

Public Accounts Committee

Oral evidence: Cost of clinical negligence, HC 1234

Thursday 20 November 2025

Ordered by the House of Commons to be published on 20 November 2025.

[Watch the meeting](#)

Members present: Sir Geoffrey Clifton-Brown (Chair); Mr Clive Betts; Anna Dixon; Sarah Green; Rupert Lowe; Catherine McKinnell; Tristan Osborne.

Justice Committee Member present: Dr Neil Shastri-Hurst.

Gareth Davies, Comptroller and Auditor General, National Audit Office; Andy Morrison, Director, Health, National Audit Office; and David Fairbrother, Treasury Officer of Accounts, HM Treasury, were in attendance

Questions 1-100

Witnesses

[I](#): Professor Aidan Fowler, National Director of Patient Safety, NHS England; Samantha Jones, Permanent Secretary, Department of Health and Social Care; Elizabeth O'Mahoney, Interim Director General, Finance, NHS England; and Helen Vernon, CEO, NHS Resolution.

Report by the Comptroller and Auditor General Costs of Clinical Negligence (HC 1335)

Examination of witnesses

Witnesses: Professor Aidan Fowler, National Director of Patient Safety, NHS England; Samantha Jones, Permanent Secretary, Department of Health and Social Care; Elizabeth O'Mahoney, Interim Director General, Finance, NHS England; and Helen Vernon, CEO, NHS Resolution.

Q1 Chair: Welcome to the Public Accounts Committee on Thursday 20 November 2025. Earlier this year, the Committee examined the Department of Health and Social Care annual report and accounts for 2023-24. We raised concerns around the lack of plans to deal with cost of clinical negligence claims. The clinical negligence liability stands at an astounding £60 billion, having quadrupled in real terms since 2006-07, and is the second largest liability on the Government balance sheet, after nuclear, I think.

Despite claim numbers having plateaued over the last decade, the cost of claims has continued to increase, particularly for very high-value cases over £1 million. We also see claimant legal costs continuing to rise, with the legal costs for claims under £25,000 being almost four times the total damages awarded. It must not be forgotten that behind these eye-watering amounts lie many tragic incidents of patient harm, and by far the most important issue is reducing the incidence of clinical negligence and harm caused to patients.

Today's session will be an opportunity to examine why the costs of clinical negligence are continuing to rise and how the Department of Health and Social Care is tackling areas where those costs appear to be disproportionate, and to explore options to improve patient safety while putting the costs of clinical negligence on a more sustainable path.

We have a good cast of witnesses with us today, including, of course, Samantha Jones, the Permanent Secretary. Samantha, will you please introduce yourself, and can your fellow witnesses then do the same?

Samantha Jones: Good morning. My name is Sam Jones and I am the Permanent Secretary at the Department of Health and Social Care.

Helen Vernon: Good morning. My name is Helen Vernon and I am the chief executive of NHS Resolution.

Professor Fowler: Good morning. I am Aidan Fowler, the national director of patient safety, a deputy medical director at NHSE, and a deputy chief medical officer at the Department of Health and Social Care.



HOUSE OF COMMONS

Elizabeth O'Mahoney: Good morning. I am Elizabeth O'Mahoney, interim DG finance for the Department of Health and Social Care, and also CFO for NHS England.

Chair: Elizabeth, have you appeared before the Committee before?

Elizabeth O'Mahoney *indicated dissent.*

Q2 **Chair:** I think the rest of you have—no, I see shaking heads. In that case, I shan't get it wrong if I offer a very special welcome to all those who have not appeared before the Committee before.

I think you have all been warned—I hope that you have, Permanent Secretary—that we will start with a few questions on how we are reforming local trusts, and on redundancies and so on. Could I go straight into that with you and ask how the funding mechanism for these redundancies will work?

Samantha Jones: I will start and then, with your permission, I will ask Elizabeth, as DG, to pick up the detail.

Chair: Of course.

Samantha Jones: As you are aware, in March the Prime Minister announced the abolition of NHS England. We are bringing the functions of NHS England back into the Department of Health and Social Care. We have been working through what that means in practice since then. In fact, when I came before the Committee previously, you asked questions about that.

We started last week with the joint executive team, which is bringing together unified leadership across the Department of Health and Social Care and NHS England. Those two bodies will remain separate for obvious reasons until the Bill has passed through Parliament. We are trying to model what we are asking everybody else to do: we are bringing together the leadership to reduce the duplication and the variation that is happening between teams. We are making sure we reduce the bureaucracy associated with that. The joint executive team, otherwise known as the JET, met for the first time last week. As Elizabeth said, she is the interim director general for finance, in addition to her role as CFO for NHS England.

As part of the announcement, the Prime Minister committed to a 50% reduction in staff numbers across the national body—the Department of Health and Social Care. We have been working through some of the detail of what that looks like and how it will be funded over the next couple of years. Last week, on 11 November, the Secretary of State set that out in a bit more detail, as did Sir Jim Mackey, the chief exec of NHS England. With your permission, I will hand over to Elizabeth to talk you through the detail.

Elizabeth O'Mahoney: I appreciate that. Obviously, a reform of this size is always going to be challenging. We have approached this in the spirit of



HOUSE OF COMMONS

ensuring that any savings that we make will undoubtedly be reinvested in frontline services and will benefit patients. That is first and foremost, and we have to keep that in the front of our minds. The way that the funding flows, we have recently released a voluntary redundancy scheme. We have engaged with ICBs, NHS England staff and Department of Health staff to ask for volunteers to come forward for that scheme. That has now been approved more formally.

Essentially, we are looking to identify in the region of 50%—about 18,000—posts that will be made redundant. Some of those posts are actually vacancies. We have had quite a lot of natural attrition over this period. Those funded posts will effectively pay for the redundancy costs, so it will be cost neutral over this Parliament. We anticipate that the changes made will save in the region of £1 billion over the next three years and then £1 billion recurrently going forward. The key thing is that, as we reduce our headcount, we must not increase our headcount going forward. That will be absolutely key for us.

I always put that £1 billion in context. I recently worked very close to the frontline, and that £1 billion is effectively more than 100,000 hip and knee operations, and would be very welcome in terms of our recovery statistics.

Q3 Chair: That is really helpful. We know the headline of what you are trying to do. This is a very large redundancy programme—18,000. How much will that cost, and how will it be accommodated within the NHS and DHSC budgets?

Elizabeth O'Mahoney: We are genuinely working through the true cost, mainly because the 18,000 is currently split at about 50% for NHS England and Department of Health. We are already carrying in excess of 3,000 vacancies, so those staff do not exist to make them redundant.

When you are making staff redundant—if people are taking up a voluntary redundancy scheme—it depends on the grade of the staff, their length of service and other things. Because the voluntary redundancy scheme has been announced in the last couple of weeks, we have launched a scheme and are asking for volunteers. That will need to be calculated. I cannot give you firm numbers. We have initial estimates, but that is as good as we have. The funding is effectively provided by those staff no longer being paid going forward releasing a funded establishment, which would pay the cost of redundancy. It is self-financing over the term.

Q4 Chair: Over the term perhaps, but how are you going to deal with it in the interim? You have announced the programme and, as I understand it, that triggers whatever cost in this year's accounts—which have not yet been budgeted for. How is that going to work?

Elizabeth O'Mahoney: Once we have had the voluntary redundancies come forward, and we know the scale for this year; also, there is some flexibility within ICB allocations and at a local level. At a local level there is not a standard amount and some ICBs have more flexibility than others. We are working at national health service level to try to afford and accommodate as many voluntary redundancies as we can this year. That



HOUSE OF COMMONS

depends on the voluntary redundancy costs. We are trying to profile our money to accommodate the cost of redundancies, recognising that those need to be made within a two-year period.

To give one example, depending on the flexibility this year, we will make some redundancies this year; if we cannot do as many redundancies because of affordability, those redundancy costs are self-financing within an annual cycle so we would phase them.

- Q5 **Chair:** I want to be absolutely clear about this—I am sorry if it is just me. You are asking ICBs and other local systems to make a substantial number of people redundant now. You are going to have to pay the cost of that in this financial year. Many ICBs and local systems have not budgeted for that and do not have the money. Where are they going to get that money from?

Elizabeth O'Mahoney: Over the settlement—

- Q6 **Chair:** I get that, but the issue is cash flow. Parliament has voted for a certain amount of money. ICBs and local systems will not have any extra money to pay those redundancies. What is the mechanism? I understand it will be self-financing over a period, but in this financial year, where is that money coming from?

Elizabeth O'Mahoney: We cannot confirm an absolute number for this financial year now because we are working through the detail. When we know that number, we will see if we can manage some of our budget from future years into this year to afford the redundancies at an affordable rate across the whole of the spending review.

- Q7 **Chair:** Now we are getting there: some money is going to be brought forward from future years. This Committee is used to dealing with money. We had a vote in Parliament; we voted for a certain amount of money. If it is going to be brought forward from future years, what is the mechanism for doing that?

Elizabeth O'Mahoney: It would be in an agreement with the Treasury.

Chair: And it will be a supplementary vote. Right, we have cleared that up. Thank you very much indeed. Sorry to have laboured that a bit, but I thought it important that we get that on the record.

- Q8 **Mr Betts:** We have had this discussion before at the Committee. Is it not an impossibly short timetable? You announced this in March, but it is only this month that you have given the go ahead for redundancies because they can be paid for. Have ICBs basically got four months to sack people?

Samantha Jones: We absolutely acknowledge the challenge of the timetable. As individuals, as the Secretary of State has said, we also recognise the uncomfortableness there has been over the last few months as we have worked through the detail of how the schemes will be delivered. I think Elizabeth will walk the Committee through exactly what the ICBs have been asked to do over the next couple of months. What we



HOUSE OF COMMONS

have asked for is for people to come forward for voluntary redundancies to take place over the next few months.

Elizabeth O'Mahoney: When the announcement was first made, a model ICB scheme was developed in a matter of about six weeks, working very closely with ICB chief executives and their boards. That considered the future roles and purpose of ICBs, as strategic commissioners are no longer required to have oversight of the provider sector. That work has happened and continued. They have had expressions of interest and have engaged with unions and with staff, with the expectation that, at some point, a voluntary redundancy scheme at a national level would be approved. While I agree that it is a short timeframe to make the changes in, the planning had already started at the time of the announcement.

Q9 **Mr Betts:** Right. So all redundancies have to be agreed by March, have they?

Elizabeth O'Mahoney: The redundancy profile in aggregate is over a two-year period, so it is redundancies by March 2028.

Mr Betts: That is very different to what the ICBs are working to in my area—they are telling everyone that they have to have it all done by March next year.

Elizabeth O'Mahoney: Because it is across the whole landscape, with ICBs, the Department of Health and NHS England, and ICB redundancies are a bigger proportionate part, ICBs are effectively moving towards a running cost of £19 a head for 1 April. We recognise the challenge on that, and we are working very closely with them.

Q10 **Mr Betts:** So what does that mean?

Elizabeth O'Mahoney: It means that people put in place plans at the start of the year to move to a model ICB scheme, and they are trying to manage to that for the end of this year.

Q11 **Mr Betts:** But if they don't, they can have extra money next year?

Elizabeth O'Mahoney: There is no extra money available next year, no. We would have to—

Q12 **Mr Betts:** But if they don't get to the model that you are asking them to get to, with the reductions in staff by March, somebody has to pay for the overrun next year, don't they?

Elizabeth O'Mahoney: I would not want to get into the details of the specific—

Mr Betts: Well, I am sorry, but I do. That is what we want to do as a Committee.

Elizabeth O'Mahoney: The details of the specific ICB, is what I was going to say. But all of the ICBs I am engaged with are confirming to me that there are plans that can be delivered by the end of this year.



HOUSE OF COMMONS

- Q13 **Mr Betts:** So every ICB will have to have in place all the necessary redundancies to get their budgets down as you are requiring them to, by March next year?

Elizabeth O'Mahoney: Yes. Plans are in place, and we are engaging very closely with ICBs.

- Q14 **Mr Betts:** Right, okay. You talk about this model plan; we were very critical in our report—which we appended to the issues we raised about reducing patient waiting lists the other day—about the lack of planning going on with these arrangements. Maybe you cannot do it now, but could you set out for us precisely what ICBs do now, what you are going to ask them not to do in future, and what you are going to ask them to continue to do? And, given that we are talking about patient services, which of those provisions will now have to be met elsewhere in the NHS, and which are going to have to be picked up by other bodies, like local councils?

Elizabeth O'Mahoney: If I may, I refer you to the letter that Sir Jim Mackey sent you, Chair, which I think outlined some of this in quite a bit of detail. I am happy to talk through that if it is helpful, or we can share—

- Q15 **Mr Betts:** You can bring that up, but I am just saying that, when Jim Mackey and Professor Chris Whitty came before us, we were told that one of the important points was whether these reorganisations will preserve the local place functions of the NHS. We were assured that they would. Jim Mackey said to get in touch if they don't.

Frankly—I will refer to my own experience in south Yorkshire, but I am sure this is going on elsewhere too—what is happening is that they are preserving the admin jobs at the centre and cutting the local place jobs. That is what I am told—because they have never consulted the MPs, despite promises. It is all going on in isolation. We represent the communities, and they have not bothered with us at all. Pearse Butler, the chair, is carrying on doing what he wants without any thought about the community, MPs or the local place elements. Why? I am sure that is happening elsewhere, as well.

Samantha Jones: I am very happy for us to go away and look at the detail of the particular ICB that you are describing, but, as Elizabeth said, after the last time we met, Jim set out in his letter to the Committee what some of the functions would be for the ICBs in terms of strategic commissioning. But we are very happy to take that away, go into more detail outside the Committee and come back to you on that ICB.

- Q16 **Mr Betts:** Right. Given the importance of this to local communities, should ICBs be engaging with their local MPs on this and involving them in the process?

Elizabeth O'Mahoney: Yes, absolutely. The letter that followed on 6 November clearly set out a number of areas where we would expect ICB functional changes to grow, to retain, to adapt and to cease. The grow functions are around population health management, strategies such as pathway redesign, commissioning neighbourhood health, looking at risk management for a neighbourhood team, and end-to-end commissioning



HOUSE OF COMMONS

pathways for your local populations. So, if anything, we are looking for the ICBs to be much more local.

Q17 **Mr Betts:** But local MPs should be involved in this process; they should be consulted about what is happening.

Samantha Jones: We would certainly expect any local ICB to discuss and engage with local MPs.

Q18 **Chair:** My ICB has not. Elizabeth, I want to try to clarify this: if I was a senior executive in an ICB listening to what you have said, I would not be quite sure what my position is. You have said, I think, that there has to be a plan in place for these redundancies in every ICB by the end of the financial year—that is for the numbers. Then the ICB has to open up an offer to try to achieve those numbers. Does that have to be done by the end of the financial year, or is it just that ICBs have to have a plan so that each ICB, and each member of staff, knows how many redundancies, but staff will not have had an offer made to them?

Elizabeth O'Mahoney: All ICB staff will have had an offer made to them already. The voluntary redundancy scheme has been launched for ICBs, for NHS England and for the Department of Health. That has already happened. The planning has started. People were anticipating that this would happen so staff were asked much earlier in the year, in the summer, for expressions of interest: "In the event that a redundancy scheme was launched, would you wish to be part of a voluntary redundancy scheme?" We could not confirm the terms at that point because it was a national scheme, but that has now happened and effectively those staff are considering if they would like to be made redundant in a voluntary redundancy scheme or not.

Q19 **Chair:** So they do know the terms?

Elizabeth O'Mahoney: They know the terms; they have made expressions of interest. In excess of 3,100 staff at NHS England have previously expressed an interest in going in this financial year. Because of the disruption at an ICB level, we are prioritising any funding available to manage that process first, recognising that their process started much earlier, and that the model ICB work is much further developed.

Chair: That is very helpful. I will hand over to Catherine to probe that a little more, now we have that clarity—thank you for it.

Q20 **Catherine McKinnell:** Just to reiterate, the challenges that Clive outlined are relevant across ICBs, so it is good to hear the potential opportunity to improve local healthcare provision, and the connectivity with local communities. Is your ideal scenario to have 100% voluntary redundancies?

Elizabeth O'Mahoney: Ideally.

Catherine McKinnell: That is what you are working towards—great.

Elizabeth O'Mahoney: We are looking whether we can redeploy staff as well. As functions are moving, some of the skills within ICBs are moving to other parts of the ecosystem. In many places, those staff are being redeployed, so there is no need to make them redundant.

- Q21 **Catherine McKinnell:** Have you given thought to where the geography might be more challenging? I am from the north-east; our ICB covers quite a vast expanse. It may not be so easy if you have a glut of voluntary redundancy applications from some ICB areas and not from others. What are you doing to make sure that it is a coherent process?

Elizabeth O'Mahoney: In the current environment, for many of these roles at an ICB level we must recognise the ability to work and live in different geographies. For example, when I worked in the south-west, some of my staff worked in the north-east. The baseline or starting positions of all ICBs are not the same. Although people are making a 50% reduction in headcount, some ICBs run at £65 a head and some ICBs are already at £19 a head. We are trying to work across systems, particularly at a regional level, and regional teams are trying to manage some of the issues that you are describing.

- Q22 **Catherine McKinnell:** Going back to the issues that the Chair raised around the financing of this, if you cannot get to 100% voluntary redundancies, how are you going to factor in the additional cost and time that are going to be involved in moving to a compulsory route, if it is needed?

Elizabeth O'Mahoney: I would need to quickly test that with my HR colleagues, if I'm honest, because the current conversations are about the timing of the voluntary redundancy scheme. In the event that we don't get to the point that we need to get to in terms of the headcount reduction, there would still be enough time in this financial year to launch and deliver a compulsory redundancy scheme.

- Q23 **Anna Dixon:** I should probably declare an interest as I previously worked for the Department of Health, and I do have quite a lot of constituents who work in NHS England in the Leeds offices who will be affected by this redundancy. It is always difficult when you are talking about such large numbers because it does affect people and their livelihoods.

Coming to this point around the redundancy scheme, we all know there is a risk that you will lose the people who you need to keep and keep the people who maybe you don't need for the roles and functions that you've decided you need. Samantha, from a strategic point of view, how are you going to ensure that the people you keep have the skills and capabilities you need for the roles and functions you've decided to keep? That goes for the centre and for the ICBs.

Samantha Jones: You are absolutely right, and that is a fundamental part of how we are moving to deliver the transformation programme in its entirety. It is incredibly challenging, and we don't underestimate the impact on individuals involved. We are very live to that in terms of the support that we are trying to give people, but not one of us thinks this is



HOUSE OF COMMONS

not the right thing to do. That is what ICBs have told NHS England, and it is what our staff have said as well.

When we are in such a challenging time, it is really important that we go back to that. It is about making the way we work and therefore the way that we nationally support locally easier. You will obviously be very well aware of some of the previous elements around duplication and man marking that did not add value to what should have been happening locally. That remains the thing that keeps us focused for the future.

In terms of your specific questions, through the transformation programme, we are looking at how we can identify, and what schemes should be in place to identify, those individuals according to the skillsets that we need in the future, and what we can do to target and retain them. I do not want to go into the detail now, but I can reassure you that as part of the programme we are very cognisant of that and we are looking at how we can do that, including using schemes from across broader Whitehall and the broader civil service, recognising how we can maintain the right type of staff. I am happy to come back with a bit more detail on those schemes, but we are very live to that issue.

Through the bringing together of the joint executive team, each individual now has responsibility from a national perspective for colleagues across both NHS England and the Department of Health and Social Care. We are clearly now looking at teams in their entirety, rather than what had been done previously, while still maintaining absolute terms and conditions of the different organisations.

For example, although I am sure Elizabeth can talk for herself, we are looking at the skillset across the finance function and the commercial function that she has responsibility for and identifying those individuals we need. We are very live to it. Now that the schemes have been launched in the way that Elizabeth said, we can understand the profile of the plan that we are trying to work to over the next couple of years.

We are also underpinning this programme by trying to have proper organisational change and organisational development support from a cultural perspective, recognising that we are bringing together different organisations—and they are very different, certainly in terms of the teams within NHS England and the teams within the Department. We are actually doing a lot of work around the culture between the different organisations and what we are trying to create for the future.

Importantly, in line with the reason that the Prime Minister announced this change originally, we want to take as much as possible down to local places, as was asked about earlier. That remains our focus.

Q24 Anna Dixon: You are absolutely right. I think I arrived in the Department in 2013 when the Lansley reform to separate the Department of Health and the NHS was taking place. With various mergers of organisations and arm's length bodies into NHS England, it has ballooned over time, so I absolutely see the need to reduce duplication.



HOUSE OF COMMONS

One of the things I would be concerned about is that there has always been a recognition that there are different skillsets and different cultures between those in the civil service and those who are more operationally focused within the NHS. I think you have mentioned it, but it is about not underestimating the challenges of creating one team, one culture, and of the NHS not sort of eating the Department, which we have seen with the culture in the past.

There is devolution, but how are you deploying people into place and providers? Is that one of the areas where you have talked about redeployment? I am trying to get a grip on how we do not lose some of the people and the skillsets not just from NHS England and ICBs, but by redeploying them into providers in the wider public sector. Can you speak more about the redeployment scheme, or is that something you wish to follow up on in writing?

Samantha Jones: If we may, we will follow that up in writing. Taking your first point: as you will be aware, I have had the privilege of working within the service with an operational focus and in Whitehall and the civil service and, yes, they are different. However, it is also not true—not that you are saying this—that one hospital is the same as another, or that one department is the same as another, nor are they similar to a Whitehall Department.

We are trying to bring together a Department that can do policy and delivery and bring those operational strengths together. When Elizabeth and I have a conversation, or when colleagues across NHS England and the Department of Health are talking about various policy areas, it is so much better and so much richer when we have policy and delivery together. Fundamentally, the person at the other end is receiving it; policy is only as good as its delivery and its impact. We will come back to you on the specifics.

Q25 Chair: Thank you, Anna—you have covered some of the area that I was going to ask about. In redeploying these skills, one area in particular worries me: that we are going to lose digital skills. How will you avoid that? The NHS has very tough efficiency targets to meet, and one of the only ways it is going to be able to do that is by improving its digital systems.

Samantha Jones: How are we going to avoid not improving?

Chair: How are you going to avoid losing really good in-demand digital skills, which you may not get back?

Samantha Jones: In part it goes back to the previous answer to your colleague. At the last Committee, I may have been slightly overenthusiastic about the possibilities that data, digital and tech give us. We know that the workforce of the future looks very different from the workforce now. In creating the new Department—subject to the will of Parliament—we will be thinking through its role and what functions and skills it requires. We will do that over the next period of time, so it will include exactly the type of skills that we need.



HOUSE OF COMMONS

Specifically on data, digital and tech, we have a significant programme that has been run jointly between the Department of Health and Social Care and NHS England anyway. We are in the process of prioritising its work programme, including what we need to do to make sure that some basic but quite fundamental housekeeping between the Department and NHS England works, such as meetings, sharing folders and so on. We should not underestimate the importance of those things. The programme also includes things such as AI when we come to answer PQs; correspondence, which is a particular focus of mine at the moment; supporting staff locally in out-patients; and digital/online, which I am sure Aidan can pick up on.

At a macro level, we are looking at the skillsets that we require in the future, and working across Whitehall with the Department for Science, Innovation and Technology about what we can do collectively across Government and how we can make best use of opportunities such as the app—I am sure we can come back to talk about that in more detail. We are supporting our staff through specific schemes to ensure that we keep the best skills and the types of skills that we need in the future, of which, clearly, digital is one fundamental area.

Q26 Chair: Thank you, Permanent Secretary. I am very anxious to get on to the main session on clinical negligence. There is one further question that I want to ask, though, and I do not mind whether you or Elizabeth answers. I think you have changed your procedures now so that people cannot just walk out of one job into another job and retain all their redundancy money, but could you just address that question?

Elizabeth O'Mahoney: Yes, absolutely; I am happy to. Under the voluntary redundancy scheme that has recently been announced, effectively people cannot return to work in public service—actually, across Government—for a period of 12 months. That is the voluntary scheme. Under the compulsory redundancy scheme, obviously that is in employment law and not a national scheme, you would not be able to return within six months.

Chair: Okay. Thank you for that answer; that was very helpful. I did say mine was the last, but Tristan has one more brief question.

Q27 Tristan Osborne: As part of phase 2, you are announcing the potential restructures and new boundaries from April 2027. Can I just get some clarity? You are going through the redundancy rounds now, but in some cases, you will not know the new boundaries for some of these organisations until two years in the future, because there might be further mergers occurring. Is it sensible that you are going through a redundancy round now, then in 2027 you might possibly have new boundaries and new mergers, and have to go through another redundancy round then? Does that not sound rather ridiculous?

Samantha Jones: The overall direction to create a new Department of course takes time, in the way that we have been talking about today. Without sounding flippant, change is a constant in the health and care



HOUSE OF COMMONS

service, particularly around how we ensure that we are able to reflect boundaries and move things forward. I would say that our planning is based on the creation of the new Department as it stands now, in terms of the boundaries that we have; like at any time, we will always come back and revisit should there need to be a different type of approach in the future.

The main components of what those individuals do will not be changing, as I think Elizabeth talked about earlier, in terms of the role of strategic commissioning and making sure that we are developing neighbourhood health services in the way that the 10-year health plan set out. The functions won't be changing; there may be some geographical boundary changes, as you are describing.

Chair: Thank you, Tristan. I did say that Tristan would be last, but we have now got hold of Sir Jim Mackey's letter, so we have new inspiration, I am afraid—and new concerns as well. I am going to ask Clive Betts to come in.

Q28 **Mr Betts:** I hope the Permanent Secretary has got some inspiration, because there is some really big stuff in here that ICBs are not going to do in the future and that they will look to transfer out. We are talking about the development of neighbourhood and place-based partnerships, as well as infection prevention, which is often very different in different communities. It goes on to talk about other issues, and about having good working relationships at local level. There are really concerning issues here that the ICBs may wish to delegate to others—transfer to others.

Chair: And where is the funding for that?

Mr Betts: Exactly. Is the funding going to transfer as well? Councils do not have loads of extra money that is going to apply to these functions.

Elizabeth O'Mahoney: For some of these functions, absolutely. If the function is transferring, quite often it is because it is being—if I think of the way we manage and oversee quality, for example, currently you will have quality oversight at a national, at a regional and at a local ICB level, but ultimately where quality oversight really happens and should happen is at a board level.

What we are trying to do is to streamline, for example, what that quality function would do, so that we are not doing it four times. We have regulatory oversight and then it happens at a local level. Some of the functions will diminish in terms of how many times they are happening, because that is not adding value. There is an illusion of control where you have multiple places where the same things are happening.

So, effectively, yes: for some functions, such as some of the cancer networks, the staff and the funding will transfer into the provider, and the provider will run that function as they are better placed to do that. In the letter, it talks about the fact that these are being reviewed for transfer, and throughout this process, we will make sure that it is a safe transfer.



Q29 Mr Betts: I mentioned neighbourhood and place-based partnerships and infection issues. These are quite important, aren't they? Who is going to do these jobs? It looks like local authorities, in the end, because the letter mentions them, but if we say that the money is going to be transferred, that means that you are not going to make the savings that you were announcing, because some of that saving is going to go in transferring money to local authorities. Is it?

Elizabeth O'Mahoney: When I talk about money being transferred, you have programme P and programme non-P. If it is delivering patient-focused service, that cost transfers to wherever the function is going, but you do not need the pay overhead to deliver it. Those are the examples I would give.

Q30 Mr Betts: But you are still going to need something, aren't you? People are doing SEND work in ICBs; that is mentioned as something to be transferred along with safeguarding and medicines optimisation. Who is going to do it?

Elizabeth O'Mahoney: I think the letter actually says "testing and exploring" these functions to see where best-placed—

Q31 Mr Betts: Look, this is really confusing. We are this stage—talking about cutting staff by 50%—and we are "exploring" what might be done.

Samantha Jones: If I may, I think what we have said is that the statutory functions such as safeguarding or SEND—crucial statutory functions—will not be transferred to another body unless there is a place for them to go that is appropriate. For example, with neighbourhood health, which we have talked about, there is currently duplication across a local place. You were rightly pushing us earlier on local place arrangements. We are saying that, if there is an appropriate other body to take these statutory functions, that will be part of the discussion that we have locally, and we will not transfer those statutory functions until or unless that is the case.

If I give you an example, an integrated health organisation, as set out in the 10-year health plan, may take responsibility for those areas, because they are taking responsibility for the whole population. We are not saying that it is the same thing across every single part of the country, because that would absolutely defeat the point of it being as local as possible. We are not saying that statutory functions will be transferred without the appropriate place for them to go.

Q32 Mr Betts: That is a helpful response, but it comes back to this: can you now set out much more clearly what is going to stay with ICBs definitely, and what is potentially going to be transferred depending on local agreements? What may be transferred and what will be transferred, and what will be transferred with money and what without money? This is all a bit mixed, at present.

Samantha Jones: I would be happy to do so.

Q33 Chair: Looking at the penultimate paragraph of Sir Jim Mackey's letter,



HOUSE OF COMMONS

just to be absolutely clear, it says, “ICBs will continue to work closely with local authorities as co-commissioners and this may include building on existing arrangements for delegation or joint exercise of statutory functions under Section 75 partnership arrangements.” Now, if you are going to transfer statutory functions from the ICBs to local authorities, presumably, that will include also the resources to do so?

Samantha Jones: Yes. I am hesitating, because I do not actually have Sir Jim’s letter in front of me—

Chair: I have just read it out.

Samantha Jones:—which is very unprepared of me. I have, of course, read it, but I do not have it in front of me. We will be going through area by area to ensure the right arrangements are in place, should they be statutory functions transferred or otherwise. In many parts of the country, however, this is already happening—as in, arrangements for joint commissioning. I am very happy to come back to the Committee in a bit more detail. I would say, if I may, that there will be different places taking different arrangements, so we would therefore want perhaps to use a couple as examples to show what that is looking like in different parts of the country over a different time period. I am very happy to do that.

Q34 **Chair:** We will look at all the transcripts and everything you have said today. We may well want to have you back in the new year to examine some of those issues, because we have an absolute duty to our constituents, particularly those who are employed in the ICBs, to ensure that they thoroughly and comprehensively know what is being offered to them and, for those who remain, what they are expected to do, and to ensure that local authorities can plan for any new function they have got. There is still quite a lot that we need to unpick that we have not today but let us digest what we have heard; we may well want to come back to you. So thank you for that.

We will now move on to the main session, which is the whole vexed issue of clinical negligence that I read out at the beginning.

Q35 **Mr Betts:** On to the main item on the agenda, which is clinical negligence, and the considerable costs involved in that. How sustainable is this, given the current state of NHS finances, which we have just alluded to in our previous discussions? What are the challenges as to how improvements can be made going forward? You have predicted major, long-term increases in clinical negligence costs. They are almost going to absorb the productivity increases you are planning for, when those ought to be going to service improvements. Are you happy with that situation?

Samantha Jones: First, like the Chair did, I start by recognising that this is an incredibly sensitive subject and that at the heart of every case we talk about there is a human. There are people who have undergone some potentially very traumatic experiences, and we do not want to make light of that as part of any of our discussions. Ideally, we want to stop people being injured in the first place. I know that Aidan will come on to talk about that in terms of patient safety.

We absolutely welcome the Report on clinical negligence. It is, of course, very well timed. At the risk of pre-emptively trying not to annoy the Committee, I will say up front that the 10-year plan set that out. Indeed the Secretary of State asked David Lock KC to carry out a full review into clinical negligence, which he has been doing, and his advice is with the Ministers. I will be unable to go into some of the detail, but I say that up front to you.

The Report, as you rightly said, sets out that the cost rise is complex. I will ask Helen to go into more detail on the cost, the breakdown and the work that has taken place over the last few years, led by Helen.

Helen Vernon: First of all, I also thank the NAO for a really thorough Report. It is an important contribution to how we understand the drivers and how we respond to the challenge of rising costs, which, as you rightly identified, are putting pressure on NHS budgets and are a significant cost to the public purse.

As the Report found, the rising costs of compensation for claims of £1 million in damages or more are a major contributor to those trends, and those relate to the most seriously harmed individuals—often claims associated with brain injury suffered in maternity care. Key features of those claims are that those harmed children require care costs for their lifetime, going on for decades into the future: support for the family, aids and equipment, and accommodation. The calculation of damages in those cases is based on private care, in accordance with the current law. Damages are also determined by court precedent—for example, access to innovative or novel treatments, which is another feature that has driven rising costs over time.

The second thing the Report rightly highlights is the issue of rising claimant legal costs, which are disproportionate for claims at the other end of the spectrum. These are also, in many cases, serious injuries—people who have suffered harm in healthcare—but for claims valued at less than £25,000 in damages, the legal costs are very considerable and disproportionate. Those are all big issues.

Q36 **Chair:** We have all read all of that in the Report. To put it into the context of Clive Betts' questions, we are spending £3.1 billion this year on clinical negligence, which one of our witnesses at our pre-hearing said equates to £350,000 per hour, every single hour, 24 hours a day, in the NHS. It is predicted to go up to £4.1 billion in the next five years to 2029-30. So it is a huge cost to the NHS, and a huge growing cost. We know all the drivers. The real question, which Clive was trying to get at, is this. What measures will you take to try to prevent that cost from continuing to escalate at that rate?

Mr Betts: Or at least, do you accept that measures will have to be taken?

Helen Vernon: Let me highlight a few things that we are doing. This is absolutely front and centre of NHSR strategy, but of course we do not control the policy framework around the law or have a direct impact on

frontline care. The most important thing is to prevent these incidents from happening in the first place, so that people are not harmed. It is incredibly important to us to feed the learning that we see from claims back into the NHS at the national, aggregated level but also locally, to try to prevent the same things from happening again. That is incredibly important to patients as part of resolving their claim.

The second thing we have been doing is keeping more claims than ever out of litigation. Over a number of years, we have chipped away at what we call the litigation rate, to reduce the number of cases that go into formal court proceedings. We now keep 83% of cases out of court; they do not go anywhere near court proceedings. It is at the litigated stage that the legal costs that I talked about earlier become very considerable. Things really ramp up when they get into formal processes. That is also incredibly difficult for the patient, their family and all the healthcare staff involved in those cases. We are undertaking more work to reduce our own legal costs as well. The NAO pointed out that we go out to tender for legal firms, to get the best value for the NHS and the best quality of advice. As we take more cases out of litigation, we are also using that opportunity to bring more work in-house so that we can further reduce the commercial legal bill.

The final thing to highlight is that in relation to the huge dataset that we hold, which goes back 30 years, on the causes of harm in the NHS, we are starting to explore technology to mine that data in a very detailed way, to see what it can tell us both about the causes of those claims and about how the claims are made up in terms of damages. That more in-depth information will help to support the Department's wider work in relation to policy.

Samantha Jones: In direct answer to the question that I think was posed, and building on that answer, yes, the Government are very concerned about the increasing liability as set out. That is one of the main reasons why our Secretary of State asked David Lock to carry out his review.

Chair: Good. We have a common starting point, at least.

Q37 **Rupert Lowe:** It does appear that we have a major problem here. Not only are more people suffering the consequences of medical malpractice, but the downstream costs of dealing with that are obviously rising. I think we have to look at the upstream and the downstream. The legal costs are a downstream result of medical malpractice in the NHS—in your Department. Permanent secretary, do you agree with me that good data is the basis on which good decisions are made, rather than bad decisions? That is how I have always run my businesses. Do you agree that that is a logical summary of how people make good decisions rather than bad decisions?

Samantha Jones: It is entirely how we would hope to do so, yes.

Q38 **Rupert Lowe:** Well, I have asked a lot of questions through my



HOUSE OF COMMONS

parliamentary office. Number of GP registrations by non-UK citizens? No data. Number of illegals accessing healthcare services? No data. Cost of treating those with no right to be here? No data. Nationality and immigration status? The NHS uses no data. Patient category breakdown between illegals and visitors? No data. Cost—monetary and time—of translation and interpretation across the NHS? No data. On questions about standards of English in the health service, I have asked what steps you are taking to ensure that overseas recruits can speak English effectively. I have not had an answer. So I am interested to know this. If you do not have this data, what do you think are the reasons why clinical negligence damages are increasing so much at the front end, not the legal end—why are these cases increasing?

Samantha Jones: With your permission, I will hand over to Aidan, as the doctor.

Professor Fowler: The first thing to say is that clearly we work all the time to drive down cases of harm. To be clear, there is no evidence that those are increasing; in fact, the level of claims has not been increasing for a while now. We are making considerable efforts around patient safety and levels of harm, and we believe we have had an impact on that over the last period through the mechanism of the patient safety strategy, which is the first strategy for patient safety that the NHS has had. It was published in 2019, just before we had a pandemic; nevertheless, we have made good progress with that work, including through the pandemic.

While it is difficult to estimate, we estimate that we are avoiding 1,000 deaths a year that would have occurred had we not done that work. It is a fundamental piece of work around how we learn from the system, investigate, involve families and patients in those investigations far more, report and learn from that reporting. You rightly made a point about data. We have a massive database, with 3 million incidents, from which we are learning, going into it a year. To be clear, and to reassure you, most of those are no-harm data points: something has gone awry, but there has been no harm as a result of it. That is about 70% of the data we see, and then another significant chunk of it is low harm. It is the minority of those reports that involve either moderate harm, serious harm or death. We are learning all the time from that.

We have made reductions, which are estimated to save UK plc—not necessarily the health system alone—hundreds of millions a year. There is far more to do, and we continue to do that and to prioritise programmes around that. When it comes to clinical negligence, one of the difficulties is that one would assume that if you reduce it, you will see a reduction in litigation, but there is a difference between where we see the majority of the harm, which tends to be in older populations, and who litigates. There is no direct connection between the two. The areas where we see the highest levels of harm are not necessarily the areas where we see most litigation, although we aim to learn from litigation and clearly wish to see it reduced through the reduction of harm. I hope that that is helpful.

Q39 **Rupert Lowe:** Thank you for that. Can you explain something to me,

then? I have had literally hundreds of NHS whistleblowers contact me. You probably know that I set up something called Restore Britain; we have our own whistleblowing line. We have literally had hundreds of NHS staff whistleblowers—I do mean hundreds—contact us about the lack of English language causing issues, as well as foreign staff not holding appropriate skills and qualifications. These people are doctors, nurses, midwives, managers and surgeons—everybody in the NHS. It is not just one subset. They are frightened of reporting it to the NHS, for the fear of the wokerati who run the NHS now; they fear reprisal, so they come to us. You must accept the fact that we need the data. What data do you hold on the correlation between foreign nationals and medical malpractice taking place in the NHS? You must look at all this data. You cannot fear being called racist or anything else. We need raw data, for taxpayers' benefit and for patients' benefit. Surely we must drill down and find out why this is happening.

Chair: I think we have got the message. Let's let Aidan answer that.

Professor Fowler: I would not want to be considered part of a wokerati, but we are very animated about issues around inequalities and so on. To the point about digital, we will get far more data from those 3 million incidents that I referred to with machine learning, but we are hand-reading thousands of those death and severe cases a year. What is not coming out of that is that there is an issue around people who have come from abroad with language and communication. There are undoubtedly communication issues around inequalities in harm, and we know that some groups are more affected by harm partly because of communication. Communication is undoubtedly important in safety, but we are not seeing, from those reports, some of the things that you are describing people whistleblowing about.

Q40 **Rupert Lowe:** So you disagree with these whistleblowers?

Professor Fowler: I am not disagreeing with the whistleblowers because I have not spoken to them. It is important that people feel able to speak up, and one of the things that we are very focused on is the concept of psychological safety and people being able to step forward and talk to us about these things.

Chair: Rupert, can I just say that if you have got cases of whistleblowers, there is a proper procedure to deal with those? If the NHS does not know about them, it cannot do anything about it.

Q41 **Rupert Lowe:** These are my whistleblowers, Chairman, but they are not reporting it to the NHS for fear of reprisals.

Professor Fowler: There are systems for them to do so through Freedom to Speak Up. I know people are very concerned about themselves when they whistleblow, but there are very safe systems for people to speak up and they do not suffer any harm as a result of doing so through our Freedom to Speak Up system.

Q42 **Rupert Lowe:** Clearly, these people do not agree.

Samantha Jones: We would encourage anybody who has any concerns to come forward and raise them through the processes that Aidan set out.

Chair: To be fair, Rupert, if the NHS does not know about them, it cannot do anything about it. We perhaps need to set up some offline meetings to see how we can deal with this.

Rupert Lowe: I am happy to do that, Chairman, but I do think that the NHS needs to improve its whistleblowing line and make sure people do feel comfortable coming forward. They would not come forward to Restore Britain's line if they thought they were going to be treated fairly by the NHS whistleblowing line. I venture to suggest that it is actually a requirement for it to improve its line. I am very happy to share the data we have got.

Chair: Let us take that offline.

Q43 **Dr Shastri-Hurst:** Before I start, I should declare a number of interests in this subject. I hold a practising certificate with the Bar Standards Board. I am an associate tenant at No5 Chambers, and my area of practice included clinical negligence and personal injury law. I have previously been a member of the Personal Injuries Bar Association, and I sat on its executive. I have previously been a member of Action Against Medical Accidents. In addition, I am registered with the GMC, but I no longer hold a license to practise. By virtue of having more than a decade in medical practice, there have been cases with which I have been involved that have involved litigation of some description, although not personally against myself. I am both a member of the Middle Temple and the Royal College of Surgeons.

I direct my questions to Ms Vernon. You have already raised the challenges for Government around the cost of damages and the fact that a lot of that is set through precedent or the Judicial College guidelines and so on. I wonder whether you could set out to what extent the rising cost of clinical negligence damages, as opposed to overall costs at this stage, are within the Government's control.

Helen Vernon: That is a really good question, and in fact, the NAO has made a recommendation that, through data analysis and through soft intelligence, we should try to establish what is controllable and what is not controllable, both within NHSR's control but also what is attributable to the legal framework.

A lot of the things that are in the sights of our strategy are things that we think are within our control: we can do more to keep cases out of litigation, we can do more to reduce the stress on families going through those cases and claiming compensation, and we can do more to do things like make interim payments at an early stage on brain injury cases. That is why we have introduced the early notification scheme for obstetric cerebral palsy that is referenced in the NAO study.

What is more difficult is the legal framework that surrounds the recoverability of damages. As you know, that provides that the individual



should be entitled to compensation that will put them back in the position that they would have been in had they been uninjured. That is why people can recover their care costs on a privately funded basis. That is why they can recover loss of earnings sometimes, with reference to family members. That is why they can recover expensive aids and equipment and get accommodation needs met, too. Those are all things that are very important to harmed individuals and their families.

We need to do more to dissect that problem in pounds and pence, so we can inform the impact analysis that the Department would no doubt wish to do in relation to any policy solutions. Certainly, there is an element, as you rightly said, that is controllable, but there is also an element that relates to the current legal framework.

Q44 Dr Shastri-Hurst: I would like to pick up some of those threads around policy decisions. Capping damages is always a difficult concept to talk about when somebody has been harmed as a result of medical accident. There are some damages that are obviously less cappable than others. For example, there is a certain value to the cost of accommodation, but in terms of general damage as opposed to special damages, does your Department have a view on looking at capping damages in respect of that?

If I can piggy-back on to that, you have mentioned the cost of private healthcare. Damages are set on the basis that that healthcare would be recovered on a private basis, or that the treatment would be on a private basis. A number of people will receive that care on the NHS, which in effect is getting a double reward. It is, of course, appropriate that these individuals are put back to where they should be as best as they can be, given the circumstances, but it seems somewhat perverse that you get access via the NHS as well as being able to hold on to the sums that you could have spent on a private basis.

Helen Vernon: Yes, you are right to raise that. It is an incredibly important issue. It goes to the heart of how damages for care, in particular, are awarded. As a broad estimate, about 60% of the very high-value settlements for damages relate to future care costs. As you say, the current law provides that you can recover those on a privately funded basis.

I would not want to talk about the policy solutions that Ministers might be considering. I can say that other jurisdictions have done it differently. For example, in Australia, which has, broadly speaking, a tort system, although it is different state by state, they have introduced caps for things like average care costs, care rates and what is considered to be reasonable. They have put caps on loss of earnings recovery. That is pegged to average loss of earnings rather than with reference to the evidence of family members. Various other caps and limits have been applied.

Other jurisdictions do it very differently. The Scandinavian countries, which have avoidable harm systems, work on the basis of a top-up of state-available care so that there is no duplication and damages are



HOUSE OF COMMONS

minimised because it is an additional cost over and above what the individual can access from existing state services.

However, it is not really as straightforward as translating one system into another. England is very unique. While we have a very thorough understanding with the Department of what the drivers are and what some of the solutions might be, decisions on that will ultimately be for Ministers.

- Q45 **Dr Shastri-Hurst:** Picking up on that, another potential area that costs may be escalated in is the lost years claims. At the moment, the case of CCC and Sheffield Teaching Hospital is going towards the Supreme Court. It is looking at challenging the case of Wiseman. What assessment has NHSR and the wider DHSC made of the impact on the ongoing expenditure and the weight of clinical negligence costs to the NHS were that judgment favour of CCC?

Chair: Neil, for the record, could you say what CCC is?

Dr Shastri-Hurst: CCC is the anonymised name of the claimant, because it is a case involving a child. The case was brought against Sheffield Teaching Hospital.

Helen Vernon: That is a significant case. It has been in the appeal courts for a while now. It was being heard in the early part of this year. We are currently awaiting judgment from the Supreme Court. It is an interesting case in its own right because, first, there is a very seriously injured child with some very significant needs. It is a very sensitive case for that reason, so I would not want to go into the detail. Before I get to the assessment on lost years, this is the kind of case that illustrates the level of care that is required. In this case, we have two carers around the clock and the judge awarded care on that basis. We have got home hydrotherapy and a number of other quite expensive interventions, given the severe nature of the disability.

For lost years, we estimate that, if successful, there will be about an £800,000 addition on each case. We have made that assessment. It is an estimate, I have to say. It depends on the variety of cases we get where lost years might apply, but that is the magnitude of the impact.

- Q46 **Chair:** For the record, could you tell us how many cases there are in that category?

Helen Vernon: We settle, on average, around 120 to 130 brain injury cases involving children every year. The lost years case that you are referring to relates to children, because it concerns their lost income beyond their life expectancy, if that makes sense. For adults, that can be recovered, because you can evidence it, but it is clearly more difficult for children.

Chair: Thank you very much. Neil, do you have any further questions?

- Q47 **Dr Shastri-Hurst:** I have one more, if I may. Moving slightly away from the damages to overall costs, what actions have been taken to reduce the



overall costs of clinical negligence? I open that up to the entire panel.

Samantha Jones: As I said, the Government recognise the cost of clinical negligence and how it is foreseen to grow over the next few years. That is why the Secretary of State has asked David Lock KC to review that and come back with recommendations on addressing it in the future. As I said at the beginning, I cannot go into much more detail at this stage.

Chair: We will probe some areas where you might think about changes, even if you cannot tell us whether you are actively considering them or not during the rest of the hearing.

Q48 **Anna Dixon:** I would like to come specifically to maternity and obstetric care. Given what you said in your opening remarks, and what the NAO Report says very starkly, these are obviously the higher value cases; they account for a significant proportion of cases, and a significant proportion of the increase in claims.

As a constituency MP, I have certainly had casework with an individual who has had a brain-damaged child with very high need, and obviously it is important that those families and children are getting financial compensation to support them with their medical and care needs. Mindful of that, Helen, what action is NHS Resolution taking to try to manage the cost of maternity claims?

Helen Vernon: As you rightly said, maternity claims absolutely dominate the costs that we referred to earlier, because of those very high-value cases that have needs going decades into the future. It is a strategic priority, and it has remained so certainly for the last six or seven years.

Underpinning that, we have two main schemes. I referred to the first earlier, which is the early notification scheme for obstetric cerebral palsy cases. That is quite innovative; it is certainly new and has not been done anywhere else. We had an issue in those cases with a time lag of an average of 11 or 12 years, so it was impossible to derive learning from those cases or get assistance to the family early on.

What we now do is ask to hear about those cases right from the start, so we hear about them right at the start from MNSI, which initiates the initial investigation. We can then accelerate the investigation into legal liability, with the family's consent, and we can identify whether or not they are likely to be entitled to compensation. If they are, we can get them some early interim payments that can support those really important early-year needs, such as aids and equipment that might make all the difference to a family in the early years.

We can also get the learning out of that case and get it back to the trust as soon as possible, as well as aggregate it nationally. In due course, we hope that it will also reduce cost, because it will reduce the inflationary impact on those very high-value losses. We are having that evaluated at the moment, with the support of the Government Actuary's Department and the THIS Institute, and we hope to be able to publish the evaluation in

the new year. If it succeeds, it should both make the experience better for the family and reduce the costs in the longer term.

- Q49 **Anna Dixon:** Can I just establish something? In the pre-panel, we heard about victims of car crashes, and the view there seems to be to get rehabilitation in very early and as intensely as possible, because the more appropriate treatment you can provide somebody, the more you can give them improvements that reduce their lifelong need. Is that what you are describing? Are you suggesting that even before this goes anywhere near litigation, support is trying to rehabilitate and treat the child?

Helen Vernon: Not quite, but almost. A brain-injured child is usually undergoing NHS care in any event, particularly in the early years, so those state support systems are in place at that time. What we normally make interim payments for are some of the things that might assist the family in the early years.

It can even include things like counselling for the family and some interim care needs, to ensure that a care regime can at least be up and running so that, for example, the family can go back to work, or to provide support, which might not be as intensive as is sometimes required for families in those early years. That is not rehab as such, but it should help with the ongoing support for that child, because we are getting in much sooner than we have been able to do historically.

- Q50 **Anna Dixon:** Professor Fowler, you might know that I did some work many years ago at the King's Fund on an inquiry into safer births. It looked at many of the historical reports on what needed to change to reduce harm in maternity services. It said that there are far too many recommendations, none of them is being acted on, and this is what needs to happen.

I fear that with the Amos review, we will find ourselves in a similar position, where another decade has gone by and we have had many reports and recommendations about things that we need to do to make maternity safer that we have not acted on. What is the point of view of the clinician leadership? Evidence from the Royal College of Obstetricians and Gynaecologists pointed to some of the changing demographics—older women giving birth and higher levels of obesity, diabetes and so on—leading to higher levels of complication and more medical complexity. From the point of view of the medical leadership, what needs to be happening to reduce the number and severity of claims in this area?

Professor Fowler: This is a highly complex area, so stop me if I go on too long, because I probably can. First, on the Amos review, which we are waiting for—we expect the final review next year—I think that, very sensibly, Baroness Amos is aiming to provide a new version of recommendations that takes into account all recommendations so far and tries to synthesise them into one report, which is really helpful. There have been a lot of recommendations and we expect more from, for example, Nottingham, but that does not mean that we are waiting for that to act.



HOUSE OF COMMONS

I will come on to the maternity issue—you mentioned maternal complexity—but on brain injury, I divide it into two areas. There is work on pre-term, as in premature babies being born and what they need in order to reduce the levels of brain injury, which is slightly different from term injury—but to be clear, I am not an obstetrician.

One thing we have seen is that term brain injury—if we look at early data, including MNSI's own data; I have a graph here—has actually been reducing. Referrals for term brain injury have been reducing, whereas pre-term has been a bit stuck. Our own work on pre-term—within Safety, we have been responsible for some of the work—has been on best practice bundles and making sure that they are more consistently applied. We estimate that we have reduced cases of brain injury in pre-term by about 500 or so—a lot.

Pre-term is not the group who mainly litigate, as I understand it—Helen may correct me on that. Most of the litigation is on term brain injury. A lot of the work has been to understand what the best impact would be to drive that down, and that broadly falls into two main categories. One is foetal distress, and you may be aware we have been very keen to have a suite of early warning scores around deterioration for all age groups.

The panel may be aware of the national early warning score, which is for adults, and the work that we have been doing on Martha's rule for that. We also have a maternal early warning score, or MEWS—I have to tell you that we are not great on acronyms—and a neonatal or newborn early warning track and trigger tool, or NEWT.

We are now developing foetal deterioration monitoring and distress monitoring as part of a programme called ABC, which stands for avoiding brain injuries in childhood. That programme is being rolled out as we speak and it examines what can be done around reducing levels of foetal distress, recognising foetal distress and intervening earlier, but also managing the impacted foetal head, which is another issue, where the baby gets stuck. Do you want me to cover—?

Q51 Anna Dixon: I am just thinking that that may be getting too technical—

Professor Fowler: It may be; I was going to stop at that point. I will just cover the maternal aspect. There is an issue in that we now have older mothers with greater levels of obesity, and those are risk factors for maternal harm, if you like, and maternal mortality. We have struggled with reducing maternal mortality in the face of that increased risk, which impacts on other things. For example, the highest cause of neonatal death is congenital abnormality, and one of the causes of that is older mothers.

Anna Dixon: Just briefly on the ABC programme, we heard in the pre-panel—

Chair: We do not want to get too much into that; we have had quite a lot of detail already. I would like to keep to the top levels please, Anna.

Q52 Anna Dixon: Okay. It was just about the learning from Victoria, Australia. We heard really quite dramatic figures—a reduction of about 50% there in



HOUSE OF COMMONS

claims and cost frequency. The idea is that if all English units could achieve the same outcomes as the top 20%, there would not only be 116 fewer infants born with cerebral palsy, but a cost reduction of up to £1 billion. Answer briefly, if you can: is that the purpose of the ABC programme?

Professor Fowler: It is in part. In part, ABC has been developed by an obstetrician called Tim Draycott, who developed the PROMPT training, which he introduced in Victoria, Australia. He has had some influence in Victoria, Australia, as well as the influence he is having here.

Chair: Okay. Anna, have you finished all your questions?

Anna Dixon: Sorry—there was a second part to the question, which was to go on to other specialties. Should I just briefly pick that up, Chair?

Chair: Yes, please.

Q53 **Anna Dixon:** The other specialty where more progress has been made is obviously surgery. Again, there are the long-standing issues—WHO programmes, surgical safety checklists and everything. What has led to the reductions in surgical claims? How are you applying any lessons from that to other areas, if at all?

Helen Vernon: We have done a lot of work with the Getting It Right First Time programme, which is part of NHS England, bringing claims data together with all the other metrics that exist in the NHS in relation to these areas, creating litigation packs and then really drilling down into the causes of those claims.

With surgery, a lot of the issues are around things such as consent and infection control. We did some specific work with the Getting It Right First Time programme on training on consent—going out and using the boots on the ground that the programme has to connect with clinicians and to use claims as an illustration of how these things can go wrong and the consequences of that, to help with the local safety interventions that need to happen to prevent these things from going wrong in the first place.

Whether there is a cause and effect between that work, I could not say; it has not been evaluated. However, it is certainly encouraging that that specialty has shown a reduction in claims following that piece of work being taken up.

Chair: Right. We need to keep this fairly tight.

Q54 **Anna Dixon:** The only other areas where the data seems to be going in the wrong way are mental health, radiology and paediatrics. Is there anything specific with those areas to explain why that is? And what might you seek to do? Again, either Helen or Professor Fowler can answer.

Professor Fowler: On surgery—I am a surgeon, so I am bound to want to talk about it—a lot has been done around, for example, the checklist and so on. However, we have to be a little cautious in attribution, because, for example, Scotland published their data on it and the decline in mortality came before the programme to introduce the checklist.



HOUSE OF COMMONS

Sometimes things are called out as a cause, and it is not clear that they are. But there have been a number of programmes in surgery.

It is more difficult to say why it is rising in other areas, other than to say that we know there is an increase in demand around mental health, and we also know that there are more diagnostics done in radiology and that there is more interventional radiology. It may be that those issues are drivers, but we would need to look at them in detail. You may have more information, Helen.

Helen Vernon: To add to that, in mental health specifically there have been some big, quite high-profile group actions. The addition of those group actions has meant that there has been a disproportionately high percentage increase.

Q55 **Anna Dixon:** Do they relate to deprivation of liberty? What was the harm in mental health?

Helen Vernon: They related to certain secure units. Without going into too much detail, they involve multiple claims arising from the same events.

Q56 **Chair:** Turning to the tables that Anna was talking about—the various disciplines that are going up and down—one that surprised me was figure 7, on the number of cases arising in radiology. Is this to do with misdiagnosis from the radiology, or is it from the actual administration of radiology?

Helen Vernon: Misdiagnosis, generally.

Q57 **Chair:** Is that something on which AI would potentially come to our aid?

Professor Fowler: Potentially, yes—in some areas more than others. For example, there is good AI reading of mammograms. It is working better in some areas than in others, but I do not have a huge amount of detail on the specific cases.

The other thing about safety in general is tracking—reports going missing and that sort of thing. We are now looking at a programme of getting digital systems in. This applies in primary care, for example, and in diagnostic tracking, where people get lost somewhere along a diagnostic pathway. That is recognised in a study by a GP called Tony Avery. Digital systems can support us in making sure we track patient pathways better so that, if you have a CT scan, the report is seen by the right person and acted on.

We also see cases where somebody comes into an emergency department with a chest injury and have a chest X-ray, and people look for signs related to the injury but do not see the lung cancer that is an incidental finding. Those sorts of cases have arisen over time, and we have to get better at tracking them.



HOUSE OF COMMONS

Chair: That is very helpful. We still have a lot of ground to cover, but we will take a break. The clock is currently at 11.27 am. Can we be back here by 11.35 am? We have a lot to get through.

Sitting suspended.

On resuming—

Chair: We now resume the session. Starting us off is Tristan Osborne, please.

Q58 **Tristan Osborne:** I am going to talk specifically about the general practice schemes, looking at paragraph 1.15. My colleagues have dealt with the medium to the top end; I will be looking specifically at GPs.

The new CNSGP scheme was introduced in 2019. There has been an indication that the numbers have significantly risen from 273 to 2,914. That is a major increase in that period of time. Clearly, there is a move of indemnity now back on to the NHS. In one breath, it says that the figures are going to be stabilising, but then they clearly continue to increase.

First, have you done any modelling around these numbers—around where the expectation will be? Are we due a stabilisation or are we due an increase?

Helen Vernon: The scheme inceptioned on 1 April 2019, which means it related to incidents occurring after that date. As you alluded to, I think that experience will grow over time. The increase from a few hundred in the first year to what is now almost 3,000 in the current year is broadly as expected. We have a reserving and pricing committee, which monitors experience on a regular basis and receives input from our actuaries, who work with us to model what that means in terms of cash flow, and where it might be going in the future.

The challenge we have with modelling where this is going to go for the GP schemes is that we do not have the complete historical experience to hand. The reason for that is because the historical claims sat, broadly speaking, with three of the medical defence organisations, so they were not on the NHS balance sheet. They were elsewhere. Only two of the three MDOs participated in the transfer of those historical liabilities. So we have got partial experience of the past, but not complete experience.

We expect to have much more information as the scheme moves on, and certainly in 10 years' time, although that seems very distant, we hope to have a much more complete picture than we do currently.

Q59 **Tristan Osborne:** I have a number of follow-ups. As you have correctly stated, 10 years is a long time. On the modelling, where are we predicting the numbers to be? Obviously, it has gone up from a smaller number—you would expect that when a scheme is implemented, but it has gone up by almost 100% in some cases. That is a significant increase in six years. Where are we modelling this over the next five to 10 years, for instance?

Helen Vernon: Perhaps to correct what I said earlier, we hope to have more information—we do not have the figures 10 years' in advance; we just know that we will have more experience to be able to produce those figures.

We do make estimates five years in advance. I do not have those to hand, but I can certainly make those available to the Committee after today, if that will be helpful.

Q60 Tristan Osborne: Thank you very much. It would be helpful.

On transparency, on these low-volume cases, we know that there is a lack of transparency around claimant compensation—the NAO reports that. But we also know that the legal costs are 3.7 times higher than the damages awarded—that is in the table on the back. There is a question of sustainability here around these high-volume, but low end awards.

Clearly, you are going to be looking five years in the future. Is there a concern about this lack of transparency, especially around legal fees and the engagement of legal practices?

Helen Vernon: It is a really important point that the NAO raises. I think there are two separate things in your question. The first is the disproportionality at the lower end—I think it is 3.7:1 for cases resolved for less than £25,000 in damages. That is one issue. The other issue that the NAO have captured in one of their recommendations is that, in addition to what is reported in our accounts, the lawyer representing the patient can also recover an element of their fee from the patient's damages.

That is not reported in our accounts. It is largely invisible to us because it relates to the retainer, the commercial arrangement between the patient and their lawyer. The NAO has recommended that we work with the claimant legal market to see if they are prepared to share more of that information in a more transparent way so we can get a better indication of the true cost.

Q61 Tristan Osborne: Permanent secretary, you said that this is part of an ongoing process and that there is stuff to do with the Minister here, but is there engagement around making that transparency much clearer? These cases have increased significantly over the last couple of years. They represent an increasing proportion of volume cases. It appears to be quite a reasonable request for these organisations to give us that information.

Samantha Jones: I would not want to go into the detail of the review that David Lock KC is carrying out, but I would expect him to cover all aspects.

Tristan Osborne: Thank you.

Q62 Chair: Helen, in our pre-hearing there was a certain amount of work being done on cases under £25,000. To put it into context very clearly, for a claimant claiming £25,000, the legal costs are £100,000 or £75,000—4:1.

That is the nonsense of the system. We were told that the Civil Procedure Rule Committee had put all its work on hold so there are no ongoing investigations into the sub-£25,000 category. Why is that?

Helen Vernon: The work of the Civil Procedure Rule Committee relates to the consultation that was run under the auspices of the previous Government by the Department of Health and Social Care on fixing costs for lower-value cases. Again, I cannot talk to the policy—I believe David Lock is looking into that—but I can say that we are working within that framework, which is essentially that lawyers can charge an hourly rate. We try to minimise the costs incurred by the other side as much as we possibly can by keeping things pre-proceedings and by trying to resolve the claim through non-adversarial means. I do not know if the Permanent Secretary wants to comment on the policy.

Samantha Jones: I would not want to go into any more detail at this stage.

Q63 **Chair:** What is the timing of the David Lock report?

Samantha Jones: The review is currently with Ministers.

Chair: That is very helpful. We will move on to Sarah Green.

Q64 **Sarah Green:** My question is on the area where the legal costs of clinical negligence cases appear disproportionate, especially when it comes to claimant legal costs. This is more of a follow-up question to Ms Jones around what the Department is doing to address the increasing amount of NHS funds being paid to clinical negligence lawyers, rather than to the individuals who are owed compensation.

Samantha Jones: At the risk of repeating myself, the rising costs of clinical negligence have been taken incredibly seriously. As I said right up front, we welcome the focus and the areas that the NAO has been looking at. The Secretary of State commissioned David Lock to carry out his review covering all aspects of policy. As I said just a second ago, it is with Ministers at present. Is it worth Helen explaining some of the work that has been done over the last couple of years to look at these costs in more detail and the actions you have taken?

Helen Vernon: Yes, absolutely. There are two things. The first is defence costs. The lawyers that we procure are on fixed and capped rates. You will see from the NAO's Report that we have broadly kept the increase in those costs level with general inflation as a consequence of that. We hope to do even more there. We have a procurement coming up, and we are also trying to bring more work in-house, so that we can do it a lower cost.

The second thing is, in relation to keeping things out of litigation, there is not just a positive benefit for patients and their families and the healthcare staff who are involved in those claims; there is also a positive financial benefit. On average, it saves £96,000 in claimant legal costs to keep something pre-action rather than allowing it to go into litigation. That is on top of the court costs and the additional costs that we incur with our own lawyers.



Q65 Sarah Green: Is there anything you can do in your organisation to improve the transparency around the additional legal fees that claimants pay out of their compensation? There is no clear figure attached to that, but is there anything you can do to increase transparency on that?

Helen Vernon: We hope so. It is a welcome challenge from the NAO in the Report, because it shines a light on the issue. It gives us the opportunity to debate that with the claimant legal market. We have increasingly worked more collaboratively with claimant lawyers, because we have a shared interest in making sure that we prevent these cases and deliver the right sort of compensation for their client. On the back of the NAO Report, we have already started some conversations with the main claimant law firms to ask what they are prepared to share and do more of in that area, on a voluntary basis.

Q66 Sarah Green: Could you write to the Committee and give us a bit more detail on that? We would be interested in learning more about that.

Helen Vernon: Yes, I would be very happy to.

Q67 Dr Shastri-Hurst: There is a huge discrepancy, having done both claimant and defendant work, in terms of the rates you get paid. I am pleased to see that fixed fees will be part of David Lock's review.

May I turn to the point of expert evidence? These cases hang on the expert evidence, yet it is often not disclosed until some way down the process. What engagement has taken place with the Ministry of Justice and with the Civil Procedure Rule Committee about looking at the pre-action protocol for clinical negligence disputes to see whether there is a benefit to having early disclosure of the expert evidence? That could often resolve issues without stacking up legal fees and mean that alternative dispute resolution could take place at an earlier stage. Permanent Secretary, what engagement has your Department had on that with other Departments across Government?

Samantha Jones: As you rightly point out, this is a cross-Government issue, and we work closely with our colleagues in the Ministry of Justice. I am going to refer back to my previous answer around making sure about the costs and the way that this is handled, looking at all policy aspects—but not going into the specifics of any particular one covered in David Lock's review.

Helen Vernon: I can add to that. I am really glad that you asked the question, because it is an area that we have responded to a number of times in consultations from the MoJ on things like the pre-action protocol. We would be really keen to shift to a position where there is an earlier disclosure of expert evidence, and perhaps even opportunities for joint expert evidence in the pre-action phase.

Aside from policy solutions, which of course are not for us, that is an area that we are exploring actively with the claimant legal market to see if we can do that on a voluntary basis. I guess it is more difficult for liability, but there is certainly much more potential for things like quantum and care



HOUSE OF COMMONS

experts, where there is often very little between the two experts who have been instructed by the NHS's lawyers and the lawyers acting for the patient. There is huge potential there, and it is certainly something that we would like to move towards on a voluntary basis, if other solutions are not forthcoming.

- Q68 Dr Shastri-Hurst:** Another issue that affects the NHS's budget is the fact that you have a QOWCS—qualified one-way costs shifting—system. Claimants who are unsuccessful in their case are not liable to pay the costs of defendants unless there are exempting circumstances such as fundamental dishonesty. Is there not a risk that that leads to claims that have relatively poor or no reasonable prospects of success being pushed longer than they should be? The cost is then borne by the NHS. Is there any cross-departmental thought on whether we should look again at QOWCS as a principle? Deposit-type orders could even be put forward by judges where, on an initial assessment, there are very poor prospects for a particular claim.

Helen Vernon: You rightly say that it heightens the risk, but QOWCS was part of a balanced set of reforms introduced back in 2013 as part of the LASPO Act. Again, it is certainly an area for consideration. In the meantime, that does not prevent us challenging the bills we are presented with by claimant lawyers for the work they do, which we do regularly. Last year we saved over £138 million on claims and legal costs by raising those challenges.

- Q69 Dr Shastri-Hurst:** I have one final question, and I would like to bring in Professor Fowler because it involves patient safety. Inquests are now routinely done under a CFA when representing families, on the presumption that those costs will be recoverable if a successful clinical negligence claim arises out of it. That changes the context of the inquest from an inquisitorial process about how things went wrong and what could be learned to something more akin to satellite litigation. Does that model of using CFAs for representation at inquests undermine the patient safety element and the learning exercises that can arise out of them?

Professor Fowler: It is not something that I have had much to do with. It would be very difficult for me to comment because I do not know the detail of the particular issue around coroners. Obviously, it is the sort of thing that our medical examiners would be more familiar with; it is perhaps something for the national medical examiner.

- Q70 Chair:** Neil raises a very important issue, Permanent Secretary. Could we have a note on that whole area? Those inquests are a sensitive thing.

Professor Fowler: We can certainly look at it and write back to the Committee.

Chair: Thank you very much.

- Q71 Tristan Osborne:** My next questions will be on alternative dispute resolution. Looking specifically at figure 13 and paragraphs 3.12 and 3.13 of the Report, alternative resolution is being applied in parts of the United



HOUSE OF COMMONS

Kingdom already, specifically Wales, where we have an alternative redress scheme as part of the NHS Redress Act 2006. Without going into too much detail—because it might be something considered in the David Lock review, and I do not want to get the standard response back—have we been looking at alternative dispute resolution approaches similar to those introduced in Wales?

Helen Vernon: We do a huge amount of alternative dispute resolution, as the NAO acknowledged in its Report. It is not a one-size-fits-all approach: you must ensure that you are offering the right thing to the family in the right case. We are the first body of our kind to set up a mediation panel. That has been running for some time, and we do considerable amounts of mediation. It is often an opportunity to bring the clinician together with the family to provide an apology or explanation, and to reconnect and rebuild damaged trust after an incident.

There are a variety of other things which you will have seen set out in the Report in the table referenced. We would like to do much more, and keeping things pre-action is definitely the opportunity to do that. The Welsh model is interesting but also has its challenges. A lot of the resolution is devolved to the local health body, which can have benefits but can also mean that there is potentially a risk of inconsistent decision making. I am not saying that that happens in practice, but it is certainly a risk to be borne in mind.

Q72 **Tristan Osborne:** I have one further follow-up. Other jurisdictions have an ombudsman-style approach to redress schemes for lower value claims—a dual-track approach. Wales does not have that approach but other nations in Europe do. Is it being considered? It would seem sensible to consider it, given the legal fees that we have been talking about.

Helen Vernon: Again, I would not want to get into the policy side, but I am aware of ombudsman-style approaches in other jurisdictions; France, for example, has a similar approach, but it is not necessarily directly translatable across into England. The PHSO obviously has very different powers, a very different remit and a very different way of looking at cases. You would need to fit that together with what we do, which is essentially to get to the right answer as quickly as we can, but using a tort threshold for recoverability, so it is not a like-for-like translation.

The other thing to bear in mind in relation to systems such as the French system is that moving to a different style of approach and sometimes a different threshold for damages can also mean you are opening out compensation to more people. That can be a good thing if you are compensating more people for things that have gone wrong in healthcare, but it also has cost consequences that would need to be carefully modelled and weighed in the balance against what that money could do for other safety initiatives.

Q73 **Tristan Osborne:** You mentioned the tort legal system that we have. Without getting into the realms of policy decisions, do you think that is a financially sustainable model at this lower end, sub-£25,000?



HOUSE OF COMMONS

Helen Vernon: The issue with the sub-£25,000 is not the tort system per se so much as the basis on which costs can be recovered, which as we talked about earlier is on an hourly rate. That is very different from other areas of personal injury such as motor, employers' liability and public liability. The two ends of the spectrum—the very high value, severe injury end and the lower value but nevertheless, in many cases, still significantly high-cost end—possibly require a different set of options. I wouldn't want to talk to policy in those areas.

Q74 Dr Shastri-Hurst: You will be pleased to know that this is my last set of questions. They are around the disproportionate costs for lower and medium-value cases. We have touched on the role of fixed recoverable costs being part of David Lock KC's wider review, but I am particularly interested in whether there are thoughts of extending them beyond the lower-value cases to medium-value cases and above.

There is also an issue that the complexity of the case does not always relate to the value of the claim. We have heard concerns from claimant lawyers in particular that this becomes a point about access to justice. Could you give a little more clarity on that?

Helen Vernon: Yes; those are arguments that I absolutely recognise and we have been debating them for some time. Coming to the first point about the medium-value end, the Ministry of Justice, with its fixed recoverable cost regimes for motor, EL and PL, has looked to extend the threshold over time, starting with a very low value and then moving it up to £25,000. It has now been moving into higher thresholds. That is the general pattern of how these reforms unfold.

The other thing is that the policy was first considered for clinical negligence quite some time ago, and there has obviously been an inflationary impact since then. The policy was first mooted 10 years ago, but if you think about £25,000 now, it would probably equate to the middle-value end.

Access-to-justice issues for people who are severely harmed but who may nevertheless have a low-value claim are an important consideration for decision making in that area. Previous iterations have considered things like exceptions for certain cases, but it comes down to what the cost regime looks like and how it provides sufficient flexibility for that complexity to be accommodated.

Q75 Dr Shastri-Hurst: We talk a lot about legal fees, but there are also fees for expert evidence. In lower-value personal injury claims, there is a tariff system or a cap on the cost of expert evidence. Is that something else that the Department is looking at to minimise costs, particularly at that lower end? That is perhaps more directed to the Permanent Secretary.

Samantha Jones: I think the David Lock review is looking at all aspects of clinical negligence, including the cost of claims and the breakdown of the way that it is worked through—that is what you would expect me to say.

Dr Shastri-Hurst: We will await that report with anticipation.

Q76 Catherine McKinnell: Neil highlighted the issue of the potential double payment by the Government, in effect: paying once for compensation and again for ongoing healthcare and care services through public services. I appreciate that that is the way that the legal system and civil procedure are set up, but I am less clear on why we do not have any clear information or data on the number of people for whom that is the case—or do we?

Helen Vernon: It is a major issue and, as you say, it relates to the legal framework. In some cases, we negotiate a reverse indemnity or a Peters indemnity where we, as part of the settlement, agree either that the claimant should not access state services, or that where they do access state services, they should receive a deduction in their annual payment subsequently. We have a number of those arrangements in play, but as the courts have expressly said, that cannot be imposed; it is part of the negotiation.

In relation to what happens after the settlement has been agreed, other than those agreements, we are not able to ask for information on either how the patient spends their money or whether or how they access state-funded services. Unfortunately, we are not allowed access to that information. There might be mechanisms that could be put in place to get a better record of that, but at the moment, that is certainly not the case.

Q77 Catherine McKinnell: Do you have a sense of the extent to which that phenomenon contributes to England being such an outlier in the costs of clinical negligence? I refer to figure 15 in the NAO Report, which I am sure you have seen. The extent to which the costs per capita for England are so much larger than other jurisdictions, other than Ireland, is stark. To what extent do you think that is a factor that contributes to that?

Helen Vernon: It is certainly a major contributory factor to the costs of certainly the very high-value cases in terms of the privately funded basis of the assessment of future care. In relation to other jurisdictions, the NAO's table is very helpfully caveated to explain that it is not a like-for-like comparison. There is nothing quite like the NHS and there is nothing quite like what we do in terms of indemnifying the NHS—it is fully comprehensive. Often other jurisdictions report only on different elements of the system, because some of it is privately insured, some of it is capped, and some of it is a top-up. They are not like-for-like comparisons, and the NAO Report was clear about that.

Catherine McKinnell: Presumably that will be looked at as part of the ongoing report into this issue by David Lock.

Samantha Jones: Certainly any policy development looks at international examples as part of its development. I would reinforce what Helen just said about the uniqueness of the NHS and the universal health system that we have.

Q78 Catherine McKinnell: That is really helpful. We have talked a lot about



the money and the costs, but, on the flipside, I think there are equal concerns about the impact on patient outcomes. You could argue that the current system is counterproductive to improving patient care in some cases, because it creates a lack of openness, transparency and candidness with patients and within the health service. It is worth discussing that today. The Dash review found that the current complaints system is very confusing and lacks responsiveness, so it would be helpful to understand to what extent the NHS centrally collects information about how trusts respond to complaints. I appreciate that I am talking about complaints rather than litigation; clearly, if we had a system that dealt better with complaints, we would have a reduction in litigation. It would be useful to understand how the NHS collects that data and makes sure it filters across the whole NHS in England so that we can learn from mistakes.

Professor Fowler: The complaints are collected centrally in themes, so there is learning from complaints centrally. This sits in the nursing directorate, but off the top of my head I think 200,000 to 250,000 complaints are looked at and themed each year nationally. The administrative nature of them comes up. You mentioned Dr Dash; only a week ago, Dr Dash and I were on a call with a particular provider that had changed its complaints process so that it always offers a face-to-face appointment as the first thing. We are looking at other models.

From the point of view of litigation, I think I am right in saying that about half the people who litigate have gone through the complaints system first. That of course means that half have not. It is hard to know the distinct connection, but it is clearly important to make sure people are treated well in the first place so they are not frustrated and do not go down a legal route when it could have been dealt with locally. We are open to new models.

It is also important to emphasise that Dr Dash and all of us are very keen to do more on patient experience. While I do not accept that we have talked too much about patient safety, as is sometimes said—I think we have talked about it a lot, and rightly so—we recognise that we need to think more about clinical effectiveness, and patient experience is the other element of quality. All that will be part of a new quality strategy, which will include going very heavily into greater patient experience and thinking about complaints, and there will be a new director of patient experience in the new structure.

Q79 Catherine McKinnell: Do you think we allocate enough resource to deal with this in the NHS?

Professor Fowler: To deal with complaints?

Catherine McKinnell: Yes.

Professor Fowler: It depends on whether you think the current process is optimal. If you do not, then it is a question of what a new model would look like and what it would mean in terms of resource. Clearly, if you took an approach of saying that it is much better to do this face to face than by correspondence, that is clinical time that will be taken up in addressing



those issues. In my own practice, I have found that incredibly helpful: it is very difficult to lay out some of the complexity in letters; it is much easier to do it face to face. I got great value out of that, and I would hope that patients and relatives did, too, but it takes up considerable amounts of time. In the current circumstances, that is not to be underestimated.

- Q80 Catherine McKinnell:** In terms of the initial response contributing to reducing future harms, one of the complaints that has been made is that the NHS is drowning in patient safety recommendations. Every time there is a complaint, incident or never event, recommendations come out of it, but they do not necessarily seem to be streamlined, co-ordinated or rolled out across trusts in a manageable way and meaningfully implemented. Do you have a response to that concern?

Professor Fowler: There are lots of recommendations out there, and we are having to manage those. With the new National Quality Board, we are looking at a new approach to how we can make more sense of recommendations and get better, stronger, smarter recommendations. The Thirlwall report identified in excess of 1,500 recommendations in the system. Managing those centrally is a huge task, and we would have to be careful about what we set ourselves up to do in looking at them. They are sent to a variety of places. However, we are getting better at setting up the way we run investigations to say, "When you finish this, we want a very smart set of recommendations." Making 300 recommendations is not going to be helpful; we need to manage that practically.

- Q81 Catherine McKinnell:** That is one of the things that is very hard when you hear some of the really tragic cases that happen, particularly in maternity services, where they often reach public attention, and you hear it happening in one trust, then another. The lessons may be learned within that trust but not necessarily effectively rolled out across the NHS. What are we doing to improve that as a systemic challenge?

Professor Fowler: When we pick up safety issues that are likely to occur elsewhere, we have a variety of mechanisms, appropriate to the particular circumstance, through which we can notify people, including national patient safety alerts. For example, I think we are issuing one now on penicillin allergy. They are appropriate for certain sets of circumstances; sometimes a more targeted approach is appropriate. One of the things we have revised is how we issue those alerts to make them more effective.

- Q82 Catherine McKinnell:** Do you collect data on never events? To what extent do they become clinical negligence cases?

Professor Fowler: I cannot tell you how often never events become clinical negligence cases.

Helen Vernon: The challenge is that it is a skewed perspective, as Professor Fowler was referring to earlier—that we get to the tip of the iceberg, and it is often driven by factors other than the level of safety.

We did capture never events with a flag on our system a while ago, but the definition has changed over time as well, so there is some



discontinuity in the trends to address. I can look at that and perhaps come back to the Committee on that point as well, if it is helpful.

Catherine McKinnell: That would be helpful.

Professor Fowler: To be fair, we are not making Helen's life easier by changing never events. Importantly, there has been an ongoing consultation on never events because some of them do not meet our definition of a never event, so there is a slightly perverse situation where not all never events are never events. In the ones that are—that is, where there are barriers that prevent them—if I give, for example, gas misconnection, we have gone from a state where there were about 10 of those a month to where we see one or two a year, so we have intervened, and it is important that we do that.

They are a very small proportion—about 500 a year—of the incidents we see, and to some extent you could criticise them for being skewed and getting more attention than other areas that are perhaps more egregious, which I accept. They can be a useful window into the governance arrangements of particular organisations.

Q83 **Catherine McKinnell:** The challenge seems to be about having a culture within the NHS that encourages practitioners and medical personnel to be open about when a mistake is made and to learn those lessons, but I think the litigation culture and risks weigh against that openness and transparency. Getting a system that can enable both seems to be where we need to get to; would that be a fair assessment?

Professor Fowler: If you look at never events specifically, when they first came in they were associated with fines. That did not do a lot for transparency. So I think it is important that we encourage people to be open by making sure they are not inappropriately punished when they step forward for that.

Catherine McKinnell: And admit, "I've made a mistake."

Professor Fowler: I think I mentioned earlier that the way we investigate has changed to a system called the patient safety incident response framework, which replaced the serious incident framework. When you see what people are doing with that—and I went to a meeting discussing some of those issues in a large London teaching trust—it is very clear that they are being very open, addressing the issues for the patient first and looking at what they have done in a very neutral, non-blaming way, and learning from it effectively. They are also looking at what their most significant issues are and focusing on those, not losing them among a whole variety of other things.

Helen Vernon: Can I just add to that from the perspective of the compensation system? One of the things that is incredibly important to us is that we continually reiterate the message that openness and transparency are absolutely the best way to prevent a claim in the first place. We have done that consistently, and supported that message with guidance and materials—including an animation recently—and trust-by-



HOUSE OF COMMONS

trust training on why that is so important and how it can be delivered well. Often the concern around transparency is much more complex than the compensation system. It goes into things such as disciplinary processes and the employer's actions—all sorts of other areas that are not necessarily about the compensation system. We are absolutely clear that that is fundamental to preventing a very difficult claim further down the line.

Catherine McKinnell: The rest of my questions were more about what solutions you are considering for this, but I understand that those solutions will be part of the ongoing inquiry and report, so I am happy to leave it for now.

Q84 **Chair:** Thank you, Catherine. I want to follow on with three questions, the first for you, Professor Fowler. It seems that some trusts have more of the serious, high-value obstetric and gynaecological claims than others. Taking Helen's point, how do you implement the lessons learned there? How do you implement retraining for the individuals involved, where it can be identified to a particular individual? As everybody says, preventing these serious cases is far better than having to litigate afterwards.

Professor Fowler: The units are carefully monitored and we have leads—the chief midwifery officer, a national clinical director for obstetrics, and neo-natal clinical directors—who are constantly monitoring data around these organisations. There is a maternity support programme, which currently has, I think, about 30 trusts within it. Where there are concerns, active support mechanisms—with senior leaders and support advisers who are embedded in the trust—support those trusts to try to drive down those incidents.

Q85 **Chair:** I have two questions for you, Helen. Catherine touched on the issue of double-counting in awards, particularly in relation to section 2(4) of the Law Reform (Personal Injuries) Act 1948. You may not, under cover of the Permanent Secretary's dictum, want to comment on this while the learned KC is looking into it, but can we be absolutely assured that this is a matter that he will look into? You may want to say more than that.

Samantha Jones: As I previously said to the Committee, all aspects of clinical negligence, including the reasons behind it, are being considered as part of his review.

Chair: That is a wonderful get-out-of-jail-free card, isn't it?

Q86 **Catherine McKinnell:** Do you collect data on how quickly complaints are responded to? As I think you have identified, Helen, there is an important correlation between responsiveness to complaints and the complainant not needing to then convert into litigation. Do you actually collect that data from all trusts?

Professor Fowler: Our standards for complaint response time and data around those standards are collected, yes.

Q87 **Catherine McKinnell:** Is that publicly available? I think it is for some trusts but not for others.



HOUSE OF COMMONS

Professor Fowler: My belief is that it is publicly available. It does not sit within my purview, but I am sure that we could feed back to you on that.

- Q88 **Chair:** My second question for you, Helen, is more general, so I hope that I will get around the Permanent Secretary's dictum. One of our witnesses at the pre-hearing—I will not say who it was—said, "I find it really quite concerning that the number of mediations and alternative dispute resolutions are actually dropping, not increasing." That seems to be going in the wrong direction. Why is that and what can be done about it?

Helen Vernon: First of all, that is not true. The number of cases that are being resolved outside of litigation has increased substantially, and we have driven that as a key priority. It is 83% now. That person may be referring to mediation, the use of which has fallen but only because we have replaced it with other ways of resolving cases. You do not need a full-blown mediation if all the family wants is a meeting with the relevant clinician, or to get in a room with their lawyer present to have a discussion about the case for two hours. We are still promoting mediation and still use it for the appropriate cases, but we use a whole range of other alternative dispute resolution methods to resolve cases without going near court.

- Q89 **Sarah Green:** This is a brief one to follow up on the initial response to harm. Helen, this is a question for you, because NHS Resolution has done some research into this. I am keen to understand from your perspective how the NHS is responding to that research. It is not just about individuals looking for answers or reassurance ending up in litigation because they are not getting the answers. There are examples from my seat where simply asking questions is automatically treated as a complaint. I am keen to understand what response NHS resolution has had to its reports.

Helen Vernon: That is a really important issue for us because we know that the upstream part of the process is key. There is a helpful infographic of ours in the NAO Report that shows that that is quite an extended period in its own right. It is on average around three years until we hear about a claim, before which a lot has happened between the patient and the treating organisation. Trusts have been really receptive to the work we have been doing with them. Our events are often oversubscribed. We get numerous requests for our safety and learning team to engage with local organisations because it is a supportive approach. We are not a regulator. It is something that is seen as supportive and welcome.

Ultimately, a complaint is feedback like any other type of feedback. What we try to encourage is that you should not end up in any formal process if you can avoid it. If you can give answers as close as possible to the treatment when the patient is ready to talk about it, rather than requiring somebody to put it into a formal complaint or a formal legal process, that is far and away the optimal solution.

- Q90 **Sarah Green:** You may feel that you cannot answer this, so it might be a cheeky question, but to follow up on that, is your sense that there is quite a defensive culture within the NHS—that they automatically go into



HOUSE OF COMMONS

defence mode when any questions are asked? I apologise if that is a question you do not feel you can answer.

Helen Vernon: It is a good question. The answer is that it is variable. There is undoubtedly a lot that we can do to improve things for patients. Professor Fowler, that might be something you want to comment on.

Professor Fowler: First, not all complaints are about medical care. Some of them are hotel and services-type complaints. They are a mix of things. At the risk of repeating what I said earlier, we are very open to other models of doing this and making sure that we reduce the level of confusion. There are many ways in which patients can approach us when they have concerns and many different mechanisms for doing it. We need to simplify that so that they know how to bring forward concerns.

On the point about it turning into a complaint because that is the mechanism we have, it is appropriate to say, "Is that ideal?" We know that there are people who have worked on this who have very good models. For example—I am not saying this because it is Jim Mackey's trust—we know that Newcastle has a very good person who leads on some of this stuff. We have looked at that. They are part of our group looking at the quality strategy—what we can learn from that and how we can make that more embedded.

As I said, on the discussion with Lincolnshire, there is a model there that we will now look at and say, "How do we do this better as part of that?" Patient experience is one of the three pillars of quality that we are looking at, and we are looking for better mechanisms for doing it. I do not think it works well for staff or patients in all circumstances. I think it works very well in some places, but it is a bit patchy and we need to try to make sure that it is consistently good for both staff and patients.

Q91 Catherine McKinnell: I want to come back on a comment that was made about training, and how you learn from complaints and mistakes. To what extent are you monitoring training compliance? My understanding is that it is not 100% and, in some cases, it is far from it. You would think one of the first steps you could take to prevent clinical negligence and mistakes being made is to ensure that mandatory training is undertaken.

Professor Fowler: There are two important things to say. First, training is not always the solution to safety issues and, indeed, is not a very effective barrier. If you look at safety science thinking, it is one of the least effective barriers, it compares with just telling someone not to do it. We are always looking for how we can build in resilience and make systems such that human error, which is what we are talking about, is less of a concern and gets picked up. It is not always the answer.

Where it is the answer, there is a really important piece about statutory and mandatory training, and we are doing a lot of work on that the moment, because it has become quite burdensome and a bit haphazard. Not all training is good quality, and we have not always looked at the impact of that training on outcomes, so there is a lot of work going on in NHS England at the moment, which will become part of the whole, on



HOUSE OF COMMONS

asking, "What does effective training look like? What is its impact on outcomes? What is essential and what is not? What are the areas of training that people might want to pick up and do because it is interesting, and what should we be requiring people to do?" We have had to have discussion with the likes of the fire service on fire training, asking, "How do we do this better?"

Not only will that work increase the quality of training, but we are already estimating that we can give back 100,000 days of activity as a result of reducing the burden of training and ensuring that, each time you move, you do not have to do the training again if you have done it recently. It is a really important area, and there is a whole piece of work on it that I think will make—

- Q92 **Chair:** Can I come in? I am glad we have had a bit of it this morning, but there is an awful lot of blame culture in the NHS. Training is about much more than saying, "Don't do that again." It is about saying, "Here's a technique, but you could do it better." Maybe there needs to be a different approach to all this. Instead of blaming somebody when something goes wrong, you could say, "How can we help you to get it right the next time?"

Professor Fowler: Yes, absolutely.

Chair: Can we embed that more in the health service?

Professor Fowler: I think that is happening in training, to make sure that people understand the options. For example, it is about making sure that things like NICE guidance are followed more, and that part of the training is about saying, "Here's what is going on in NICE recommendations that you should be following in your practice."

Catherine McKinnell: That is really helpful, and it is reassuring that it is being looked at. I guess what we need to see is the data that would help us to understand the extent to which training would have made a difference in clinical negligence, or even just complaints. What I am getting from this session today is that we need a lot more data on quite a number of areas so that the NHS can respond in the most productive, constructive and efficient way possible for taxpayers' money. That was a bit of a statement, rather than a question.

Chair: That's fine.

- Q93 **Anna Dixon:** Thank you to our witnesses; it is really great to hear the commitment to continuing patient safety work, and making sure that there is action and learning. We have now had the duty of candour within the health service for some time—obviously, the Hillsborough law will bring in that duty of candour more broadly. To what extent do you believe the duty of candour is fully embedded in the NHS?

Professor Fowler: I rather wish you had asked me this in a week's time; I have a Committee on this issue next week, so I will be better briefed.



HOUSE OF COMMONS

In all seriousness, we recognise that the duty of candour has been a bit mixed. There is an ongoing review of the duty of candour by the Department of Health. Obviously, we are looking at, and taking into account, what the Hillsborough law means for the health service. It supports what we are already doing to some extent. I think it is really well done in some places, and it is a really important. In some cases, it just encourages people to do what they naturally wanted to do anyway, but perhaps they felt inhibited by the threat of litigation or whatever. It is saying to people that it is absolutely right to be candid.

I think the review will look at some of the complexity of recognising when it is and isn't appropriate. There is a set level of "moderate harm"; well, what constitutes moderate harm, and is the duty of candour enacted and so on? When is it appropriate? Sometimes, we have to do it retrospectively: we pick up an historical issue and then have to apply the duty of candour, and there are pros and cons to that. A lot of that is the subject of the Department of Health's review. I have not seen the outcome of that yet, but it will be saying, "Okay, we have had this for some time. Let's stop, look and see how it's going. What more could we do, or what could we do differently, to enhance its use?"

Anna Dixon: I hope you understand why I am asking, given how important we are saying an open culture is to reducing harm. I wanted to make sure that you saw the duty of candour as something that would support and enhance the safety culture.

Professor Fowler: Yes, absolutely.

Q94 **Anna Dixon:** The Dash review looked at the fact that there were many organisations with different responsibilities in this space. I suppose I come back to where we started: there is HSSIB and the MNSI—a new one I learned of today—then obviously there is NHS Resolution, the patient safety work in NHS England, which will be reorganised into the Department of Health, and the Patient Safety Commissioner. There is a lot of reorganisation of those bodies, and some consolidation to reduce duplication. How will you ensure that, when you come out the other side of this, and also while you are going through it, there is real clarity about the responsibilities and accountability for patient safety in the system?

Professor Fowler: This is an important point. We think of patient safety in a number of phases, one of which is the middle phase, which is referred to as the bureaucratic phase, where things can become quite burdensome. These bodies are brought in for good reason, to address an issue. In changing them, you have to be sensitive to the fact that you do not want to go back to where you were before they were brought in.

There is a lot of change going on. MNSI is the maternity and neonatal investigation unit that was part of HSIB—as it was at the time—and then was taken into the CQC. The current plan, as I understand it, is that HSSIB as a whole will go into the CQC, but we need to be careful that it maintains its independence in doing so. We already work with all these bodies; we work closely on the safety agenda, and we get together to

discuss issues and make sure that, as a group, we are sighted on what is going on.

From an efficiency perspective and a public perspective, you would want to look at rationalising that where possible, but you would take a cautious approach so that you do not accidentally set yourself backwards by removing a bit of bureaucracy that is there for a very good reason and has an important function.

Q95 Anna Dixon: From the public point of view, and probably from a clinician point of view, when are they going to see this change, in terms of both reduced harm and a simpler system to navigate?

Professor Fowler: I think the simpler system is coming already. The Patient Safety Commissioner is now part of MHRA, there are movements for some bodies to be in CQC, and there are movements to take functions out where they are felt to be repetitive.

On the public perspective, I would go back to where I started, which is that we are already seeing a reduction of harm as a result of patient safety efforts. We are doing our best to calculate that. As I say, this has caveats, but, on an avoidance-of-death basis, we are estimating 1,000 a year at the moment. We want to go further than that—that is 9% or 10% of the whole—and more so in other harms. We are actively working on it and we are seeing the impact.

On some of the big policy areas, such as the patient safety incident response framework, which I think will have big impact, we have already seen an impact in smaller providers, who are coming forward and saying, “We have halved the number of incidents as a result of this work.” I am not suggesting for a minute that everyone will be able to do that, or quickly, but it will have an impact over time. It is relatively new.

Q96 Anna Dixon: Helen, in terms of this Committee coming back and looking at the public liabilities from clinical negligence—which sit second only to nuclear decommissioning—and recognising that much of that is baked in, because the claims go well into the future, how rapidly do you think we will see a fall in the new claim totals and new liabilities?

Helen Vernon: Unfortunately, I think that is an impossible question to answer, first because, as you say, a lot of it is baked in, but also because trends in claims can very much be influenced by things like the legal environment. The last bump in claims volumes that we saw was because of a major reform to funding arrangements through the LASPO reforms back in 2013, which had absolutely nothing to do with safety. Much as I would like to be able to say when the curve will turn, I am unfortunately not in a position to do that.

Q97 Anna Dixon: Perhaps, then, you can have a go at it, Samantha. The whole purpose of this hearing is to bear down on harm, claims and legal costs. In your answers, you have told us about a lot of things that you say are being done. Will they make a difference?



HOUSE OF COMMONS

Samantha Jones: The purpose of the David Lock review is to scrutinise and make sure we are able to address all the things that have been outlined today. As I have said on a number of occasions, the review is with Ministers. The purpose of the review is absolutely to address the rising cost of clinical negligence.

To go back to your previous question about accountability, which is really important, Dr Dash's review of patient safety identified that it is cluttered. There are a number of bodies that had responsibility for patient safety quality. The 10-year plan sets out how we will oversee quality and safety in the future.

The more specific point that I wanted to make about accountability is that something that Sir Jim and I are very focused on as we go through this transformation is who is accountable for what, specifically between the Department of Health and Social Care and NHS England. As we go through this joining and transition period, we are maintaining independent responsibilities and being very clear about who has responsibility for what arm's length body—where the particular aspect gets reported, who and how, and what the timeline associated with it is. There is a risk through this change, but there is a specific focus on accountability.

Anna Dixon: Apologies, Chair, but at the start of this part of the hearing I should have declared that I am an officer of the all-party parliamentary group on patient safety.

Q98 **Chair:** Thank you for putting that on the record.

I want to ask one or two more questions. First, Professor Aidan, I think the NHS could do more to help itself. We have talked about the duty of candour, but I have been involved in some of these cases, and my constituents have just said, "All I want is an apology." It is very difficult to get that in some cases, and I think that is because people in the NHS are afraid of being called out for having got something wrong. We all make mistakes in life, but I think the NHS could be more open in admitting quite quickly where things go wrong, because that might keep some of these lower-value claims out of the courts.

Professor Fowler: Yes, and I think we are endeavouring to encourage a culture in which that is exactly what happens. There is no resistance to that, certainly not centrally. I accept that it is not your constituents' experience—I am one of your constituents—that it is always perfect.

Q99 **Chair:** The second thing is about how complaints are dealt with. Maybe this is a question for you, Helen. I have had cases where things have gone wrong, and people have had very great difficulty getting their medical records. I assume that is because the NHS is worried about litigation, but surely that ought to be no excuse for delaying people getting access to their medical records—that is, to their hospital records and what actually happened in intensive care at the time. Surely whatever the NHS has should be fully open and available to any patient who wants it at any time.



HOUSE OF COMMONS

Helen Vernon: Yes, I completely agree. There are laws on that, and rules that trusts are required to comply with on the disclosure of records. That should not be happening. One thing we have done is to regionalise our team, so that we are working across all areas locally with NHS trusts to identify particular issues that might escalate into something further down the line. The disclosure of records is clearly one of those, because if a patient is not able to get a reasonable response to a reasonable request, they may well go to a lawyer to help them out with it.

Q100 Chair: That is often what happens. I wonder whether at the bottom end that would help to keep some of the low-value cases out of the courts. On that subject—I know we have had a lot out of this “Get out of jail free” card today—I wonder whether your organisation is open enough to change and whether we will need to change the system for those low-value claims. I cannot stress enough how unsatisfactory the system is, when for claims of £25,000, the legal fees can be £100,000—up to four times as much. That is nonsense. I am wondering whether we will need to mandate some form of alternative dispute resolution for the low-value cases—perhaps mediation, which we talked about, perhaps alternative dispute resolution or perhaps the ombudsman. Is David Lock looking at all those areas?

Samantha Jones: David Lock is looking at all aspects of clinical negligence and of the cause behind the rise in costs. I am not trying to subvert the Committee at all—I know we will come back at various times to talk about this in future—but his review is with Ministers. I can assure the Committee that he is covering all aspects of clinical negligence, and the Government are committed to addressing it.

Chair: Thank you, Permanent Secretary. To quote the same gentleman I quoted before, “The issue for me is that over the last 25 years or so there have been repeated inquiries and reports. The NAO Report of 2017 gave exactly the same conclusions as it did in 2025.” I really hope that for all our sakes—for the patients’ sake particularly—this review will produce something different from what we have now, and that it will be acted on in good time. Otherwise, I fear we will have you back before this Committee a lot of times in future.

I also have to say that we were not terribly satisfied that your Department had thought through the changes to local systems—exactly how the redundancies would be operated, what they would cost or how the money was going to be dealt with—so, probably after we have considered the whole matter, I will write you a fairly comprehensive letter asking some questions. If we do not get answers to those questions, we might well want you back here in the fairly near future to explain what is happening. Thank you for your help this morning, everyone. It is appreciated.