HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: NHS litigation reform, HC 740

Tuesday 1 February 2022

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Watch the meeting

Members present: Jeremy Hunt (Chair); Lucy Allan; Rosie Cooper; Dr Luke Evans; Barbara Keeley; Taiwo Owatemi; Sarah Owen; Dean Russell; Laura Trott.

Questions 115 - 196

Witnesses

I: Jill Edwards, mother whose daughter suffered a severe injury at birth

II: Maria Caulfield MP, Parliamentary Under-Secretary of State (Minister for Patient Safety and Primary Care); Helen Vernon, Chief Executive, NHS Resolution; and Matthew Style, Director General for NHS Policy and Performance, Department of Health and Social Care.

HOUSE OF COMMONS

Examination of witness

Witness: Jill Edwards.

Chair: Good morning, and welcome to the third and final evidence session of the Health and Social Care Select Committee inquiry into NHS litigation reform. Later on, we are pleased to welcome back to the Committee the Minister for Patient Safety and Primary Care, Maria Caulfield; the director general for NHS policy and performance at the DHSC, Matthew Style; and Helen Vernon, chief executive of NHS Resolution.

First, we are going to hear from Jill Edwards. Jill's daughter, Kirsty, was born in 1983 at the Royal Shrewsbury Hospital following a very traumatic labour and an emergency C-section. Kirsty suffered a brain injury, leaving her with cerebral palsy. It took a protracted legal process and 24 years for them finally to receive compensation, which they did in 2007. My colleague, Lucy Allan, who is Jill's MP, is going to ask her some questions. Welcome, Jill, and over to you, Lucy.

Q115 **Lucy Allan:** Thank you, Chair. Good morning, Jill. Thank you so much for being with us today. Thank you also for your courage in fighting for Kirsty for so many years against the odds.

Jill, after Kirsty was born, how long did it take for you to find out that there had been serious errors in the care that you and Kirsty received?

Jill Edwards: I always thought there was something wrong, but obviously I could not get the answers. I changed GPs, and it was my new GP who told me that it was not my fault, as I was led to believe, even though they did not actually say it was my fault. When I spoke to them about having more children, because by that time it was 1989, he said it was nothing to do with me and it was the birth.

Q116 **Lucy Allan:** You had been under the impression that somehow the care that you received was not related to the birth defects that Kirsty had.

Jill Edwards: Yes. I asked questions, obviously, immediately after she was born when he told me how bad she was and everything. Bear in mind that I was 20 years old and, dare I say it, a bit naive. He just said that it was one of those things. I had all that kind of thing said to me. Even after, I asked and asked. She was diagnosed at nine months with cerebral palsy, and from there I never stopped asking people about why she was like this and what had happened. I knew everything until I went into theatre, but I did not know any more than that. I never got the answers.

Q117 **Lucy Allan:** Did Shrewsbury and Telford Hospital Trust ever give you a full explanation as to what actually happened, and why Kirsty had—

Jill Edwards: No.

Q118 **Lucy Allan:** Never? They did not take you aside and say, "Look, the cerebral palsy was due to an accident at birth"?

Jill Edwards: They told me it was a brain injury, but they did not say anything about how it was caused or anything. I just thought it was something to do with me.

Q119 **Lucy Allan:** You went to see a GP some years later, and then what happened?

Jill Edwards: I changed GPs and went to see him, like you do, at a new consultation. We talked about everything. We talked about Kirsty because she came to the GP with me. Obviously, I asked questions about whether, if I went on to have any more children, that would happen to them. When I asked that question at Shrewsbury, they said they could not guarantee that it would not happen.

Q120 **Lucy Allan:** At that point, presumably, you decided to find a solicitor who was willing to take your case. Why do you think it took 10 years for the court finally to rule in your favour? What were the obstacles you had to overcome to get to that point?

Jill Edwards: The obstacles I overcame were trying to find, back in 1989 or 1990, solicitors who were experienced in all of that kind of litigation. The first one I went to did nothing. For two years, I never heard anything. Obviously, with solicitors, you just think, "I'll let them do what they've got to do." I then went to another solicitor, who I knew a bit more. He said he would have a look into it, but he was very up front and honest with me and said that it was really out of his field and his depth.

It was 1996 by the time I eventually found a solicitor who took it on but he said he could not make any promises. That is how the ball started rolling. I had three solicitors up until that point.

Q121 **Lucy Allan:** All that time you were caring for Kirsty, who was quite severely disabled as a consequence of the birth trauma. How did fighting a case alongside that impact upon you, Kirsty and your family?

Jill Edwards: It was really difficult. Bear in mind as well that in 1992 I had my son. I was again under Shrewsbury hospital. At that point, they had already been notified that I was looking at legal action. I dare say that one of the consultants was not very pleasant to me. He told me that it was all in my head, that I had delivered this baby and that, if he had been about when I was having my daughter, he would have got her out. He would have killed it, but he would have got her out. Am I allowed to say what he went on to say?

Q122 **Lucy Allan:** Yes, go ahead.

Jill Edwards: He went on to say that I had a pelvis like a bucket, size seven feet and my baby should fall out.

Q123 **Lucy Allan:** Would you say that again? I just missed that point.

Jill Edwards: When I went to see him—I think I was about six months into my pregnancy with my son—I said I was always told that I would have a caesarean after having Kirsty. He would not allow that. He said I had to labour. He said that I had a pelvis like a bucket, size seven feet, and therefore my baby should fall out. He refused to let me have a caesarean. He said that he would be around when I was having my son, which absolutely terrified me.

I actually went back to my GP and begged him to send me to Wrexham. He said he could not, and I had to go to Shrewsbury. I was so scared of going back to that hospital because I just thought, "You know, I am going to go through all this again, what I went through with my daughter." When I went into labour, it was the middle of the night. Luckily, it was a Sunday evening so that labour progressed, and I ended up having a caesarean again.

Q124 **Lucy Allan:** Going on to the court process and the trial, can you describe what happened? After you found a solicitor and the case was being fought for you, can you describe what happened in court and at the trial, and how that made you feel?

Jill Edwards: The whole thing of getting solicitors, the QC and the barristers, took a long time before they admitted liability and causation. Kirsty was 21 at that point. Time was running out. There are lots of things you do not know, as a person like me, and I did not realise about the legal side of things. I was not aware—I did not know—that a child only has until they are 21 to start off. They kept putting obstacles in the way, saying that they had lost the notes and this, that and the other. They said that they had not got the birth notes. My solicitor and my barrister then made them swear on an affidavit, and lo and behold they were produced. That is when we found out what had gone on in theatre.

Then they admitted liability and causation. Kirsty was 21 at that point, but then they would not come to a decision about how much compensation Kirsty would get. It took another couple of years. We had to go to court in March 2007.

Q125 **Lucy Allan:** At the point when they admitted liability, did they apologise to you? Did they have a meeting with you?

Jill Edwards: I had a meeting with them at Liverpool law court, where they literally shoved a letter across the desk towards me. In that letter was the apology. It was a photocopy. I was told that I would get a proper written letter, but I never did. It just said, "We are really sorry about the events on 30 January 1983." That was it, basically.

Q126 **Lucy Allan:** Following the award of compensation, what was your experience of the way that money has been managed and how it has been used to care for Kirsty?

Jill Edwards: I don't know where to start with that one. All through the process—the litigation and everything—things were not explained properly. I am not a solicitor. I am not in the legal thing, so everything is quite scary and in an environment that is not normal to me. Everything comes as a shock, if you get me. I had never heard of the Court of Protection, and that is where they told me the money was going. I did not know anything about the Court of Protection itself or what it means.

Kirsty had to have capacity reports done on her and stuff like that. In one way, I was very pleased about the money being looked after because, obviously, it was such an amount that I did not want the responsibility. I wanted to make sure that everything was done properly for her. On the other hand, I do not know where her money is. Everything she needs practically has to be begged for, if you get me. It is not an easy process. It is quite a scary process.

Q127 **Lucy Allan:** One thing that struck me when you first told me about your situation was that there was no advocate working alongside you. There was just you, and you were having to navigate all of these different procedures and people who were very experienced in their field and capable of blocking everything you tried to do in order to secure Kirsty's future. It is a huge testament to you that you were able to keep fighting. I really admire your courage for doing that. It is an incredible story.

I have just one other question. In terms of how the money is spent, is it easy for you to influence that? Are you able to say, "This is what Kirsty needs and this is what we want to spend the money on for Kirsty"?

Jill Edwards: It is not that easy. At the present moment I am swapping solicitors from one to another because I am really fed up about how the money is working. Bills do not get paid. I get things and pay for them, and then try to get the money back. It is very difficult. It is not an easy thing to go through. There is no book with it. For me, it has been like a learning curve and it never stops. I have always been doing that since the day she was born. Everything has been very difficult.

Most of the time I absolutely dread walking into a solicitor's office because I and my daughter are made to feel like we are powerless. For me, I feel like she is a prisoner. She might have everything she needs, in a way, but on the other hand she does not have freedom. She cannot move house, for instance, or do anything like that because you are controlled by all these people around you. When the Court of Protection came out, I was not sure at first, when I first met them, who they were, what they were and what they did, or whether I had a voice for Kirsty to say, "I'm not happy about this," or, "I'm not happy about that." I did not understand it all.

Q128 **Lucy Allan:** I think one of the worst things about your case, when you first told me about it, was the fact that Shrewsbury and Telford Hospital Trust never told you that cerebral palsy was caused by a lack of oxygen at birth, and that you were then led to think that maybe it was just one of those things. With them not coming clean like that, did it have a long-term impact on your ability to deal with the situation?

Jill Edwards: Yes. Even to this day it has been a horror story. It has been horrendous, to be honest. I went somewhere that I thought you could trust people and they knew what they were doing, and I ended up being a guinea pig all through my labour. Obviously, when I signed my consent form to go to theatre, I thought it was over and my baby would just be out and safe, but then I found out what had happened in that theatre. I had lost total control over my body. People were doing things recklessly, in my eyes. I have to live through that trauma; every day I have to look at my daughter and live with that. She was 39 on Sunday. It was her birthday, and it can never be a happy day.

Q129 **Lucy Allan:** Thank you very much, Jill. I really appreciate you coming today, but also your courage over the years in getting justice. You are a real testament to the power of a mother fighting for her child. Thank you so much.

Jill Edwards: Thank you.

Chair: Thank you very much for joining us, Jill. Do stay tuned in, as we are now going to talk to the Minister and various senior people about what needs to change as a result of stories like yours and many other people's stories. For now, thank you very much indeed for joining us. It is much appreciated.

Jill Edwards: Thank you.

Examination of witnesses

Witnesses: Maria Caulfield MP, Helen Vernon and Matthew Style.

Q130 **Chair:** We now move on to our second panel this morning. What we are trying to establish this morning is whether there is still resistance from the Department of Health, the Treasury and the MOJ to fundamental reform to try to prevent stories like Jill's happening again, or whether there is a genuine openness to change.

When I was Health Secretary, I found that there was very strong resistance to complete change. The administrative scheme, which was a small step in the right direction, was basically stopped after I left office so the blob struck back. I think we are trying to establish this morning whether that blob is still out there in force, or whether there is genuine willingness to engage.

I will say this right at the outset to the Minister. I appreciate that it is not her decision alone and it needs other Departments to play ball to make real change, but she has to defend the Government's position as a whole. Having acknowledged that, I hope she will at least feel free to share with us a bit more about her own personal perspective.

Let me start by asking you one question about Jill's story. It happened some time ago. The birth was in 1983 and the resolution was a shocking 24 years later in 2007. Are you confident that there are not stories like that happening today?

Maria Caulfield: First, can I start by saying to Jill and Kirsty that I am very sorry for the experience that they have had. They were traumatic events, particularly not being told that the birth process was the factor that led to the problems for Kirsty. It was a while ago. I am hopeful that things have changed and that systems have been put in place to make that better.

At the time, NHS trusts were responsible for handling claims like this. That has now changed. We now have NHS Resolution. We have Helen here from NHS Resolution, which is a much better system for patients. Our priority is absolutely improving patient safety, to try to reduce the incidence of births where things like what happened to Jill are happening. We are having some success in that. Since 2010, neonatal deaths are down by 29% and stillbirths are down by 25%, so we are improving patient safety. Hopefully, there are fewer cases of people like Jill going through that.

Where there have been problems, NHS Resolution takes a very different approach from the way NHS trusts used to. First and foremost, we have introduced what is called the early notification scheme. They actively track incidents like that in hospitals. If they spot an incident, they flag it straightaway and start the process of talking to patients and staff, trying to deal with the issue of compensation and trying not to let it get to court. We heard about the traumatic experience that was and how many years the process takes.

It is a very different culture now from the way Jill would have experienced it. You would have started much of this work yourself as Secretary of State, Chair. There is a changing culture in hospitals as well. We now have the duty of candour. A hospital would have to say up front that there had been a problem, apologise for it and start the process of investigating it and giving the information to patients, which clearly did not happen in Jill’s case.

There is also much greater freedom for staff to speak out, whether or not it is maternity staff, with the whistleblowing process. There is a safeguarding process in place and staff have the freedom to speak out if unsafe practice is happening. We also have the CQC. Both patients and staff have the ability to contact the CQC and trigger inspections if they are concerned about practices.

I am hoping that the culture has changed, not just for the process of dealing with clinical negligence but for patient safety and improving the ability of people to raise flags when good practice is not happening.

Q131 **Chair:** Let’s get to the heart of the question. The reason we decided as a Committee to do this inquiry is that we recognise that there has been progress on neonatal death rates, but when it comes to severe brain injury the pattern is not clear. There is not a clear downward trajectory. It is up and down.

As evidence for this inquiry, your Department helpfully provided us with this table. It sets out very clearly that in the latest figures we have, which are for 2018-19, towards the end of that decade, where we have seen the 29% reduction in neonatal deaths, England has a cost per capita for clinical negligence claims of £42, compared with Sweden, which is £5, and New Zealand, which is £19. Last year, it was £2.2 billion in new claims and £8.3 billion in additional liability. Billions and billions of pounds of your budget is being spent on clinical negligence. It is more than the cost of running several of our largest hospitals put together.

On top of that, if we had the same neonatal death rate as Sweden, 1,000 fewer babies would die every year. Cutting to the chase, are you up for fundamental reform to bring down the cost and save babies' lives?

Maria Caulfield: Absolutely. You make the point very well that, while cases are actually falling, the cost is rising. We know it is about 1.5% of the total budget. Bodies like the BMA have come out in the past and said that the money being spent on clinical negligence is taking away from frontline resources. We accept that.

We are up for the challenge. Yesterday, as a small but important step, we wrote to the Committee to show that we are committed to this. We have introduced a fixed recoverable costs scheme, which is going out to consultation. That is for the lower end of the claims; for claims of less than £25,000, we are going to cap the legal costs involved in those claims. The compensation will still stay the same for patients who are claiming. We want to protect that right, so if something has happened, the patient will have the right to go through the process and claim clinical negligence; but by just fixing the legal costs for small-value claims, it is estimated that we will save something like £454 million over the next 10 years. It is an estimated £7 million in the first year.

That is a small change because the majority of the costs are in the larger claims. Maternity in particular is around 10% of the claims but 50% of the costs. We are going to do a wider piece of work. There will be a consultation announced shortly on the wider picture. We want to use some of the evidence that you gain in this inquiry to try to shape that.

Q132 **Chair:** Thank you. We are going to ask you some questions about that fixed recoverable costs announcement, although I have to say that it would have been much more helpful if we had known that at the start of our inquiry rather than in the final week before the final evidence session. We will come to that.

I want to ask you a question about this table. You actually revised the data in the table and resubmitted it. The resubmitted table shows that New Zealand, which has a no-fault scheme, actually ends up spending half the proportion of total healthcare cost that we spend. We spend about 2% of our health spend on this and they spend about 1%. When you considered alternatives to our current system, were you looking at the new data that you just submitted or the old data that turned out to be incorrect?

Maria Caulfield: We are looking at the new data. When we launch a consultation, it will be based on the current data. We are open to all options. One of the concerns I have, if you look at the table, is that even in countries that use similar systems to us right now—Scotland, Canada and Australia, who use a tort-based system—their costs per capita are significantly lower. There is something in our system that means the cost is much higher. Being honest with the Committee, we are not quite sure what those factors are. We are improving safety and that does not seem to be reducing the cost. The compensation levels that patients are getting are pretty even; they are going up a little bit, but not significantly. It is the legal costs that are the significant piece of why they are rising.[1]

Other schemes, like the avoidable harm schemes or no-fault schemes, have significantly more claims. The whole purpose of them is that it makes it easier for people to claim, but they are often capped at a limit. I think the upper limit for a number of the schemes is £1 million, which would be less than some of our patients get. They get full compensation.

I am not against any scheme; we want to look at every single option. The concern that I would have is that until we get to the nub of the problem as to why our cost per capita is so much higher, if we move to an avoidable harm or a no-fault scheme and if those rates of cases went significantly higher, we might end up paying significantly more in clinical negligence and taking even more money away from frontline services. We are really keen to deep dive into this and find the nub of the problem. That is why inquiries such as this are helpful in looking at all the aspects.

Q133 **Chair:** I welcome your honesty in saying that you are not quite sure. That is not always the case with people who give evidence to the Committee. It is also a little bit disturbing for us because we want to make some conclusions. Could you let us know in the next month what your conclusion is as to why those other tort law systems are cheaper?

Maria Caulfield: I am not sure we will get to a conclusion in a month. Helen has done a lot of work on how we can look at the legal costs, but I am not sure we will get to the nub of—

Q134 **Chair:** I am going to have to challenge you because this cost the NHS £2.2 billion last year and £8.7 billion in additional liability. No Select Committee has ever looked at this in the past. We have been doing our inquiry for some time and it is not really acceptable—in fact it is totally unacceptable—for you to tell me that you cannot tell us the answer to this issue in a month. You have an army of officials there. If you are not prepared to tell us in a month, that says to me that you are not addressing the issue with urgency.

Maria Caulfield: As you said yourself, when you were Secretary of State you started looking at this problem. Many people have looked at why the

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[1] Note from witness: a correction letter has been published here

costs are rising. I think it is one of those areas where there is no simple solution. There are a number of factors.

Q135 **Chair:** Very specifically, are you declining to provide us with your—

Maria Caulfield: I am not declining.

Q136 **Chair:** Within a month, will you give us your analysis as to why the costs are so much lower in Wales, Scotland, Canada and Australia? That does not seem to me an unreasonable thing to do.

Maria Caulfield: I can give you an analysis, but I am not sure that it will give you the answers that you are looking for. That is what I am saying.

Q137 **Chair:** We just want to know what your analysis is.

Maria Caulfield: I am very happy to give an analysis; I do not think that is a problem, but if we had an answer as to why our costs were so much higher, we would be implementing the change to address that right now.

Q138 **Chair:** I am going to settle for a month. Thank you, Minister. When you do that table, could you also as part of the analysis add the neonatal death rate and the disability rates for all those countries? I think it is a very important additional factor as to what the safety rates are. This was the other area I want to ask you about. We had very compelling evidence from Dr Pelle Gustafson from the Swedish system and Professor Ushiro from Japan, which also has a no-fault system but just for cerebral palsy. It is the kind of thing that Jill was talking about with her daughter, Kirsty.

They said that a major reason why their safety rates are better is that they have removed the adversarial element from the system. In this country, you only get compensation if a court agrees that there has been clinical negligence. That obviously makes hospitals, doctors, midwives and nurses defensive and makes it much harder to get to the bottom of things because no one wants to be found guilty of clinical negligence. They said that being able to get compensation without having to prove clinical negligence and basing it on avoidability, not blame, was a major reason why they were able to put learning at the heart of what they do. Are you up for those kinds of changes?

Maria Caulfield: We are open to looking at all options and experiences from other countries. What I would say is that some of the other international systems are not without their faults as well. There is a limit, for example, in Japan as to the amount of compensation that can be claimed. It is only for specific maternity cases. It does not cover all aspects. They do not then cover additional costs that may come later in life, whereas our system looks at the whole person.

There is no perfect system out there, but as part of our work and in launching this consultation we will be looking at all aspects. I think the fixed recoverable costs show that we are serious about it. It is not just about reducing the amount we are spending on clinical negligence. It is making that process easier for patients who have been through a terrible time and need to make a claim in the first place. I do think that some of the measures, like the early notification system, are changing that culture. NHS Resolution try, where possible, not to go to court. They try to settle out of court and not necessarily apportion blame.

Taiwo Owatemi: Can there be an ethnicity breakdown in that table, given all the evidence we have received?

Q139 **Chair:** Yes. Can you add any details you have on ethnicity because we have also been troubled by the higher propensity of people from minority ethnic backgrounds to suffer these problems?

With Japan, I totally take your point. It is very hard to compare the schemes. The critical point for Japan, both for former Treasury mandarins like Matthew but also for people at DHSC like you who care about patient safety, is that since they introduced that scheme in 2009 the number of cerebral palsy cases has gone down from 419 to about 300. It has gone down by a quarter, whereas we do not have a discernible drop in the number of severe cases in this country. I hope you can do that.

I want to bring in my colleague, Luke, but I have one final question. When you are considering this, will you also be looking at the impact on staff? Staff find it incredibly traumatic to be thrust into an adversarial system when they have chosen the medical profession because they want to help people. They suddenly find that the thing they want to do most of all, which is to be open and honest about things that have gone wrong, is something they are advised not to do.

Maria Caulfield: I think the culture has changed in the NHS. I do not want to keep going on about the early notification scheme, but part of that process is learning from the situation that has happened. Because they have picked up a number of cases with brain injury, they are running a brain injury reduction programme. They are looking at foetal monitoring and why there have been problems around that.

The whole ethos is really changing into a culture of learning rather than a culture of blame. That is why there is whistleblowing protection for staff. That is why staff are able to contact the CQC if they have concerns. It is so important that we learn why these incidents happen. There is a whole factor of reasons why that is. Staff must feel supported that, when there has been a mistake, they are able to speak out and able to learn from that experience as well. Many staff when you talk to them say, “We were raising these issues for a long time, and it was only a matter of time before something happened.” It is so important that staff feel comfortable. From my own experience, encouraging staff to use things like Datix means that, if there are early warning signs, they are being picked up before mistakes happen.

I cannot speak for every clinical area, but I do feel that the culture is changing and staff are being supported when these incidents happen.

Matthew Style: Chair, perhaps I could pick up your point about staff in particular.

Chair: Please do.

Matthew Style: I have met colleagues from Japan and Sweden to discuss their schemes. I was particularly struck by colleagues from Japan talking about the impact on the standing of the relevant profession and the impact on recruitment and retention rates. It is definitely something that is in our mind, as you suggest.

The other point I want to add in particular, in light of the very powerful evidence from Jill at the start of the hearing, is that, of course, as well as looking at cost and safety data, it is important that we look at patient, carer and family experience of the processes. Helen is the expert on this, of course, but we are looking at that as part of the evaluation of the early notification scheme. I think that is a really critical part of it, as the evidence this morning has made very clear.

Chair: On that, we heard very strong evidence that the current system, notwithstanding the improvements that I personally believe have happened under Helen's watch, fails very badly. Even if you expedite a process, it still takes an average of five years to settle the more difficult claims. For the first two years you have a severely disabled child you get no help at all, and those are the two most critical years.

Thank you for that comment. Let me bring in my colleague, Dr Luke Evans.

Q140 **Dr Evans:** Thank you, Chair. Minister, I am keen to dive into the staff side a little bit further. What would you say to the accusation that NHS staff work in a culture of fear in the NHS?

Maria Caulfield: As I said previously, I cannot speak for every institution but I feel that things have changed, certainly in the last 10 years. We have introduced protection for whistleblowers. There are freedom to speak up guardians in all trusts, supported by a national guardian. They are there so that if staff feel that there are incidents or they have been involved in an incident, they have the protection to speak up. It is a very difficult situation when a case is being investigated. It is stressful, even when it is really well handled, for staff too.

Q141 **Dr Evans:** I am not going to go into the details, but the Dr Bawa-Garba case is renowned among the medical profession as proving the difficulties. It was a horrific incident that happened with system-based problems. It feels like it lands on the responsibility of the clinician. In the context of what we are talking about, it is part of the problem. We know there are protections, but you even said it yourself; people say that there has been a problem with the system for a long time and it has finally been picked up.

How do we change that? You will know from your clinical career, as do I, that many of our colleagues feel that they are practising defensive medicine. No matter, even if they speak out, that it is because they are asked to cover a shift late after having stayed on, or suddenly the SHO is off the ward because they are sick and they have to pick up another ward. The clinician individually has a really tough decision. What do they do? Do they say, "No, I am only safe to cover one ward," and therefore not go into work, or do they take that on, but knowing they have the additional risk of filling in a system that is likely to lead to potential safety implications? How do you justify that? How do you break that down?

Maria Caulfield: Staff should be being encouraged in clinical areas that if there are staffing issues, whether it is the number of staff on duty or them being asked to do an extra shift or sent to a clinical area that they do not usually work in, which often raises concerns among staff, there is what is called the Datix system in many trusts. Some trusts have different systems to flag areas of concern, and staff are encouraged to do so because that is how we see a pattern of behaviour. Managers are able to pick up that there is a regular shortage of staff or that staff are being asked to work longer hours or in different clinical settings from where they are used to, and that should be discussed and measures put in place to try to stop it.

When I was first in clinical practice, if you did an incident report something had happened. Today, staff are being encouraged to report things before they happen but that may increase risk factors. I think the culture has changed.

Q142 **Dr Evans:** From your experience of Datix, which is great for flagging up, did you get any feedback when you submitted a Datix?

Maria Caulfield: Yes, you should. All staff should. It should go to the next line manager. There is a whole tiered approach to its getting reported. What should happen, and certainly happens in the clinical areas I have worked in, is that as an individual who has reported a Datix you should get feedback. Collectively, if there have been incidents that have happened, there should be an update every month about reports that have been made and lessons that can be learned, and then teaching from it.

Q143 **Dr Evans:** The argument from the Government is that the system has changed. The perception may not have got through though. On that basis, what role do the GMC, the Nursing and Midwifery Council and all those groups have to play? There is a feeling and perception out there that you are simply paying your money to be policed, and that as soon as you step out, you are going to get clobbered because you got it wrong. That is the broad feeling that people work under. How do we address that? It sounds like the Government are saying that the system is there; yet there is a perception that it is not and perception is reality.

Maria Caulfield: Again, I cannot speak for all trusts in all clinical settings. That is what should happen and in my own clinical practice is what has happened. For regulators like the NMC—to declare an interest I am registered with the NMC—there is very much a culture of learning from incidents raised. If they are investigating someone who is on the register for whatever incident, it is not a nice process to go through but it is very much a culture of, "What happened, why has it happened and how can we learn from it?"

I am very much aware of the strain that an investigation puts on clinical staff and the whole clinical unit. If something has happened, whether they were on duty or not, it really affects staff morale.

Q144 **Dr Evans:** That is really helpful. In the Swedish evidence that we heard, one of the biggest things that the witness found comfort in was that he was able to say, "I have made a mistake," and the state would step in and recompense. He still has to live with that, but he said it was a comfort. We do not have that as clinicians in this country.

Helen, perhaps you might be best placed to speak on that. It seemed to change the culture and the dynamic between the clinician and the patient because there is an offering that you can give. What do you see from the NHS, and what can we learn from that point of view?

Helen Vernon: Thank you, and thank you, Chair, for the invitation to give evidence.

There is a lot to learn from other jurisdictions. The Swedish example is a good one of how a non-adversarial process can prompt reporting. In our system, the claim comes very much at the end of a series of other processes. It is incredibly important, however, that clinicians are encouraged and supported to report incidents, not with an eye to an eventual claim but in order that those incidents can be brought together by NHS England and Improvement for learning purposes nationally, irrespective of the compensation process. That is something we very much try to encourage right at the front end, even though we are not involved at that time because the claim has not happened. We are very much aware of the fact that clinicians may feel that they cannot report because there may be the prospect of a subsequent claim.

We have tried to dispel that. We have a leaflet called "Saying Sorry", which is very clear that reporting an incident from the off and saying sorry and providing an explanation is absolutely the right thing to do. It is more likely to prevent a claim further down the line, because it is a well-handled incident, than it is to cause one.

The other thing we have worked on, together with our NHS trust partners, is a document called "Being Fair" and what is called a just and learning culture charter. It ensures that clinicians are actively supported through the process as a positive thing, again without regard to any subsequent compensation claim that might arise.

Q145 **Dr Evans:** Given what you have said—that you are encouraging people to say sorry—and given that we have acknowledged there is a fear, do you think we are under-reporting the incidents coming in and, if so, by how much?

Helen Vernon: I am probably not the best person to comment on that. The incident reporting does not come to us. Where we have incident reporting is in relation to neonatal brain damage. We hear about those cases through the early notification scheme, which was alluded to earlier. We actually measure the strength of the reporting against the criteria that we set for that scheme by reference to external databases. There is a neonatal database held by Imperial, for example. That ensures that all of those incidents are actually coming in to us and to HSIB as well. We have included that as an action in our maternity incentive scheme, so that if trusts are not reporting those cases as they should be, there is a financial penalty for not doing so. That is only in relation to those particular types of incident. For the remainder, the reporting process is very much managed by NHS England and Improvement.

Q146 **Dr Evans:** That is a fair point, but it is interesting that you have chosen to say that people need to say sorry and people need to get in because of that implication. It suggests that people do not know that in the service—the frontline clinicians—because the other argument could be, "Don't come to us. There are too many claims coming in; we've got too many problems." I appreciate that as an organisation you are at arm's length from the NHS, but the perception is that we need to do more to educate our staff about what the process is, and patients as well. Is that a fair assessment? Is that what you are getting at?

Helen Vernon: I would agree with that because new generations of clinicians are coming through all the time. It is important that they do not end up with the same misconceptions about indemnity that cause all of these problems in the first place. There is a lot of work to do with clinicians in training to make sure that they are aware of how the indemnity works. It is not like motor insurance, for example, where you should not admit fault when you crash into somebody else. It is quite the opposite. We want healthcare staff to be open and transparent right from the off.

Q147 **Barbara Keeley:** I have some questions first for Helen Vernon about legal aid and no win, no fee. Of the cases you receive, how many are funded by legal aid and how many by no win, no fee agreements?

Helen Vernon: The vast majority of cases are run now on no win, no fee arrangements. That has not always been the case. I was terribly saddened to hear of Jill and Kirsty's experience, by the way; no family should have to struggle like that to get compensation. Possibly in 1983, when Kirsty was born, there may have been legal aid funding for that case. It was certainly more prevalent for those sorts of cases. Nowadays, ever since the reforms in 2017, the vast majority of cases, even for cerebral palsy, are run on a no win, no fee basis. Very small numbers, probably less than 100 or so, would now be on legal aid. I could give the Committee the exact figures in a subsequent note, if that would help.

Q148 **Barbara Keeley:** Including birth injuries, do you know and can you tell us how many birth injury cases are funded by legal aid and how many by no win, no fee?

Helen Vernon: I would be very happy to come back to the Committee with the exact numbers. There has been a shift. Prior to the 2017 reforms, large numbers of birth injury cases were still funded by legal aid. After that, due to the shift in funding arrangements that those reforms introduced, large numbers moved across to no win, no fee arrangements. That is very much the norm now.

Chair: On that point, when you get back to us with the famous table, it would be really helpful if you could put the proportion of spend you estimate is used on legal fees across those different countries. Even if we spend the same proportion as New Zealand, if in fact a third of our fees are going to lawyers, whereas in New Zealand's case 99% is going to families, that is also important data.

Lucy Allan: Can I come in quickly on no win, fee?

Chair: We'll let Barbara finish her question.

Q149 **Barbara Keeley:** Let me finish my question, if I may. I am just trying to get to the bottom of this. If you can let us have the information, that would be useful. Is it your take that there are cases brought on a no win, no fee basis that could be brought on a legal aid basis?

Helen Vernon: Yes. I think that is very much for the individual lawyer to advise their client on, based upon their particular circumstances. We are obviously not privy to the advice in those cases. We have, in fact, challenged the shift from legal aid to no win, no fee on cases that moved the funding basis just on the cusp of the reforms coming into place. We have a case in the Court of Appeal where we raised that challenge.

The lawyer acting for the family will advise them on the various funding arrangements available to them in the best interests of the family and the child.

Q150 **Lucy Allan:** Has no win, no fee driven up costs?

Helen Vernon: It is well described in the National Audit Office report of 2017 that no win, no fee and the shift in funding arrangements has certainly had an impact on the legal market, and therefore on the volume of cases brought. In terms of the costs, though—

Q151 **Chair:** Has it increased them or decreased them?

Helen Vernon: It drove an increase specifically when the arrangements changed, because a large number of cases were brought on the old-style funding arrangements in advance of the reforms coming into place.

Q152 **Barbara Keeley:** I think you said the number of cases increased. My colleague was asking about whether the costs had increased. Have both increased?

Helen Vernon: The increasing costs are very much derived from damages inflation, primarily, particularly at the higher end for very severe brain injuries for children, which carry—

Q153 **Lucy Allan:** The legal costs are what I meant. If you have a no win, no fee, are you going to end up paying more legal costs than if we had had better access to justice through legal aid?

Helen Vernon: I do not have the analysis that would demonstrate that. I think it would probably need a more thorough impact analysis than I am able to provide here. What I can say—

Q154 **Barbara Keeley:** I think we need that though. I very much think we need that.

Chair: Let's request it, if we could.

Helen Vernon: I can certainly provide some numbers on the split between legal aid and no win, no fee, and the costs that apply to both of those. I do not think that I would be the right person to comment on the extent to which they would be driven—

Q155 **Chair:** Who would have those numbers? Very simply, we are trying to understand whether the move to no win, no fee has driven an increase in the legal costs we pay.

Barbara Keeley: Or is it just the numbers? You mentioned an increase.

Chair: The numbers and the cost per case. Who could give us that information?

Helen Vernon: I think the Ministry of Justice would have some information on how the legal market has responded. There are obviously costs on both sides of the fence.

Q156 **Chair:** Let's ask the Ministry, and if you could help us on that, we would really appreciate it. It is useful for you to know as well.

Maria Caulfield: That was part of my response when you asked me to respond in a month. It is that sort of detail that we are trying to work through at the moment. There is a range of factors that are increasing the legal costs, which I think are the main driver of overall costs.[2] We need to get to the nub of that. I am very happy to respond within a month, but they are the sorts of deep dives that we need to be doing.

Q157 **Barbara Keeley:** Minister, as the Chair mentioned, the Department has issued a consultation on fixed recoverable costs in lower value clinical negligence claims. I have to join the Chair in saying that comes very late in our inquiry. It is very difficult for us. It clearly would have been better for us if we had heard that earlier.

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[2] Note from witness: a correction letter has been published here

You mentioned that the Department thinks the scheme would save £454 million. I understand that the Society of Clinical Injury Lawyers has worked with NHS Resolution to develop a collaborative approach to reducing costs. Clearly, we all want to see costs reduced, but how has that collaborative approach worked, Minister? Has it led to clinical negligence claims falling for a couple of years, as I understand it has?

Maria Caulfield: There is collaborative work. Certainly on the fixed recoverable costs, we are working with the Ministry of Justice and obviously the Treasury team as well. There is recognition that reform and change are needed. The work on fixed recoverable costs has been going on. Consultation started back in 2017, so this has not happened overnight. It is important because we want to show a direction of travel. We have started the consultation. It ends in April and there is likely to be a statutory instrument required to make the changes that are there. Even though we announce things, they still take time to put in place.

Q158 **Barbara Keeley:** I understand, but what we are saying here in this Committee is that, if you had this on the stocks and you knew it was going to be announced and was being worked on, we ought to have heard about it sooner.

Let’s leave that. The point I am concerned about in the FRC scheme is access to justice and access to litigation. Taking it outside clinical negligence claims and more generally, what we have seen as Members of Parliament is a real erosion in access to justice for our constituents through lack of legal aid. I note from the evidence that we have had presented to us that claimant representatives—people who represent the people who have been damaged—express strong opposition to fixing recoverable costs in clinical negligence litigation.

They believe it is unsuitable because of the complexity and variability of the subject matter. They think, and we have had a number of organisations say this, that it will erode the fundamental right of access to justice. It will drive down the public’s ability to access justice. That would be my concern about the scheme. I think we can all agree about the need to reduce costs.

You touched on the 2017 National Audit Office report. That found that current proposals to reduce costs will not be sufficient to curtail the rising clinical negligence bill. What impact do you think the fixed recoverable costs scheme would have, taking into account not just saving money, which of course this whole picture represents, but on access to justice?

Maria Caulfield: Absolutely. Following the 2017 public consultation on the fixed recoverable costs, there has been considerable consultation and work with a variety of stakeholders to get to the point where we are today. The fixed recoverable costs scheme has a number of issues.

First, we know from the lower value claims it would cover that the legal costs are often double the compensation that patients get. Can it be a fair use of taxpayers’ money to justify that?

The second point is that the fixed recoverable costs scheme is not just about saving money, although that will be a key aim of it. It is about making the process faster, quicker and fairer for patients, so that they are able to reach a settlement as quickly and easily as possible. That will obviously help patients who are going through quite a tough time anyway. That is why they are seeking compensation. It is not just about saving money, although our point is that it should not be right that lawyers are getting double what their clients get in compensation. It is also about making the process faster, more efficient and easier for patients.

Q159 **Barbara Keeley:** I have two more questions. Will the fixed recoverable cost proposals guarantee that there will not be cases where the legal costs are greater than the damages paid to the claimant, as you have talked about? Will there be a guarantee?

What we are concerned about on this Committee is to make sure that a good proportion of the money is paid out in damages. That is what should happen.

Maria Caulfield: Absolutely. Until we have done the consultation and looked through it, I cannot give you a guarantee. The aim of the scheme is to reduce the legal costs, to cap the legal costs. The fees will be capped. The award of damages is not necessarily in our hands. Helen could clarify that for me. That is the aim, but from my point of view I do not think we can guarantee that legal fees will not be higher. The whole point of the scheme is that we are trying to tackle the fact that now they are often double what patients are getting.

Helen Vernon: The arrangement that the solicitor reaches with their own client is not something that can necessarily be changed by a fixed recoverable costs regime. What the FRC regime can do is fix the cost that the defendant has to pay to a successful claimant. The two do not interact in quite that way.

Barbara Keeley: I see. I come back to the point, though, that there is still the fear that these proposals, and I have concerns about access to justice and access to litigation, will not be sufficient to curtail the rise in clinical negligence bills. We are still in the position, Chair, where we need to examine this. You said that we might look at it further.

Q160 **Chair:** I want to clarify it, because I am confused now. Is the fixed recoverable costs proposal fixing the legal costs or the compensation payable to people who have suffered loss?

Maria Caulfield: The legal costs. The compensation is not affected. It is just the legal costs.

Q161 **Barbara Keeley:** Can I have some clarification on the questions that I was asking? Does that mean there will be cases where, as with every other area that used to be covered by legal aid, it will not be possible for people to make a claim because they will not get coverage for it? What behaviour do you expect to follow from that?

Maria Caulfield: This is standard practice in many other claims. Fixed recoverable costs are not a new thing. In most injury claims and personal legal claims it is in place already. This is one of the last areas.

Q162 **Barbara Keeley:** I think we understand that. What I am saying is, what behavioural change will there be? Do you expect the impact of it will be that lawyers will just turn round and say, "This is complex"?

Maria Caulfield: Where it is in place in other sectors. it has not affected people's ability to seek legal representation.

Barbara Keeley: I do not believe that is the case, actually, because constituents find it very hard to get legal aid.

Chair: Thank you.

Q163 **Lucy Allan:** I want to move on and talk about settlement and negotiation. Perhaps I could start with Helen. There has been progress in the number of cases being settled out of court. What more can be done and what further progress can we see around the corner on settling out of court without having to engage in legal proceedings?

Helen Vernon: That is a really good question. As you mention, we have pushed hard to increase the number of cases that are resolved out of court using things like mediation as well as other forms of dispute resolution to achieve that. We currently settle 74% of cases without going anywhere near court, which is more than ever before; only 0.3% go to trial.

We want to go further, though. We think that cases should only go to court deliberately when it is absolutely necessary for that to happen. Some of the work we have been doing with the claimant legal market to work more collaboratively to explore more innovative ways of dispute resolution has been bearing fruit, particularly during Covid when we moved to things like remote mediation.

An important step that we think collaboration has particularly been able to target is what we call a more upstream approach to cases that are likely to become claims. Historically, we received cases over three years after the incident—on average, about 3.1 years. Generally, they had been tipped into legal proceedings because they were up against a limitation period of three years. What we have agreed with the claimant legal market during the pandemic is that they should come to us first to seek an extension of limitation so that they do not have to issue court proceedings from the off and so that we have the opportunity to discuss the case and potentially settlement for their client.

Q164 **Lucy Allan:** What happens when there is clear evidence of avoidable harm and system failure, and then you have the issue of clinical negligence? If we have identified the avoidable harm, is it not possible at that stage to say, "Right, let's reach a settlement and let's give you what you would get if you went to court," rather than having to force people to demonstrate clinical negligence through a court process? Is that the thrust of what you are trying to do?

Helen Vernon: First of all, we certainly do not want to force things into a court process. Quite the opposite. We want to keep them out of court because it is stressful and expensive for everybody.

Q165 **Lucy Allan:** Patients are not really concerned about demonstrating negligence. If there is evidence of avoidable harm and there has been clear systems failure, and those have all been identified and agreed, at that point settlement must be what both parties desire. I cannot imagine that anyone, even in an extreme case, has a profound need to demonstrate that clinicians were negligent. What is forcing those cases to go on to court?

Helen Vernon: It is important to be clear that we work within a negligence system. That is the law. That is the legal framework within which we have to operate and settle claims. That is how our regulations for operating the indemnity schemes are established as well.

We can only make a payment where we are satisfied that there is a case of negligence, as opposed to an avoidable harm threshold, which is the threshold used in some of the other jurisdictions that gave evidence to this inquiry. Having said that, we try to get to the right answer as quickly as we possibly can. We ensure that, where there is clear evidence of negligence from an investigation or a complaint process, we move straight to making that admission and then starting to discuss compensation with the family and their representatives.

Q166 **Lucy Allan:** Which then requires the clinician to have to defend their reputation and their potential future in their profession.

Helen Vernon: Not always. Because our indemnity is organisation based, we cover the NHS trust rather than the individual clinician, at least in so far as trusts are concerned; it is the organisation that is at the centre of the process rather than the individual. In fact, it is quite rare for us to get cases that are just focused on one person, one healthcare professional, as opposed to the full panoply of things that happened during the patient's care that might have led to their injury.

Q167 **Lucy Allan:** If a case like Jill's were to happen today, what would happen in terms of mediation and making sure that took place at an early stage before the parties became very entrenched in their own particular position? What would happen in Jill's case today to get the mediation going?

Helen Vernon: What is interesting about Jill and Kirsty's case, and what really struck me, is that at the start they really struggled to get any answers. They struggled to get representation. I heard from Jill that she was probably on her third set of lawyers before the claim actually got going.

Nowadays that is a case which is, more likely than not, suitable for our early notification scheme. First of all, you would have HSIB conducting an investigation into the incident. We would then very rapidly overlay a liability investigation on that case to try to ensure that, if there is a compensation entitlement for Kirsty, we can at the very least start to think about making some interim payments of damages to help with the immediate needs that are really important to families, prior to working through with the family what their long-term requirements might be in relation to Kirsty's care.

Q168 **Lucy Allan:** Is there any merit, in your view, in making mediation and ADR compulsory before the litigation process commences?

Helen Vernon: Mediation is best carried out on a voluntary basis because of its nature. It is a consensual thing, bringing the parties together with a genuine intent to resolve the issues in question rather than being something where people just tick a box and it has been done.

Mediation is not the only form of dispute resolution. We try all sorts of different ways of trying to keep cases out of court, like roundtable meetings, resolution summits and early neutral evaluation. Some of those things are mentioned in the fixed recoverable costs consultation as good practice for the future. We should absolutely try every method at our disposal to reach a resolution without it having to go into court proceedings.

Q169 **Lucy Allan:** Minister, we have discussed this already, but I want to press you a little bit further. Are you reluctant to consider alternatives to litigation? If that is the case, why is that?

Maria Caulfield: We are happy to look at all options. In the work that we have done around improving patient safety, our absolute priority is reducing the number of incidents that are happening in the first place. We are making progress. I highlighted the improvements around maternity, but there is a lot more to do. Outside that, we are seeing reductions in things like hip fractures and falls in healthcare settings and reductions in infections in hospitals. We are trying to improve patient safety as the absolute priority.

Q170 **Lucy Allan:** The question is around litigation and trying to move away from litigation and consider alternatives to litigation, as we see in other countries. I sense a reluctance to consider a whole different model. I was just wondering whether that is the case and, if so, what is the thinking behind it. Why are we wedded to litigation as the best means?

Maria Caulfield: We have shown with NHS Resolution that, where we can settle things without going to court, that is where we want to be. The figures speak for themselves. The majority of cases are now resolved without going to court, which makes it easier for families and staff as well. It is becoming a learning process. It is not necessarily always an adversarial stand-off, but there will be some cases.

I have constituents who have had clinical negligence claims where they do not necessarily want the compensation. They want their day in court. They want to hear exactly what happened. There will be cases like that, where people feel that they want to go down that road. I do not think we can exclude it forever. For everyone, often the easiest, quickest and most sensitive way is to avoid that where we can.

Q171 **Lucy Allan:** The Ockenden review is just about to report, next month. Certainly, in my experience of talking to some of the people who have been affected, what they really want is not so much their day in court but some sense of acknowledgment, recognition and apology at an early stage. They feel that the only way to achieve that is by going to court.

You are right that it is not about compensation. It is much more about recognition of what they have been through and what they have suffered. It is a great shame that we cannot achieve that other than via litigation. I would love you to take away the idea that we might look at alternatives to litigation very seriously because, certainly in my experience as a constituency MP dealing with many cases like we heard this morning, recognition, acknowledgment and apology, in the sense of responsibility and ownership by the trust, would have solved so many long, drawn-out legal cases.

Maria Caulfield: Yes. I know that you have campaigned very hard on the issues for your constituents around Ockenden. I think the evidence is there. When you look at research that has been done in this area, the way a complaint is handled at the initial stages makes a huge difference. It is acknowledging that there is a problem, which is why we now have the duty of candour, and being open with those who have been affected, and sharing. We heard from Jill that she could not even get the patient notes to find out what had happened.

We are very aware of the difference that makes. That is what we want to encourage, because it is working. Where we are able to settle these things out of court and not go down that long and protracted route, it is in everyone’s interests. With fixed recoverable costs, certainly in the smaller claims, being open and honest, acknowledging mistakes and saying sorry for them actually makes a difference in terms of reducing costs, and is a better process for patients. We are not excluding it in any way, but we need to look at the options on the table before we make any final decisions.

Q172 **Lucy Allan:** Matthew, do you want to come in on that?

Matthew Style: If I may, perhaps I could draw out two points from the responses to the questions that you have been asking. The first is, of course, to say that the early notification scheme, and indeed the special health authority which we are establishing to have dedicated capacity for rapid investigation of maternity related incidents, should, hopefully, help with the point you are making about recognition and rapid investigation being important.

The other point, which again resonated with me from the international evidence and from speaking to colleagues from other countries and indeed from Jill’s story this morning, is that the point at which a payment is made is also important. Chair, you mentioned yourself the importance of the early years following an incident and the importance of families receiving support at that time. That is another thing we have to look at, even within the current system and the current statutory framework. What we can do to improve the timeliness of claims, the earlier recognition of an incident and overall the patient, family and carer experience is an important part of the work we are doing, as I said earlier.

Q173 **Laura Trott:** All three of you mentioned the early notification scheme. I want to go into a bit more detail about how you think that is working. Helen, can I turn to you first?

Helen Vernon: We have been running it for coming up to five years. The incidents we have seen through that scheme are cases we would never normally have seen. We would normally hear about them seven or eight years after the event. It is giving us the opportunity to engage with the family right from the start and to ensure that we are picking up on the issues that are driving those sorts of claims with the trust as well, and engaging with the heads of midwifery, for example, on things which might need to happen in order to prevent those incidents from happening again.

It is very much learning from those incidents in real time, as well as having the opportunity to think about issues of legal liability and, as I mentioned earlier, the small interim payments that might support the family in the early years. That also has the effect of mitigating costs further on, because if we are meeting needs in real time, they will not translate into much larger losses further down the line.

Q174 **Laura Trott:** Have you seen any evidence that there has been a reduction in these types of injuries in babies since the scheme was introduced?

Helen Vernon: I think it is early days at the moment because—

Q175 **Laura Trott:** It is five years, isn’t it?

Helen Vernon: It is almost five years, but by definition these are incidents we would not normally have seen, so we have no direct comparator.

Q176 **Laura Trott:** Isn’t it extraordinary that you would not have seen them for seven or eight years? These are really serious failings, and some of the most serious failings that the health service can overcome. I find it very surprising that normally you would not see them for seven to eight years afterwards. Is that true of all serious failings within the hospital system?

Helen Vernon: It is true of the brain injury cases and has historically been the case. It is not now the case, since the scheme. Generally, it is because the needs of the child take some time to fully manifest themselves, until six to seven years afterwards. Even though a solicitor might have been involved for the family much earlier, when it comes to NHS Resolution, historically it has been much further down the line.

Q177 **Laura Trott:** I understand the point. From the figures I have here, you receive approximately 230 cases annually. Surely, if the scheme was successful, we would see a reduction in those numbers. Would that not be fair to say? It has been going five years, which is not an insignificant amount of time.

Helen Vernon: Those numbers are claims which relate to historical incidents. If a claim comes through the door now, it might actually relate to an incident in 1995, for example. Those numbers relate to incidents spread over a number of years.

Q178 **Laura Trott:** How many are you now getting through the early notification system that you have put in place? What have the numbers been like over the last five years?

Helen Vernon: We have changed the criteria over subsequent years to try to narrow the entry gate into the scheme. We started off with a very wide cohort. We were getting 700 to 800 incidents, as was HSIB. We have now narrowed that down, in the most recent year, to cases where there is evidence of a neonatal brain injury. Those are more in the hundreds now.

Q179 **Laura Trott:** Why did you narrow the criteria?

Helen Vernon: Because we were finding that while we were capturing a wide cohort, the scheme lacked specificity in terms of the type of case that was likely to have negligent harm resulting in a long-term brain injury.

Matthew Style: I think it is right to say, Helen, that we have an evaluation of the scheme under way. That will be an important piece of evidence in assessing whether the scheme is having the intended benefits that we will take into account as part of considering what a wider set of reforms might be. As I said earlier, part of that evaluation will look at patient experience. Picking up the questions that Dr Evans was asking earlier, it is important that we look at clinician experience of interacting with the scheme, given the very important points that the Committee has raised today.

Q180 **Laura Trott:** The thing I am slightly concerned about is that if we are saying that previously we would not have known about issues for seven to eight years, and now we have a system whereby we are having 700 or

800 serious failings being notified which previously, according to the evidence you have just given, the health service at the top level would not have been aware of, where are the extra 600 now going? What is going to happen to them? How can we be sure that they are followed up and seriously looked into? What is the system going to be for those schemes if they are not being picked up by this central hub now?

Helen Vernon: There are a couple of points. The first is that the 700 cohort were not necessarily serious failings. They fulfilled clinical criteria set by the Royal College of Obstetricians and Gynaecologists, but the 700 are not indicative necessarily of failings in the system.

Q181 **Laura Trott:** But something pretty awful must have happened for them to be—

Helen Vernon: It is a baby that had been unexpectedly admitted to the neonatal unit, so clearly the family have had a really terrible course, but not necessarily as a result of failings by the maternity unit. That is the first thing.

The second thing is of course that the new special health authority that will be looking at these incidents, and taking over the responsibilities of HSIB in that regard, will be looking at all of those cases as well, and not just from a legal liability—

Q182 **Laura Trott:** The whole 700 cases and not just the narrow criteria? All of the cases where there has been an incident where a baby has been unexpectedly injured, or died or admitted having serious trauma?

Helen Vernon: I am probably not the best person to speak to the criteria.

Matthew Style: Its remit will not be limited just to early notification scheme cases, no. The focus will be to investigate the cases where there is the greatest potential for learning across the system. We very much hope that will be the ethos and the purpose of the function that is being established.

Q183 **Laura Trott:** It will be the narrower piece or definition that we are talking about here.

Matthew Style: The remit will not be limited by that particular definition. I think the focus and the principal purpose is not only to get rapid resolution and rapid investigation for families, patients and carers but, as I say, to maximise the learning opportunities. It is an independent body. That is quite important because there will be freedom to select cases, as I say, where the benefits of the work are greatest.

Q184 **Laura Trott:** In a quote I have here from the NHS, it says, "The early notification approach has already led to rapid learning and recommendations for safety improvement."

Minister, can you talk a little bit about how that has worked and what you have seen? We have said it is too early to understand whether it has an impact on baby deaths and serious brain injuries, but what rapid learnings have been put in place as a result of this system?

Maria Caulfield: Obviously, the early notification system picks up on cases but then it takes a while to identify clusters of incidents that would indicate a pattern of cases that need to be looked at in terms of practice across the board.

As part of the early notification scheme there are a number of areas that they have picked up and are doing intensive work on. Brain injury reduction is one of those that they are looking at. They are also looking at the use of foetal monitoring and making sure that best practice is looked at there. There is enhancing neonatal care as well. Those are some of the areas where, as a result of their work, they have identified pieces of work that then need to be taken further.

Maternity also comes under me. We know that, while we are doing well or improving on neonatal deaths and stillbirths, there is still a huge amount of work to do. That is why we set up the maternity disparities taskforce, which will be meeting shortly. We are again going to deep dive into the areas of concern. The early notification scheme helps identify the areas that we then need to drill down on.

In maternity in particular, there will be a real focus on how we can improve outcomes. Learning from clinical negligence claims is one of those areas. The special health authority, as we are in the process of setting that up, will look at the scope of that as it goes forward. We are not necessarily limited to specific criteria at the moment.

Matthew Style: Another important objective for the maternity investigation programme and for the SHA will be to improve the capacity of local trusts to investigate in a way that is responsive to patient concern, and is faster and more effective. It is right that there is an independent capacity, but it is also right that we work to improve across the board and improve the experience at local level.

Q185 **Laura Trott:** As a final point, we did a maternity safety inquiry as part of this Committee. One of the things that you will know is that the same mistakes seem to be repeated over and over again in different trusts. The central oversight of what is going on and ensuring that that is not happening is really important. While I absolutely take your point, Matthew, about individual trusts, the problem is that this is being replicated over and over again. It would be helpful, Minister, to have your assurance that the focus of what you are trying to do will be to make sure that the pattern stops repeating itself.

Maria Caulfield: With the early notification scheme, it obviously takes time to see a pattern of cases where there is clear concern that it is not just happening in one trust and that there is an issue. The whole aim of it is that there is not just learning in that trust, but that that best practice is then shared across the board.

Laura Trott: Thank you.

Q186 **Chair:** I want to follow on from Laura's point, if I may. What we found in our maternity safety inquiry was that, for sure, progress has been made and we all welcome that, but there is a structural problem which causes what Laura was talking about, namely the fact that the same mistakes seem to be cropping up over and over again with absolutely horrific consequences for families.

What seems to happen now is that, despite all the determination to improve patient safety and maternity safety, when something awful happens there is a kind of "Oh my God" moment of stasis, where everyone freezes and doctors and nurses worry about whether they are going to be hauled in front of the GMC or NMC, the trust is worried about its CQC rating and everyone is collectively worrying about lawyers and clinical negligence. It is not because they are personally going to have to pay because there are schemes that mean the NHS pays centrally, but because they might have to be found guilty of clinical negligence before a payment is made and there is the thought that it is going to last five years.

The one thing that does not happen is that lessons are learnt, because there is a kind of limbo period that can last years. In well-run hospitals they have shortened that process and there are definitely improvements. My last question is very straightforward. Would you consider a very radical process improvement, building on the early notification scheme, where we had something like an obligation on every hospital to have a six-month safety window, for want of a better phrase? The moment something terrible happens there is a six-month window in which there are two very straightforward objectives: No. 1, the family involved is told the absolute truth of what happened; and, No. 2, safety lessons are learnt, not just for that trust but for the whole of the NHS.

Within that safety window there would be four things. First would be the early notification scheme, but not just for brain injury; it would be for every incident, whether babies, adults or anyone, where there is a reasonable prospect that a medical error was made.

Secondly, there would be an independent investigation as to what happened to get to the bottom of it.

Thirdly, safety lessons would be learnt and disseminated to the whole of the NHS.

Fourthly, there would be a trust apology and decision as to whether they are going to accept liability, with an agreement that that needs to happen within six months. The problem at the moment is that there is this period of limbo. I am not trying to make policy on the hoof, but are you open to making those kinds of changes as we go forward?

Maria Caulfield: The consultation that will be coming forward is to look at the wider picture of clinical negligence and not just the cost element. Much of what you have described is part of the process of clinical negligence. I think we will look at all of those options when the consultation opens. It is not just about how much people get paid in compensation. It is not how much we spend on legal fees. It is about the whole process and making it work for patients.

We have some really good progress in maternity. While we need to get that rolled out in practice, I think we could look at some of the good work that has been done there for other areas of clinical negligence as well. The wider scope of changes to clinical negligence will be covered in the consultation.

Q187 **Chair:** But you are open to process reform.

Maria Caulfield: Certainly we are open to looking at all options because it is important that we improve the process for patients, and for staff as well. It is a tough time for staff when they go through any investigation. We need to make that open and honest for everyone involved.

Q188 **Chair:** Matthew?

Matthew Style: If I may, Chair, I want to pick up on the cultural piece in your question. I think all the work that has been done points to this. There is a big leadership question in trusts about how these cases are handled. We have put £500,000 out to support leadership training, specifically in maternity services, in order to try to support leaders in tackling some of the cultural issues that sometimes stand in the way of learning and rapid resolution.

It is broader than that, and it gets into the work that we have commissioned from General Sir Gordon Messenger on leadership more generally across the NHS. I think that consistently better leadership would be an enabler of some of the changes that the Committee is keen to see.

Q189 **Chair:** Sarah Owen, who has left us, wanted to confirm that, in this famous piece of work you are going to be doing before the end of February, you will include neonatal death rates by ethnicity, in so far as we have that data, because that is a particular interest of hers.

Lucy Allan: And socioeconomic background as well. It is the whole education, poverty, age—

Chair: Absolutely. Let’s throw that in. The breakdown of neonatal deaths would be of great interest to the Committee.

Matthew Style: A lot of work has been done on the health disparities angle to that question as part of the broader, long-term plan goals on maternity safety. I am sure we can include that in some supplementary evidence.

Chair: Thank you. Last but not least, Dean.

Q190 **Dean Russell:** Thank you, Chair. In my question I want to build very briefly on the maternity discussion. I have had conversations with constituents and women who have had very difficult situations with miscarriages and stillbirths. One of the things that comes out of that is that sometimes there is concern about negligence and the issues we have talked about today, but at other times they are not quite sure. One of the things that really came through was the lack of mental health support that they had afterwards.

When looking at policies and so on, how much beyond the financial aspects of litigation and the learnings, which are absolutely critical, has mental health support been looked at and a better process to help people deal with what can be incredibly traumatic life experiences? Is that something that will be in the future?

Maria Caulfield: Certainly when there has been a bereavement—a stillbirth or a neonatal death—we now have bereavement midwives who specialise in looking after mums and parents going through that process, either if they know that a bereavement is likely to happen or if something happens unexpectedly. They spend a lot of time at the time of a stillbirth or a neonatal death, but then a considerable period afterwards, but we do not have enough of them.

I have been to King's College to meet the team there. They do amazing work. They say to me that having a specialist midwife—midwives are very specialist anyway—who can look after the family as a whole at such a difficult time, whether that has happened from natural causes or there has been a clinical negligence incident, does make a difference. I am very keen to look at how we can support midwives. They are very keen to take on some of this extra training and role, and I am very keen to look at how we can support them in doing that.

Q191 **Dean Russell:** That is very good to hear. Matthew?

Matthew Style: We were discussing earlier that, as well as looking at cost, outcome and safety data, we need to consider the patient, family and carer experience. That is one of the key things we have to have in our mind when we look at different options for reform. I very much agree with the point you were raising.

Q192 **Dean Russell:** Absolutely. One of the things that also comes through is, as you just pointed out, the support given to families. When somebody goes through an awful crisis like this, or a life-changing moment, it is often the families that they look to for support. Again, I do not know how much we are equipping families with the right information to know how to support them, or where to go for support from bereavement midwives.

I appreciate that you might not have the numbers right now, but is there a way we could get an update on how many bereavement midwives there are across the NHS currently, and what the plans might be in terms of projecting for training for that?

Maria Caulfield: I could certainly send the Committee the figures. They have grown up historically. Some units have them because they have midwives who wanted to take on the training, and the units have been very keen to support them in developing that role. Some units do not have access to them at all. We can get you the figures, but more work needs to be done to support midwives who are keen to take up those roles.

Q193 **Dean Russell:** Thank you. On the international view, we have had evidence previously from international experts about what is happening around the world. Through your work, have you seen any exemplars that you would like to adopt here or policies that you think we could be learning from in what is going on elsewhere in other countries?

Maria Caulfield: It is difficult. That is why we need to look at all the options in the round. It is very difficult to make international comparisons. We have a very different healthcare system from many countries in the world. We have a very different legal system. The health and social care support that patients have varies too.

There is an assumption that you can just lift up and slot in a different system from the UK, but that may not necessarily work. We pay full compensation at the moment as part of our system. In some of the no-fault countries, they have a limit of £1 million. Is that something we want to do? I am not saying that we do or we do not, but we need to look at all of the options. There are complexities.

For example, Japan was mentioned. They introduced some pieces of safety work at the same time as they introduced changes to their legal framework, so it is quite difficult to decipher which has made the biggest difference or whether there has been any interconnectivity at all. That is why we want to do a proper piece of work, to make sure that, if we do change things, we change them to make a better impact for patients.

Q194 **Dean Russell:** Do you want to come in, Matthew?

Matthew Style: It is difficult to compare the schemes. I was talking recently to colleagues in Sweden, for example, and seeking to understand the relationship between the level of claims that they pay out and the degree of support that is available through the wider health and social security system in Sweden. It makes it harder to translate the lessons, but we are very committed to international learning as part of this exercise.

Dean Russell: I have one very final question. Minister, just now you used the word "interconnectivity". One of the other aspects I have heard first hand is the lack of interconnectivity in lessons learnt. Somebody might go through a bereavement, and you might have litigation or complaints being made. That might be with a hospital, but then the GP or other parts of the system do not know about it. That can often make it very difficult for somebody already going through a traumatic experience to have to relive that and explain it to other parts of the system, especially when you have a wall go up with lawyers and everybody not saying anything. It makes it even harder.

Is that something that is being looked at in terms of how data is shared? It is not just the quantitative date—the numbers—but the qualitative data in the human stories and the positions people find themselves in.

Maria Caulfield: There are a number of ways that best practice can be shared. Obviously, we have NICE guidelines in clinical areas. I was thinking of a Westminster Hall debate I did a couple of weeks ago on sickle cell, where MPs were describing that some of their constituents had hours-long waits for pain control. The NICE guidelines are very clear that they should be getting pain control within the hour. I could be wrong, but I think those are the NICE guidelines for sickle cell.

Where there are best practice guidelines, they should be implemented. The CQC will look, when they are doing their inspections, at areas like that. They cannot look at every single NICE guideline when they are doing an inspection. There are measures in place to share best practice, but there is no doubt that we need to do better.

Matthew Style: I think you raise an important point specifically around the role of colleagues in primary care supporting their patients. Indeed, the Chair and I were discussing in another context the power of personalised care in general practice and the difference that makes. It is something for us to take away as well.

Dean Russell: Thank you.

Q195 **Chair:** As a final point, there is always resistance to any reform, as all of us know in this room. It is always easy to look at another country and say, "Well, it is not quite an exact comparison because this is different or that is different," but the thing that does not lie is the numbers in the table that you yourself have provided, which show that we spend double the proportion of any other country that we have been able to identify, and 20 times more than some countries, on legal costs as a proportion of our total health spend.

The other area where the numbers do not lie, despite enormous efforts on patient safety, is the fact that our neonatal death rates are still significantly higher than many other European countries'. If you take those two together, if I can be so bold as to say this, it would be a real dereliction of all of our duties to say that there is not an enormous amount that could be learned from other countries when considering bold reforms.

I have a very specific final question for you, Matthew. You have announced that you are going to be setting up a special health authority. Will it determine whether there was avoidable harm in the investigations that it looks at?

Matthew Style: Not specifically, no. That will not be the specific purpose of its investigations.

Q196 **Chair:** Could I ask you to reconsider that? It seems to me that if we are going to the trouble of setting up a new quango with very important responsibilities to do independent investigations, and we are not asking it the $6 million dollar question everyone wants to know, which is, “Was a mistake made?”, what is the point of going to all that effort?

I leave that with you, not to give an answer now but I wonder whether it is something you could look into. It seems to me that that is the single most important thing that you would want to know from an organisation doing all that work.

Matthew Style: The key purpose will be to make sure that there are family-focused investigations, that families get answers to their questions quickly and that the learnings from those are shared. Chair, I will of course take your question away as part of the set-up phase.

Chair: Thank you very much indeed. Thank you all. It has been a very productive discussion. I declare this session closed.