Public Accounts Committee Call for Evidence: Costs of Clinical Negligence Response from Action against Medical Accidents – November 2025

Executive Summary

1. Action against Medical Accidents (AvMA) is the UK's leading charity supporting those who are avoidably medically harmed and advocating for patient safety and justice. Our unique position across the legal and healthcare sectors provides a clear view of the systemic issues driving harm, litigation and rising costs in the NHS.

2. The NHS repeatedly fails to **learn from mistakes** which in turn hampers productivity. Over 1,400 recommendations from public inquiries lack coordination, meaning progress is piecemeal and lessons, including from litigation, are lost. Programmes like Getting It Right First Time show that structured learning from litigation can improve outcomes and reduce claims, but such approaches are rare.

3. Implementation of the **Duty of Candour** remains poor, with most harmed patients unaware of their right to openness and explanation. When honesty and apology are lacking, people understandably turn to legal routes. The absence of structured support for those harmed, such as through a **harmed patient care pathway** adds to the huge human and financial costs, further fuels litigation and damages staff morale.

4. The **complaints and redress system** is broken—slow, inconsistent and inaccessible. The Health Ombudsman's Alternative Legal Remedy rule compounds this and should be abolished.

5. AvMA supports reforms to reduce clinical negligence costs but warns that proposed **Fixed Recoverable Costs** risk denying access to justice for serious cases which are nevertheless considered a low value financial claim. True savings will only come through a system that learns from harm, supports patients and staff, and responds with honesty, transparency and compassion.

About AvMA

6. For over 40 years AvMA has assisted individuals and their families after suffering avoidable harm in healthcare, providing compassionate support, clear guidance and a pathway to justice during what can be one of the most difficult times in their lives. Each year we support many thousands of people to seek answers, apologies, make complaints or access redress to support their ongoing care and treatment.

7. By listening to those affected, we also work to bring about meaningful change to improve the health and justice services which support harmed people. We campaign for stronger patient safety initiatives, greater accountability in the NHS, and a system that treats people fairly, and responds with honesty, learning and compassion. Engaging daily with lawyers, medical experts, healthcare professionals and coroners, we are uniquely positioned to understand the clinical negligence landscape - the causes of ever spiralling costs, the potential drivers for change, and most importantly, the patient perspective. We never lose sight of the fact that each pound spent on clinical negligence represents an injured person who needs our support.

The Drivers for Failure

Failure to learn and improve

8. In her *Review of patient safety across the health and care landscape,* Dr Penny Dash rightly identified that the NHS is awash with recommendations to improve healthcare: over 1,400 recommendations from 30 public inquiries that have taken place primarily in England and Wales over the last 30 years. The NHS has no structured approach to assessing and prioritising these recommendations or tracking and reporting progress. As a result, opportunities to learn and improve in anything other than a piecemeal, knee-jerk way are lost to the system. Accordingly, progress is not made and mistakes repeated. Lessons that the NHS should learn from litigation are lost. Programmes such as *Getting it Right First Time* (GIRFT) have demonstrated some success in areas such as orthopaedics, and this may account for some of the improvement in claims reductions in this speciality highlighted by the NAO in their recent report. Sadly, the NAO did not evaluate this possible linkage, but it could indicate possible ways that lessons from litigation can be learned and further improvements – and costs reduction – found.

Failure to effectively implement the Duty of Candour

9. Despite the roll-out of a statutory Duty of Candour into the NHS in 2014, very few people who come to AvMA having suffered avoidable medical harm and to whom the Duty of Candour should have been applied, knew anything about it and had no communication about the Duty. As our response to the DHSC's Call for Evidence for the Duty of Candour review in 2024 shows, the NHS's implementation of the Duty was at best mixed and at worst poor. This is disappointing as the many people who come to us for support and advice are seeking clear communication, openness and transparency about what happened to them alongside a meaningful apology. When these basic needs are not met, it can come as no surprise that they go on to engage a solicitor to advocate for them, driving the potential for increasing claims.

Failure to support those harmed

10. Hearteningly, in her recent review, Dr Penny Dash acknowledged that, "It is particularly challenging for those who have, or believe they have, been harmed or suffered poor outcomes of care." Recognising that in a high risk setting such as healthcare avoidable harm will arise, the NHS does not plan for this eventuality nor has in place a care pathway for those affected, which often includes family and loved ones. The NAO suggest in their report that the cost associated with this preventable harm, whilst hard to quantify, is considered to be in the order of 8.7% of healthcare budgets annually across OECD countries. This figure does not include the cost of care, therapies, aides and equipment, adaptations and any loss of earnings which is unquantified. This is a significant drain on healthcare resources as well as productivity, not to mention the human costs for patients and staff impacted. A care pathway is an imperative and although not without associated costs, would almost certainly alleviate the pressure on litigation by meeting the various needs of a substantial amount of patients, one of which is to get a full and open explanation about their treatment, what went wrong and why as well any learning from it to prevent or reduce future risk of such an error being repeated.

11. Avoidable harm also adversely impacts any staff involved. At a time when the healthcare workforce is under huge pressure, surely it makes sense to invest in this area as part of the NHS' duty of care that it owes to its staff and wellbeing, as well as considering the many other benefits that could be had, not least to productivity which is undermined by every issue of avoidable harm that needs to be addressed.

12. For these reasons AvMA has collaborated with the Harmed Patients Alliance to develop a harmed patient care pathway. This is a restorative pathway designed to support patients and families who have been avoidably medically harmed to get the support and care they need and which denied them very often compounds the original injury that they faced. We strongly believe that such a Pathway, if adopted by the NHS, would go a long way to repair the psychological harm that many patients face and would reduce some of the claims that litigation that arise from poor treatment and aftercare.

Complaints handling and Redress – a broken system

13. *"Complaints and concerns are often poorly handled with patients or users or patients and user groups describing delays and poor-quality responses. Many complaints are not handled within the statutory timeframe of 6 months. A recent survey found that over half of people who made a formal complaint were dissatisfied with both the process and the outcome of the complaint."*
    Dr Penny Dash, *Review of patient safety across the health and care landscape,* 2025.

14. This quote perfectly summarises the experiences of the individuals we support. People who cannot get satisfactory answers to their concerns about their care and help to understand what went wrong and why, are likely to turn to other avenues for advocacy and support – including solicitors. The many people we support do not start out seeking to litigate but may feel they are without other options once faced with the silence that greets their reasonable requests to the NHS for answers. It is also clear to us then that the NHS complaint system requires urgent reform.

15. What's more, the problems with the first tier NHS complaint system are compounded by the second tier, the Health Ombudsman. Their threshold for accepting complaints for investigation is very high. Furthermore, they are bound by the *Alternative Legal Remedy* rule which means where they believe a complainant has an alternative remedy (such as via the courts) then that route should be pursued, and the Ombudsman will not look at the complaint. Given the wider societal drive to try and resolve matters without recourse to the courts, we find this rule to be arcane and believe it should be scrapped. Moreover, we see through our casework various examples of where the Ombudsman applies this rule in an inconsistent and detrimental way. We are pursuing this with the Ombudsman, but clearly, if people cannot seek redress through the Health Ombudsman then again, they are left with being driven to litigation which in turn, can be a driver for increased costs.

16. We would make a more general observation about the complaint system which is that it could be developed to help resolve some clinical negligence claims where the value of the claim is low and where the NHS accepts some responsibility for the harm that was caused. At the moment, the family in such situations is forced to litigate to

secure any financial redress, but other alternatives could be developed using for example ex gratia which may avoid the costs of litigation.

Legal context and accessibility

17. AvMA recognises that the current spend on clinical negligence claims is too high and we are supportive of any initiative that fairly and efficiently reduces the legal costs without compromising access to justice in low value claims. It follows that AvMA does not object to the principle of Fixed Recoverable Costs (FRC) in clinical negligence claims but in order to ensure that access to justice is maintained, the rates of pay on the fixed costs must be fair and commercially viable for claimant solicitors otherwise this will create "legal deserts" for those who need access to legal advice. Claimant solicitors are already bound to recognise by the courts the principle of *proportionality* and do not take cases where it appears that the cost of bringing proceedings will exceed the damages awarded. This means that there are already low value claims with clear merit that are not being brought because of the application of the proportionality test.

18. AvMA is unable to say what a commercially viable figure is, this is a question best put to those who support the legal community. However, many claimant lawyers specialising in clinical negligence work have expressed the view that the rates of pay proposed in the last consultation on FRC in clinical negligence claims were too low and consequently not considered commercially viable. If that is correct, the result will be that specialist lawyers will not take on cases where the value is less than £25,000. To contextualise this, it means that cases involving the death of children are at serious risk of not being able to secure representation, such as the death of baby Harry Richford, whose grandfather Derek Richford used the inquest into Harry's death to open the door to an inquiry into East Kent Hospital's maternity unit.

19. Additionally, the current FRC proposal does not recognise the fact a low value claim can still be a complicated claim to run (such as Harry Richford's above). Neither do the proposals make any suggestions around learning lessons from the litigation process - a missed opportunity.

20. The reputational risks are high for lawyers who may run clinical negligence cases under the proposed FRC terms. Given the low rates of pay, they will need to deduct any shortfall in their costs from their client's award of damages. It needs to be understood that the shortfall is different from the success fee that solicitors can charge for winning the case, it is the shortfall in costs that risks severely reducing their client's award and possibly even wiping it out altogether. The shortfall is the difference between the hourly rate agreed between the solicitor and the client and the amount which is recovered from the otherside, for example if the hourly rate is £100/per but only £60/hour is recovered from the otherside, the shortfall is £40/hour. There are no protections for preserving the injured claimant's damages other than those that exist in relation to the success fee which is ringfenced so it can never be more that 25% of general damages (damages allowed for pain, suffering and loss of amenity) and any past losses which are awarded. This situation puts harmed patients at a disadvantage and risks creating a conflict in the solicitor/client relationship.

21. Part of the FRC proposals for Clinical Negligence claims included streamlining the existing court process – we believe that could be a good thing especially if it speeds up the litigation process as intended. However, some of the proposals such as mandatory neutral evaluation have not been trialled in clinical negligence and need to be monitored carefully. For example, the current proposal is a review after three years of introducing FRC for clinical negligence – we believe that is too long and a better timeframe would be a review after 12 months.

22. The NAO report includes a key finding that "The government may be paying twice in some instances of clinical negligence: once through compensation and then again through providing treatment to the claimants" - this is sometimes referred to as "double recovery". The report talks in terms of damages being calculated on the presumption that care will be provided by the private sector and not the NHS. However, this comment grossly over- simplifies what is in practice a very complex situation. The report does recognise that "t*here is no estimate of the extent to which clinical negligence claimants go on to use publicly funded health or social care services for their conditions, and little is known about how damages are used by claimants"* this alone recognises that such assertions are no more than conjecture.

23. Damages are only ever awarded in relation the additional injury caused by the negligence. Any disability that may arise due to the original health complaint is not compensated for. Take, for example, a child who because of negligent treatment at birth now has cerebral palsy. If that cerebral palsy claim is settled on a compromise basis (as they often are) of a 60% admission of liability, the claimant will only be able to recover private costs for 60% of the injury, not the entire injury. The reality is that claimant will still need a full package of care, but private funds will only be available for 60% of it, in those cases the claimant needs to look to the local authority for the other (non-negligent) 40% portion of their care. In turn, that situation might give rise to a perception of double recovery, but that is not what has happened.

24. The situation is further complicated as local authorities often cut back on the care offered owing to funding constraints – the 40% package of care offered today may be considerably more comprehensive than what is offered in two years time. Local authorities' views on what amounts to a comprehensive care package also differ and funding arrangements vary.

25. To be fully understood, this issue really needs to be subject to an inquiry/review on its own and for the purposes of considering the cost of clinical negligence claims as it does not go to the core root of the problem.

26. More progress may be made in seeking to control clinical negligence costs, by recognising that different solutions and/or processes may need to be found to accommodate the different types of claims. Some low value claims (up to £25,000) may be capable of resolution at the complaints stage as described above, whereas higher value claims may need different considerations, particularly where future losses form part of the claim. The more complex claims such as birth injuries would not be suited to resolution at an early stage, certainly not without families having specialist legal representation.

The NAO report – some final observations

27. Overall, we welcomed the recent review undertaken by the National Audit Office and believe that their report was a thorough assessment of the landscape of clinical negligence costs and many of their drivers, which are highly complex. We would, within that context, make the following observations:

28. The report very much focused on the costs to the NHS of litigation, there is a wider societal cost attached to harm that patients and their loved one and families incur. The closest the report gets to quantifying this is referred to on page 33 of the report where they point to OECD research that suggest that preventable harm costs 8.7% of healthcare budgets –which relates to the direct costs of the care to correct the effects of harm. It does not include the indirect costs such as damage to staff morale, mental and physical wellbeing and lost NHS productivity. There is also no reference to the cost to the person who is harmed which can also include the economic impact on them if they cannot work or care for their family, a need to draw benefits, as well as other less tangible costs. We believe it is incumbent on Government to undertake a wider impact assessment of these costs and losses to the NHS and the wider economy and society.

29. The NAO report a key finding that "the government may be paying twice in some instances of clinical negligence: once through compensation and then again through providing treatment to the claimant". As is stated above, the position presented by the NAO is an over-simplification. Further, the NAO presents no evidence for this finding which must beg the question why they raised it. We say that in the context of this issue being a much contested area of public policy.

30. We were disappointed at the limited consideration that the NAO made around the drivers of costs in relation to Medical Experts and their increasing fees. This gets a short reference in paragraph 2.14 but in our view needs to be examined in far greater detail and this report was a missed opportunity. Expert fees are a crucial part of proving a clinical negligence claim, the complex nature of these cases is such that these reports are invariably expensive and therefore contribute to the high cost of claims.

31. The report notes that increases in claims volumes are the main factor in cost increases over the past 20 years. It fails to acknowledge the significance of how changes in funding arrangements have impacted on this area of work. Conditional Fee Agreements were first introduced to clinical negligence work in about 2000 and took some years to bed in, and subsequently the After the Event (ATE) insurance market also evolved. This has enabled lawyers to provide representation to injured patients who had previously been denied access to justice because they were outside of the financial limits to qualify for legal aid but unable to afford to pay fees on a private basis. It is likely that many more clinical negligence claims existed before the emergence of CFAs and ATE insurance, but the cost of bringing proceedings was not within the reach of many injured patients thus their claims were not brought, their voices not heard and the patient safety issues remained obscured.