's management of the schemes against appropriate peers and comparators.

Clinical claims

- 8.44 NHS LA provides indemnity cover for clinical claims to every NHS Trust in England and is in a unique position in terms of its size and the extent of the coverage it provides to its members. It is difficult for the NHS LA to benchmark its management of clinical claims against similar organisations in terms of complexity of case mix and scale.

- 8.45 Notwithstanding this difficulty, there is scope for the NHS LA to benchmark one of its core functions, namely the procurement and management of legal services. In 2013/2014, the NHS LA's clinical negligence expenditure on Defence legal costs amounted to approximately £92.5 million for claims closed in 2013/2014¹; the NHS LA, therefore, manages a significant amount of legal services.
- 8.46 There are a number of other organisations that, likewise, procure and manage considerable amounts of legal services including those operating specifically in the area of clinical negligence (e.g. Medical Defence Organisations) and those operating in other sectors (e.g. commercial insurers).
- 8.47 The Review recognises the achievements of the NHS LA in achieving value for money in its spend on legal services through the last legal panel tender exercise, described above in Tendering and Contract efficiencies.
- 8.48 Nonetheless, there is scope for NHS LA to assess how other organisations procure and manage legal services and NHS LA should consider whether such benchmarking would be of use.
- 8.49 The Review also noted that the pricing of the NHS LA's indemnity cover is significantly cheaper than the price offered on the commercial insurance market. Foundation Trusts may elect to leave CNST and obtain cover on the commercial insurance market. The price differential between the NHS LA and the commercial insurance market remains a key factor behind the NHS LA's retention of its NHS members.

Non-clinical claims

- 8.50 The 2011 Industry Review compared the LTPS offered by the NHS LA against its database of Employers Liability claims and Public Liability claims². In 2013/2014, the NHS LA made around £40.2 million in payments in respect of LTPS; this contrasts with total payments made by NHS LA for CNST in 2013/2014 of around £1,192.5 million³.
- 8.51 The 2011 Industry review Report⁴ indicated that:
- NHS LA LTPS claims were not being closed as quickly as the benchmark (this could potentially have a negative impact on claims costs overall)
 - The average paid values and average total costs of the NHS LA LTPS claims were higher than the benchmark.
- 8.52 The Review recognised that the benchmark data used in the 2011 Industry Report could have been based on comparators which had a substantially lower risk profile than the members of the NHS LA's LTPS; therefore, the benchmarking findings in respect of the NHS LA's LTPS claims should be treated with a degree of caution.
- 8.53 In any event, since 2011 there has been improvement in the performance of the NHS LA in respect of LTPS claims, in at least one of the areas flagged in the 2011 Industry Report. The Review suggests that the NHS LA should continue to monitor its performance against these areas.

¹ See the NHS LA Annual Report and Accounts 2013/2014.

² As set out on page 24 of the 2011 NHS LA Industry Report (April 2011), the benchmark data used in the Marsh Report reflected "the claims profiles of UK companies for Employers Liability, and UK and European companies for Public Liability (with the majority being UK based)".

³ See NHS LA Annual Report 2013/2014.

⁴ Pages 24 to 27, 2011 Industry Review of the NHS LA Report (April 2011).

9. Adapting to the challenge

Addressing the regulatory and policy challenge

- 9.1 NHS LA, as a special health authority, delivers to a policy framework owned elsewhere. It is subject to regulatory powers and legal imperatives set by the Department of Health, the Ministry of Justice and others. These act as both enablers and constraints to the potential for wider efficiencies in the claims environment.
- 9.2 NHS LA has to balance the provision of fair access to justice and protecting the public purse in the course of carrying out its functions. The current market environment is one of continued claims growth, disproportionate claimant costs and a growing number of providers of claimant services entering the clinical negligence arena.
- 9.3 NHS LA and other indemnity organisations, particularly the medical defence organisations, have already undertaken analysis of the specific drivers of increasing claimant costs and how these can be managed. Action is needed to address both claims growth and growing costs of litigation.
- 9.4 The Department is well placed to engage and facilitate discussion with a range of stakeholders impacted by the claims regulatory framework, as well as the owners of that framework. With that in mind, the Department should take a lead with the NHS LA in instigating a review with a view to further action.
- 9.5 This review of the options around claimant costs should also consider the long term affordability of damages levels. To do this, the Department should support NHS LA dialogue with Ministry of Justice and other partners in considering options that contribute to the overall cost of litigation.
- 9.6 Evidence suggests there is scope for action to include:
 - Mandatory fixed costs for clinical negligence claims (with damages up to £100,000) – the framework for recovery of costs could be fixed for claims between £1,000 and £100,000. There is an increasing disparity between defence and claimant legal costs as well as a growing disparity between claimant costs and level of damages, set out in figure 4 in Section 4. A fixed cost recovery scheme has potential to reduce the costs to the NHS budget⁵.
 - Increase in the court discount rate – the current discount rate of 2.5% was set in 2001 but has been subject to consultations since. The rate is based on an assumption claimants would invest in Index Linked Government Stocks (ILGS) producing an annual return of 2.5%. In practice, many claimants have invested in a mixed portfolio of equities. An increase in the discount rate of 0.5% could reduce not only annual costs to the NHS, but would also reduce the level of provisions. Any such proposal would need to be discussed with the Ministry of Justice as the discount rate is set by the Lord Chancellor and is governed by a strict legal framework.
 - Removing recovery of After the Event Insurance costs from clinical negligence claims – non-clinical personal injury claimants can no longer recover ATE insurance costs from defendants whereas, currently, the costs of expert reports on liability and quantum for

⁵ NHS LA estimates (2013)

clinical negligence claims can be recovered from the defendant. Removing the recoverability of ATE premiums in clinical negligence cases could reduce costs to the NHS, bringing clinical negligence claims in line with non-clinical claims. An alternative to complete removal might be to limit the costs of reports to the rates used by Ministry of Justice in publicly funded cases.

- Changing the assessment of long term care – the basis of large settlements could be modified to reflect the reality of long term care. Assessments of awards to settle long term, lifetime care, could be undertaken on a more systematic basis, for example using local authority or clinical commissioning group eligibility assessments of the level of care, rather than by independent experts. Such a move would make the assessment more transparent whilst allowing courts to take into account the most up-to-date practice, remove the adversarial nature of litigation from the process, and allow the Courts to be guided by a more consistent assessment of care needs. Care could also be commissioned through the clinical commissioning group or local authority to assist the claimant in identifying a reputable care provider. This would improve quality and transparency, and has the potential to reduce costs.

9.7 Additional action can be taken to address both claims growth and cost at local level, and is outlined in this review. This could include:

- learning from claims data, including the root cause of avoidable harm resulting in claims
- a review of any unintended consequences of regulatory changes eg LASPO
- considering the role of local control through mediation, voluntary excesses and/or delegated authority limits
- lead action to improve public awareness of the consequences of claims growth.

It is recommended:

- ***By 31 October 2015 the Department of Health reviews options to appropriately limit claimant legal costs. In particular, the Department should consider how it can work with NHS LA, Ministry of Justice and others in government to review the potential to introduce fixed costs for clinical negligence, and the recoverability of After the Event Insurance costs from NHS LA. [Recommendation 4]***
- ***Further work should be led by the Department with the NHS LA, Ministry of Justice and others in government, by 31 January 2016, on the level of settlements to identify the main items which would lead to more effective and equitable awards. [Recommendation 5]***

Increasing local accountability

9.8 The review has also considered new delivery models in support of the main risk pooling schemes.

Raising public awareness

- 9.9 Investing in public facing information, in partnership with members, could enable NHS LA to raise awareness and engage the public in a conversation on the cost and funding of litigation in the health sector.
- 9.10 The review received evidence about an increasingly litigious society, of a current and past correlation between personal injury claims growth and economic downturn. Consideration was given to a range of information publicly available identifying examples of how and when the public could make a claim against a NHS organisation. There was no evidence of equivalent information within the public domain that sets out the impact and consequences of claims on the NHS.
- 9.11 There is a gap in knowledge and perception about the reality of the cost of claims and how claims are funded. There is no publicly available information that highlights the consequences of claims on local NHS budgets. That is not to deter those patients and the public with claims that have merit but, as set out in Stage 1, there is now a more proactive claimant legal services sector that is contributing to the rise in costs and the lack of a public discussion on claims could give the impression of consequence free claims. There is also a need for a dialogue on the costs and difficult decisions needed to reduce the cost of claims. Some action to address costs is set out in Sections 4 and 9 of this report, and evidence from other sectors points to some merit in exploring a public conversation alongside this action.
- 9.12 NHS LA have already produced patient focused communications such as 'Mediating claims in the NHS' and this format could provide a basis for how NHS LA might approach the development of wider public facing information.

Review the re-introduction of local delegated authority or voluntary excesses

- 9.13 The 2011 Industry Review recommended that the option of a delegated authority scheme be promoted. Under this arrangement trusts would handle their own claims up to an agreed limit e.g. £25,000, with a discount on contributions to reflect the reduction in workload for NHS LA. Following on from this, consideration has been given to the evidence on local delegated authority or voluntary excess limits. With the need to interface with the new EL/PL portal, there are practical difficulties in extending delegated authority for the non-clinical area. However, there is scope for a review of this area for clinical claims
- 9.14 In 2002, the NHS LA removed the excess on CNST, its main clinical scheme in response to the 2001 National Audit Report on handling clinical negligence claims in England. Recognising the time lapse since the removal of excesses, and in particular the more recent growth in claims, in response to member views, more specific consideration has been given to whether the absence of excesses contributes toward a weakening of ownership by some members of the risk management and claims agenda.
- 9.15 There is some evidence that local delegated authority either through excesses (as in other jurisdictions) or through local management of small claims, can result in faster settlements and reduced claimant costs. Delegated authority to settle small claims could support trusts in maintaining a local dialogue with patients and their representatives. From an efficiency perspective, local management of small value claims would need to be underpinned by clear protocols and information systems, but has the potential to reduce the volume of claims handled by NHS LA, freeing up specialist time for more challenging claims.
- 9.16 There are risks attached to local delegated authority, such as disaggregation and assurance of the data, as well as the possibility that claims are undervalued and revert to the scheme too late in the

process. The wider risk is an overall reduction in NHS LA's ability to strategically manage the claims portfolio, with a requirement on local reporting to ensure members benefit from the central expertise and ability to identify similar themes and, potentially, significantly increased administrative costs.

- 9.17 Evidence was received from some scheme members and stakeholders that re-introduction, on a voluntary basis, of voluntary excesses or an incentivised delegated authority scheme would give members greater ownership and control. Some members have, or have access to, experienced in-house claims management teams (sometimes with qualified lawyers) who believe their organisations to be well placed to take on additional local management of claims, particularly at lower values. However, it is noted that members would require funding for local management and a financial incentive through the schemes, and it is unclear whether this would have the support of member boards as opposed to their in-house teams. Transferring greater responsibility for lower value claims to members could increase local accountability for claims risk. This could potentially reduce the resource requirement on NHS LA claims teams, allowing their expertise to be better directed to higher value, more challenging claims.
- 9.18 NHS LA should review whether reintroduction is appropriate, recognising the risks and benefits. The review could be taken as an opportunity to consider the practicality of retaining the excess for LTPS.

Alternative dispute resolution

- 9.19 Since the Mid Staffordshire NHS Trust failures, there have been concerted efforts to make health and care services more responsive to patient and family concerns and complaints. The response to public failures in health has included:
- more explicit action to address poor quality care
 - a strengthening of early warning mechanisms
 - improvements in patient and family information
 - more ways for concerns and complaints to be heard.
- 9.20 Concerns, complaints and claims are on a continuum. The minority of patient and family concerns become complaints and, similarly, only a small proportion of complaints become claims. There is evidence that poor communication causes the progress of concerns through the system. NHS LA is already part of the wider work at national level to ensure concerns and complaints are effectively handled. An information sheet has been produced on 'saying sorry' and in July 2014 NHS LA launched a twelve month mediation pilot.
- 9.21 The mediation pilot provides an opportunity for more rapid learning in an area of redress that is less adversarial and as such, places patient and family experience at the heart of the local approach. The pilot is targeted at resolution of low financial value, sensitive claims, in particular providing a route for handling concerns about the care of frail and elderly people from which there have been recent increases in claims. Mediation will be prioritised for those cases notified to members involving a fatality, with NHS LA providing access to an independent and appropriately accredited mediator from an approved panel.
- 9.22 Consideration has been given to the potential for mediation to generate savings as part of a wider range of redress. Mediation has potential to minimise legal costs, by reducing the need for recourse to the courts. There are additional benefits of early resolution of disputes including clinical staff not being taken away from practice to participate in a legal process.

- 9.23 During the course of the review, members demonstrated a clear appetite for early access to mediation. Following evaluation of the pilot, there should be an opportunity for NHS LA to engage the broader member base in the development of and the planning for roll out of a national mediation panel.
- 9.24 Taken as part of a wider NHS LA offer, greater access to mediation will bring members greater choice and control over claims risk, costs and organisational reputation.

Supporting litigants in person (unrepresented claimants)

- 9.25 NHS LA report increasing numbers litigants in person ie claimants without legal representation. This reflects a growing trend for 'do-it-yourself' action that is not restricted to the health sector. Notwithstanding the challenge, these cases can present to NHS LA and local claims teams in handling cases efficiently; there is an incentive to consider this as part of the wider effort to reduce the increasing claimant costs. Providing low level support directly to litigants in person, or through patient organisations and locally based Patient Advisory and Liaison Service teams, could represent a small saving. NHS LA could learn from other parts of the personal injury market, notably financial mis-selling where banks and other financial institutions as well as consumer websites have adopted simple, well designed templates and guides for the public.

Evidence and consideration of NHS LA adapting to the challenge

- 9.26 A clear narrative linking the impact of claims on the public purse, more specifically the monies available for NHS services, has the potential to increase ownership of the consequences and might drive down claims without merit, whilst increasing a wider sense of responsibility for claims across health services and, potentially, reducing harm.
- 9.27 There are three main areas that could benefit the service to members and to the NHS LA operations, but ultimately to patients who have been subject to avoidable harm. These are:
- NHS LA reviewing a package of alternative local level options, can improve and increase the offer to members. It may be possible to introduce greater involvement at a local level whilst also retaining the key benefits of a specialised central management function. The review observed a number of other risk pooling schemes operate a system of voluntary local excesses, and these present a potentially useful source of learning for NHS LA.
 - Mediation which offers the NHS LA a chance to manage both cost and reputation at all stages of a claim.
 - Integration (see section 6 (c)) that presents both opportunities and risks from an indemnity perspective. There are high risk specialties included in the new models of care that would benefit from NHS LA expertise in ensuring there is indemnity cover for patients.

It is recommended:

- ***By 31 December 2015, NHS LA should lead work with a cross section of members, the Department and other stakeholders to evaluate whether i) an extended programme of local delegated authority and ii) arrangements for local voluntary excesses could work. [Recommendation 7]***
 - ***NHS LA should evaluate its pilot mediation programme by 31 October 2015 and at an early stage enter wider discussion with members and external partners on the evaluation results and the roll out of mediation as a less adversarial, mainstream model of redress.. [Recommendation 8]***
-

Stage two conclusion

The NHS LA provides efficient, cost effective indemnity schemes to providers of NHS secondary care services. These are based around a claims protocol that operates across a tripartite of Scheme member, the NHS LA and Legal Panel. The current system is generally effective, although some members feel there is scope for greater consistency.

The environment in which the NHS LA is operating has changed rapidly in recent years. With a large growth in the number of claims and significant rises in claims costs over the past few years. The review found examples of where the NHS LA are working to achieve efficiencies on claims; these include reducing the proportion of claims which lead to payment by defending claims which lack merit. This approach resulted in 44% of clinical claims dealt with by the NHS LA in 2013/2014 closed with no payment made for damages. With the NHS LA also increasing the number of challenges of claimant solicitor costs and increasing focus on fraud and losses measures have resulted in savings.

The NHS LA and their stakeholders have identified wider savings that can be achieved, through the safety and learning function and through support for patient safety activity. There are also savings that can be achieved through working with others, to pursue regulatory reform.

The review found the NHS LA has the opportunity to become more customer focused in its operations, whilst recognising there may be a need for investment in this.

Overall, the NHS LA is an operationally efficient, well led and run organisation, representing good value to the public purse. In concluding this, the review has considered wide evidence from the NHS LA, comparator bodies, scheme members and other expert stakeholders on the NHS LA's performance, governance and the delivery of administrative and wider efficiencies.

Overall, the NHS LA is an operationally efficient, well led and run organisation, representing good value to the public purse. In concluding this, the review has considered wide evidence from the NHS LA, comparator bodies, scheme members and other expert stakeholders on the NHS LA's performance, governance and the delivery of administrative and wider efficiencies.