HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: NHS litigation reform, HC 740

Tuesday 11 January 2022

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Watch the meeting

Members present: Jeremy Hunt (Chair); Lucy Allan; Paul Bristow; Dr Luke Evans; Barbara Keeley; Sarah Owen; Dean Russell.

Questions 46 - 114

Witnesses

I: Michael Mercier, Principal Solicitor, New Zealand Accident Compensation Corporation; Dr Pelle Gustafson, Chief Medical Officer, Löf (Swedish Patient Insurer); George Deebo, Executive Officer, Virginia (USA) Birth-Related Neurological Injury Compensation Program; and Professor Shin Ushiro, Professor and Director, Division of Patient Safety, Kyushu University Hospital, Executive Board Member Japan Council for Quality Health Care.

II: Peter Walsh, Chief Executive, Action against Medical Accidents; Guy Forster, Director and Executive Committee member, Association of Personal Injury Lawyers; Lauren McGuirl, Director of Commercial Services, Centre for Effective Dispute Resolution; and Simon Hammond, Director of Claims Management, NHS Resolution.

Examination of witnesses

Witnesses: Michael Mercier, Dr Gustafson, George Deebo and Professor Ushiro.

Q46 **Chair:** Good morning, happy new year and welcome to the second evidence session of the House of Commons Health and Social Care Select Committee's inquiry into whether we need to reform the way the NHS handles litigation and clinical negligence claims.

We are very troubled on the Committee by the fact that last year we paid £2.2 billion in new litigation claims and incurred liability of over £8 billion in future claims. We want to ask whether this is the best way to spend our very precious health resources. We want to learn whether other countries do things better. In our first session, we heard about some of the problems with our current system, particularly from families who had experienced harm and had been let down by the system.

This morning, we are going to look at what happens in other countries and see what we can learn. We will hear later from those who help patients seek compensation and mediate disputes, as well as from NHS Resolution, which manages claims for the NHS. First, I welcome our very distinguished panel of international experts.

Joining us from New Zealand is Michael Mercier from the Accident Compensation Corporation of New Zealand. It is 11 in the evening in New Zealand. We are delighted that you are joining us, Michael—thank you very much indeed. George Deebo is the executive officer of the Birth-Related Neurological Injury Compensation Program in Virginia, in the USA. Professor Shin Ushiro is professor and director of the Division of Patient Safety at the Kyushu University Hospital in Japan and executive board member of the Japan Council for Quality Health Care. We welcome back to the Committee from his log cabin in Sweden Dr Pelle Gustafson of the Swedish patient insurer Löf. We are really grateful to have you here today, and thank you for taking the trouble and sparing the time.

Let me start, if I may, with an old friend of the Committee, Dr Gustafson. I want to explore the Swedish system in more detail. When you last spoke to us, Pelle, you said that part of the reason for the lower level of neonatal deaths in Sweden, which is about half the rate of the UK, was that your system supports medical staff in acknowledging when something has gone wrong and improving things so that the same mistakes do not happen again. Other people have said to us that there are other reasons why that happens in Sweden: it is a more equal society, you have a lower proportion of higher-risk births, and there are other demographic reasons why that difference might be the case.

To what extent is it your legal system, and the fact that it is easier to access compensation and that you reduce confrontation between patients and the medical system, and to what extent is it Swedish society that means you have a dramatically better safety rate?

Dr Gustafson: Of course, there are two parts of it. Each and every country and each and every healthcare system goes into a situation from where they are and so on, but every system can be improved. This is part of the explanation of the decreasing numbers of both baby injuries and maternity injuries—mostly pelvic floor injuries—but wherever you start from, you can always improve. The way we have worked together with the professional organisations is not the only contributor to the development that we see in Sweden, but I would say that it is a major contributor, in that we work together with the professionals. From wherever we start, we always try to improve. I think that holds for each and every country all over the world; you can always improve.

Q47 **Chair:** Give us some sense of the issue of high-risk pregnancies. The main argument that people who do not want to change our system in the UK come back with is, "Ah yes, but in the UK we have a higher proportion of higher-risk births for all sorts of demographic reasons." Can you tell us whether your logic applies to that category of birth as well? Obviously, you must have some higher-risk births in Sweden.

Dr Gustafson: Yes, we have. The statement could easily be refuted by saying that wherever you start from, and especially if you have a large proportion of high-risk pregnancies, the reason to do something is so much larger than what you do and where you do it. It is, of course, dependent on the reason for having such a large proportion of high-risk pregnancies.

The notion that you cannot, or should not, do anything because you are more or less well-off when you start is very hard for me to understand. Wherever you start from, you can always do something. If you have a higher risk of a pregnancy ending up badly, the reason to do something is so much larger, at least in my opinion. I think that statement or that notion is quite easily refuted. You can always do something.

Q48 **Chair:** Thank you. One more question for you. We often talk about Sweden, but I have been upbraided in the past by Danish colleagues who say, "We also have a very good system in Denmark," and that it is just as good as the one you have in Sweden. Can you tell us about what your Scandinavian colleagues do, to your knowledge? Is it a reasonably similar approach to the approach you take in Sweden, or are there some important differences?

Dr Gustafson: There are more similarities than disparities. The explanation goes back to the early 1970s, when the systems were built up in all of the Nordic countries more or less at the same time, and actually more or less by the same group of people. The basis is some kind of insurance-based solution. Exactly how it is run differs from country to country. In Sweden, we have a national patients insurance company. In Norway the scheme is very similar, but the way they handle it is actually part of the Government system. In Denmark, it is more of an investigation committee. In Finland, it is a group of insurance companies, but the principles and the insurance terms and requisites are very much the same.

We work preventively, which is somewhat different, and it very much depends on what we can do. I think we are the most free to do something, as we are an independent insurance company and not a state or Government institution. It is correct to say that the Danes are doing a lot of work too, but they have not worked in exactly the same way as we do. In all Nordic countries, some kind of preventive work is going on.

Chair: Thank you.

Q49 **Dr Evans:** I have a very quick question to follow up on that, Dr Gustafson. In a broad spectrum across the world, if you would like to aspire to someone, as Sweden, which country or countries would you hold at the very top of the pillar and why?

Dr Gustafson: If you take all preventive work as regards patient safety, I would say that I am personally very impressed by Scotland. In Scotland, you have a long-standing tradition of working. You have development in the right direction. You have a system that is fairly equal all over the place and you also have improvement activities going on. I am very impressed by Scotland.

I would also say that I am quite impressed—you must not take this as bragging—by the Nordic countries as an example of what you can do and how you can do it. I think there are things to learn from what we do in the Nordic countries. I do not want to point at Sweden especially, but I think the prerequisites of the Nordic systems and the way they allow you to work with those issues is a good one.

Q50 **Dr Evans:** It is no coincidence that you are on the panel.

Dr Gustafson: I am particularly impressed by the Scottish work over the last 10 years. There are a lot of things that we, in the Nordic countries, can learn from Scotland too.

Q51 **Chair:** When I was Health Secretary, I tried to persuade the head of patient safety in Scotland to come to England, but unfortunately I was unsuccessful. Thank you very much. We will come back to you, Pelle, but I would like to go to Michael Mercier in New Zealand.

Thank you so much for joining us. New Zealand has a slightly different system from Sweden. Sweden's compensation is payable on the basis of harm being avoidable, but in New Zealand it is a no-fault system so it is an even lower threshold. Could you explain how the Accident Compensation Corporation works? Explain how that threshold works and, in particular, whether there is any evidence that it has helped to reduce overall levels of patient harm.

Michael Mercier: In terms of what we are talking about, it is treatment injury that our legislation provides for that is the relevant thing we cover for. It is important to note that there are two steps for ACC. One is to get cover for the injury you have suffered. Secondly, once you have cover, you get a series of entitlements for that injury.

Taking the first step, the treatment injury concept is a relatively new concept. We brought that in in 2005. Yes, it is a very low threshold. It basically means that if you have been hurt, or suffered injury during treatment and that treatment is not an ordinary consequence, was not a necessary part and was not wholly or substantially due to your underlying condition, you will get what we call cover. That will then be the gateway to get the various entitlements that flow from that.

The important thing about the New Zealand system is that it is an exclusive system, in that it takes away civil litigation rights. Apart from exemplary damages, you cannot sue for compensatory damages for any personal injury that ACC has given you cover for. I mention that because I think it is important, in that it helps to gain the co-operation of the health sector to put in claims for things that, if it was in a civil litigation system, they would be very reluctant to do. If we had an option to sue in New Zealand, I think there would be more reluctance for providers to actually say, "This patient has been hurt, I am putting a claim in and I am the one that did the treatment."

Hopefully, we have moved away from that in New Zealand since 2005. Prior to that we had what was called medical misadventure. That was a concept that originated in 1975; 15% of medical misadventure was medical error, so it was located in medical negligence concepts. In 2005, Parliament was making a real step to get away from that punitive fault-based or semi-fault-based system to gain co-operation and support from the health sector in order to get a better focus.

That brings me to your second question. It is not really a yes or no answer. What it has done is enable us, with the number of claims that have come forward, to say, "Here is where we need to put our focus on patient safety." Those of you who have read our treatment patient safety report for 2021, which is on our website, will know that we focus on six injury areas. We have those areas because of the number of claims that we have. They are either very high-cost claims or claims that have disproportionate numbers for what you would expect.

Q52 **Chair:** The main argument against the New Zealand system—it is one that I heard when I was Health Secretary—is that, because you effectively automatically give compensation to everyone, there is a lot of what people in the Treasury would call deadweight costs. Those are people who, in our current system in the UK, or in England, do not make a claim but would automatically get a claim under the New Zealand system. The concern is that the New Zealand system ends up being very expensive. Is that a concern that is echoed in New Zealand?

Michael Mercier: Not really, because when you look at the statistics only 68% of the claims that are made get accepted. Perhaps the main factor why a claim does not get accepted is that there simply is no evidence that an injury has been suffered; a person lodges a claim but they are unable to establish that there has actually been an injury suffered.

First, I would say, no, I do not think it is a situation where, because everyone is accepted, we have more claims. They are not. That is the answer to that. One thing about the additional claims—a very interesting statistic—is that entitlement claims, which are the ones that go through to costs where a person gets weekly compensation or attendant care, home help support and that kind of thing, are going down compared to the ones that are coming in. That means that the figures seem to show that we are getting more claims, but they are not serious claims. The serious claims seem to be going down. The ones that actually cost money seem to be going down.

Q53 **Chair:** Do you think that is because the system is learning the patient safety lessons that arise from those serious claims?

Michael Mercier: It is too early to draw that conclusion, but certainly that is where we would like to see it going. For instance, one area particularly in the six areas that we are focusing on is prescription medication, particularly for foetal anti-convulsive. We are seeing those rates decline. There is not really any definite evidential support for that, but we would like to think it is because of the patient safety and preventive information that is being produced, not just by ACC but by various organisations, about medication and pre-birth medication. That is one area, particularly, that is an indication that we are having success in having the claims and having the information that those claims give us, and being able to target those particular injuries to have a positive effect on outcomes.

Q54 **Chair:** Thank you. I would like to go in the other direction around the world, if I may, to George Deebo, who is kindly joining us from Virginia. I want to ask you about the Virginia birth injury programme. As I understand it, this was originally set up to deal with spiralling clinical negligence claims that were even deterring some physicians from practising in the area because they were worried about the high risk of claims and the risks to them personally.

I think we can all understand that having a system like you have operated in Virginia could control the total cost of a system. The very specific question I want to ask you, because we do not have an insurance-based system in the UK, is, what has been the impact on the incidence of those events? Has the introduction of your scheme in Virginia led to better rates of patient safety and lower incidence rates of harm?

George Deebo: That is a good question. I am not sure I can speak as directly to that as I would like to because, as an administrator, we do not really get into that part of the programme so much. We are more on the administrative side of it, administering the benefits to families.

What I can tell you is that the programme is about 35 years old and the number of entries seems to have levelled off at about eight to 10 per year. That has been pretty steady for the last 15 or 20 years. I have been with the programme for 20 years, and for at least the last 10 years it has been pretty steady at about eight to 10 entries into the programme per year. From my perspective and the information I see on a regular basis, that is probably as close as I can get to answering your question.

Q55 **Chair:** And it was growing before?

George Deebo: It was very up and down before in terms of coming into the programme, at least. We can certainly say now that the programme is well known, and people take advantage of it. The number of people coming into the programme is probably a good indicator as to the incidence.

Q56 **Chair:** Is it an automatic entitlement, George, or do you have to show that there was a mistake made in order to get the compensation?

George Deebo: It is actually a no-fault programme. You don't have to show that there was any kind of mistake or fault or anything of that nature. It is a very narrow programme obviously, only for birth injuries. You have to meet some very narrow criteria. If you meet those criteria, there is a process with experts and even a hearing if needed, but very rarely do we have to have hearings these days. Probably one in 10 at most has any kind of hearing; otherwise it is done fairly administratively. Both sides look at the information, and if the child meets the qualifications they are entered into the programme and, of course, they are in the programme for life and the benefits are for life.

Q57 **Chair:** A final question before we move to Professor Ushiro. I understand that there is a similar scheme in Florida, but why do you think that more states have not adopted a system like yours in Virginia?

George Deebo: That is a good question. I have talked to many states. Certainly, I would say one of the reasons is that there is opposition from certain sectors to having a programme like this. There are, I guess, competing interests. Even in Virginia we see opposition to the programme today after 35 years. Certain sectors of attorneys would rather not have us there, but overall most of them feel we do a pretty good job and serve a good purpose.

You are right: there is another almost identical programme in Florida. New York has a programme that is not quite the same, but it is a birth injury programme.

The other point is that the issue has grown so much since 1987, when this was set up. People are trying to look at a lot more different issues at one time. The real purpose behind the programme was to take the most expensive cases out of the system, which it has certainly done, but if you want to cover more than that, you have to look at expanding it or look in other directions.

Q58 **Chair:** Thank you. Finally, before I bring my colleagues in, I want to talk to Professor Ushiro. Thank you so much for joining us.

I think you are an obstetrician as well, practising part-time. Japan introduced no-fault compensation for perinatal care. I think it is for cerebral palsy cases, from memory. A key element of your system seems to be the sharing of data and information from individual cases in order to reduce overall levels of harm. Could you tell us how successful the scheme has been in Japan?

Professor Ushiro: Thank you very much. In the first place, I am originally a surgeon, not an obstetrician, but my older brother and my father were obstetricians. I have a lot of friends who are obstetricians in my country.

Our system was launched in 2009, aimed at supporting a disabled child and their family, reducing conflict between medical professionals and the family, and improving perinatal care through investigation and prevention. We provide monetary compensation to a family immediately after their petition is completed, to support their life. All approved cases move to investigation. We produce an investigative report on individual cases, which is later delivered not only to charitable facilities but to families, so that the family knows what happened during the labour.

Initially, medical professionals claimed that families would sue professionals and bring more lawsuits when they read the investigative reports, but what happened was the opposite. Over the last 10 years, we successfully observed a decrease in the number of lawsuits related to obstetrics and gynaecology by 75%.

Families have always said that they have five wishes. First is recovery back to what they used to be; secondly, a genuine apology to a family or patient when the case is negligent; thirdly, an investigation; fourthly, prevention; and, fifthly, compensation. Our system copes very well with the five wishes of victim families and patients.

To create a learning system, as we obtain a lot of data related to cerebral palsy, in close co-operation with medical professionals, we publish a prevention report on an annual basis. We produced a textbook on foetal heart rate monitoring. Medical professionals share these products in their annual congress or their scientific meetings or in other opportunities.

We have observed a decrease in the number of cerebral palsy cases. We have specifically observed an improvement in foetal heart rate monitoring techniques and reduced the excessive administration of uterine contraction agents. We have improved our neonatal resuscitation rates over the last 10 years. So far, our Japanese society regards our system as successful and helpful.

Q59 **Chair:** I want to ask you about the data. Do you have any exact data as to what the decrease in the number of cerebral palsy cases is, or the decrease in the neonatal death rate?

Professor Ushiro: I have statistics on profound cerebral palsy cases approved in our system. In the first year, in 2009, out of the population of our new-born babies we approved 419 cases. With the same eligibility criteria, recently we approved 300 and something, so we have observed a decrease.

When we investigate individual cases, we very often conclude that the probable cause of cerebral palsy is unknown—it is probably because of a genetic factor or a chromosomal abnormality. We now conclude that the reason is unknown in 40% of cases, but at the beginning of the system we concluded that in 30% of cases. We think that now the malpractice cases or erroneous cases are decreasing and that what remain are the cases of unknown cause, probably because of a genetic factor.

Q60 **Chair:** What is the decrease in malpractice cases? Maybe you could write to us.

Professor Ushiro: When we approve cases, we do not argue whether the case is negligent or not. We call our system a no-fault compensation system. Years later, they may sue the doctors or midwives, so, finally, they will find whether the case is negligent or not. The lawsuit is less frequent in my country. So far, we probably have only 100 cases that were ruled to pay damages payments in the court out of 3,500 cases that were approved.

Q61 **Chair:** Could you possibly supply us with the data? You said 300 and something cases down from 419 cases. Could you supply us with the exact data and the dates? That would be very helpful, as would any evidence about the decrease in the lawsuits.

Professor Ushiro: Sure.

Chair: Thank you very much; that is very helpful. I am going to bring in my colleague, Barbara Keeley.

Q62 **Barbara Keeley:** Thank you, Chair. These are questions for Michael Mercier. Thank you for your initial responses to the Chair's questions.

You talked earlier about the treatment injury threshold that you brought in in 2005. How did that affect the number of claims and the number of successful awards?

Michael Mercier: It did not affect the type of awards because, as I explained, once you get your cover, your entitlements flow from that. The awards were the same, depending on the person's circumstances, as they would have been under the regime that existed before.

The actual cover criteria, which changed in 2005—the move to treatment injury—created a significant upsurge in claims. From the data that the Committee already has, you will see that the number of claims per capita in New Zealand is relatively high, and that is an illustration of the increase we have had since 2005. Some might say that is a bad thing, but in a sense what we see is that it illustrates a level of comfort by medical providers to put in claims when there may previously have been more reluctance because of the more negligence-based and vigorous reporting requirements that existed prior to 2005.

Q63 **Barbara Keeley:** Thank you. You talked about moving away from the point where people might have been unwilling to co-operate because now, obviously, they cannot be sued. Do you get full and early co-operation from medical professionals in providing information? Obviously, you still have to establish whether there is evidence. Do you get that co-operation?

Michael Mercier: Generally speaking, yes. It is very rare for medical professionals to hold out, certainly in my experience. Having said what I said before, I was not at all suggesting that we moved to no-fault in 2005. New Zealand has had no-fault since 1974. The shift in 2005 was more subtle, from what was medical misadventure, which itself had a medical error or negligence component, to a test that was completely free of any negligence or connotations of that kind. That has been the shift.

There was another critical shift in 2005. Prior to that, if there had been medical error, ACC was obliged to report the actual practitioner responsible to a patient safety responsible body. In 2005, the obligation shifted to simply being an obligation to report the risk of harm, without being in any way focused on the individual practitioner who might or might not be responsible. That was a very significant shift also in getting the buy-in of providers to feel free to lodge claims.

Q64 **Barbara Keeley:** Can you describe how the ACC translates data from cases it handles into learning and improved care for the New Zealand health system? Has that changed or improved? How does it work?

Michael Mercier: I can be reasonably confident in saying that, because of the greater data we have and the greater number of claims, it is more easily transferable. The six focus areas I mentioned earlier, which our patient safety report talks about, are the direct result of the patient injury data that we get through the increased claims being translated into initiatives. They are multi-organisational initiatives. It is not just by ACC. They are initiatives that can then be focused on those areas to improve patient safety. Does that answer your question?

Barbara Keeley: Yes, I think it does. Thank you.

Q65 **Lucy Allan:** Good morning to all the panel. I am really interested to hear everything we have had presented to us this morning. In England, we have a defensive culture and a very adversarial process in ensuring that compensation is made to families. There is often a failure to apologise. I was very interested in Professor Shin's comments on the apology.

I have a question I would like to ask each member of the panel under your different systems. Could I start with Professor Shin? Are medical professionals confident that they will not suffer any kind of reputational damage by admitting when something went wrong? I understand that there is no-fault and these different systems, but you still have to admit as a medical professional that something went wrong on your watch, and there are issues around what your colleagues will think of you and what your patients will think of you, as well as your future career development. If we could start with the Japanese model, how do we get round the reputational fear that clinicians might have in admitting when things go wrong?

Professor Ushiro: Thank you very much for your question. We still have a sense that, if we are blamed by patients and families, we feel very ashamed, and our reputation is injured. In that respect, things are the same in my country too. Every year, all medical professionals and medical institutions buy private insurance for possible damage payments in the future. Particularly for our perinatal care, we have a no-fault compensation system.

It is not very difficult to admit our error because we are supported by the insurance system. Speaking about our situation and who is covered by no-fault compensation, it is very much easier to admit the error. Automatically, an investigative report is published. They share the report with the patient and the family. Compensation is given and lawsuits are decreased. They feel much more comfortable now than they were without the no-fault compensation system.

Q66 **Lucy Allan:** Mr Mercier, how does that work under your no-fault system in New Zealand in terms of reputational issues for clinicians?

Michael Mercier: I do not think it is possible to say that there are not reputational impacts. I think the focus was on actually trying to minimise those as much as possible. No, in situations where a provider has been found to have caused injury—one of our tests is the could and should criteria—I do not think you can say that their reputation will not potentially be harmed by that.

The other thing is that there are other areas in New Zealand, and other organisations, like our Health and Disability Commissioner, who may make findings that are specifically about that provider—this is separate from ACC—that might have a very much more direct reputational impact on them. I do not think it is possible to say that in New Zealand having a no-fault system means that the providers do not have a reputational impact. As I said before, it is about minimising and making that as little as possible to encourage co-operation.

Q67 **Lucy Allan:** Dr Gustafson, do you have any comments to make on the Swedish model?

Dr Gustafson: I have two comments. The first is on the systemic level. Since we do not report anything, when we get a claim we handle that claim and it stays between us and the claimant, and of course the provider. No names are mentioned. We also separate the compensation for the patient from the supervisory part of it. That is why, if you want to do something in the supervisory way, you have to file a separate claim. The supervisory has nothing to do with money.

The second part is that I have myself, as a practising orthopaedic surgeon, helped two separate patients to file claims. I must say that I felt relief in being able to mention to them that we had a compensation system, because I knew very well that I had done something that I should not have. I felt relief when I could say that. I do not think you should emphasise too much hiding things or not talking about them.

You can expect that a number of physicians are happy at being able to compensate patients or other individuals. They know that they have done something that was not supposed to happen. The issue at the systemic level is to separate compensation from supervision, and not having leakage between those two systems.

Q68 **Lucy Allan:** That is a very important point, and very encouraging to hear. Mr Deebo, do you have any comments on this under your Virginia model?

George Deebo: I have to echo a lot of what you have just heard. I cannot speak for the physicians; I am not a physician. First of all, it separates the two issues: the care and the medical side. I can say that all the claims are reviewed for quality of care, although they are not reviewed by the birth injury programme. They are reviewed by separate state agencies for quality of care.

A third part, as some others have said, is that physicians—the OB folks—in the state are very supportive of the programme. We talk with them every now and then. It is very encouraging and positive for them to know that, if something does happen, the child will receive excellent benefits and care throughout their entire life.

Lucy Allan: Thank you.

Q69 **Paul Bristow:** I have a quick question for all four of you, and if you could answer it that would be really helpful. If there was one criticism you would make of the system in your respective countries, what would that be? I will start with Dr Gustafson.

Dr Gustafson: The only person who can file a claim with us is the patient or a representative of the patient or family. I think we are still a very inclusive system, but the system is of no worth at all if you do not know about the system and the possibility to file a claim. I would say that the major weakness in our system, which is based on the patient or a representative of the patient or the family being the only ones that can file a claim, is that if you do not know of the system you will not get any compensation, even in cases where perhaps you are entitled to it. That is the problem. If you do not know about us, you do not know about it.

Q70 **Paul Bristow:** That is a very good point. Mr Mercier?

Michael Mercier: In New Zealand, I would probably say that it is the complexity of the treatment injury provisions. They have been subject to a number of court decisions, which have, hopefully, clarified them, but they are extremely complex. This reflects the Chair's question to me before and my answer about all claims being accepted. Well, all claims are not accepted. There are a number of reasons for that. One of the reasons is that there are a number of quite complex aspects, particularly in relation to what is an ordinary consequence, or the extent to which something is wholly or substantially due to an underlying condition. Those are two of the key ones, but there are other complexities as to what constitutes treatment in terms of our criteria. That would probably be the one thing that would be top of my focus. Honestly, there are probably a number of things I would say, but that would be my No. 1.

Q71 **Paul Bristow:** Thank you. Mr Deebo?

George Deebo: It is tough to say what the top one would be. I think there are three that only add some value. Frankly, there are many families who would rather go through the court system and sue. They do not always realise what the outcome may or may not be, and possibly the odds against them.

The programme is very specific in who it covers. Some folks would like to expand that quite a bit. Other than that, it is just the typical administrative kind of thing. We have to provide all of the benefits in a very timely way. Unfortunately, sometimes that does not happen, but we try to make it happen as quickly as possible.

Q72 **Paul Bristow:** Thank you. Professor Shin?

Professor Ushiro: We compensate a certain proportion of all the cerebral palsy population. If people are rejected from our system or are not eligible for our system, they complain that they want to be treated equally. Our compensation money is a fixed price. They claim that they want to be compensated by introducing a grading of the price for compensation in order to cover more cerebral palsy, from severe cerebral palsy to mild or very slight cerebral palsy.

Our compensation system was launched in the wake of surging conflict and the need for quality of care. It is not the social security system. The people who are rejected should be covered by the social security system, by the Government, but the Government do not have enough budget, so probably their life is not very easy. We want to expand our system, but our budget is also restricted. I think this is the problem.

Paul Bristow: Thank you very much indeed.

Chair: Sarah Owen—and happy birthday.

Q73 **Sarah Owen:** Thank you, Chair. Thank you, panel, for your interesting and informative evidence today. My question relates to the questions of two of my colleagues—Barbara and Lucy. When you were making these system changes at the start, how were the different systems initially welcomed, or not, by medical professionals, the wider workforce and in particular trade unions as well? Were there any barriers to the changes, and how did you get past them?

George Deebo: From what I understand, when the programme was first developed it was done in the midst of a crisis, when the medical malpractice insurers had threatened to basically pull out of the State of Virginia and then OBs would not have had any coverage. Certainly, from the physician side, I think it was welcomed as far as being implemented was concerned. As to the opposition, certainly many trial lawyers did not want to see the programme intervene. I think those were the opposite sides that we still deal with to this day to a large degree. Does that answer your question?

Q74 **Sarah Owen:** Yes. Was there any opposition to any of those changes, although they were being made in a crisis? Was there a period of consultation and review at all?

George Deebo: The opposition, as I mentioned, was really from segments of the legal field. There certainly was a lot of debate, from what I understand. I was not involved in it specifically at that point, but by and large it was seen as something that had to be done to preserve obstetrical care in the state.

Q75 **Sarah Owen:** Mr Mercier?

Michael Mercier: I would have to take it back to 1974, because in 2005 the changes I have been talking about were welcomed by everyone. I am not aware of anyone who was very much in opposition to the way it changed. Certainly, the initial concept of no-fault insurance was introduced in a Bill that was introduced in 1972 and the scheme did not take effect until 1974. That Bill met quite substantial opposition, largely from lawyer groups who were obviously interested in personal injury actions, which were going to go. So yes, there was significant opposition.

One of the slightly interesting things about that, though, is that the term medical misadventure, which was the forerunner of what we currently have as treatment injury, did not come in until a year after the scheme started. I suppose it is quite likely that at that stage a lot of personal injury lawyers were not really thinking so much about medical practice as being caught by ACC, because it was not specifically in the legislation. In hindsight, most people would consider that it was, in general, under the broad auspices of the legislation from the start, but it was not specifically introduced until 1975. There may have been an almost taken-by-surprise element for medical misadventure, which certainly was not the case for personal injury claims generally, which, as I say, met with a lot of opposition.

Q76 **Sarah Owen:** Thank you. Professor Shin?

Professor Ushiro: Our system was launched in 2009. In 2007 and 2008, I travelled across Japan to deliver lectures on the coming no-fault compensation system. There was a lot of opposition, particularly to the publishing of the investigative report. Medical obstetricians very often told me that a patient might sue a doctor more frequently by applying part of the compensation money to file a new lawsuit. However, patient representatives opposed the view of obstetricians in the introductory committee, saying that they sued doctors and midwives because they did not tell the truth about what happened in the delivery. I mediated between the two sides. Finally, it turned out that lawsuits decreased by sharing the investigative reports.

I would like to describe how to overcome this hurdle. Time and achievement overcame the hurdle. Privately, the insurance companies were really delighted to have a no-fault compensation system. Before our system was launched, they paid a lot of money in damage payments for cerebral palsy, but the number of damage payments decreased, as I told you, so they were really happy to have the system.

Q77 **Sarah Owen:** Thank you, Professor. Dr Gustafson?

Dr Gustafson: I was not around as a practitioner in the late 1960s and early 1970s when the Swedish and Nordic schemes were introduced. I have spoken to those who were there, and from what I have heard, there was practically no opposition at all because we had nothing. What we had then was a bad conscience about the fact that perhaps 50, 70 or 100 people managed to get some kind of compensation for avoidable injuries.

The major thing was that we had to fix it. We could not have a situation like that. We had to do something. We all had to chip in. What I can say from my own personal experience is that there is no serious opposition from anywhere around Swedish society today. The system has never been, in the last 15 to 20 years, questioned in the way of, "We cannot go on like this. It does not fulfil the requirements from the patient, from relatives, from the professionals and from society's point of view." Today there is very little opposition to the system or questioning about the system.

Q78 **Chair:** Is that one of the reasons that you are regularly rated as one of the happiest countries in the world, Pelle?

Dr Gustafson: It could be. I was very intrigued by what Professor Shin said; if we focus on who is the main character, it is the patient and the family. If you have a system that explains what happened, it sends a signal that we are sorry we did this and that we are doing preventive work, and if you could combine that with the society point of view, and you have a system that is cheap to run and that is quick, expedient and inclusive, I think you have something that is close to the best you can achieve. It has been very interesting to hear from various parts of the world that all of those successful systems, and thus systems not being questioned, have those components.

Chair: We have to move on to our next panel, but there is a final brief question from my colleague Luke Evans.

Q79 **Dr Evans:** There are several that I would like to go into, but I'll keep it short. My final question is for Michael Mercier. You said there is a no-blame culture, which is very much welcome. You also said that you have no named clinician. I am a clinician myself, I should admit, as a general practitioner.

I am interested in how you keep up with those who are underperforming as clinicians if they are not reported. We have malpractice cases in the UK where surgeons carry out operations that were not needed or were unwanted. They make national level news, so it does go on. How does New Zealand deal with that if there is no way of suing or identifying it? What safeguards are in place on clinicians to make sure that the public are safe and have trust when they see a surgeon?

Michael Mercier: I have largely been talking about ACC, but we have a Health Quality & Safety Commission in New Zealand. As I mentioned before, we also have a Health and Disability Commissioner. The first organisation is charged with looking at patient safety in the context of provider quality and healthcare quality generally, while the second can actually take action and respond to complaints from patients and the public. We have a no naming situation in ACC in the compensation situation, but that does not mean that New Zealand does not have a system for providers being brought to account if they need to be brought to account.

Q80 **Dr Evans:** Is that understood by the public and the professionals? The problem I am struggling with is that it is merged in the UK and there is a crossover. It sounds like it is very distinct, which means that you know you can be open and honest with regards to the ACC and what they are dealing with, and then you have to have the protection that you need for the public and the individual who is being accused of malpractice. Am I right that there is a massive distinction, and it is very obvious on that point?

Michael Mercier: There is. I think that echoes some of the comments by other panellists of the need to have that distinctness in any successful system. You keep the compensation system separate from anything that relates to maintaining the quality of the providers.

Q81 **Chair:** I have a final quick question to Professor Ushiro, if I may. You said it is a no-fault system, but you do not pay compensation in Japan to everyone. Does that mean it is only the more severe cases of cerebral palsy that get compensation?

Professor Ushiro: Yes.

Q82 **Chair:** It sounds like it has been quite successful in Japan. Do you think there is a good argument for extending that to other forms of medical harm and medical error?

Professor Ushiro: Yes, we have arguments like that. Even the Supreme Court of Japan published a report saying that the system should cover more medical specialities. The problem is the budget. We are still suffering in the budget for expanding the compensation system, but there is an argument.

Q83 **Chair:** Thank you. Finally, a question to George Deebo. A no-blame system: do you think there are lessons for US and UK politics as well as medicine?

George Deebo: I do not know if I want to weigh into that question. All I would say is that I think for the families or the children who are entered into the programme, many of whom are not children anymore, it is a very successful programme. It provides for their needs. It has a wide array of benefits such as home care and paying for their insurance. It provides a lot of stability and assurance to those who are injured and their families.

Chair: Thank you. We have had a very interesting session. On behalf of the whole Committee, a very big thank you to George, Michael, Shin and Pelle for joining us from the four corners of the globe. We have really enjoyed listening to you. Thank you for joining us.

Examination of witnesses

Witnesses: Peter Walsh, Guy Forster, Lauren McGuirl and Simon Hammond.

Q84 **Chair:** I now move to our second and final panel this morning. I welcome Peter Walsh from Action against Medical Accidents. He is someone who has campaigned for a very long time in this area. Guy Forster from the Association of Personal Injury Lawyers has given me very helpful behind-the-scenes advice in the run-up to this inquiry. Lauren McGuirl is from the Centre for Effective Dispute Resolution and Simon Hammond is director of claims management at NHS Resolution.

Thank you all very much for joining us. I am sure you have been listening to the panel that we heard this morning. Peter, as someone who works with families who have been harmed, could you tell us what you think the strengths and weaknesses are of our system and what you think we can learn when you look at other systems in other countries?

Peter Walsh: Thank you very much for having me, Chair. As you say, we look at this as a charity very much from the patient and family's point of view. We have 40 years' experience of advising and supporting people who have been affected by avoidable harm in healthcare.

Nobody who comes to us would turn to litigation lightly. It is often a last-gasp attempt to get a sense of justice and to get to the bottom of what has actually happened after people have experienced denial after denial. We often have to warn people who are even contemplating litigation in this country that it is a very stressful and difficult process. It has its weaknesses. It is stressful, both for the family and for the people on the other end of a claim. It can be costly or difficult to bring a claim, particularly since the loss of legal aid in the vast majority of clinical negligence cases.

On the plus side, it upholds access to justice and the principle of access to justice for the people who need it. Only a small proportion of the people who come to us for support every year—less than 10%; about 3,000 people—actually end up going anywhere near a lawyer. Those who need a lawyer really need a specialist lawyer who has been accredited as a specialist in clinical negligence to help navigate the system.

I would argue that there is plenty of potential, much more potential, to exploit and improve the current system before we start changing the whole law of tort in this country and traditional notions of access to justice for people who have been harmed by other people's negligence. For example, about 80% of claims that go to proceedings, where proceedings are issued, end up settling in favour of the claimant. That tells us something very pertinent. There must have been opportunities for the NHS to recognise, if they had investigated thoroughly and professionally, that they were indeed at fault, and to get around the table and settle those claims.

While there are a host of improvements we could make to the present system, I think we need to be very wary of throwing the baby out with the bathwater or leaping to a solution before we have grappled with the root causes of high costs in clinical negligence that could be reduced by better investigations, earlier admissions and a more constructive atmosphere overall.

Q85 **Chair:** Can I challenge you about why we would not want to learn from countries like Sweden, which has half our neonatal death rate, or Japan, which has seen a decline in the number of cerebral palsy cases even though they, initially, thought that it was something where the cause was unknown and unknowable? They have decided that is not the case and that they can actually have a significant reduction in cerebral palsy cases by better investigations. Why would we not want to learn from those countries?

Peter Walsh: We absolutely would want to learn from those other countries. It is right that we are attempting to learn from those other countries. In fact, this is not new. As you know, Sir Liam Donaldson, in his report "Making Amends", recommended a no-fault scheme—

Q86 **Chair:** Sorry to interrupt, Peter, but in both of those countries, we have just heard from people who were very specific and said that the non-adversarial nature of their system was one of the key reasons why they had seen a reduction in patient harm. Is that not something we should learn from here?

Peter Walsh: It is if it can be borne out by the evidence. I am not sure that there is absolutely hard evidence that the improvement in patient safety in the countries we have mentioned is as a result of their compensation scheme. In Sweden, for example, I am sure Professor Gustafson would confirm that there has been massive investment in patient safety and in staffing levels.

Q87 **Chair:** We asked him very specifically, and he was very clear that it was the non-adversarial nature of the system that was responsible for significant improvements.

Peter Walsh: I think he said it was a contribution. It would be very informative to see the hard evidence about what exactly led to the improvements. It will be a mixture of things. It will be the massive investment they have made in staffing and patient safety practices, as well as perhaps the contribution that the new scheme has brought.

Of course, we are looking at different systems. They are different systems of social care, where people have comprehensive healthcare. In this country, that is often not available. We also have our legal system, such as it is, with its weaknesses, where a lot of improvements could be made. NHS Resolution, for example, is making attempts to get to earlier identification of where mistakes have been made and settling claims without the need for litigation.

Q88 **Chair:** On that point, let me bring in Guy Forster. For the purposes of transparency, we should say that Guy Forster represented Sue Beeby, who gave evidence in a previous panel. Sparing your blushes, Guy, Sue is very clear that you did an absolutely fantastic job and you were the only person she could turn to in a really desperate situation when her son was born severely disabled.

I think we all recognise that in extremis the law has an incredibly important role to play, but what do you think are the strengths and weaknesses of our system, and what do you think we can learn from other countries?

Guy Forster: Picking up on something that Peter said, certainly one of the great weaknesses of our system is where our claims start off. It is sadly not uncommon that people come to us when there may be multiple processes going on. It could be an HSIB investigation. It could be a complaints investigation. By the time they come to us, they can feel that the profession has closed ranks.

Part of the problem that we have not got to grips with, in all of this, is the way in which we respond to incidents in the first place. That is something that the healthcare system needs to get to grips with before we start looking at litigation reform. To my mind, it is a question of making sure that we have independence within investigations themselves and that they give good, thorough recommendations that can be followed up in implementation, and also—

Q89 **Chair:** Sorry to interrupt, Guy, but do you think it is a step forward that we have the independent HSIB investigations? I know that they are not always perfect—

Guy Forster: Absolutely I do.

Q90 **Chair:** But we do, in the serious cases, have an independent investigation. You support that, do you?

Guy Forster: I think it is incredibly important. We know from past cases and investigations by the NHS that it is incredibly difficult to analyse one's own performance. Having that degree of independence gives credence to the recommendations that come out of it.

Part of the problem that we have currently with HSIB is the ability to make sure that recommendations are implemented and followed up. Some of the learning that we have around the country can be quite ad hoc. The NHS is a huge organisation. There will be learning within single units. There will be learning nationally. What we do not have is a cohesive way of pulling all that learning together. I do not see a need to generate more information around learning. What I see a need for is to pull that together and make sure it is properly disseminated across the NHS.

What I think is really interesting from hearing the international panel is that the aims of those systems are very much like our own. The difficulty for us comes in the need to recognise that there are things we can do differently. There is no shortage of people who are willing to get round the table to discuss how we can refine the current system, but the issue, to my mind, is that we are moving in a direction that allows great collaboration between the parties.

In the last annual report we had, NHS Resolution—I am sure Simon will talk to this—attributed the reduction of cost to greater co-operation between the parties. There are certain things happening now that we need to pilot and see the outcomes of, but certainly we should be looking at better and earlier ways of resolving disputes.

Q91 **Chair:** Can I ask you this very specifically, Guy? In Sweden, Japan and New Zealand, the three representatives all said that one of the reasons that they are able to improve exchange of information and speed up the learning is that the entitlement to compensation is not based on having to prove that a clinician or a hospital was clinically negligent, and you get no-fault access to compensation. In Sweden's case, it is on the basis of avoidability. In Japan's and New Zealand's cases, it is no-fault access. They all said that made an important difference in improving and speeding up the learning process. Do you not think there is an argument, if it is working well in those three countries, that we should consider it here?

Guy Forster: I think the elements that we need to be considering here are how we better improve learning within the NHS system and not relying on litigation as a means of providing those answers, which should be given in the first place, with good independent investigations.

The stumbling block with the administrative schemes so far has been that the costs involved to administer those kinds of schemes are likely to be much greater than what we are dealing with. Yes, we are dealing with huge figures at the moment. I should add that those figures obviously belie huge catastrophic injuries on behalf of patients. These are people, at the end of the day, who have been harmed through no fault of their own. When we are looking at these kinds of schemes, the eligibility criteria will be greatly widened. Either that is going to cause an astronomical cost that will not be sustainable for the system or we have to look at tariffs or tokenistic types of damages, which are not very responsive to the needs of injured patients.

To my mind, we are better off looking at our current system and looking to refine areas to make things more efficient, to reduce costs and, more than anything, to make sure that the needs of patients are put first.

Q92 **Chair:** Thank you. I want to bring in my colleagues. I am going to bring in Barbara Keeley first because I know she has to go, but I very quickly want to ask a question of the other two panellists.

Lauren McGuirl, thank you for joining us. You are one of the people who operates the NHS mediation scheme. One of the potential reforms that has been proposed is that we should require everyone to go through mediation before they start a process of litigation. Do you think there is merit in that?

Lauren McGuirl: I do. I think it is important to look at cases on a case-by-case basis, but ultimately what we see in the mediation process is that it is about getting the parties to engage, in particular when you are looking at a clinical negligence dispute where there is high emotion and there will often be ongoing care between the patient and the NHS—an ongoing relationship. Getting the parties to be able to talk to each other to see what happened on the other side, to ask questions and to get an explanation and have those lines of communication, is really very key.

We heard today from the four colleagues who spoke earlier about the different systems. Some of the overwhelming themes that continue to come out both from them and the patients who spoke in the previous session at the end of last year were the need for open lines of communication, the need for continuing engagement, the need to be heard and the need to be able to tell your story. Mediation provides all of that.

The litigation process, once it kicks off, can become very positional. The longer that the parties are positional, the more entrenched they become. Starting a mediation process at an early stage, even if it is just to get the patient to be engaged—it does not necessarily have to be a complete resolution—will result overall in more engagement and more resolution remedy for the patients. It will also reduce costs because claims that would have been filed are not. It will not go to the point that Peter and others touched on, which is patients saying, “I felt like I had no choice. I didn’t want to bring a lawsuit but I felt that I had no choice.”

If you can get them around a table, in particular with a skilled mediator who can provide a safe space where they are able to engage in a very constructive manner, it can go a long way to addressing the remedy point, which is really the aim of the system.

Q93 **Chair:** I have a final question, before I bring in my colleagues, to Simon Hammond from NHS Resolution. Thank you very much for joining us.

I think most people would say, despite all the difficulties in the system in the UK, that as far as NHS Resolution is concerned things have been getting better in recent years. You have been able to resolve more cases without going to court. NHSR has speeded up its processes.

I know it is not your job, as someone who is effectively working for the state, to recommend big policy changes, so let me ask the question in a slightly more gentle way. Listening to the evidence we heard from other parts of the world, what do you think we can learn from countries like Sweden, Japan and New Zealand, and Virginia in the US?

Simon Hammond: Good morning, Chair, and thank you for inviting me today.

One of the key things that I took from this morning was very much around how they work with others. I thought, from what Guy and Peter said, it was very much around how we can improve earlier intervention. Going to what Lauren has just said, it is also about how we can actually start to look at getting together immediately with the clinician and saying sorry. Something we have promoted quite a lot with some of our publications is about being fair and saying sorry. That is certainly something I took from the other panellists this morning. They work with other organisations and the clinicians in recognising the incident and what you can learn, and not necessarily from just the clinical negligence environment.

Chair: Thank you. We temporarily lost our picture of you, but we heard you loud and clear. That was very helpful.

Q94 **Barbara Keeley:** Yes, we can hear you. This is a question to Simon Hammond. International compensation systems seem to be able to resolve complex cases very quickly. What lessons from abroad can we apply in England to shorten the time it takes to resolve cases? We have heard from witnesses whose cases dragged on for years. I think that is a very significant element in our system.

Simon Hammond: For some reason, I seem to be having some technological problems. It will not let me start my video, for some reason.

Barbara Keeley: We can hear you, though.

Simon Hammond: Excellent. On the question around speed, I think we have to take into consideration, and I would caveat this with the restrictions that we spoke about this morning from other panel members, that there are various different eligibility criteria. There are also different ways that the systems compensate.

Certainly, we heard from our colleague from the United States that needs were on an ongoing basis. In our system, we have a once-and-for-all settlement. Therefore, when we are talking about settling cases and looking at metrics, we probably are not measuring a like-for-like environment. Eligibility to, essentially, our indemnity schemes, and whether a claim should be accepted, can be processed quickly. We often get to a position where we admit that there is an entitlement to compensation, but then we have to go through a series of steps to identify what the person's needs are, what a harmed patient requires on an ongoing basis, especially in cases of severely injured children. They have to go through developmental milestones before we can fully assess what their needs are for the rest of their life. It is sometimes difficult to make direct comparisons between international jurisdictions and our jurisdiction on the point of settlement and the time to settlement.

However, we very much intend to continue our dispute resolution mechanisms. Guy has already alluded to the fact that we are working collaboratively across the entirety of the industry to try to make sure that our process is as effective as possible to ensure that we keep clinicians and harmed patients out of full court proceedings as much as possible and make sure that we can resolve their cases in an efficient way as quickly as possible.

Barbara Keeley: Thank you.

Q95 **Dr Evans:** My first question is for Guy. What do you think, given your experience, is the mental state and the way clinicians approach patients in this country when it comes to having legal backing behind them? What do you see when you look at your cases?

Guy Forster: When a client comes to us in the first situation, as I say, they will already have had quite a dialogue with the trust from the outset. If that is dealt with well, actually it can be very much a non-adversarial process. You might be led to think that it is a situation in which the sides very much become entrenched, and it becomes a battle, but when things are done well and investigated properly and the dialogue is done well, the question quickly becomes, "What are the person's needs currently and in the long term?" That is what good looks like.

The difficulty is when they come to us and may well have been led to believe that nothing could have been done differently, but they still have very strong feelings that actually many questions are unanswered, and their needs have not been met. It is the sort of thing that Lauren spoke about—not being able to have the kind of dialogue where the issues are opened up.

From the point of view of a clinician, obviously we work with clinicians in the work that we do, so in order to do our cases we need the support of clinicians to prove those cases. The clinicians tell us that the fear of litigation is not what is driving any form of blame culture or not being able to learn lessons. We hear that there are other much more important factors such as workload levels, staffing issues, a toxic culture and poor leadership. It is all of those things that we hear time and again in reports that need to be fixed.

We had a recent situation at West Suffolk Hospital, with the treatment of a whistleblower. That was nothing to do with litigation, but everything to do with cultures around that organisation. I am by no means singling out that organisation; these things are widespread. The important thing to take from this is that when we go into these types of situations, it is incredibly important to make sure that there is a non-hierarchical discussion between patients on the one hand and clinicians on the other, who themselves will be upset by the very incident that has occurred—

Q96 **Chair:** Can I jump in for a moment? I am sorry, Guy. I want to understand precisely what you are saying. We had the famous case of Allyn Condon, who lost his son, Ben. He went into a meeting with doctors at the hospital in Bristol and left his phone recording. They agreed that he could record the meeting, and then he forgot that his phone was there and left the room after the meeting. The phone was still recording. The doctors then proceeded to have a completely different conversation from the one they were prepared to have in front of him, including saying things like, "He was right, wasn't he, the father, in what he said?" Then they said, "Can we delete this recording?"

We all understand that it is not just fear of litigation. People are worried about the GMC and they are worried about reputational damage to themselves, their unit and their hospital, but you are surely not saying that litigation is not one of the factors that causes a defensive culture.

Guy Forster: The situation that family had to go through was absolutely horrific. It took far too long to resolve.

Q97 **Chair:** It is still not resolved, by the way.

Guy Forster: No, quite. The issue for me is that, actually, the fear of litigation is very low on the list. There are intrinsic problems in our healthcare service that need to be sorted out first. We hear of scandal after scandal, whether it be East Kent, Morecambe Bay or the latest one at Nottingham. We hear these things time and again. Throughout, there are cultural issues that need to be grappled with. The important thing, of course, is to enable people to be open and candid. We have to ask ourselves why that is not happening.

Q98 **Dr Evans:** Guy, can I pull you up on that—the Chair has beaten me to the first punch on this—because I think you have hit on something wider? As a practising clinician, I know, from the ones I speak to and who have come in front of us, that one of their concerns is exactly that. It is all the system pressure: being asked to do another duty because someone has dropped out; the team is falling apart; they are working extra hours;

there is an A&E queue so they have been called down to help in a different department to get it sorted.

Fundamentally, you are right; they are system-based problems. However, the responsibility is duly put on the clinician individually, with the decision they take, how they manage and what they do. That often ends up, in my experience, with people making more defensive decisions on how to keep people in and what tests to request. It is more defensive. It is very easy for an A&E consultant to say, "Well, it's clearly not chest pain," when I refer someone up as a GP. It is not heart related, but they will do an ECG, blood tests and keep them in hospital for four hours to do that rather than making that assumption.

Is it your impression that actually, if we improve the greater system, that will relieve it and allow this to happen, or should it be the other way round? What I am getting at is, should it be bottom-up? Should clinicians be coming out and saying far more, "No, we are under huge amounts of pressure. This is what is going on," and pointing fingers at the system? Or is it the system top-down that should allow clinicians not to have that pressure in the first place? It is a very scary place for a clinician to say, "Yes, I have made a mistake, but if you look at what I was dealing with, I was looking after 50 patients on one ward when I was only supposed to look after 30." There is that correlation from the clinician's point of view. They are always thinking, "It doesn't matter because if I go to court I am responsible. I was looking after 50 patients, even though it should have been 30." Do you have a thought on that?

Guy Forster: I do. I think there is a perception problem. It is systemic. Litigation asks questions of the system rather than necessarily of the individual. If you reform the litigation system, you are still left with the difficult issues around reputation and regulation that we heard about from the international witnesses. That does not disappear. You still have those other pressures.

Clearly, clinicians often do not have the time or the resources to be able to respond to those issues. Actually, we are talking about basic honesty and integrity. There are opportunities to—

Q99 **Dr Evans:** That is really interesting. Can I interject again? A famous case that came to light, and got a lot of doctors very upset, was the Bawa-Garba case, which was about where she had moved around, what she had done and her reflective learning. I do not want to pull all that apart, but that was very reflective and hit a note in NHS staffing about how you feel exposed, where you are going and what that means for reflective learning, given that her journals were used as evidence in dealing with her.

Has the system moved on since then? Have there been lessons learnt, or what should we be learning from those kinds of cases? You are right; the reality may be different, but if perception is driving most staff in the NHS, that is part of the problem. Let's face it, most staff will not come into contact, hopefully, with a court case, or it will only be one in their career.

Guy Forster: Absolutely. There needs to be the support to create a just culture to be able to have those discussions. I do not believe that the reform of litigation is necessarily the key to that. I think the key is actually getting the responses right first time and making sure that clinicians are supported and that patients are supported through that process.

What we really lack in this country is consistency in how patients and clinicians are dealt with once harm has occurred. If we were able to have a consistent pathway that essentially said, "These are what the needs are for everybody involved," and made sure that those were met, we would have a much better system whereby we could keep dialogue going and perhaps clinicians would not feel quite so inhibited to speak up.

Q100 **Dr Evans:** There is one final question from me. We heard, very interestingly, in the last panel before from the professor from Sweden that, "One of the best things was that I knew when I made a mistake that the state and the system were there to compensate. I had something to offer." Most clinicians want to be able to give the answer or want to be able to rectify the wrong. That is human nature. Do you think we can learn more about that system? How does it currently work in British practice?

Guy Forster: In British practice, there is the outmoded sense that by saying sorry you are somehow admitting liability. It is absolutely not true. NHS Resolution has been clear for years that saying sorry is not tantamount to admitting liability. It is not a question of getting yourself into trouble with the regulator. What we need is a supportive organisation that actually dispels some of those myths and recognises that, at the end of the day, all anybody wants is for the harmed patient to get the support that they need and for the clinicians to be able to learn the lessons of the mistakes that were made. We need a system that encourages that from the outset, with thorough investigations, which are independent—that is key—and produce real action plans that are properly implemented. We do not have that right now.

Q101 **Chair:** Peter Walsh wants to come in.

Peter Walsh: Thank you. On that point, I was very struck by what Professor Gustafson said. I can really equate that with discussions I have had with other clinicians in this country, and others. The vast majority of clinicians want harmed patients to be compensated fairly, and they want that to be made easier. One of the things that is making it easier is the duty of candour in this country. It is no longer optional not to be open and honest. There is a real imperative about that.

The main point I want to make is that, while there are lessons we can learn from other systems and perhaps we can build upon them to ensure that they are completely fair to all concerned—for example, that they compensate on the basis of need, as opposed to an arbitrary tariff amount—it could be much easier even under the current system.

For example, to take a doctor in Dr Gustafson's position, first of all, we have the advantage in the NHS in England, and the UK in fact, of vicarious liability. It is not the doctor who is liable; it is the NHS that is sued. In that situation, you recognise that there has been an incident. You get around the table with your patient safety and governance people. You contact NHS Resolution and say, "Look, this is barn door. We really ought to be doing something for this family." The family should have access to a specialist form of independent advice and advocacy to explain their options to them. In that scenario, the most likely and best outcome for everyone would be to settle the case without the need for litigation, and you would also learn the lessons, so that everyone walked away from it a little bit better than they would have done had it gone to court.

Q102 **Chair:** Thank you. Two colleagues want to come in, but can I follow up on something you said, Guy? I am quite puzzled by your logic, and I want to see if I can understand it better.

Of course, it goes without saying that the best outcome would be if we did not have these terrible tragedies and people got it right first time. The question we are trying to understand is why we do not, and in particular why we do not have a learning culture whereby we learn from mistakes. Of course, there are lots of reasons why these things happen, including staffing shortfalls, lack of access to good technology, lack of training and all sorts of things you can point to.

We have heard some pretty compelling evidence this morning. Dr Gustafson made the comment that he was very relieved that his two orthopaedic patients could access compensation. In this country, to access compensation, you have to prove clinical negligence. In this country, if he had been an orthopaedic surgeon, he would not have been so relieved about that. He would have been worried that the only way they could access compensation was if there was a successful claim of clinical negligence. Obviously, that makes a doctor much more defensive. We have had a lot of evidence today from Scandinavia, Japan and New Zealand that makes it easier for people to access compensation, either on a no-fault basis or on an avoidability basis. It removes the defensiveness and allows a much less confrontational relationship and allows lessons to be learnt.

I cannot really understand the defensiveness that I am sensing from both of you about changing our system. I am sure there are lots of other things we need to do as well. In this Committee, we have looked at lots of those things, but one of the things causing that defensiveness is surely the fact that you have to go to court and prove clinical negligence before you can get compensation. That makes doctors, nurses and midwives very nervous.

Guy, can I ask you the difficult question that has to be asked? Last year, £2.2 billion was paid by the NHS. There is a huge industry of clinical negligence lawyers. I think getting on for half that amount was legal fees. Is there self-interest in the legal profession that makes you want to resist change?

Guy Forster: Absolutely not. As I say, it is really important to remember that behind these large figures we are talking about people who were harmed, at the end of the day. When you look at the process, it is not the case that everybody needs to go to court in order to receive redress because, actually, three quarters of those who receive damages in some way will receive them without the need for proceedings at all.

My suggestion is twofold. First, we need to make sure that the responses to incidents are properly carried out so that we recognise early on where there are concerns and failures in care. That can expedite things. We can look at the likes of HSIB, who are now doing the investigations that are a springboard for our early notification scheme. That looks to expedite the maternity scheme and, as Peter says, gives an opportunity to say, "We've got this wrong. Let's make sure these families are looked after."

There is still a proportion of cases that go on to court proceedings that really ought not to. We need to be honest about that and understand what is driving it. If the issue is actually that NHSR and the lawyers acting for the defendants are not able to have the resources to investigate the case properly, we need to properly resource them. If the issue is that we are not getting the families around the table with the clinicians early on, we need to change that. The most important thing in all of this is to make sure that we are having proper investigations from the outset. That will expedite these kinds of cases.

Q103 **Chair:** Do you support independent investigations? Do you think that is an important thing?

Guy Forster: I think it is the key. We want to make sure that when we have mediations and alternative dispute resolutions we are encouraging that pre-issue. There is no question about it. We should be leaving court for the disputes that really cannot be mediated, decided or resolved. It is important that families have the opportunity to see those disputes through when a decision cannot be reached or resolved.

Q104 **Lucy Allan:** I want to come in on the mediation point. Lauren spoke very powerfully at the outset about the need to get people round the table before positions become entrenched. Lauren, what are the obstacles to that happening? How do we speed it up in order to improve the mediation process?

Lauren McGuirl: A lot of claimants and defendants think that they need to fully investigate everything in relation to the claim before they can have a meaningful discussion. That is simply not the case. Often at the outset, the high emotions and reactions on both sides lead to the positional points that we have all discussed, and which even the international panel touched on. Essentially, clinicians get worried and they do not know what they can or cannot disclose. In the meantime, patients are trying to figure out what is going on and how they fix it, and how they prevent it from happening again.

In order to have the parties able to come early on, it is about having a steer such as, "Have you considered mediation? Is this something that you have thought about? Is this something that you have agreed?" Having mandatory mediation is also a possibility and, we think, would be quite powerful. Further, looking at the system that we have now, before the claim is provided with directions in a court, if it is to go down the litigation route, it is about whether the judge has looked at whether you have really engaged in talking to each other, or you have just sat behind the pieces of paper that you are exchanging.

When you are looking at a legal claim, it is a limited lens. You are looking at whatever the legal test is that has to be met, and you are looking at the evidence that has to be presented in that way. Clinical negligence cases are much broader beyond that lens. Therefore, it is important that parties know that it is available, that they have resources to understand how it works and that they are steered in that direction, so that they can avail themselves of those resources.

Q105 **Lucy Allan:** Thank you. Can I quickly bring in Simon Hammond, if you are still there? What does NHS Resolution do to persuade people that they should go down the mediation route and to enhance co-operation in mediation?

Simon Hammond: We recognise that mediation is important, but it is one of a number of tools for dispute resolution. We certainly would not advocate that mediation be required in every case. There is a host of cases, as others have alluded to, and nearly three quarters of our cases settle pre-proceedings, without formal court proceedings having to be issued by the claimant to receive compensation or an answer of eligibility.

In that sense, we automatically work with claimant lawyers. We encourage claimant law firms and, where possible with litigants in person, claimants themselves to enter a process of discussing the case, be that by a stocktake meeting, a roundtable or face-to-face or telephone negotiations. In a certain class of case, mediation is one way of resolving it. We encourage that as much as possible. Our strategy is resolution prior to court proceedings.

Q106 **Lucy Allan:** Is that openness and transparency, and the need to recognise that something has gone wrong and communicate that to the family, something that you now see happening in the NHS, or is that still an obstacle to resolution?

Simon Hammond: It is difficult to answer that question because we only see a small proportion of claims reach us compared with incidents that occur in the NHS. We always encourage openness and candour. We have produced literature on that. I think my colleagues have referenced the material already. We always encourage that because it then removes some of the adversarial nature. Saying sorry is not tantamount to an admission of liability. That is a completely separate threshold test.

In a mediation situation, we encourage trusts or clinicians to attend, where possible. We have been really successful through the pandemic in doing that through virtual means, so that we do not take people away from their day job and very busy clinicians do not have to take complete days out of their schedule to attend a mediation. Having them there remotely in a similar environment to the one we are in today means that they can attend simply to express their view to the family, while we can move on to the actual settlement of the claim without necessarily their involvement. We have had really good success through the pandemic, working with others, in achieving that.

Chair: Thank you. We have Dean Russell and then we will conclude with a final question from Luke Evans.

Q107 **Dean Russell:** My question, coming back to you, Simon, is regarding the learning and the process of learning. As part of the process, do you have a record of all the data on similar types of incidents and what led up to them, so that other organisations in the NHS can learn from that and make sure that they do not repeat the same mistakes that may have led up to an incident or an accident, or a situation that then leads to litigation?

Simon Hammond: Yes. We hold a really unique position. We have all of the data from clinical negligence claims that are presented to us. We have a safety and learning function in our organisation that reports back to trusts on annual scorecards. They also do thematic reviews and publish volumes of literature to help the system.

We also recognise that it cannot just be us that deliver that learning. We work with system partners across the whole of the NHS to derive learnings. For example, in the EN scheme we work with a variety of system partners in the maternity safety space to deliver some of the learnings that we see occurring through claims. Those learnings are obviously triangulated with incident reports and complaint reports through such initiatives as the Getting it Right First Time production that we co-authored with them on learning from litigation claims.

Q108 **Dean Russell:** Do you have a track record of how much that has impacted on or reduced incidents of a similar nature? For example, if there is a particular type of issue that has happened in the past, has that learning been truly embedded, and is the impact of the learning measurable, or is it the case that people are doing the training but it is not necessarily seeping through to the whole organisation to reduce future harm?

Simon Hammond: I would probably refer back to earlier comments made in some of the international comparisons for that question, because it is difficult to measure the impact specifically that we can provide. We are not the training body. We can make recommendations but we obviously work in a complex health system, where lots of others are also system partners with us, to deliver those learnings. Therefore, it is difficult for us to actually measure a direct impact and say, "This piece of literature had that impact on the totality of the system." We are confident that people take into consideration the publications that we produce, and then embed them for the purposes of learning from what we have seen in clinical negligence claims.

Q109 **Dean Russell:** Would it be helpful if there was a wider body or measure of those sorts of things? If a particular type of incident or accident has then led to litigation, surely as a body of the NHS you would want to be able to see that there is a fall in that, post litigation or post the incident, across the entirety of the NHS. I understand what you are saying about the training piece, but if that does not exist as it currently stands, would it be something that would be worth perhaps putting into place in the future?

Simon Hammond: I think I would reference there the Getting it Right First Time initiatives. In conjunction with many others, including us, they have documented where there have been falls and different variations of standards that have been applied across the NHS. As a result of their programme, they have witnessed reductions in both the claims and incidents that have occurred. I think that type of learning already exists.

Q110 **Dean Russell:** Thank you. It is more the measurement of the reduction. Finally, if I may, with regard to patients and those who have gone through what at times can be life-changing and awful situations, how much are patients involved in the post-learning process? Do you have patient voices within that training so that it is not just looking at it from a clinician's perspective but also understanding the sorts of issues and the concerns and language that patients might have been using in the run-up to raise their concerns that were not perhaps picked up on in previous cases?

Simon Hammond: If I can be clear, we do not deliver the training as such at local level. We often necessarily implement and encourage training programmes, but we do not deliver them across the totality of the systems. I thought I would make that point clear.

Coming to your main question, we take families' views, and we often publish literature that includes case histories. Our safety and learning function attends mediations as well, so they can include families in discussions with the trust and clinicians on what can be learnt from their individual cases.

Q111 **Dean Russell:** Excellent. Can I ask one further question, if I may go to you, Lauren, from a dispute perspective and your expertise in that area? How important is it for families during the dispute resolution process to know that learnings are in place so that others do not go through the same issues, or are they generally more focused on their own situation? What is the general trend of that?

Lauren McGuirl: First and foremost, they will be dealing with the impact that personally affects them, but of very, very high importance—you heard it from the patients who spoke to this Committee—is that they want to ensure that there are lessons learnt and protections put in place so that it does not happen again. That sits well above the priority of compensation, which is often the lowest on the list.

It is being able to ensure that the issue is being dealt with holistically and appropriately, and, lastly, as we heard time and again from all of the panellists, in a very timely manner, so that it is not lingering for several years before potentially the learning fully comes out. That is really what they are looking at. It is a very high priority, and it is why, whether you want to call it mediation or facilitation, having a neutral party who can essentially help the parties have that discussion in a safe and constructive manner is really key early on.

Q112 **Dean Russell:** Very finally to you Lauren—my final, final, final question; it is such an important topic around the learning and putting patients at the heart of this—how much do you see that long-term engagement happens? Once the dispute resolution happens, and perhaps litigation, do you happen to know whether there is long-term engagement with those families to let them know how things have been embedded in the system and let them know that those learnings have been put in place to let them know that their raising it made a difference?

Lauren McGuirl: That is where our involvement ends. While we are there for the mediation, and often we will be involved for a small time afterwards helping the parties to solidify their agreements in relation to that, what we are involved in is the next stages, which is where it goes after the patient has been able to voice their issues. I think that is where Simon comes in and, more importantly, where safety and learning comes in.

As Simon mentioned, it is very common for the safety and learning team to attend a mediation in order to gain learning. One of the things that the mediators invariably ask at the end of the mediation is, "Are there any more general points? Is there anything else you would like to share or discuss?", and the parties are able to deal with that. That is all done in a confidential and privileged discussion, which helps go back to the issue that we talked about earlier, which is having clinicians or representatives from the NHS being concerned about how it is going to impact. It is a confidential and privileged discussion, so they are able to share more openly and candidly.

Dean Russell: Thank you very much.

Chair: For our truly final question, Dr Luke Evans.

Q113 **Dr Evans:** Given what Lauren said about compensation and its position, I was struck by Peter's response when you said no to tariffs on conditions, which slightly jarred with what the professor in Japan talked about. He argued that one of the criticisms they deal with is that there should be grading within cerebral palsy of what they pay out, and he suggested that would not work. I am struggling to understand your position on the juxtaposition of how we get that right.

If compensation is lower down—as taxpayers we want to reduce that burden, and of course primarily we want to stop mistakes happening in the first place—should they be there? Is it better to have a system that learns and the money is reinvested from that, and yet still get some compensation, or to increase the compensation and get into a situation where we ask, "If they are wealthy parents and they have a baby, what are their life opportunities?" Where does that get us to? How do you square that circle?

Peter Walsh: I think we need to look at it through the lens of justice, particularly in the case of patients and families who have been affected by perfectly avoidable, even negligent, occurrences or incidents. It would be intolerable, I think, that having already suffered that massive insult and harm, they have to foot the bill for the cost of that to society by having their access to justice diluted by having their compensation top-sliced. That is what I meant about the danger of going down a tariff-based approach. If we had a system that was based on learning and on avoidability, as opposed to apportioning individual blame, it is something that we and most patients would welcome with open arms so long as all of the criteria are met in terms of fair compensation, independence and impartiality, timeliness, and so on.

The trouble is that, so far, every time this has been looked at, the proposals that have come up have been too costly. Sir Liam Donaldson's proposals were ditched because they were too costly to compensate people fairly; likewise, with Sheila McLean in Scotland. I was on her working party that came up with a no-fault scheme, which was well designed. It was not accepted by the Treasury because they realised that if they compensated everyone fairly on that scheme, they could not afford it. Even the rapid response redress scheme consulted on by the Department of Health a few years ago had at its centre paying for the administration of the scheme by taking 10% of the needs-assessed award of damages that a court would make to a brain-damaged baby. That is what we have to square. Can we afford a scheme that, in an ideal world, would be something we would all want, while still maintaining access to justice?

Q114 **Dr Evans:** On that question, the professor said that one of the big political arguments is that social care, the state, should pick up the other side. That is the budget constraint where they have the problem. Is it better to get a system in place and then have a fight over it and where that budget will range, or carry on with the system we have and still have the potential problems? It is the devil and the deep blue sea I feel I am asking you about.

Peter Walsh: It would be asking a lot for the kinds of families that you have heard giving evidence to the Committee, and the people we have daily conversations with in our charity, to risk the security of their family's care going forward by saying, "Let's fix the first bit and hope that social care will be able to pick up in the future." We know the state of social care in this country is not where it should be. Even with the recent award, it will only bring it up to what is needed to cope with current demand. If all these people suddenly turned up to social care to meet the needs that would have been met through compensation, we would be in an awful state and very different from the situation in Sweden.

There are things we can do short of the really, really radical proposals which, if they were affordable and ideally designed, most people would like. I think what both I and Guy have been saying is that, while it is not perfect, there is much that we can fix and improve in the current system, so why don't we get on and do that? We know if we all get round the table that there are enough constructive people and wise heads to make a big difference very quickly while we consider other options.

Chair: That is a good note to end on. Our observation from this morning has been that it is worth looking at what is happening in Sweden because they have a much lower compensation bill as a proportion of their total healthcare spend and GDP, and they have much better safety rates—about half our neonatal death rates. They win on both counts, so I think we would be negligent as a Committee if we did not want to see what we could learn from places like Sweden and Japan, who have started on that journey.

We have had a very good, frank discussion. I do not think any of us would disagree with your point, Peter, that there are many other factors involved. Regular viewers of what this Committee says will know that we talk a lot about workforce pressures and the importance of that when it comes to patient safety, so we would certainly wholeheartedly agree with that.

We have had a very open and valuable discussion. We are very grateful to you for joining us, Peter, Guy and Lauren, and Simon, the faceless example of NHS bureaucracy, who actually gave some very good answers despite the fact that we couldn't see you. Thank you all for joining us for this morning's very important session.