



House of Commons
Committee of Public Accounts

Managing the costs of clinical negligence in hospital trusts

Fifth Report of Session 2017–19

*Report, together with formal minutes relating
to the report*

*Ordered by the House of Commons
to be printed 23 November 2017*

The Committee of Public Accounts

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Publication

Committee reports are published on the [Committee’s website](#) and in print by Order of the House.

Evidence relating to this report is published on the [inquiry publications page](#) of the Committee’s website.

Committee staff

The current staff of the Committee are Richard Cooke (Clerk), Dominic Stockbridge (Second Clerk), Hannah Wentworth (Chair Support), Ruby Radley (Senior Committee Assistant), Kutumya Kibedi (Committee Assistants), and Tim Bowden (Media Officer).

Contacts

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Summary

The annual cost of the clinical negligence for trusts has quadrupled over the last decade—from £0.4 billion in 2006–07 to £1.6 billion in 2016–17—taking already scarce resources away from frontline services and patients. Despite longstanding concerns about these predictable rising costs, the government has been disappointingly slow and complacent in its response. There seems to be a prevailing attitude of defensiveness in the NHS when things go wrong, and a reluctance to admit mistakes, which is likely to be leading to more clinical negligence claims. The lack of consistent data across the system means that the NHS still does not fully understand why some people suffering harm choose to make claims or the root causes of negligence, so it is not well placed to learn from its mistakes. It is important that patients suffering as a result of clinical negligence are compensated and that lessons are learned but the mix of stretching efficiency targets, increasing financial pressures and patients waiting longer for treatment carries the risk of clinical negligence claims spiralling out of control without effective action. The government needs to take bolder and more coordinated action to prevent this from happening.

Introduction

The NHS, including NHS trusts and foundation trusts (trusts) are legally liable for any clinical negligence by their employees. Since 1995, NHS Resolution (the operating name of NHS Litigation Authority from April 2017) has provided indemnity cover for clinical negligence claims against trusts in England, through its Clinical Negligence Scheme for Trusts (the Scheme). The Department of Health (the Department) oversees NHS Resolution and develops policy to manage the costs of clinical negligence. NHS Resolution is responsible for dealing with claims, including funding defence costs, and any legal costs or damages that become payable. From 2006–07 to 2016–17, the number of clinical negligence claims registered with NHS Resolution each year doubled, from 5,300 to 10,600. Annual cash spending on the Scheme quadrupled over this period, from £0.4 billion to £1.6 billion. The estimated cost of settling future claims has risen from £51 billion in 2015–16 to £60 billion in 2016–17. There are two main factors contributing to the rising costs. First, increasing damages for a small but stable number of high-value, mostly maternity-related claims. These accounted for 8% of all claims in 2016–17, but 83% of all damages awarded. Second, increasing legal costs resulting from an increase in the number and average cost of low-value claims. Over 60% of successful claims resolved in 2016–17 had a value of less than £25,000.

Conclusions and recommendations

1. **Increasing financial pressures on the NHS have started to affect waiting times and the quality of care, which risks leading to even more clinical negligence claims and in turn even greater cost.** Almost 40% of clinical negligence claims against trusts are related to a failure or delay to diagnose or treat a patient. Many trusts face financial challenges and ever-rising demand, including delivering stretching efficiency savings. The Care Quality Commission, in its 2016–17 State of Care Report, highlighted that future quality of care is precarious as the system struggles with complex demand, access and cost pressures. The increasing financial pressure on trusts, has already started affecting standards of care. In particular, more and more patients are waiting longer for their treatments, which could increase the risk of future clinical negligence claims. NHS staff are working under huge pressure which may also affect trusts' ability to deal effectively with complaints. Spending on clinical negligence is forecast to increase from 1.8% of trusts income in 2015–16 to 4% by 2020–21, further reducing the amount of money available for patient care.

Recommendation: *The Department and NHS Improvement should report back to us by April 2018 on how they have ensured that trusts prioritise resources on patients that are most at risk of harm from increasing waiting times in the NHS.*

2. **The government has been slow and complacent in its response to the rising costs of clinical negligence.** This Committee has raised concerns about the rising costs of clinical negligence claims on numerous occasions, going back to at least 2002, but costs have continued to rise. Annual spending is expected to double by 2020–21 to £3.2 billion compared with £1.6 billion in 2016–17, and current action proposed is unlikely to stop this growth. The Department told us that the only way, within the current arrangements, to bring down the costs of high-value cases is to reduce the number of cases by improving patient safety, particularly in maternity cases. It has introduced a range of maternity initiatives to improve maternity care but their impact on the number of claims made is not yet clear. The government also highlighted an option of seeking a change to the current legislation (from 1948), which requires that damages levels assume private provision of health and care costs, even though patients will receive free NHS care. On the rising number of low-value cases (less than £25,000), but which have high legal costs, NHS Resolution has introduced a voluntary mediation service to resolve claims and avoid costly legal processes, but only 71 cases have used this service so far. It is clear that tackling the rising costs of clinical negligence requires urgent and far-reaching action by more than one government department, but currently there is no overarching cross-government approach to tackling this issue.

Recommendation: *The Department, the Ministry of Justice, and NHS Resolution must take urgent and coordinated action to address the rising costs of clinical negligence. This includes:*

- *reviewing whether current legislation remains adequate, and reporting back to the Committee by April 2018;*
- *continuing to focus on actions to reduce patient harm, in particular, harm to maternity patients; and*

- *appraising further measures to reduce the legal costs of claims, for example whether mediation should be mandated for certain types of claims.*

3. **The government did not assess the impact of changes to legal reform on the volume of clinical negligence claims.** On the rising number of low-value cases, but which have high legal costs, the Ministry of Justice accepted that government could have predicted the impact that legal reforms have had on the number of claims and claimants' legal costs. These legal reforms included the introduction of 'no-win-no-fee' agreements, to promote access to justice among people who would not have been eligible for legal aid, and the capping of legal fees for road traffic accident claims which led to more clinical negligence firms moving into the clinical negligence market. The Ministry of Justice told us it had taken action to address some of these issues and that it hopes to extend fixed recoverable costs to as many litigation areas as possible, particularly clinical negligence claims below £25,000.

Recommendation: *The Cabinet Office should consider including the “cost-shunting” impact of a policy when the impact assessment is produced and report back to the Committee by June 2018.*

4. **The NHS's culture when things go wrong appears to be predominantly defensive, rather than candid and transparent, which limits its ability to learn lessons.** This Committee has reported before that the NHS appears to be defensive when things go wrong. Although there have been initiatives such as duty of candour, the NHS has started from a low base and the progress towards an open and transparent culture is slow. There is a growing body of evidence that when things go wrong many people simply want an apology, or want to know that the issue is being dealt with and that it won't happen again. However, they may make a claim if they are dissatisfied with the response they receive from trusts following a harmful incident. We are concerned that there is no system in place to understand which hospitals are doing well in managing harmful incidents and complaints, to identify good practice and to promote wider learning between trusts. Recent research suggests that greater transparency does not lead to a greater number of claims.

Recommendation: *The Department and NHS Resolution should work with trusts to identify and spread best practice in handling harmful incidents and complaints. This should include how trusts say sorry and support patients when things go wrong.*

5. **A lack of consistent data across the system means the NHS does not understand why people do (or do not) make claims, or the root causes of the negligence.** The profile of patients who make claims differs significantly from those who suffer adverse events. For example, people aged 65 and over experience more harmful incidents than those of working age but are much less likely to make a claim. NHS Resolution told us that the propensity to claim is also significantly higher among those who have had a year off work as a result. Currently, only about 4% of people experiencing a harmful incident make a claim. A small change in the likelihood of people making a claim could have a significant impact on the number of claims. Data on incidents, complaints and claims are not collected using a consistent

classification and, therefore, the NHS does not have a good understanding of why some people make a claim and others do not. A new data system for incidents is being introduced which NHS Improvement believes should help.

Recommendation: *The Department, NHS Improvement and NHS Resolution need to work with trusts to ensure that a consistent classification is used across incidents, complaints and claims data. They should then use these data to provide insights into the reasons behind clinical negligence claims. They should report back to the Committee with a plan on how they should approach this by April 2018.*

6. **The time taken to resolve cases is rising, which is likely to worsen patients' experience as well as increase costs.** The time taken to resolve cases increased by four months on average, from 300 to 426 days, between 2010–11 and 2016–17. On average every extra day taken to resolve a claim is linked with an additional legal cost of more than £40. There can be several reasons for delays, some of which are within NHS Resolution's control and some are not. NHS Resolution has to live within its budget, and so must manage the pace of settlements to remain within this limit. Some delays have been due to bottle necks at court and the Ministry of Justice told us that it is aiming to streamline court processes for clinical negligence cases. Delays can also happen if the NHS fails to investigate or notify NHS Resolution quickly of harmful incidents that have occurred.

Recommendation: *The Department, the Ministry of Justice and NHS Resolution need to clarify why it is taking longer to resolve claims and report back, by September 2018, on what actions they are taking to address this issue.*

1 Rising costs of clinical negligence

1. On the basis of a report by the Comptroller and Auditor General, we took evidence on managing the costs of clinical negligence from the Department of Health (the Department), the Ministry of Justice, NHS Resolution and NHS Improvement.¹

The Clinical Negligence Scheme for Trusts

2. The NHS, including NHS trusts and foundation trusts (trusts) are legally liable for any clinical negligence by their employees. They must pay compensation (damages) to the claimant, and pay their legal fees. Since 1995, NHS Resolution (the operating name of NHS Litigation Authority from April 2017) has provided indemnity cover for clinical negligence claims against trusts in England, through its Clinical Negligence Scheme for Trusts (the Scheme). The Department of Health (the Department) oversees NHS Resolution and develops policy to manage the costs of clinical negligence. NHS Resolution is responsible for dealing with claims, including funding defence costs, and any legal costs or damages that become payable.²

3. From 2006–07 to 2016–17, the number of clinical negligence claims registered with NHS Resolution under the Scheme each year doubled, from 5,300 to 10,600. Annual cash spending on the Scheme quadrupled over this period, from £0.4 billion to £1.6 billion. The estimated cost of settling future claims has risen from £51 billion in 2015–16 to £60 billion in 2016–17. In addition to the increasing number of claims, there are two main factors contributing to the rising costs of claims. First, increasing damages for a small but stable number of high-value, mostly maternity-related claims. These accounted for 8% of all claims in 2016–17, but 83% of all damages awarded. Second, increasing legal costs resulting from an increase in the number and average cost of low-value claims. Over 60% of successful claims resolved in 2016–17 had a value of less than £25,000.³

Tackling the main factors behind rising costs

4. This Committee has raised concerns about the rising costs of clinical negligence claims on several occasions, going back to at least 2002. More recently the Committee has urged government departments to tackle the underlying causes of these rising costs, in reports in 2013, 2014 and again in 2016.⁴ However, although much of the rising cost was predictable, annual spending is still expected to double by 2020–21 to £3.2 billion, and current action proposed is unlikely to stop this growth. The forecasting of the future costs of clinical negligence does not currently go beyond 2020–21 so the Department does not know what it expects to happen to costs after that time.⁵ Small changes in the assumptions used by the court, when calculating the amount of damages to award, can have a big impact on the level of damages awarded. For example, a recent change of the

1 C&AG's Report, [Managing the costs of clinical negligence in trusts](#), Session 2017–19, HC 305, 7 September June 2017

2 [C&AG's Report](#), paras 1–2

3 Qq 2–4, 6, 10, 13, 14; [C&AG's Report](#), paras 4, 12, 13, 2.16

4 Committee of Public Accounts: [Handling Clinical Negligence Claims in England](#), 37th Report of Session 2001–02, HC 280, 13 June 2002; [HM Treasury: Whole of Government Accounts 2010–11](#), 37th Report of Session 2012–13, HC 867, 11 April 2013; [Maternity Services in England](#), 40th Report of Session 2013–14, HC 776, 31 January 2014; [The Government Balance Sheet](#), 19th Report of Session 2016–17, HC 485, 14 October 2016

5 Qq 3–5, 10, 11, 13, 27, 67, 112; [C&AG's Report](#), para 9

discount rate, an adjustment of the lump sum awarded to take account of the annual income earned from investing this sum, has added an estimated £500 million to the costs of claims in 2016–17, and £3.5 billion to the estimated cost of settling future claims.⁶

5. On the small number of high-value claims, the Department told us that some of the cost increases are for good reasons, such as an improvement in life expectancy rates for people who suffer maternal incidents. The Department acknowledged that the only way, within the current arrangements, to bring down the costs of high-value cases is to reduce the number of cases, by improving patient safety, particularly in maternity cases. The Department, NHS Improvement and NHS Resolution have introduced a range of initiatives to improve maternity care and reduce the number of still births. In recent years, the number of maternity-related incidents has remained quite steady.⁷ The Ministry of Justice also highlighted an option of reviewing the current (1948) legislation, which requires that damages levels assume private provision of health and care costs, even though patients will receive free NHS care.⁸

6. On the rising number of low-value cases, but which have high legal costs, the Ministry of Justice accepted that government could have predicted the impact that legal reforms have had on the number of claims and claimants' legal costs. These legal reforms included the introduction of 'no-win-no-fee' agreements, to promote access to justice among people who would not have been eligible for legal aid, and the capping of legal fees for road traffic accident claims which led to more clinical negligence firms moving into the clinical negligence market. The Ministry of Justice told us it had taken action to address some of these issues and that it hopes to extend fixed recoverable costs to as many litigation areas as possible, particularly clinical negligence claims below £25,000.⁹

7. NHS Resolution has also introduced a voluntary mediation service as a way of resolving claims without formal court proceedings. NHS Resolution told us that only 71 cases have used this service, with the new service meeting resistance from some claimant lawyers who prefer the more formal route for resolving claims. The Ministry of Justice acknowledged that alternative dispute resolution, including mediation, is currently not working very well in the civil justice system and that the Civil Justice Council has suggested compulsory mediation in some areas of civil business.¹⁰

8. Tackling the rising costs of clinical negligence requires action by more than one government department, but currently there is no overarching cross-government approach to tackling this issue. The Department of Health and the Ministry of Justice told us that they work together closely, and the Ministry said it would like to set up a joint programme board between the Departments and be more creative in their thinking on issues such as the law of damages and alternative dispute resolution as it applies to health.¹¹ Countries which have most successfully controlled clinical negligence costs have carried out legislative reform.¹²

6 Qq 96–97; [C&AG's report](#) para 2.14

7 Qq 2, 6, 12, 41, 50–55

8 Qq 98, 113

9 Qq 9, 10, 66, 113; [C&AG's Report](#), para 14

10 Qq 57–59, 73–74; [C&AG's Report](#), para 3.23

11 Qq 7–10, 67, 113–115; [C&AG's Report](#), para 10

12 Q 86, [C&AG's report](#) para 2.15

NHS culture

9. When this Committee last reported on whistleblowing in March 2016, it noted that an independent review into creating an open and honest reporting culture in the NHS reported that a significant proportion of health workers were afraid to speak out.¹³ Although there have been initiatives, such as duty of candour, to encourage trusts to report incidents, NHS Improvement recognises that across the NHS there is still huge variation in terms of having a culture that very quickly admits its mistakes, investigates them and learns from them. NHS Improvement told us that the staff survey indicates that overall, a greater proportion of staff now feel able to report an incident than previously.¹⁴ The Department told us that data transparency is essential to achieving this cultural change.¹⁵

10. There is a growing body of evidence that when things go wrong many people simply want an apology, or want to know that the issue is being dealt with and that it won't happen again. NHS Resolution noted that evidence suggests that taking these actions, often ensures that a harmful incident does not turn into either a complaint or a claim. Recent research suggests that greater transparency does not lead to a greater number of claims. However, people may make a claim if they are dissatisfied with the response they receive from trusts following a harmful incident.¹⁶ NHS Resolution plans to work with the Parliamentary and Health Service Ombudsman, to better support trusts in post-incident handling and where possible prevent escalation into a complaint or a claim.¹⁷

11. The Department and NHS Improvement told us that trusts rated as outstanding are generally more transparent and focused on learning lessons when things go wrong. However, they could not provide us with a list of trusts that are doing well in managing harmful incidents and complaints. NHS Improvement noted that the contribution trusts pay to the Scheme is based on the trust's claims experience for the last five years and its exposure to future claims, measured by staff numbers and activity. So if a trust is reducing the number of claims made against it, the price it pays for indemnity cover comes down.¹⁸

Improving understanding and supporting learning

12. Currently, only a small proportion (less than 4%) of people experiencing a harmful incident will actually make a claim. But some patient groups are more likely to make a claim than others. For example, people aged 65 and over experience 53% of harmful incidents, but they only make 23% of all claims. NHS Resolution told us that patients' propensity to claim is also significantly higher among those who have had a year off work and therefore lost earnings, as a result of a harmful incident. Even a relatively small change in the likelihood of, for example, over 65s making a claim could have a significant impact on clinical negligence costs.¹⁹

13 Committee of Public Accounts: [Making a whistleblowing policy work: progress update](#), 29th Report of Session 2015–16, HC 602, 11 March 2016; [Freedom to Speak up: an independent review into creating an open and honest reporting culture in the NHS](#), Sir Robert Francis, 2015.

14 Qq 12, 21–22, 28, 67, 75, 77

15 Qq 67–70,

16 Qq 28, 37, 57, 75, 89–90; [C&AG's report](#) para 2.6

17 Q 36

18 Qq 16–20, 23–26; [C&AG's report](#) para 1.4

19 Qq 34, 35, 37; [C&AG's report](#) para 15

13. NHS Resolution collects data on claims, and shares this with trusts through an online portal. The portal also provides some benchmarking information that allows trusts to compare their performance against an anonymised peer group. The National Audit Office's report noted that trusts had mixed views on the usefulness of the information, and found this data of limited use in helping clinicians gain insight to help improve patient safety.²⁰ For the Getting It Right First Time initiative on orthopaedics, trusts have been able to review claims data and clinical indicators together, and NHS Improvement told us that greater transparency has had an impact as there has been up to an 8.5% reduction in orthopaedic litigation costs.²¹

14. Trusts collect data on incidents and complaints, though the national reporting and learning system. However, data on incidents, complaints and claims are not drawn together into one system, or collected using a consistent classification so it is difficult to get a composite picture, to stop incidents from occurring. NHS Improvement told us that the national reporting and learning system will be replaced by 2019, and that this new system should better support the collection of consistent data.²²

20 Qq 5, 38–42; [C&AG's report](#) para 3.20

21 Qq 27, 38

22 Qq 43–46, 72

2 Patient experience

Time taken to resolve claims

15. Handling claims requires a balance between paying appropriate damages for valid claims quickly and efficiently, while defending the NHS from claims which are without merit, or where the damages sought are not proportionate. Between 2010–11 and 2016–17, the average time taken to resolve a claim following notification increased by four months, from 300 to 426 days. On average every extra day taken to resolve a claim is associated with an additional legal cost of more than £40.²³

16. There can be several reasons for delays, some of which are within NHS Resolution's control and some of which are not. NHS Resolution considers that 250 cases is the optimal number of cases a claims operator can handle effectively. NHS Resolution told us that since the National Audit Office's report, which found the average caseload per claims operator to be over 250, it had recruited more claims operators and that their average caseload was now 196. NHS Resolution refuted claims submitted in written evidence to the Committee that it slows the resolution process down by contesting the vast majority of claims it receives. NHS Resolution noted that 66% of the cases it resolves are settled before the court is involved, and only 0.7% of the cases which it resolves go to a full trial.²⁴

17. The Committee also received written evidence from a law firm raising concerns that delays occur because the NHS fails to investigate or notify NHS Resolution quickly of harmful incidents that have occurred. NHS Resolution told us that it now requires trusts to notify it of obstetrics incidents within 30 days, in order to speed up resolution of these cases.²⁵ NHS Resolution also confirmed that it has to live within its budget, so must manage the pace of settlements to remain within this limit.²⁶ Another factor that can impact on how quickly some claims can be resolved is the capacity of the courts to deal with cases. The Ministry of Justice told us that it is aiming to streamline court processes for clinical negligence cases, possibly including joint expert reports on individual cases.²⁷

Financial pressures on the NHS

18. Many trusts face financial challenges and ever-rising demand, including delivering stretching efficiency savings. The Care Quality Commission, in its 2016–17 State of Care Report, highlighted that future quality of care is precarious as the system struggles with complex demand, access and cost pressures, but notes that quality of care has yet to go down.²⁸ However we are now seeing more and more patients waiting longer for their treatments. Almost 40% of clinical negligence claims against trusts are related to a failure or delay to diagnose or treat a patient. Therefore, longer waiting times could increase the risk of future clinical negligence claims. NHS Improvement told us that patients on

23 Q 57; [C&AG's report](#) paras 18, 3.4

24 Qq 60–64, 92–95; [C&AG's report](#) para 18, submitted evidence

25 Qq 5, 57, submitted evidence

26 Qq 78–86; [C&AG's report](#) para 18

27 Qq 65–66

28 Qq 10, 30; Care Quality Commission, [The state of health care and adult social care 2016/17](#), 12 October 2017

waiting lists that may well come to harm should be brought forward. It also told us that so far, reviews of people waiting longer than desirable indicate that the level of harm to them has been extremely low, although it would need to watch this going forwards.²⁹

19. NHS staff are working under huge pressure which may affect trusts' ability to deal with complaints effectively. For example, NHS Improvement acknowledged that staffing levels for human resource provision across trusts is variable, which could impact on the trusts ability to deal effectively with complaints.³⁰ The rising costs of clinical negligence will add to the financial pressures faced by the NHS. Spending on clinical negligence is forecast to increase from 1.8% of trusts income in 2015–16 to 4% by 2020–21, further reducing the amount of money available for patient care. Trusts spending a higher proportion of their income on clinical negligence are more likely to be in deficit, which in turn can have an impact on patients' access to services and quality of care.³¹

29 Qq 29, 31–33; [C&AG's report](#) para 16

30 Qq 102–111

31 Qq 10, 13–14; [C&AG's report](#) para 8

Formal Minutes

Thursday 23 November 2017

Members present:

Meg Hillier, in the Chair

Geoffrey Clifton-Brown

Shabana Mahmood

Martyn Day

Layla Moran

Chris Evans

Bridget Philipson

Draft Report (*Managing the costs of clinical negligence in hospital trusts*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 19 read and agreed to.

Introduction agreed to.

Conclusions and recommendations agreed to.

Summary agreed to.

Resolved, That the Report be the Fifth of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Monday 27 November 2017 at 3.30pm]

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the [inquiry publications page](#) of the Committee's website.

Monday 16 October 2017

Question number

Sir Chris Wormald, Permanent Secretary, Department of Health, **Richard Heaton**, Permanent Secretary, Ministry of Justice, **Helen Vernon**, Chief Executive, NHS Resolution, and **Dr Kathy McLean**, Executive Medical Director, NHS Improvement

[Q1–115](#)

Published written evidence

The following written evidence was received and can be viewed on the [inquiry publications page](#) of the Committee's website.

CNT numbers are generated by the evidence processing system and so may not be complete.

- 1 Irwin Mitchell ([CNT0004](#))
- 2 Medical Defence Union ([CNT0001](#))
- 3 Medical Defence Union of Scotland ([CNT0003](#))
- 4 Moore Blatch LLP ([CNT0002](#))

Published correspondence

The following correspondence was also published as part of this inquiry:

- 1 [Correspondence with Personal Injury Claims Arbitration Service Ltd.](#)

List of Reports from the Committee during the current session

All publications from the Committee are available on the [publications page](#) of the Committee's website.

Session 2017–19

First Report	Tackling online VAT fraud and error	HC 312
Second Report	Brexit and the future of Customs	HC 401
Third Report	Hinkley Point C	HC 393
Fourth Report	Clinical correspondence handling at NHS Shared Business Services	HC 396
First Special Report	Chair of the Public Accounts Committee's Second Annual Report	HC 347

Public Accounts Committee

Oral evidence: Managing the costs of clinical negligence in trusts, HC 397

Monday 16 October 2017

Ordered by the House of Commons to be published on 16 October 2017.

Watch the meeting <http://parliamentlive.tv/event/index/2b1752ba-10ad-45a7-9319-bf6ce6f5f433?in=16:41:44>

Members present: Meg Hillier (Chair); Heidi Allen; Geoffrey Clifton-Brown; Gillian Keegan; Shabana Mahmood; Bridget Phillipson.

Sir Amyas Morse, Comptroller and Auditor General, Adrian Jenner, Director of Parliamentary Relations, National Audit Office, Jenny George, Director, NAO, and Marius Gallaher, Alternate Treasury Officer of Accounts, HM Treasury, were in attendance.

Questions 1-115

Witnesses

I: Sir Chris Wormald, Permanent Secretary, Department of Health, Richard Heaton, Permanent Secretary, Ministry of Justice, Helen Vernon, Chief Executive, NHS Resolution, and Dr Kathy McLean, Executive Medical Director, NHS Improvement.

Written evidence from witnesses:

– [Add names of witnesses and hyperlink to submissions]

Report by the Comptroller and Auditor General
Managing the costs of clinical negligence in trusts (HC 305)

Examination of witnesses

Witnesses: Sir Chris Wormald, Richard Heaton, Helen Vernon and Dr Kathy McLean.

Q1 **Chair:** It is standing room only for everyone today. It is something about you; since you got your knighthood, Permanent Secretary, there is no holding back the public. Sorry, I am not rubbing that in, Mr Heaton; I am sure yours will come. It always does, with a sort of inevitability.

Welcome back to the Public Accounts Committee on Monday 16 October 2017. This is our third session of the day, and I thank the Committee for their endurance, as well as the Permanent Secretary, who has been with us the whole time. We are now moving on to the issue of managing the costs of clinical negligence in the NHS, and Gillian Keegan is going to pick up this knotty issue for us.

Q2 **Gillian Keegan:** Medical negligence claims inflation has considerably outstripped other forms of inflation; the spend has quadrupled over the last 10 years to a staggering £1.6 billion. What is going wrong?

Sir Chris Wormald: I will start, and then I will hand over to some of my colleagues. We think that the National Audit Office Report on this subject gets it pretty much spot on. I think it has done a very detailed job, building on the work that particularly NHS Resolution did about identifying where the cost drivers in the system are. I would not disagree with any of the conclusions that the NAO bring, about where those costs come from. I would tend to characterise them—and I will ask Helen to add a bit—in this way: underlying all this there are two rather distinct phenomena with different causes and different solutions.

We see a rise—some considerable rises—in very high-value cases, which result in the vast majority of the damages. Some 83% of damages relate to 8% of the cases. It is particularly maternity safety cases that are the big driver of cost. I struggle to find the right words, but some of the cost increases are for reasons that people would applaud. The life expectancy rates—Kathy might like to add something on this—of people who suffer maternal incidents are considerably better than they used to be, which is, of course, a fantastic thing but it means that any award of damages that are about lifetime costs will be considerably higher. That is what we can see. As I say, the underlying thing is a good thing. The only solution to that part, or the only long-term solution—this is one of the reasons we wanted Dr Kathy McLean here—is to have fewer of those incidents. So the answer in those very high-value cases is everything that we and our colleagues in NHS Improvement are doing to try to reduce the number of



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original incidents and, as I think you know, we have done a lot around maternity safety in particular, which Kathy can speak about. That is one phenomenon of driving the cost.

The second phenomenon, which I will ask Helen to say a bit more about, is this expansion in the number of much smaller cases, which does not, I think it is fair to say, appear to relate particularly to changes in the NHS—that is, there were not more incidents. There was the same number of incidents, more of which now come to court. As we go through this discussion—as I say, it was an excellent Report—we should keep the distinction between those changes in the legal market that are driving the large number of low-level cases and the changes in medical practice that are driving the high-level case. The combination of those two things explains the numbers. Helen, would you like to add something?

Q3 Gillian Keegan: I agree that the NAO Report does a very good job of looking in the rear-view mirror. However, many of these factors and drivers could have been anticipated or forecast. So what did you do? Did you foresee any of this risk and did you take any actions or carry out any activities to mitigate it?

Sir Chris Wormald: Yes, and figure 15 on page 39 of the NAO Report—I will not read through it—is an extremely clear summary of the issues, the actions that have been taken and the effect of those actions. A number of these issues had been long predicted and, indeed, we see them across the world—we see them in Australia, the United States, etc.—and the answers go well beyond the health service, as the NAO correctly points out. There are a range of things on which our colleagues in NHS Resolution have been leading actions, things that are within our control. As I say, I will not go through it, but figure 15—I might ask Helen to add something, as she manages—

Chair: Sorry, I did not introduce the witnesses. I will introduce you as you speak. Helen Vernon is the chief executive of NHS Resolution.

Helen Vernon: Thank you. I agree with Chris and with the NAO. It is huge challenge. The drivers are multiple. Some of them interact with each other, some of them do not, and some of them fall within our—

Q4 Chair: I know that. I think the point is about why you did not do anything sooner. Could you answer the question?

Helen Vernon: Of course. Coming to anticipating what we are doing about it, we have had a focus on claimant legal costs for some time. We noticed that, in response to some of the changes in the legal environment, claimant legal costs have become increasingly disproportionate, particularly in relation to the lower-value end of damages. That is coupled with an increase in the number of claims coming through in that lower-value damages range.

Chair: But Ms Keegan actually asked, why didn't you do things about it earlier? That was her question. Forgive me, but we have read the Report, and we have had a good, long answer from the Permanent Secretary.



Q5 Gillian Keegan: All these things were changes that you could see coming. That is my point. While this is interesting, there is an awful lot of “No, not me. Somebody else. I can’t do anything about it.” It does not give you a great deal of comfort.

Helen Vernon: There are probably two elements to that. One is controlling the volume of claims coming through, and the second is controlling the incidents that lead to those claims. Dealing with the second of those first of all, we have taken steps to increase the amount of learning we extract from claims and to share it with the NHS to support them in tackling those drivers. In particular, we have supplied them with some granular information about where their claims are coming from, and have provided them with scorecards and insight into their claims in real time. For example, we have provided organisations that are experiencing high numbers of the very high-value claims that result from obstetrics with more analysis of obstetrics claims. Our teams have gone into the trusts in question to go through that information in detail. The difficulty with that is that there is a time lag.

Gillian Keegan: Again, it is the rear-view mirror.

Helen Vernon: Exactly, yes. One of the things we did at the start of this year was to try to reduce that time lag considerably. Currently, the time lag between an obstetric incident occurring in a trust and our finalising the settlement is in the region of 11 years, about five to six years of which is accounted for between the incident occurring and it being reported to us. Since 1 April, we have reduced the time lag to 30 days. Within 30 days of the incident occurring, the trust will report it to us so we can extract learning more rapidly and share that with them for the purpose of preventing future incidents.

Q6 Gillian Keegan: Do you think that if you had had that kind of thought process earlier, you could have saved the massive increase that is now burdening the NHS? Again, these are all foreseeable facts. You could have looked at this problem and thought, “What is it I need to do to stop this happening?” Clearly, cutting it down from five years for learning about it and 11 years for resolving it is a pretty obvious place to look.

Helen Vernon: That is one of the steps we could take. There is a lot of work going on in relation to maternity safety—I think Kathy can speak about that. We have highlighted that maternity is the burgeoning area for high-value damages claims, in particular. Actually, the number of incidents has remained quite steady over a period of time, but each one is a multimillion-pound settlement, so clearly reducing those incidents by a small percentage would substantially reduce our spend.

Gillian Keegan: Okay. We are going to go into the detail—

Sir Chris Wormald: I will give you a slightly blunter answer to your question. There are clearly things we could have done earlier. Earlier this year, NHS Resolution set out a very clear plan for the next five years, which will cut some of these costs. Would that have had a huge impact on the total bill? No, because, as the NAO set out, there is no single, easily



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dealable-with cause. Yes, there were things we could do earlier. Would you be looking at a substantively different run of numbers had we done all those things earlier? Probably not.

- Q7 **Gillian Keegan:** Do you even have the management structure? Do your three departments sit together regularly with this in focus trying to come up with mitigating or risk management measures to try to ensure you reduce this burden on the NHS?

Sir Chris Wormald: Yes, we talk a lot.

- Q8 **Gillian Keegan:** Just talk a bit about. Not “talk a lot”; a formal structure that is actually tasked with resolving this.

Sir Chris Wormald: Yes, we have working groups between us. You can take some of the examples of the things we are currently—

- Q9 **Chair:** Can you give us an example of one for which you have had public meetings—

Gillian Keegan: And that had an impact.

Chair: Yes, and that had an impact.

Sir Chris Wormald: Richard might want to say a little more. Take the example of what we are doing about fixed recoverable costs, which we do completely hand in glove with the Ministry of Justice. Indeed, we are merging with the process of the Lord Jackson reviews that it is running. That is a very clear example of where the NHS bit interacts with the legal system bit. We have a joint set of proposals going forward. Richard, do you want to say a little about that?

Chair: Richard Heaton is the Permanent Secretary at the Ministry of Justice.

Richard Heaton: My perspective tends to be around the costs regime of the legal market. You are absolutely right: a lot of this stuff could be predicted. Some perhaps not. It is not always easy to predict how the market will behave. There were, as the excellent NAO Report documents, things that drove a high watermark in this sort of litigation, stemming from some changes way back to 2000 up to 2010 to increase the efficacy of conditional fee agreements. For example, for a few years it was possible to claim your success fee: recoverable costs. With 100% uplift of a success fee it was possible to reclaim your insurance premium. Those things were done to promote access to justice among people who would not have been eligible for legal aid. But it drove what I think can be seen pretty clearly as a huge bulge of litigation.

There are some signs that the high watermark has passed—this is where a bit of foresight came in—because of a bunch of things that were done in 2013: success fees were abolished; insurance premium recovery was abolished; and referral fees were abolished. A couple of things happened that were perhaps less foreseeable. Lawyers moved out of the road traffic accident area, the public liability area and the employer liability area



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because fixed costs came in and this area suddenly became more profitable. That accounted for some of the market flow in.

As Chris says, the next big thing I think we can do—my Department cares a lot about costs across the board; disproportionate costs really impede access to justice—is to try and extend fixed recoverable costs to as many areas of civil litigation as possible. The traditional view has always been that that has been too difficult in this area, because this is really complicated, you have got lots of experts, and a grid of costs will just not work. That was the public response to the consultation that my Department and Chris's Department worked on earlier this year. The Civil Justice Council said it is too rough and ready and will get in the way of access to justice. Instead, Lord Justice Jackson said, "Why don't you try cracking the process for these claims and make that more streamlined? If you can do that, it is fair enough to put a fixed recoverable cost regime on that." He recommended that we refer this to the Civil Justice Council to come up not just with a fixed recoverable cost regime, but also with a streamlined procedure. That is a recommendation I am happy to tell the Committee that Ministers have accepted, so that is what we will do.

The more that we can make costs foreseeable, clear and proportionate, the more we will bear down on the cost incentives for solicitors to bring cases of this sort.

Q10 Gillian Keegan: Bearing that in mind, then, we have this challenge yet again. It was £1.6 billion last year but it is forecast to be £3.2 billion by 2020. Again, in front of us, it will go up even further. Many trusts are facing financial challenges and ever-rising demand. That is not news to any of us. Plus they have efficiency plans in place, which are rather stretching, anyway. How will this be managed and how will we make sure that it does not have an impact on the budgets available? This will be 4% of the budget if that forecast is true.

Richard Heaton: These are not my budgets, but, as a public servant working alongside Sir Chris, I care a lot about this money. Two things: there are some changes that have not worked through. The NAO points that out. The LASPO reforms came in on 1 April for agreements that had been entered after 1 April, so there was quite a lot of bulge. There was a kind of closing down sale and quite a lot of bulge of litigation still working itself through. We hope that the numbers will be helped by the reforms done in 2013.

The other thing is the fixed recoverable costs regime: 60% of cases in this area are worth under £25,000. Those are the areas we will go for first. I am very optimistic that we can get a decent FRC regime in here. Are we doing enough together? If I am honest, I think the NAO Report was a good prompt. We do work together in all sorts of working groups, but I think we need a joint programme board not only to look at the success of what has happened and just to ask ourselves whether we can play with the costs regime further and whether we can streamline the process, change incentives—



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Q11 **Chair:** You are right, it is a good prompt, but, as Ms Keegan has highlighted, why has this had to be prompted? In fact, the former deputy Chair of this Committee, Richard Bacon, first raised this in 2001. It has been a large chunk of the whole of Government accounts that we have looked at. We were a bit surprised by the response from the Treasury earlier this year about it being a good idea: when it is a big number we should look at it.

Richard Heaton: We have been looking at it. We had the Jackson report in July and we have already acted on it, so we are not waiting.

Q12 **Chair:** Sorry, that was July 2017. This is something that has been around. It is your budget in the Department of Health.

Sir Chris Wormald: Yes, it is. As I say, if we keep the distinction between the two things. Richard has covered the plan of action around the lower-level claims. We just have to work our way through that. As I say, short of doing what some jurisdictions have done—this comes back to the Comptroller and Auditor General's question in his Report about big legislative tort reform, which is what Australia and some parts of the United States have done and goes beyond the delivery questions we normally discuss here—the only answer on those big value cases is to have fewer incidents. As I am sure you know, that was not prompted by this Report. There has been a long period of focus on how trusts in particular reduce the number of these tragic incidents. That is the answer to the question you asked, but Kathy, do you want to add a bit?

Dr Kathy McLean: Yes. As the Permanent Secretary says, we have been focused on safety for some considerable time. I will just do a bit of general and then I will home in on the specifics.

So, post the tragic events at Mid Staffordshire and the report by Sir Robert Francis, a number of things—in fact, a huge number of things—have been done around safety. Obviously, there were the Care Quality Commission and the inspections; we know the CQC has inspected all organisations. We know that between 2016 and 2017 there has been a drift to the improvement side, so there's been an improvement in overall quality and safety in organisations. And there has been a whole rack of different things. We know that changing the culture around safety is really important, so we have had a focus on freedom to speak up—the duty of candour—and an encouragement for organisations to report incidents, and we have seen the incident numbers being reported go up. That does not mean that there are more of the high-end, harmful incidents; it's about more of the incidents that we regard as almost near-misses that we can learn a lot from. And the national reporting and learning system, which I will come back to, has about 2 million of those a year, so a tremendous amount of learning.

I will get on to the specifics, because we know from the Report, which again we at NHS Improvement absolutely welcome—

Chair: Can we just assume that you all welcome the Report? It's a NAO Report; it's been agreed. We can cut this, because we could be here all



night. We're not being rude, Dr McLean, but you have more useful things to tell us than that.

Dr Kathy McLean: Because of the high number in obstetrics, it's particularly helpful that we are focusing very much on improving safety in maternity. And in November 2015, the national ambition to reduce stillbirths by 50% by 2030 was launched, with the aim of reducing stillbirths by 20% by 2020, and some resource has been made available to help with that. And in October 2016, the Secretary of State launched a safer maternity care action plan—

Chair: Okay. We will come on to maternity, I think, with some specific questions. I have been very indulgent with witnesses and we know you have a lot that you want to share about what you are doing and what you've been doing for the last couple of years, but there have been some specific questions and I urge—it is not particularly aimed at you, Dr McLean, you just happen to be the last person to speak, but if you could just answer the questions, we are all briefed up and ready to go. So, Ms Keegan, on that—set us an exemplar.

Q13 **Gillian Keegan:** I would like to dig into some of those policies and some of those improvements. This is a massive part of the budget and it is going to grow. If it's true and it's £3.2 million in 2020, what impact does that have on the service to patients? Have you actually analysed that?

Sir Chris Wormald: Well, it goes into the general pressure on the NHS that we've discussed before and the Comptroller and Auditor General has reported on. We don't cost out specifically what that would—

Q14 **Gillian Keegan:** But you can foresee this one?

Sir Chris Wormald: Oh, yes, as we can with many of the other pressures on the NHS. So, I'm not going to say that that particular £1.6 billion of extra cost has a particular effect as opposed to any other pressure on the NHS. Just like all pressures with which we deal, we will want to see it come down, not simply, as I say, for the cost reason. All the things that Kathy is describing, you try and do because you want to be a great health service—

Q15 **Gillian Keegan:** Again, it's like you're kind of a victim to it. I mean—

Sir Chris Wormald: No. You've said that twice and I don't agree with that at all. What we are setting out, as honestly as we can, is that there are a series of things that are within the health service's gifts and we are taking measures across all of those things. There are then a series of things that are within our joint gift with the Ministry of Justice and, as Richard has described, we are taking action on those things. There are then a set of things that are not in our gift, and I do want to be absolutely clear about that; the NAO has raised that as the right question. We are focused on how we do the things that we can control. So I'm sorry, I don't recognise your—

Q16 **Gillian Keegan:** Let's look at that then. Which hospitals are handling clinical negligence well? Which ones have best practice? Do you measure



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it? Do you share it? Can you give us information on that?

Sir Chris Wormald: Yes.

Helen Vernon: That goes to the way in which we price the main indemnity scheme. We price it on the basis of experience and exposure. If trusts are reducing their claims experience, their price will come down, and vice versa, although obviously we adjust that for the amount of activity they undertake as well.

Q17 **Gillian Keegan:** But one of the drivers of that was activity itself—volume—as opposed to just best practice, so that does not answer the question specifically.

Helen Vernon: So 60% of the pricing relates to their claims experience, which can only be driven by negligently caused incidents.

Q18 **Gillian Keegan:** But there was a correlation between those incidents and the amount of activity. I think that was clear—the more you do, the more you may have a claim.

Helen Vernon: Yes, and we consulted on the pricing back in 2016—

Gillian Keegan: But that is not best practice, or, indeed, worst practice.

Q19 **Chair:** Can you name any hospitals that are doing a particularly good job?

Gillian Keegan: Yes, the question was, can you name some hospitals that are specifically doing a good job of managing clinical negligence claims? Do you look at that?

Helen Vernon: On the relationship between the exposure and whether if you can do more of something, you get better at it, when we consulted on our pricing in 2016, that point was raised by the membership. We have recently commissioned some work on that from a risk consultancy, to look at the correlation between exposure, which is the amount of activity you do, and exposure in terms of the number of negligently caused incidents that result.

Q20 **Chair:** Does anyone else have an example? Dr McLean, at NHS Improvement, is there an example of a hospital that does this particularly well? There are two things; one is about managing this particular issue, and I have another question that follows on.

Dr Kathy McLean: In terms of the money, I would have to leave that to NHS Resolution, but I think it is fair to say that those organisations that are outstanding or have a really good culture around this are doing better than others. That is why they aspire to—

Q21 **Chair:** You talk about culture, and you talked about the duty of candour earlier. We have looked at whistleblowing in this Committee. The NHS does not have a great track record on that. If you are a whistleblower in the NHS, it can be very damaging to your career, and there can be a lack of openness as a result.



Dr Kathy McLean: We measure this through, for example, the staff survey. That is done annually for all organisations, and in it there is a series of questions that indicate whether staff have witnessed a harmful incident, which we know is going down, and whether they feel that they could report it well, which is going up. We feel that those sorts of cultural questions are really, really important. High scores in the staff survey on those questions correlate well with the trusts that have been rated by the CQC's inspections as outstanding.

Q22 **Gillian Keegan:** You are probably coming from a very low base there. The defensive nature of the culture of the NHS is very high, for many reasons, so you are probably coming from a very low base, in terms of whether you really have a culture that learns from its mistakes and very quickly admits them and investigates, to provide the information for the resulting process and so on. Do you really think that that is in place? Looking at this, I don't feel as confident as you seem to be.

Dr Kathy McLean: Like with many things, there is variation. There is huge variation across—

Q23 **Gillian Keegan:** That is why we asked about best practices and best hospitals, and we still have not heard a name.

Dr Kathy McLean: I can give you names of the outstanding trusts, if you wish, but—

Q24 **Chair:** So you are basically saying that if a hospital is outstanding, it is good in this area.

Sir Chris Wormald: When you look at the characteristics of an outstanding—

Chair: I don't want to have a long discussion about it. I am just seeing how we can get a list, quickly.

Q25 **Gillian Keegan:** I think the CQC is probably measuring other things more than this.

Sir Chris Wormald: Well, no—this is where I don't quite agree with you. When you look at the characteristics of outstanding trusts, they do a lot of other things, but they are the organisations that focus on learning lessons and being transparent in whatever.

Q26 **Gillian Keegan:** I have sat as a governor on an outstanding trust, and I make these comments with that in mind. It is still an extremely defensive culture.

Sir Chris Wormald: Are we part-way through a journey? Yes, we are.

Chair: We're always on a journey—deary me. In PAC bingo, that gets top marks.

Dr Kathy McLean: Can I give you an example? Last week, I spent a day at two separate trusts that are on a quality improvement journey. In one of them in particular, there were some fantastic examples of the staff



being very much in the space of speaking out. They described how they had been able to reduce not just falls but the actual fractures from falls. It was all due to the fact that the staff were engaged and open. They had been empowered to do their work, and that is the sort of culture we are trying to encourage, so that we reduce the harmful incidents.

Q27 Gillian Keegan: Will these things that you are talking about, which are all very generic, bring down the forecasted claim of £3.2 billion? How are you managing that? Be very specific because it costs a lot of money and it takes away from patient care.

Chair: Not just money—a fall and the result of that are devastating to someone's life.

Dr Kathy McLean: It is absolutely dreadful. Therefore, I think we are all motivated to do that. What I would say is that there is a whole range of things and I can pick out loads of specifics, for example the learning from deaths programme. We know that there is a lot to learn from those processes. We know that some of the investigations—the CQC published a report in December last year—were not as good as they needed to be. We know that the Healthcare Safety Investigation Branch came into being in April and it is going to help the NHS to do investigations better. On the learning from deaths programme, all the trusts have been publishing their new policies—they are working on that and they have been trained to do better investigations.

I think that all those things together will gradually have an impact. I can give you an example about orthopaedics where it has already reduced: the getting it right first time programme has made things transparent, because they discovered that on orthopaedics, the trust did not know its litigation numbers. They have been around and, actually, there has been a reduction, initially of 5% and then 8.5%, in litigation costs.

Gillian Keegan: If you measure it properly you may get a change in performance, but I do not get the feeling that you do.

Q28 Geoffrey Clifton-Brown: I am interested in why some people make claims and some do not. In my long experience as an MP, when I have had a problem—there have not been many I am glad to say—I have found it to be extraordinarily difficult to get anybody in the NHS to admit any formal responsibility, let alone say sorry. I think that in a lot of cases, if an apology were quickly issued it would take the sting out of the whole case.

Chair: A very quick answer to that please.

Sir Chris Wormald: I think that basically we agree with that.

Geoffrey Clifton-Brown: I want to go on to a different subject—

Chair: Actually, I want to move on as we have covered some of these subjects in a previous discussion.

Q29 Bridget Phillipson: We know from the NAO Report that nearly 40% of current claims relate to failures and delays in diagnosis or treatment. The



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NAO warns about the potential for that to get worse due to waiting times, given the pressures on NHS services. We also know that there is a time lag in those claims coming through the system. What is being done to mitigate the risk of delayed waits leading to an increase in claims?

Sir Chris Wormald: All the things that Kathy has described. To be clear, and I think that the NAO was very clear on this point, we have not yet seen that effect. It has flagged it as a future possibility.

Q30 **Bridget Phillipson:** That is true.

Sir Chris Wormald: The recent CQC State of Care made a point of saying that despite the pressure on the NHS, quality has not gone down and indeed it has gone up in a number of cases, so we are not yet seeing that effect. There is not a different answer than all the things that Kathy has already described. There is much further to go, but if a hospital is doing all those very basic things about quality very well, its claims go down, as Kathy was describing.

Q31 **Bridget Phillipson:** There is excellent work being undertaken to understand the wider drivers and I will come on to some of those, but surely there must be a risk that if people are waiting longer to be treated and, if that leads to adverse consequences, given the pressure on services we are facing the prospect of that ballooning figure increasing further if people have to wait longer to receive treatment.

Sir Chris Wormald: I will ask Kathy to comment, but of course we do not want people to wait—

Chair: Please answer the question, otherwise we could be here all day.

Sir Chris Wormald: It depends on the clinical nature of the individual. There are a number of people who wait where it will be painful and inconvenient but does not actually cause harm, and there are other people—

Q32 **Chair:** Such as with a knee replacement?

Sir Chris Wormald: Those sorts of things, and there are other cases where you can cause harm.

Q33 **Chair:** I think that, self-evidently, Ms Phillipson is talking about the waits that might do harm.

Sir Chris Wormald: If we have the kind of safety culture that Kathy was describing, the NHS will be prioritising those most dangerous cases. Although that is quite a generic answer, there is no other way to this than every trust in the country, every medic in the country and every person in the health service taking the right decisions around safety. Is that fair enough, Kathy?

Chair: We are asking the questions. Ms Phillipson, are you happy with that, or do you want to ask Dr McLean—

Bridget Phillipson: Well, if you would, yes.



Dr Kathy McLean: Yes. For some things—cancer, for example—we have a very short waiting time. Of course, we anticipate that if patients who might have cancer were waiting a long time, they could well come to harm, so we obviously endeavour to meet those standards and we are working very hard on that. On other things, it will absolutely come down to clinical prioritisation. When a clinician deems that a patient who is on a waiting list may well come to harm, they should be brought forward. There are also reviews of those who are waiting longer than is desirable. So far, whenever those reviews have been done, the level of harm to those who are waiting has actually been extremely low indeed. Any harm is not good, but the level of harm is extremely low. We need to watch this very carefully as we go forward.

Q34 **Bridget Phillipson:** Returning to patient motivation, do we really understand why some patients make claims and some patients do not? This is a very complex area, which the NAO looks at in its Report, and I know that it is difficult. Do we really know why some patients who suffer an impact from an adverse incident choose to claim and some patients opt not to do so?

Helen Vernon: A lot of it is to do with communication. I reiterate what Chris said about candour and transparency being critical in that. We have long promoted that as a way of avoiding a claim rather than prompting a claim. The NAO Report points out an interesting demographic factor: the rate of claims among the over-65s is lower than the rate of incidents. We supported a study of the demographics by Professors Fenn and Rickman, who were reporting for the Nuffield Trust, and they found the same correlation. The propensity to claim is also significantly higher among those who have had a year off work as a result. There is almost certainly a correlation: those who have had a protracted loss of earnings wish to meet their needs by pursuing a claim for that loss of earnings, which of course is less of an issue for the over-65s.

Q35 **Bridget Phillipson:** But we would be in a far worse situation if some of those older patients, who might not have suffered such a loss of earnings, decided to pursue the NHS, quite legitimately.

Helen Vernon: Yes.

Q36 **Bridget Phillipson:** Are we doing enough to understand how trusts handle complaints? Is there any connection between the way complaints are handled by trusts and whether those complaints lead to claims against the NHS?

Helen Vernon: Instinctively, we think there is. There is a weak correlation between complaints and claims. We found that in our analysis, and the NAO concurred with that. We have announced an intent, with the Parliamentary and Health Service Ombudsman, to better support trusts in post-incident handling—in doing right at an early stage some of the things that prevent something from escalating into a complaint and then going up to the ombudsman or, in turn, from escalating into a claim. That is a lot about communication skills, handling, transparency and candour, and it is about involving families in investigations as well.



Q37 Bridget Phillipson: I think most people would recognise that the NHS is a valued institution. We all want treatment when we need it. We all want to make sure that the people looking after us are properly paid and well supported. Given the vast nature of the NHS, a relatively small number of cases lead to a claim in the first place. Surely, the vast majority of people would just want an incident dealt with, would perhaps like an apology, or would just like to understand that this will not happen to someone else's family.

Helen Vernon: I agree with that. That is something that successive reviews have found is the case and can very often ensure that an incident does not turn into either a complaint or a claim. We need to increase the level of support we provide to trusts locally in order to ensure that that happens.

Sir Chris Wormald: But again, there is a very big distinction between small value claims and large ones, which is where obviously—

Bridget Phillipson: Yes, and we will come on to higher value claims.

Q38 Shabana Mahmood: I want to ask you about the data that you collect on claims. You apparently have an online portal that shares data about claims with trusts, but it is apparently not that useful. What data do you share via that online portal?

Helen Vernon: We have actually got quite good feedback from the trusts. We have a customer survey every year and they quite like the extranet. It gives them real-time visibility of their claims as they come in and as they settle, and it also gives them some benchmarking of their claims against their peer groups.

We mentioned the getting it right first time initiative. Actually, claims data is now finding its way through GIRFT into the national dashboards, so that the claims data can be reviewed alongside clinical indicators, in context. We have a confidential advisory group exemption to roll that out over the next year. We have started with things such as orthopaedic surgery and we are hoping to extend that to other specialities through the GIRFT programme, which is sponsored by NHS Improvement.

Q39 Shabana Mahmood: So everybody can go onto this online portal and see anonymised data about claims, and you are using that to benchmark?

Helen Vernon: The individual trusts can. For data confidentiality reasons we cannot allow the trusts to see each other's data, but they can see themselves benchmarked against an anonymised peer group with a trend line.

Q40 Shabana Mahmood: Who does the review of all the trust data then, if they cannot see each other's and there is no peer process? Who is overseeing it?

Helen Vernon: We publish anonymised data on our website. We have something called Factsheet 5, which breaks down all the expenditure

across all trusts, by trust, so you can see that expenditure, although it is obviously not patient identifiable.

Q41 Shabana Mahmood: I am interested in that, because your answer implies that you have a system in place, but the NAO Report, at paragraph 3.20, on page 47, says that during the NAO's fieldwork "trusts expressed mixed views on the usefulness of the information shared by NHS Resolution. They told us that the data it collects, in its current format, is of limited use in helping clinicians gain insight to help improve patient safety."

Helen Vernon: I agree with that conclusion; it is something we need to do better at. We have tried different ways of doing that, because not everything suits everybody. For example, we have started to produce leaflets on high-claim areas—things like pressure ulcers in maternity, for example, which should never happen. We bring it to life with real case examples and data, so that those leaflets can be literally shared on the wards with clinicians.

Q42 Shabana Mahmood: Instead of creating a system and spending money to have an online portal, would it not have been better to have consulted first with the trusts about what data would have been useful, and what format it would have been most useful in, and gone ahead and done that, rather than starting with something and then realising it is not fit for purpose?

Helen Vernon: We did consult with trusts prior to putting our extranet together and, as I said, we have had positive feedback from them in the customer survey that we run. I think the trusts' comment about the usefulness of the data probably goes more to their pricing. They struggle with the pricing because it is a pay-as-you-go scheme. We collect in what we expect to pay out, so there is no ready reckoner for them to see whether, if they adjust their experience level here, it will produce a certain price result there. That is because they are all relative to each other. I think that is where that comment comes from, rather than the extranet.

Q43 Bridget Phillipson: I would like to understand how all the different component parts come together on a practical level to try to ensure that we have a system that reduces incidents and means that claims do not arise in the first place. At a practical level, how does the Department work with NHS Improvement and NHS Resolution to bring everything together to try to stop incidents arising in the first place?

Chair: The Permanent Secretary is handing it to you—lucky you.

Dr Kathy McLean: I think that there is more that we can do to join together, but one of the things that we can definitely do, which is quite timely, is make sure that the data—all the things that you have referred to, whether complaints, claims or incidents—triangulate. I mentioned earlier the national reporting and learning system. It is actually in the process of being replaced, and will be replaced by 2019, so we are linking with NHS Resolution and others to make sure that the new system is more effective at doing that, and making good use of all the different data and



bringing it together. At the moment there isn't anywhere you can go that actually draws that together.

- Q44 **Bridget Phillipson:** It feels as if there are good bits of work going on in different places, but how is that all drawn together to stop these incidents happening in the first place? We will come on to the incidents but, as you mentioned, they are life changing, dreadful and tragic. We all want to stop that. How do the different component parts of quite a fragmented NHS come together to try to stop those incidents occurring?

Dr Kathy McLean: I am sure the Permanent Secretary will want to say something on that.

Sir Chris Wormald: That is one of the reasons why we constructed NHS Resolution in the way that we did, so it has that wider focus on how things are resolved. The heart of it is the NHSI system that Kathy described, and the good practice for trusts—where the vast majority of these costs comes from—comes together in that process. It is right that we have made some progress on how we share useful information out of the claims process into that, but we need to make more progress. When we are looking at reducing incidents, however, the much wider data set that Kathy described about the number of incidents—whether they result in a claim or not—and all that safety data are probably more important than the claims data. As others have pointed out, whether something results in a claim can be slightly random. Those claims data are very useful if you are managing claims, but not necessarily if you are trying to drive safety in hospitals. What Kathy has described is where it comes together. We need to do more to bring the data that NHS Resolution has into that system.

- Q45 **Bridget Phillipson:** I understand the point about there being things that do not work as well as they could as opposed to the number of claims that are being made, because the two are not necessarily the same thing. We know from the Report that a lot of people do not make claims when they might have good cause to do so. The NAO Report seems to underline the point that data are not being collected in such a way that allows a wider understanding to be drawn across the NHS about the common factors in cases that have given rise to claims. How do we ensure that we have a system that records not only a claim, how much it cost and in which area it took place, but the common factors within that area that will stop these things happening in future?

Dr Kathy McLean: The data are absolutely vital to underpin it, but it is also—I think this is what you are getting at—the relationships and working together across the system. Certainly, since the new chief executive for NHS Resolution has arrived, we have met and, under the auspices of the Department of Health, we would ensure that people come together to ensure that changes happen—as well as having the data.

Sir Chris Wormald: You're basically right. The change from the NHS Litigation Authority to NHS Resolution is more than a name change; it is a move from an organisation that was largely focused on handling amounts



to one that is much more engaged with how we stop incidents in the first place and how we feed that in. Is that clear enough?

Q46 Bridget Phillipson: Do you want to respond?

Helen Vernon: That is the basis of it. We have set out a five-year strategy that Ministers approved in April. A key part of that is producing better-quality intelligence for the NHS about the causes of their claims. We kicked off that work this year with a study, "Five years of cerebral palsy claims", to pull out the causal factors that lead to those cases. To add to what Kathy said, I think the key is an agreed and consistent taxonomy so we are not coding claims in one way, incidents in another and complaints in yet another. We are providing input into the development of the patient incident management system to ensure that we get to that point.

Q47 Bridget Phillipson: On a separate note, where do STPs fit in all this in terms of changing the way that services are delivered for better outcomes for patients? That is what I don't fully follow about the different component parts and all the things that are going on in the system. Where do STPs sit?

Sir Chris Wormald: I do not think STPs have played a prominent role in this issue. There is some cost on the GP side of this, but the vast majority of costs is about what happens in trusts—how individual hospitals are managed. I do not think that has been a particular focus of STPs and, to be honest, I think that is probably right. As I say, the vast majority of costs are about decisions and processes in trusts, so that has been our very clear focus.

Q48 Bridget Phillipson: We all want to ensure there is value for money, but much of the focus on STPs is about ensuring that outcomes for patients are better—some of the changes are about delivering better outcomes for patients, as is argued. I do not know where STPs and wanting better outcomes for patients sit within this.

Sir Chris Wormald: There are two questions there. Yes, of course STPs are focused on the wider outcomes—that is absolutely core—but when we are talking about incidents that lead to damages, that is mainly things that happen within trusts and should be the focus of the trust management. Do you agree with that, Kathy?

Dr Kathy McLean: Yes, I do. I think it is maybe worth mentioning that the serious incident framework, which links the commissioners and the trust in reviewing what has happened, is being reviewed at the moment. I think that will take into account the new context in which people are working.

Q49 Gillian Keegan: Will that review have some targets in it, in terms of outcomes, time length or best practice?

Dr Kathy McLean: We probably won't call them targets as such, but we will probably refer to them as timeframes, milestones and expected time. Some of those are quite long at the moment within the current arrangement.



Q50 Bridget Phillipson: Could I go on to maternity and how that connects, in part, to STPs? Maternity obstetrics is rightly a focus of the Report, given that 10% of claims lead to nearly 50% of damages awarded. However, last year—this may have changed since—the Royal College of Midwives suggested that many of the STPs that have been published did not really focus on maternity and weren't focused on some of the outcomes around Better Births and the work the Department is doing. Is that changing or improving? Are we going to see a bigger focus on connecting those issues?

Dr Kathy McLean: Yes. I think that was probably just at a point in time. There are a number of things in place. For example, there is the maternity safety collaborative, which brings people together across a patch, and there is now an enormous focus on cross-system working on maternity. I think that is where we will get a lot of the benefit. There has already been evidence of improvement in outcomes through that work.

Q51 Bridget Phillipson: That is what I was driving at with the question around STPs. Yes, of course, where you have individual adverse incidents, you want to consider what is happening. However, given some of the recommendations around the number of births that should be delivered within units and the patient safety that results from that, I am really asking whether we can improve patient safety and potentially some of these claims by just getting the structures and systems right, so that we stop these things happening?

Dr Kathy McLean: The structures are one thing, but I think it is also about the way that people work together across whatever that will be—they have changed over the years. We know that there are already, through Each Baby Counts and so on, things that these maternity collaboratives and alliances can put in place that are starting to have an impact on the outcomes, whether that is stillbirths or poor outcomes.

Q52 Bridget Phillipson: Looking at the Report prior to today's session, it was quite shocking to consider that, of three in four cases that were looked at, stillbirth or brain injury could have been avoided. The Report acknowledged that there were complex factors in why those incidents happened in the first place, and that, in one in four cases, they couldn't really consider what had gone on, given poor record keeping or an inability to draw some of that together.

Again, that goes back to the issue around people who claim versus those who don't claim. In the event that you had a child who suffered a long-term brain injury, of course you would need help and support, on a purely practical level, to simply make sure that your child was looked after and comfortable. There must be a lot of people who would not seek to lodge a claim with the NHS, but we have, as you will know, a very high rate of stillbirth compared with our European neighbours. I just wonder there is more under the surface that isn't featured in the Report, because it does not get that far—a lot of pain and distress, as well as the obvious cost that results.



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Dr Kathy McLean: Absolutely. I think the bundle of things that could be done from Saving Babies' Lives that were described, around smoking during pregnancy and so on, and also the approach to learning from deaths, all need to be fed back in so that we actually improve all of the time. I think it is an ambitious aim. We are not in the best place on stillbirths in this country. We have a long way to go, but we are already showing improvement over the last three or four years; there has been a measurable improvement.

Sir Chris Wormald: But also, for exactly the reason you say—making the data transparent—

Chair: Absolutely. People need to know.

Sir Chris Wormald: Making the litigation data transparent, as you say, only tells a very small percentage of it, which is why there is a huge focus on whether we can make all of that transparent to drive a learning culture.

Q53 **Bridget Phillipson:** A final question on this. A consultation was published on the rapid resolution and redress scheme for severe avoidable birth injury, and I think the summary response was to be published. I couldn't find it; perhaps it has been published.

Sir Chris Wormald: No it hasn't been published. We are considering it at the moment.

Q54 **Chair:** Any timescale?

Sir Chris Wormald: I don't have a timescale for you.

Q55 **Chair:** Perhaps you can write to us when you do?

Sir Chris Wormald: It is a very—

Chair: We don't need to go into it. We can wait for the answer. At this point in the hearing we are not going into why it may be delayed. I am aware of the time. We were hoping to finish by around 7 o'clock, because this is our third session of the afternoon. I am going to ask Mr Clifton-Brown to provide an exemplar of asking a tight question, then I am going to go back to Ms Keegan and Ms Allen.

Q56 **Geoffrey Clifton-Brown:** This question is really for Richard, but possibly Chris, to comment on, regarding your joint discussions between your two Departments. Richard, your Department will be aware of a whole range of litigation systems. In order to reduce those costs the judge in a lot of areas of the law will require, before it comes to court, that some sort of conciliation or arbitration procedure precedes a court-led, full-blown litigation system. What discussions have you had about ways of reducing litigation costs by using conciliation and arbitration procedures?

Richard Heaton: You are right. There are some areas of litigation—family, employment—where the parties are required to—

Chair: We agree that Mr Clifton-Brown is right. Could you answer the question? Sorry, I am just aware of time.



Richard Heaton: In an area as complicated and difficult as this, any arbitration system has to be sector-specific. I would look to colleagues in NHS Resolution and the Department of Health. I do not think that a court-mandated scheme, such as you would find in a straightforward building case, will meet the complexity of this sort of case. I would expect something as sector-specific and tailor-made as Helen has described to be the right method here.

Q57 **Gillian Keegan:** We are going to move on to looking at NHS Resolution's improvement in handling claims. It is clear that the length of time has a direct impact on the size of the legal costs. We have received written evidence from a law firm that has an assessment of why the length of time has increased. It basically says that failure to conduct an early investigation is the cause, leading claimant lawyers to then initiate expensive investigations themselves. Again, this is about culture and people putting their hands up quickly and trying to investigate quickly what has happened. What is it that you are doing, because the legal costs are ballooning and this is something that you can really control 100%?

Helen Vernon: Our purpose, since we were set up, was set out to resolve claims fairly and quickly. We do that with the benefit of expert medical and legal advice right at an early stage. We also try to keep cases out of formal court proceedings wherever possible, and we do that in 66% of the cases that we handle. There was reference earlier to alternative ways of resolving disputes, and we embrace that as well. We have a pre-action protocol for clinical negligence, and it requires us to respond within four months of receiving a letter of claim. The clock starts ticking as soon as we hear about the case, and then we provide a full response on liability within that period.

We also use mediation, and have increasingly pushed cases towards mediation as a way of resolving claims without formal court proceedings. To be frank, we have found that quite difficult to get off the ground, particularly because there has been some resistance from claimant lawyers whose preference is for the more formal route of—

Geoffrey Clifton-Brown: Of course.

Q58 **Gillian Keegan:** I guess they would, wouldn't they? But it is for you to set the direction here, and not for you to be directed by the legal profession.

Helen Vernon: Indeed, and we do have cost consequences if we offer mediation and it is refused. The fact that we are turned down does not mean that we are not still promoting it and pushing it forward. Actually, it is probably incorrect to say that there has been a homogenous response across the piece. We have had some claimant lawyers engage with it very well, and since we put a formal panel in place we have mediated 71 cases. It is small in the scale of things, but it is still much higher than years ago.

Q59 **Chair:** When you say "small", does that mean they are small in number—71 is not a big number—or is it about the complexity?



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Helen Vernon: It is across a range. We piloted a mediation service last year and we put 50 cases through. Those were focused on fatal and elderly care cases, because those are often the cases where the individual does not have an advocate available for them. That is particularly in elderly care cases, where we have seen that they represent quite a low proportion of claims, so we thought that they were particularly suitable for mediation. We have rolled that out across the piece, and we procured for a mediation panel, which came into place in December last year. We will now mediate anything, of any value, at any time.

Q60 **Gillian Keegan:** Okay, but one of the other things the law firm said was that NHS Resolution—your own organisation—seemed to be determined to contest the overwhelming majority of claims.

Q61 **Helen Vernon:** I disagree with that.

Q62 **Gillian Keegan:** Because you are being driven by the legal profession, who are telling you that that is the best way to resolve it.

Helen Vernon: I disagree that we defend cases unnecessarily, if that is the implication of the letter, and I think it is.

Q63 **Gillian Keegan:** It is a decision that you take deliberately. You have just mentioned the small number of mediations, which must be almost a rounding error in terms of the numbers. The evidence is there: most cases are going to court.

Helen Vernon: They are not, actually. Sixty-six per cent of the cases we resolve do not go anywhere near a court, and only 0.7% of the cases which we resolve go to a full trial. I think those figures are in the NAO's Report.

Q64 **Gillian Keegan:** To a full trial.

Helen Vernon: Yes.

Q65 **Gillian Keegan:** Okay. This may be for Mr Heaton. In terms of the court, one of the other delays is availability of the court, court time, expert witnesses and so on. Do you have an idea of capacity planning? Who is responsible for that?

Richard Heaton: I was not aware—I did not pick this up from the Report—that capacity in terms of judges' sitting days is particularly a blocker here. I was not aware of that, but I may have missed something from the Report.

Jenny George: In figure 19, there is a list of some of the factors that can impact on how quickly a claim can be resolved. One of those is capacity of the court.

Q66 **Gillian Keegan:** I guess it is logical, as well, isn't it? There has got to be a plan in place to ensure that all this complex stuff comes together, including the expert witnesses.

Richard Heaton: What I would say is, as I said earlier, Lord Justice Jackson observed that you cannot impose fixed costs on a system as



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complicated as this. You need to improve the system. So the key is to improve the system—that is the way to drive down costs. With a more streamlined system, you would have fewer reports, fewer backwards and forwards. You might even have joint reports between the parties. I think that is the key. The other key is the courts and tribunals reform programme generally, which is to introduce greater efficiency—

Chair: We have covered that a lot in this Committee, so you can park that thought.

Richard Heaton: That will bring greater speed and efficiency—

Chair: So that will impact on this. That is good to know, because we have looked at that a lot.

Q67 **Gillian Keegan:** I am still concerned that a lot of what we have heard today really rests on improvement in the culture: putting the hand up quickly and saying sorry to mitigate other activities; getting to quick investigations; and quickly sharing data among all of you and among other trusts. That is crucial to managing this, and still if it is going to be £3.2 billion by 2020, God knows what it will be by 2025 and so on. That is absolutely critical, and it is within all of your management gift.

Sir Chris Wormald: We agree with that. There is some outstanding practice out there in the NHS and, as Kathy was saying earlier, there is some variable practice. We have got further to go. Obviously, changing, evolving the culture of something as huge as the NHS does take time and it is all the very sorts of nuts-and-bolts things that Kathy was describing earlier that we need to see driving that culture.

Personally, I know that my Secretary of State would agree with this: transparency of data is absolutely essential to it. When we have seen culture change, there has been that. On that specific point—

Q68 **Chair:** But there has been some resistance, hasn't there, on transparency of data from some clinicians?

Sir Chris Wormald: As the Committee is well aware, there are types of NHS data it is very difficult to make transparent, for all sorts of very good reasons, but—

Q69 **Chair:** But you are telling us that you are not taking your foot off the pedal on that.

Sir Chris Wormald: But in terms of what will drive culture change, the transparency of data—

Q70 **Chair:** Okay. Just to be clear, you are not taking your foot off the pedal on the desire to have more transparency.

Sir Chris Wormald: No, absolutely not. Sorry, I misunderstood the question.

Chair: Okay. Bridget Phillipson—with a very quick point, I hope.



- Q71 Bridget Phillipson:** What can we do to improve complaints handling by NHS bodies, whether or not it has any bearing on the number of claims coming through, in terms of both timeliness and the nature of the response? I find sometimes responses are slow and, when the response comes, perhaps it does not really shed much light on what has gone on.

Dr Kathy McLean: I think this comes down to a few things, some of which we have already touched on, which are around the culture, but it is also around the leadership in organisations. In the best organisations the chief exec, the medical director, the nurse director—the people at the top—pay attention to this and personally look at things. Also, through our various programmes that we are working on in terms of the safety space, we are working with organisations in order that they get ahead of things—they see families early on, and they do not wait until later in the process to start trading letters, because actually the advice is: see people, have the conversation, say sorry and start to put it right. You were saying earlier, I think, Ms Keegan, what people want is to know that this will not happen again to someone else—that is the big thing for them. The duty of candour is helping with that.

We have been working on this stuff since about 2013 in a way that I have never seen in all the 30-odd years I have been in the NHS—the focus on safety has never been greater. We are starting to see some benefits, but there is a lifetime—

- Q72 Bridget Phillipson:** Defence of this is not unique to the NHS—I totally understand that. None of us particularly likes to feel that we got things wrong, or wants to accept that we have done that, I understand, but I just do not fully appreciate how this improvement is being followed through by NHS trusts—complaints as distinct from serious incidents as distinct from claims. Whether or not it has any bearing, can we not just bring a bit more pressure to bear on making some changes and having some improvement? At a constituency level, it does not feel wonderful sometimes.

Dr Kathy McLean: That is very helpful to hear—your real experience. I think as well, going back to what we were saying earlier about joining up how we describe things—the taxonomy—and the sharing of that information so that we can triangulate, again the very good trusts do handle this better than others. Absolutely, we will focus even more on this, I think.

- Q73 Geoffrey Clifton-Brown:** I would like to follow up my question to Richard. I got a blank no, but two questions later I heard Helen say, “We have taken 50 cases to mediation.” I appeal to you again to look outside the box to see whether there is not scope to reduce the cost of litigation and lawyers’ fees. Of course they want to take full-blown litigation to court, because they increase their fees by doing so.

You hinted at one of the ways of reducing litigation costs—by agreeing a statement of principles that are agreed, leaving the ones that are not agreed to court. I suspect—sorry, very quickly, Chair—in answer to my earlier question about people who do and do not make a claim on the



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NHS, that if in some cases they were offered quick mediation or quick conciliation, they would settle out of court just like that.

Richard Heaton: I realise that my last sentence might have sounded glib. Two things: first, I do not think that ADR, alternative dispute resolution, is working very well in civil justice at the moment. Tomorrow you will see an interim report from the Civil Justice Council looking at exactly this and suggesting that we should look again at compulsory mediation in some areas of civil business. I did not mean to say that it did not have a part to play. What I meant to say is that in this particular area I think it would have had to have a particular health flavour to it.

Geoffrey Clifton-Brown: Which may not be ADR, but mediation certainly.

Richard Heaton: Absolutely. Mediation as a form of ADR.

Q74 **Geoffrey Clifton-Brown:** Also agreeing a statement of principles where there is agreement, before it goes to court, would save the court costs when it gets there.

Richard Heaton: I commend to you the publication tomorrow, which is an interim report from the Civil Justice Council on exactly this.

Q75 **Gillian Keegan:** Following on from that, this is a really basic kind of service, isn't it? People need to feel listened to when they have a problem or a complaint, not stonewalled, pushed somewhere else or put in a position where they are defending themselves. You talk about best practice, but the best practice of organisations is where the basic culture is one in which failure is celebrated—"Fail fast and let everyone know quickly, so that we can spread that throughout the organisation." Of course that is the only way you can catch it, particularly in an organisation the size of the NHS. You could be taking action on that tomorrow, in terms of putting in place those services that ensure that everyone is listened to and that the customer care basically—the patient care—includes that, rather than a defensive response which forces people down the steps leading to this situation.

Chair: Dr McLean, do you have anything quick to add?

Dr Kathy McLean: I absolutely agree with you, but I think we are making progress—clearly not everywhere fast enough. Absolutely we are doing that—

Q76 **Gillian Keegan:** There is a correlation between how fast you go and how much you control this ballooning cost.

Dr Kathy McLean: Completely agree. If you look at hospitals that claim to be among the safest in the world, like the Virginia Mason, they are absolutely in this space as well.

Q77 **Chair:** You paint a rosy picture, but we have looked at whistleblowing, as I mentioned earlier. It is a very big problem in the NHS how whistleblowers are dealt with, which we have not got time to go into now.



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Dr Kathy McLean: No, but every trust has got a freedom to speak up guardian as well, so they are making some progress.

Q78 Gillian Keegan: There is just one point, as well, that we have not raised. I understand that if you have got to the end of this very long process—11 years, or however long it has taken you—because of the way your budget works, you often have to delay settlement, because NHS Resolution has run out of funds for the year. Is that really how it works? In that case are you incentivising having an everlasting, ongoing delay cycle?

Helen Vernon: We operate to an annual budget. We have to predict what we are going to spend quite some time in advance. For the spending review we put figures years in advance, predicted on how we expected that provision to unfold.

Q79 Gillian Keegan: And how often do you get that right? What is your forecast accuracy?

Helen Vernon: Our forecast will obviously be adjusted every year.

Q80 Gillian Keegan: What is the accuracy of the previous year?

Helen Vernon: It is difficult to say how accurate—

Q81 Gillian Keegan: Do you not measure it?

Helen Vernon: We certainly measure it on a month-by-month basis, and sometimes on a week-by-week basis

Q82 Gillian Keegan: You could add that up—months into a year.

Helen Vernon: But you are talking about the pace at which cases fall for settlement, and that is something that we report on regularly through our Department of Health quarterly accountability reviews.

Q83 Gillian Keegan: Do they not delay if you have run out of money?

Sir Chris Wormald: I do not think we have had any fall in that category. I will absolutely check. I am not aware if we do.

Helen Vernon: Certainly if we reach a situation where the budget is getting tight, that does not preclude making admissions of liability. It does not preclude making interim payments for damages.

Q84 Gillian Keegan: But it means it might go into the following financial year, which will incur more legal costs as you try and string out the process—I would imagine.

Helen Vernon: In the event that that happens the settlement would fall into the following financial year, yes.

Q85 Gillian Keegan: And the legal costs would go alongside that—would be increasing.

Sir Chris Wormald: Let me go away and check whether this has ever actually happened. It is a fair challenge. On the basis of your question



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would we not rather cash-account for this budget, I have to say, many other budgets—

Q86 **Chair:** Perhaps we could ask it a different way. What countries do this well, and is there any way we can learn from them?

Sir Chris Wormald: The countries which appear to have most successfully controlled costs have gone into the big question that the C and AG asked in the Report and gone into legislative reform. That is what Australia has done. That has a lot of issues attached to it; but when we look at where has actually brought costs down it tends to be those countries that have answered it not at a health service level.

Q87 **Chair:** Is there any correlation between levels of staffing internationally?

Sir Chris Wormald: Not that we have seen, I think.

Helen Vernon: No, I do not think there is any evidence of that, although we have said—

Q88 **Chair:** Internationally or in the UK?

Helen Vernon: We have commissioned some research on that from the risk consultancy I referred to earlier. Internationally I am not aware of anything, no. Most of the research is around the effect of tort reform on jurisdictions that have introduced limits, for example, on damages.

Q89 **Gillian Keegan:** Transparency and best practice are key to making the improvements you need, and looking at other countries is absolutely critical to doing that, and sharing that among the organisation.

Helen Vernon: There has been some research on that recently published. I think it was about two weeks ago. The *BMJ* published an article on some research work that had been done in the US, which demonstrated that there was no link between increased transparency and increased claims, therefore supporting the view that you expressed earlier that transparency and candour has to prevent cases turning into claims, not the other way round.

Q90 **Gillian Keegan:** And an apology.

Helen Vernon: Yes, indeed.

Q91 **Bridget Phillipson:** One final question, just to return to the issue of complaints: can we just try and simplify the means by which patients make a complaint about NHS services? There is such a complex web of different organisations responsible for different things. I recently looked at one NHS website that said, "If it is not this, then go here. If it is about that, go there. If it is about that, go there." What happens in the case that I dealt with, where it touches on a number of different areas? Reading that as a patient I am not quite sure you would know where it is you would go to complain.

Dr Kathy McLean: Obviously there is the NHS complaints process, which ultimately ends up with the public health service ombudsman, if that is



where people want to go. What we are doing—and I think they may ask us to do something around where particular complicated complaints are across a number of different organisations. This is where it runs into real problems and you need an organisation to take a lead in that, and co-ordinate. I don't disagree there are issues, but I can't commit here that we will reform the whole of the complaints process. But I completely agree it needs to be as simple, accessible and transparent as possible.

Q92 Shabana Mahmood: Ms Vernon, 250 cases is the optimal number for each claims handler to handle. Is that correct?

Helen Vernon: Yes. That's right.

Q93 Shabana Mahmood: What is the average number of cases at the moment?

Helen Vernon: At the moment, 196. We have recruited with permission of the Department of Health, so we substantially reduced our caseload figures below where they were when the NAO looked at our case load figures.

Q94 Shabana Mahmood: Are you confident that you now have enough staff to make sure that that number doesn't creep back up to 250?

Helen Vernon: Yes. And we are continuing to recruit because we want to get some other work off the ground in the areas we have talked about, such as data analytics, so we need to backfill that generally from our case numbers.

Q95 Shabana Mahmood: Are your new recruits straight out of university—graduate level—or are they from a broader range of experienced claims handlers?

Helen Vernon: We tend to mix our recruitment 50:50 between insurance-claims-qualified staff and solicitors. At the moment about 50% of our claims staff are qualified solicitors.

Q96 Chair: Just on some quick points, then I will ask Ms Keegan and Ms Phillipson to come back on any last points they have. I am not sure if it's you Mr Heaton, or maybe it is the permanent secretary at the Department of Health. They recently announced a discount rate of less than 1%, so not a big impact on the settlement potentially. Have you done a calculation of what that would do to the costs of clinical negligence over time?

Richard Heaton: I understand that the change to the discount rate that was announced would have added—I've got the figure of £3.5 billion, but I'm not sure what period that is over.

Q97 Chair: Can you write to us just to clarify that?

Richard Heaton: Yes.

Helen Vernon: Should I help? It is £3.5 billion on our provision and this year's expenditure estimates about £500 million in additional cost.



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Richard Heaton: Thank you.

Chair: One of the things that has puzzled us looking at this is that all the calculations for ongoing care are based on private health care.

Helen Vernon: That's right.

Q98 **Chair:** But we have a national health service. All taxpayers pay for the NHS, it's not free, but why is it calculated on the basis of private health care costs, not NHS?

Richard Heaton: It is a 1948 Act of Parliament, which was last looked at about 10 years ago and no action was taken, there was no consensus to change, but it is something we can look at.

Q99 **Chair:** So it is right from the birth of the NHS? That is interesting. I should just draw attention to our sister Committee, the Public Administration and Constitutional Affairs Committee, which did produce a report about the health service's Safety Investigation Branch. It is interesting it is up and running because we haven't passed legislation for it yet. Will the legislation make a difference to what it can do?

Dr Kathy McLean: It is part of us at the moment, so it is managed as an arm's length bit of us, so that we keep it at distance, but we have to provide the employment, the basic salaries and that sort of thing.

Q100 **Chair:** Will the legislation make any difference to how it operates?

Dr Kathy McLean: The Bill has been laid in Parliament, as you are probably aware. I think that it will ensure that it is completely independent and perceived to be completely independent. It is functioning independently.

Q101 **Chair:** So practically its work, you would hope, would be much the same?

Dr Kathy McLean: I think its work will be much the same, but I think they would like very much to be independent, and that's what the advice says.

Sir Chris Wormald: There are some other themes in the legislation, which are required for it to work properly, the safe space—

Chair: Let us hope that in the middle of this rather—

Sir Chris Wormald: We took the view that getting it going—

Q102 **Chair:** We have a legislative drought at the moment so I can't see why it won't get voted on at some point—I'm sure they can fit in somewhere in the acres of time we have between votes. We briefly touched earlier on staffing issues, but is there any correlation, Dr McLean, with shortfalls in staffing? We are not talking about numbers of staff, because I know even intensive care units configure themselves differently. But if you have a staffing shortage, perhaps just a difficulty in recruiting obstetricians in an area where you have got more locums, does that have an impact on claim rates?



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Dr Kathy McLean: I am unaware of that having an impact on claims. Obviously in some areas it will potentially have an impact on how many patients fall and that sort of thing, because they are not being supervised. But I don't personally know.

Q103 **Chair:** Ms Vernon, do you collect this information?

Helen Vernon: No. Most often, the claims that we see are multi-factorial so it wouldn't be possible to isolate a staffing issue as part of that.

Q104 **Chair:** In my own area where there has sometimes been an issue about vacancies, even some vacancies from years ago, perhaps filled up with people who were not well qualified, that is where the complaints come to me. MPs get relatively few, compared with other people, but certainly I have heard that from colleagues around the House. I am amazed we are not looking at that, because we have got certain subject areas, such as A&E doctors, where we know we are very short. Is anyone looking at doing any of that analysis? You are the man in the hot seat.

Sir Chris Wormald: We look at it all the time from a safety perspective. NHSI intervenes where staffing is inappropriate for safety. I do not think we have ever seen a causal relationship with claims.

Q105 **Chair:** Well, it will probably be over a long period of time, because some of those claims will not be claims until some time afterwards.

Sir Chris Wormald: I will check whether anyone has looked at that—

Q106 **Chair:** It seems quite obvious to me. The other issue on staffing is HR resourcing. I came across an example of someone working in HR who was dealing with a claim of some behaviour by a member of staff that had caused harm to a patient. There was one HR professional for the whole of the county area they covered to provide advice. The clinical manager spent a lot of time having to deal with this, which seemed a disproportionate use of time. Also, however good a clinical manager they were, they might not have been very good at HR, although I cannot comment on that. Is that a problem you have picked up anywhere, Ms Vernon or Dr McLean?

Helen Vernon: Not in terms of claims experience, no. It is not something that has been a feature.

Q107 **Chair:** But if you have got bad human resource management and a problem with staffing, you are not going to solve some of the problems. Dr McLean, you talked about a duty of candour and it all being great.

Dr Kathy McLean: Certainly within a hospital, people would be working as a team across their executive team and their portfolios and with teams beneath them, but it is fair to say that there is a variable amount of HR provision in different organisations.

Q108 **Chair:** Let us say you have got a weak member of that team who is making some clinical errors and people have called that out. There still has to be a disciplinary process and proper legal process to go through.

Dr Kathy McLean: Yes.

Q109 **Chair:** You might have less staffing at that level. It does not seem very sexy when we talk about hospitals and people doing emergency operations, but the staff at the HR level can play an important role in ensuring that issues are resolved. You have not done any work to look at that or you do not know of any work—

Dr Kathy McLean: I do not know of any specifically, but as part of the overall look at things such as the model hospital, where we are looking at the amounts of this sort of resource in the back offices, I am sure that will emerge. It will be variable.

Q110 **Chair:** When will we have any sight of that work?

Dr Kathy McLean: I would have to go back and ask the team that is leading that.

Q111 **Chair:** It would be very helpful, because it is also about clinicians' time doing things when they should be managing patients and so on.

Dr Kathy McLean: Absolutely.

Sir Chris Wormald: The CQC looks at leadership and management processes, and I am not aware that it has raised that particular issue, but I can see how it could arise.

Chair: I can see that it might get buried in the middle of a CQC investigation. As Ms Keegan says, they are looking at other things.

Sir Chris Wormald: We will ask the CQC whether it has observed that issue.

Chair: It would be helpful if you could write to us on that. Does Ms Phillipson or Ms Keegan want to sum up on any of the issues that have been raised?

Q112 **Gillian Keegan:** The fundamental issue is that the more we spend on this, the less money there is for patient care. You are on a worrying trajectory. The forecast for 2020 is £3.2 billion. What is the forecast beyond that? Have you looked at it? When do you forecast that this will peak? Most importantly, what is the cross-departmental management strategy to get a plan so that you can say, "If we do this, this and this, at that point we expect this to start to be controlled"? At the moment, you are not controlling it.

Sir Chris Wormald: I don't think we have projected it post-2020.

Helen Vernon: No, the projection is essentially the provision. How that provision unfolds backwards into cash flows is something we have not projected beyond; we project four to five years in advance, but that breaks down as well into what we know about. There is about £13 billion-worth of claims that we know about. The biggest number is what we call the incurred but not reported provision, which is incidents that have happened in the NHS that have not yet come to us as claims. That is



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about £37.5 billion. So the projection is essentially that provision figure. The cash flows are the figures that the NAO referred to in their Report.

Q113 **Gillian Keegan:** And what is the management plan and strategy for when this is going to be controlled?

Sir Chris Wormald: On the second part of the question, this goes to the question that the Comptroller raised in his value-for-money study, which we agree needs to be answered. I don't know what the right answer is, but that question, which goes beyond what we talk about here into policy and legislation—

Chair: We have covered that.

Richard Heaton: I think we are doing all we can on costs. The reason I would like to set up a joint programme board with my Department and the Department of Health is to look at things like the 1948 Act and to look at how ADR would work in a health context. I just think we have to be really creative on this. As I say, I think we have been quite effective on costs. If we can get fixed recoverable costs landed in this area, that would be a huge achievement. No one said it was possible. It is blue-sky thinking on things like the law of damages, the 1948 Act and ADR as it applies to health.

Q114 **Chair:** So really it is quite a lot wider than what we have read on the internet.

Richard Heaton: I think we should go wider, yes.

Q115 **Bridget Phillipson:** I absolutely agree. There is lots of good work happening in different parts of the NHS to try to understand how we can avoid incidents and improve patient safety and outcomes, but I would like a better understanding of how, as well as the work going on across Government, the different NHS bodies will work together to get the outcomes that we all want to see.

Richard Heaton: We, of course, have to devise a system that works for everyone, not just for one party. That is our other interest in this.

Chair: Thank you very much for your time. It has been a marathon session for the Committee—and for the Permanent Secretary at the Department of Health.

Sir Chris Wormald: A pleasure.

Chair: But you are paid good money, and clearly you got a knighthood for a reason. Our transcript will be available in the next couple of days. I cannot predict exactly when our Report will come out, but we will get it out as soon as we can—possibly before Christmas, we hope. Thank you very much indeed for your time.