House of Commons

Health and Social Care Committee

NHS litigation reform

Thirteenth Report of Session 2021–22

Report, together with formal minutes relating to the report

Ordered by the House of Commons to be printed 20 April 2022

HC 740
Published on 28 April 2022
by authority of the House of Commons

Health and Social Care Committee

The Health and Social Care Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health & Social Care.

Current membership

Rt Hon Jeremy Hunt MP *(Conservative, South West Surrey)* (Chair)

Lucy Allan MP (*Conservative, Telford*)

Paul Bristow MP *(Conservative, Peterborough)*

Rosie Cooper MP *(Labour, West Lancashire)*

Martyn Day MP (*Scottish National Party, Linlithgow and East Falkirk*)

Dr Luke Evans MP *(Conservative, Bosworth)*

Barbara Keeley MP *(Labour, Worsley and Eccles South)*

Taiwo Owatemi MP *(Labour, Coventry North West)*

Sarah Owen MP *(Labour, Luton North)*

Dean Russell MP *(Conservative, Watford)*

Laura Trott MP *(Conservative, Sevenoaks)*

Powers

The Committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the internet via www.parliament.uk.

Publication

Committee reports are published on the Committee's website at www.parliament.uk/hsccom and in print by Order of the House.

Committee staff

The current staff of the Committee are Stephen Aldhouse (Senior Committee Specialist), Matt Case (Committee Specialist), Joanna Dodd (Clerk), Nicola Fisher (POST Fellow), Sandy Gill (Committee Operations Officer), James McQuade (Committee Operations Manager), Conor O'Neill (Clinical Fellow), Rebecca Owen-Evans (Committee Specialist), Anne Peacock (Media and Communications Manager), and Yohanna Sallberg (Second Clerk).

Contacts

All correspondence should be addressed to the Clerk of the Health and Social Care Committee, House of Commons, London SW1A 0AA. The telephone number for general enquiries is 020 7219 6182; the Committee's email address is hsccom@parliament.uk.

You can follow the Committee on Twitter @CommonsHealth

Contents

Executive summary

1. Every year in England the NHS spends over £2 billion compensating patients who suffered harm during their treatment. A process that is supposed to deliver justice and incentivise improvements fails to do either: lessons are rarely learned and for families accessing compensation is slow, adversarial, stressful, and often bitter. Those who are most in need usually wait the longest and the system often appears arbitrary - based not on need but on whether clinical negligence can be proved.

2. At the same time, the costs of the system have continued to grow at an eye-watering rate. Ten years ago the NHS paid £900 million in damages; last year it was £2.17 billion - equivalent to the annual running costs of the biggest hospital Trust in England or four average sized hospitals. This sum is set to double over the next decade to £4.6 billion, and around a quarter of such costs go not to families but to lawyers. The English NHS spends 2% of its total income on clinical negligence compared to half that level in New Zealand or Sweden.

3. On top of the amount actually paid out, the NHS is incurring around four times that amount in future liabilities - £8.3 billion in 2021/22 alone. The rate at which such liabilities are being incurred adds urgency to the need for reform.

4. Advocates of the current system said that the best way to diminish costs is for the NHS to reduce harm and improve patient safety. There is, of course, a basic logic to this, but snowballing costs are not related to a decline in patient safety, rather they are the result of a growth in claims and steep increases in the value of awards and claimant legal fees. Indeed, adversarial litigation makes learning from mistakes harder not easier. Rather than reviewing cases in a way which accounts for context and system failure, a system focused on clinical negligence by definition seeks out individual failings. The lawyers who succeed in clinical negligence cases are not, ultimately, experts in medical practice, patient safety or systems failure but highly skilled legal professionals adept at demonstrating negligence.

5. We heard powerful testimony from people who have been through the labyrinthine process of litigation. We heard how much they relied upon solicitors who become their advocates and guides. But whilst we do not doubt that there are many excellent solicitors who act in the best interests of people who have suffered terrible trauma, the fact that their guidance, advocacy and compassion is so valued only underlines the necessity for change. Legal professionals will only take commercially viable cases with a prospect of success, meaning many people who have suffered harm never benefit from such expert advocacy.

6. Maintaining a costly and adversarial litigation system is evermore at odds with our understanding of how the NHS should respond to failures in care. England's system of clinical negligence stands in stark contrast to international best practice in terms of patient safety. In other countries, gains are made by careful system-wide analysis rather than an insistent search for individual error. The creation of the Health Service Safety Investigations Body (HSSIB) as a statutory body to undertake no-blame safe-space

investigations maps out the direction of travel for reducing harm and improving patient safety. Shortly, however, HSSIB will lose responsibility for 1,000 of the most serious maternity incidents which will not, therefore, benefit from no blame investigations.

7. We urgently need a system where the biggest priority is the prevention of future harm. This system should review the facts and circumstances of a case and compensate patients not on the basis of whether there was clinical negligence, but when there has been medical error or best practice was not followed. Any investigation should prioritise the identification of system changes that can be disseminated across the NHS to prevent mistakes from being repeated. Even if the threshold for compensation is not met, the patient or family should receive an explanation of what happened and data related to patient safety should be harvested and fed back into the system. We have taken evidence from various successful international schemes that each use a different threshold and we do not seek to be prescriptive over which threshold should be used, but it should be based around a system performance test and not individual fault. We recommend that the Government should consult widely at home - and evaluate best practice from abroad - to ensure that the bar is set appropriately.

8. Our central recommendation is therefore that the NHS adopt a radically different system for compensating injured patients which moves away from a system based on apportioning blame and prioritises learning from mistakes. An independent administrative body should be made responsible for investigating cases and determining eligibility for compensation in the most serious cases. Reconstituting the new Special Health Authority, which will take over maternity investigations from HSSIB, would be an efficient way for the Government to implement our recommendation. This would be the most effective long-term way to reduce both the number of tragedies and the cost to the NHS. Changing from a blame culture to a learning culture is not easy but can be accelerated by some simple but important changes to current NHS processes which we encourage the Government to adopt.

9. Firstly, there needs to be a change in the law so that access to compensation is based on agreement that correct procedures were not followed and the system failed to perform, rather than the higher threshold of clinical negligence by a hospital or clinician. Whilst this widens the pool of people entitled to compensation, the evidence from countries that have adopted such an approach is that overall costs will be lower not higher.

10. Then, in all cases, compensation should be based on the additional costs necessary to top up care available through the NHS and social care system rather than the current outdated assumption that all care will be provided privately.

11. When deciding compensation, the link to supposed future earnings leads to the manifest unfairness that the child of a cleaner receives less compensation than the child of a banker. This contradicts the basic principle of equality that sits at the heart of our health system and should be scrapped for all NHS-related clinical negligence claims involving children under 18 years of age.

12. Before any court case there should be compulsory use of alternative dispute resolution mechanisms (ADRs). This often happens before the start of a trial but should

happen before the issuing of any court proceedings. The Government should consult on the format of ADR and whether ADR should include mediation or be an inquisitorial, ombudsman-style process.

13. Every hospital should have adequate numbers of staff trained in "just culture" practices to reduce confrontation and relationship breakdown between injured patients, their relatives, and bereaved families.

14. Learning lessons fast is essential but not possible with the current system. Whenever a potential litigation case arises there should be a standardised process across the NHS which focuses on the overriding priority to learn from mistakes and prevent tragedies being repeated. This process should last a maximum of six months and, at a minimum, should include the following elements: an independently led investigation involving both families and the Trust; implementation of any safety recommendations made; and communication of such lessons to the wider NHS.

15. In parallel, an investigation by an independent administrative Alternative Dispute Resolution body should have been completed and a determination on liability for compensation released to the family, the Trust and NHS Resolution. It is then a decision for the Trust and NHS Resolution as to whether to accept liability for a mistake or negligence and to commence payments. If at the end of the six-month window liability for cases relating to maternity care has not been accepted these would fall within the remit of the Early Notification scheme and NHS Resolution.

16. Implementing a new administrative system would be a significant task and one which may be best achieved in stages. The most complex and expensive cases are those related to birth injuries which leave children seriously disabled so it may be appropriate to pilot new changes in this area as has happened in Japan. Once established, and having proven its value, the administrative system should then be expanded to accommodate all claims for compensation made against the NHS.

17. Once established, the new administrative body should also agree a memorandum of understanding with the Office of the Chief Coroner to ensure consistency of investigation and provide transparency as to the process for the disclosure of information for inquests.

18. The reforms we recommend may appear daunting, but we concluded they can be achieved because, in various guises, administrative compensation systems have been adopted with great benefits in New Zealand, Japan, Florida, Virginia and across Scandinavia, where both cost savings and safety improvements have proved possible. In fact, a similar system is already in place for low-value cases in Wales and in 2006 Parliament passed legislation for low-value cases to be taken out of the clinical negligence system in England but the legislation sits on the statute book unimplemented.

19. Although the system would be no less generous in its awards than the courts, patients would always retain the option of pursuing clinical negligence cases and seeking redress via litigation. Evidence from abroad, however, indicates that, when given the choice, patients and families prefer the simpler administrative process and, in the system we recommend, the new body would be the mandatory first port of call for anyone who thinks they are entitled to compensation.

20. We also believe that the administrative body we propose should be empowered to change the way compensation is awarded. At present compensation is awarded on a 'once and for all' basis, but we recommend that awards be made with periodical review built in so that they can become responsive to the changing needs of patients. The requirements of a child with birth injuries, for example, can evolve over time and the most effective system would be one that can provide initial compensation within weeks of a claim and then be adapted to meet the individual child's requirements as they grow and develop.

Introduction

21. Dissatisfaction with clinical negligence litigation is a long-standing aspect of the health service in England. As far back as 1978 the Royal Commission on Civil Liability and Compensation for Personal Injury, chaired by Lord Pearson, recommended that no-fault schemes for compensating injured patients that had recently been established abroad should be investigated by the Government. In 1997 the renowned legal scholar, the late Patrick Atiyah, "wrote a visceral polemic calling for reform" in which he rejected the concept of tort litigation in personal injury claims.[1]

22. Parliamentary efforts to reform clinical negligence have been made for decades but have had little success. In 1990 Rt Hon. Harriet Harman MP introduced the Compensation for Medical Injury Bill and a year later Rosie Barnes MP introduced the National Health Service (Compensation) Bill which aimed to "establish a Medical Injury Compensation Board" which would award compensation to injured patients "without having to prove negligence on the part of the National Health Service".[2] Neither Bill reached the statute book. Ten years on the Labour Government said in their 2001 General Election manifesto that they would reform the clinical negligence system but, as we discuss in this report, although legislation made its way through Parliament in 2006 no meaningful reform was ever implemented.

23. The inadequate nature of the clinical negligence system was highlighted by the then Health Committee in its 2009 report into Patient Safety. The Committee was "appalled" by the then Government's failure to implement the redress scheme it had legislated for in 2006 and recommended its immediate implementation because harmed patients and their loved ones had to "endure often lengthy and distressing litigation to obtain justice and compensation" whilst the NHS "spends considerable sums on legal costs."[3] They said that clinical negligence was "hindering the development of a safety culture in the NHS" and went so far as to urge consideration of a new system where "litigation over clinical negligence" would be "entirely replaced by a statutory right to compensation" which could be delivered "without the need to prove negligence as required under tort law."[4]

24. The failure to reform clinical negligence or improve the process of compensating injured patients was brought into sharper relief by conclusions of the National Audit Office's (NAO) 2017 study, Managing the costs of clinical negligence in trusts. The NAO found that that the policies introduced by the Government to address the rapidly rising costs associated with clinical negligence were unlikely to succeed. They reported that a multitude of factors, many of which were outwith the responsibility of the then Department of Health, contributed to the rising clinical negligence bill but concluded that the Government had no coherent strategy for reining costs in.[5] The cost implications of clinical negligence are now very significant. Between 2006–07 and 2019–20 the annual cost to the public purse quadrupled from £600 million to £2.3 billion.[6] The total liabilities which stood at £9 billion in 2007 now amount to more than £82 billion.[7]

1 The Bar Council (NLR0069), para 13
2 HC Deb, 5 December 1990, National Health Service (Compensation), Volume 182 [Commons Chamber]
3 Health Committee - Sixth Report of session 2008–2009, Patient Safety, HC151–1, 3 July 2009
4 Ibid
5 National Audit Office, Managing the costs of clinical negligence in trusts, HC 305 session 2017–2019, 7 September 2017
6 Department of Health and Social Care (NLR0070), para 8
7 Department of Health and Social Care (NLR0070), para 9

25. This is not the first time a parliamentary committee has addressed the issue of clinical negligence litigation and compensation for injured patients. Nor is it the first time in this Parliament that we have considered the matter. We examined clinical negligence litigation in the context of maternity safety as part of our inquiry into the Safety of maternity services in England. Our report, published in July 2021, echoed the conclusions of our predecessor Committee:

> the clinical negligence process is failing to meet its objectives for both families and the healthcare system. Too often families are not provided with the appropriate, timely and compassionate support they deserve. For those delivering maternity care, the adversarial nature of litigation promotes a culture of blame instead of learning after a patient safety incident.[8]

26. Our report recommended the Government implement its Rapid Resolution and Redress Scheme which was intended to provide compensation in birth injury cases without the need for litigation.[9] We also recommended that "the Department brings forward proposals for litigation reforms that award compensation for maternity cases based on whether an incident was avoidable rather than a requirement to prove clinical negligence".[10]

27. Disappointingly, in their response to the report the Department of Health and Social Care said that there was no need to introduce its Rapid Resolution and Redress Scheme because they had concluded that the benefits were being delivered by other mechanisms and it would not help to "address the high and rising cost of clinical negligence cases."[11] We do not agree with the Government's analysis and believe that the Government's approach to addressing the problems connected with clinical negligence litigation required more detailed scrutiny. We launched an inquiry with broad terms of reference to capture the central debates and controversies. However, over the course of our work we particularly focused on the patient experience, costs, and the relationship that exists between clinical negligence litigation, learning, culture, and patient safety.

28. Our call for evidence received over 70 responses, many of which provide a detailed and comprehensive analysis of how clinical negligence litigation works, how it may be reformed and what the implications of reform would be. We held three evidence sessions and are grateful to all our witnesses, who participated both forthrightly and constructively. As our inquiry progressed it became apparent that it was essential to explore how patient compensation is managed in other countries which operate very different systems, and therefore we are particularly grateful to Michael Mercier, Principal Solicitor, New Zealand Accident Compensation Corporation; Dr Pelle Gustafson, Chief Medical Officer, Löf, the 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, who joined us from different corners of the globe to discuss the systems they oversee.

8 Health and Social Care Committee, Fourth Report of Session 2021–22, 6 July 2021,The safety of maternity services in England, HC 19, para 101

9 Ibid, para 103

10 Ibid, para 104

11 Department for Health and Social Care, The Government's response to the Health and Social Care Committee report Safety of Maternity services in England, CP 513, September 21 2021, para 84

29. Most of all, however, we are grateful to Sue Beeby, Jill Edwards, Joanne Hughes and Scott Morrish, who gave moving and powerful evidence about their experiences of the NHS investigation system, the serious injuries suffered by their children because of medical error and, for Sue, Joanne and Scott, the tragic loss of a child. They all described failures in care and the abject failure of the system to properly investigate and understand what went wrong. Tellingly, however, each used their personal insight to provide a detailed analysis of how the system should respond to tragic incidents and how clinical negligence litigation relates to that response. What came through most powerfully from their evidence was a firm commitment that no other families should have to endure what they experienced when tragic incidents occur.

1 Clinical negligence - how it fails

The sad truth is that I "won", I was given compensation. All my legal costs were paid, but I felt devastation. (Joanne Hughes)[12]

Background

30. Clinical negligence is the breach of a legal duty of care to a patient by members of the healthcare professions, or by others acting on their decisions or judgements, which causes harm to the patient. The Bolam test, established by a clinical negligence case brought in the 1950s, is central to determining if care fell below the standard that a patient could reasonably expect because the clinician did what "no other reasonably competent clinician in that field would have done."[13] If clinical negligence has taken place, a patient or their representative may claim for damages against the clinicians or their employers.

31. Tort litigation is strictly limited in the outcomes it can achieve.[14] Its only purpose "is to restore an injured patient's life, as much as that is possible, to where it would have been, but for the needless injury."[15] A clinical negligence claim will determine only "whether the defendant had a duty care; whether that duty was breached and whether that breach caused the damage that requires compensation."[16]

32. Currently, NHS bodies are legally liable for any clinical negligence by their employees and must pay compensation in the form of damages to the claimant, and pay their legal fees. The arrangement covers employees of all NHS Trusts and NHS Foundation Trusts, and, since April 2019, general practice has been covered by the GP indemnity scheme. Private contractors, such as dental practitioners, are legally liable for any clinical negligence claims they might receive. Litigation provides the only route by which those who have been harmed can access compensation.[17]

33. The Medical Defence Union set out succinctly that the "singular function of a clinical negligence claim is to provide compensation for the patient."[18] They observed that the system is designed to find "evidence related to a single incident" and the process "determines whether the defendant had a duty of care; whether that duty was breached and whether that breach caused the damage that requires compensation."[19] Most significantly, there is no intention within litigation "to investigate or make any findings or provide commentary on the wider implications of the case under examination."[20]

34. NHS Resolution is the national NHS body for England which defends clinical negligence claims and pays compensation to injured patients. It has its own in-house team of legal professionals but also uses a panel of eleven external legal firms to manage and defend claims.[21] Although NHS Trusts do not have to participate in NHS Resolution's

12 Q22
13 The Bar Council (NLR0069), para 38
14 The Centre for Socio-Legal Studies (NLR0063)
15 Association of Personal Injury Lawyers (APIL) (NLR0016)
16 The Medical Defence Union (MDU) (NLR0019)
17 The Centre for Socio-Legal Studies (NLR0063)
18 The Medical Defence Union (MDU) (NLR0019), para 14
19 Ibid, para 15
20 Ibid, para 15
21 Legal firms appointed to NHS Resolution legal panel, 21 January 2022, [Accessed 29 March 2022]

schemes, of which the Clinical Negligence Scheme for Trusts (CNST) is the largest, all NHS Trusts are members. The CNST covers all clinical negligence claims against NHS bodies for incidents occurring on or after 1 April 1995.[22]

35. In 2017 the National Audit Office reported that "[c]linical negligence can occur in any care setting and affects patients of all ages" and claims can "arise from a wide range of specialties within hospitals, although claims may have different characteristics."[23] The NAO noted that "claims related to obstetrics are relatively few in number but account for a significant proportion of settlements with high value damages."[24] The origins of clinical negligence claims are broad, but in 2017 the most common reported causes were:

- "Failure to perform a treatment or a delay in performing it (22% of claims);
- Failure to diagnose a condition or a delay in diagnosing it (17% of claims);
- Inappropriate treatment (7% of claims) and
- Problems during operations (6% of claims)."[25]

Clinical negligence is adversarial and distressing

36. Sir Ian Kennedy QC, who chaired the Bristol Royal Infirmary Public Inquiry from 1999 to 2002 and is now Emeritus Professor of health law, ethics and policy at University College London, has said that clinical negligence is an "outdated, arbitrary and scandalously expensive system" and there exists a "stranglehold that lawyers exert over a system that should be putting the interests and needs of patients first."[26] The Medical Protection Society (MPS) said the current system is "neither equitable nor appropriate" because clinical negligence "does not provide all families and children who suffer child-birth injuries with appropriate compensation and support, only those who are able to prove fault against a healthcare worker".[27]

37. We heard that the system, which requires patients to prove fault, is inherently adversarial.[28] Sir Robert Francis QC, who chaired the two Mid Staffordshire NHS Foundation Trust inquiries and the Freedom to Speak Up Review, said that even when a complaint arises "all parties are thrown into an adversarial situation right from the outset".[29]

38. Peter Walsh, Chief Executive of Action Against Medical Accidents, said that the litigation 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."[30] In their

22 NHS Resolution, Clinical Negligence Scheme for Trusts, [Accessed 29 March 2022]
23 National Audit Office, Managing the costs of clinical negligence in trusts, HC 305 session 2017–2019, 7 September 2017, para 1.7
24 National Audit Office, Managing the costs of clinical negligence in trusts, HC 305 session 2017–2019, 7 September 2017, para 1.8
25 National Audit Office, Managing the costs of clinical negligence in trusts, HC 305 session 2017–2019, 7 September 2017, para 1.8
26 Sir Ian Kennedy, Clinical negligence reform is an ethical and financial necessity, 9 August 2021 [Accessed 12 April 2022]
27 Medical Protection Society (MPS) (NLR0032), p 2
28 Medical Protection Society (MPS) (NLR0032)
29 Q25
30 Q84

evidence the Government acknowledged that the clinical negligence system in England does not operate effectively for everyone who has suffered harm as a consequence of medical treatment:

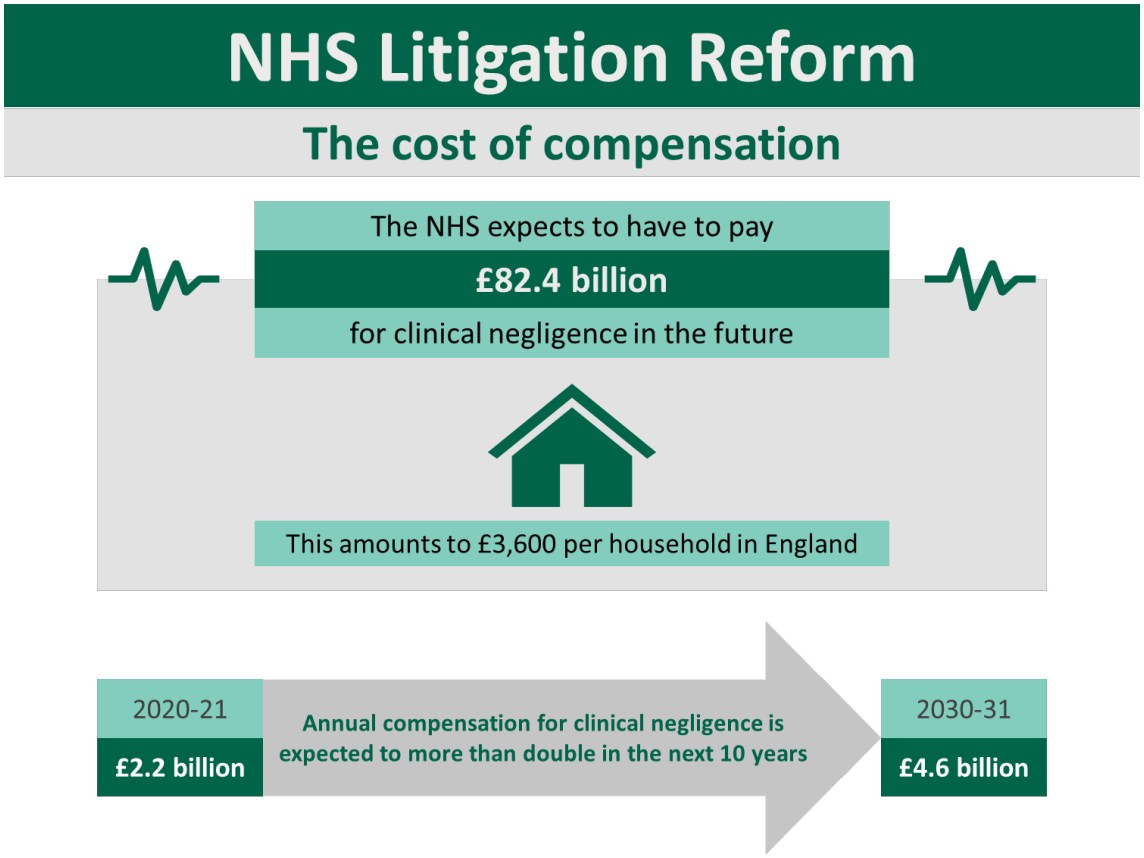
> We recognise that current legal processes prescribed for bringing and settling claims do not always serve claimants or NHS staff well. The system is complex and can often take years to reach a conclusion.[31]

39. A defining feature of clinical negligence is the distress it causes for those involved, whether they be defendants or claimants. Peter Walsh told us that when advising people who have suffered harm or loss Action against Medical Accidents "often have to warn people who are even contemplating litigation in this country that it is a very stressful and difficult process."[32] Scott Morrish, the father of Sam, who died suddenly and unexpectedly aged just three, said that in their long quest to discover the truth about Sam's death he and his family had never considered pursuing litigation because "he saw litigation only as a means of reducing Sam's death to a financial equation" and he "thought that it would be toxic."[33] Mr Morrish, who since his son's death, has become an expert campaigner and advisor in relation to safety and candour in the NHS, added that "it would be kinder and perhaps more humane if compensation could be addressed quickly and early."[34]

40. A general practitioner told us that facing a clinical negligence claim is "hugely stressful for the accused health care professional", noting that "emotional damage often contributes to healthcare professionals leaving the profession."[35] This argument was echoed by Bevan Brittan LLP who said that healthcare professionals leaving the NHS as a consequence of clinical negligence claims was "a hidden but real cost of litigation."[36] Academic evidence we received reported that litigation in relation to Cauda Equina Syndrome (CES), a rare and severe spinal condition, was very stressful for defendants, particularly because of the time it takes to resolve claims and because there was no formalised way to inform clinicians that they were party to a claim.[37] Hempsons Solicitors said that the disproportion between the salary of a midwife (circa £24,000 - £38,000 per annum) who is held to blame for a birth injury which results in an award with value of over £30 million can have "a devastating effect on the morale of the service."[38] Maria Caulfield MP, Minister for Patient Safety and Primary Care, acknowledged that even well-handled cases can be stressful for all parties and that when something goes wrong leading to an investigation it can place a significant strain on a "whole clinical unit" and negatively "affects staff morale."[39]

31 Department of Health and Social Care (NLR0070), para 47
32 Q84
33 Q6
34 Q44
35 Dr T Derry (General Practitioner at NHS) (NLR0025)
36 Bevan Brittan LLP (NLR0058), p 1
37 Dr Gillian Yeowell (Associate Professor at Manchester Metropolitan University); Dr Sue Greenhalgh OBE (Consultant Physiotherapist Bolton NHS FT & Clinical Fellow Manchester Metropolitan University at Bolton NHS FT & Manchester Metropolitan University); Professor James Selfe (Professor of Physiotherapy at Manchester Metropolitan University) (NLR0010), para 2.2
38 Hempsons Solicitors (NLR0014), para 2
39 Q140, Q143

Clinical negligence is expensive



Increased cost to the taxpayer

41. In England the NHS spends over £2 billion, or almost 2% of the NHS resource budget, compensating patients who suffered harm during their treatment.[40] Ten years ago the NHS paid £900 million per year in compensation, but by last year this figure had increased to £2.17 billion. The annual sum paid in compensation is set to double over the next decade to £4.6 billion by 2031.[41] At the end of 2020 the Treasury published figures which showed that "the provision for clinical claims is now worth a staggering £3,600 for every household in England, compared to £700 per household 10 years ago."[42]

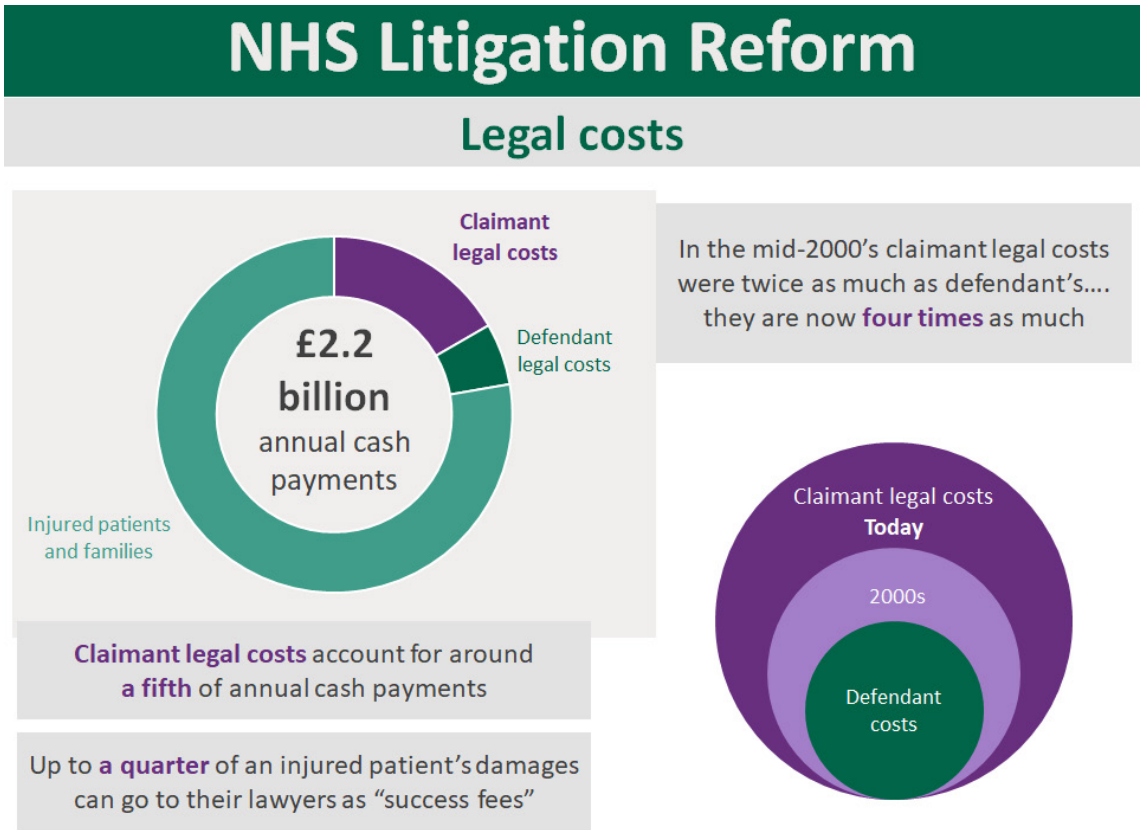
42. The Government's evidence highlighted the extent to which costs have grown. They reported that claims against NHS providers had "increased four-fold between 2006–07 and 2019–20 from £0.6 billion to £2.3 billion" and the Government's total liabilities for clinical negligence "increased from £9 billion at 31 March 2007" to £82.4 billion by March 2021.[43] Furthermore, the Government's projections show that liabilities within the Clinical Negligence Scheme for Trusts (CNST) - the largest scheme which meets the costs of clinical negligence for NHS Trusts and accounts for 95 per cent of cash payments - could by the end of the decade snowball to £155 billion and annual cash payments could reach £4.3 billion.[44]

40 Department of Health and Social Care (NLR0070), para 8, figure A
41 Department of Health and Social Care (NLR0070), figure C
42 The Medical Defence Union (MDU) (NLR0019), para 9
43 Department of Health and Social Care (NLR0070), para 9
44 Department of Health and Social Care (NLR0070), para 10, figure d

43. In their evidence the Government explained that high value claims settled at £3.25 million and above account for the majority of cash payments, reporting that in "2019–20, these awards accounted for 58% of payments for compensation, and 48% of total costs across all claims."[45] Most of the cost to the taxpayer of clinical negligence originates from birth injury cases, which by 2021 accounted for 11% of claims by number but 59% of the damages awarded.[46] The Government said that high value awards related to birth injury "are growing at rates significantly higher than inflation."[47]

44. There are multiple factors which may account for the rapid growth in awards related to birth injury, and these range from awards reflecting increases in the cost of living, the impact of the discount rate which is designed to ensure that claimants do not unduly benefit from interest that may be earned from investment of large awards, and other actuarial and legal developments which "further increase the size of claims".[48] The Government pointed to increased life expectancy and the cost of social care as being important factors. However, they said "these factors alone cannot fully explain their steep rise" and that "precedent setting" by the courts may have influenced the inflation of awards.[49]

Growing legal costs



45. Allied to growth in the highest-value awards has been inflation of legal costs within clinical negligence. Legal costs have grown substantially since the middle part of the last decade, increasing "fivefold from £98 million to £496 million" in the ten years from 2006–

45 Department of Health and Social Care (NLR0070), Annexe B para 10
46 NHS Resolution, Annual report and accounts 2020/21, 15 July 2021, HC 387, Figures 9, 10
47 Department of Health and Social Care (NLR0070), para 13
48 The Bar Council (NLR0069), para 12 c
49 Department of Health and Social Care (NLR0070), para 14

2007 to 2016–2017.[50] In addition, the Government's analysis has found that legal fees now exceed claimant awards "in 74% of clinical negligence settlements below £50,000" and in lower value claims "the average claimant legal cost per claim doubled from £10,121 in 2006/07 to £22,124 by 2020/21."[51] However, the Medical Protection Society said it was not only low-value claims which had disproportionately high claimant legal fees. They highlighted that in 2015/16 "total defence costs were 19% of the damages - whereas the claimant costs were 99%" in cases with damages payments of between £50,001 and £100,000.[52] Additionally, in cases where damages were "between £100,001 and £250,000 the total defence costs were 15% of the damages, whereas the claimant costs were 72%."[53]

46. Claimant legal costs now account for 77 per cent of all legal costs within clinical negligence.[54] The Government's written evidence noted that since the mid-2000s the "average claimant legal costs per claim grew from double to quadruple the size of average defendant legal costs per claim."[55] The Centre for Socio-Legal Studies at the University of Oxford summarised the extent to which legal fees inflate the costs of clinical negligence:

> Between a quarter and a third of the cost involved in clinical negligence goes to fund lawyers rather than to harmed claimants. In 2018/19 the total income to the legal community of the clinical negligence market was over £650m, with the total paid in compensation in the region of £2bn.[56]

47. We heard that the most effective way to achieve financial sustainability would be to improve patient safety and reduce the number of incidents which demand compensation.[57] As a practicing solicitor said, the cost to the public purse "of litigation is directly linked to patient harm. The more patient harm, the more litigation."[58]

48. There is, of course, a basic logic to this argument, but increasing costs are not related to a decline in patient safety, rather they are the result of a steep increase in the value of awards and claimant legal fees. The Government's evidence said that they "do not believe any measurable decline in safety is driving the long-term rise in the cost of clinical negligence claims" and that it would be wrong to assume that "reductions in harm would necessarily drive a similar reduction in numbers and costs of claims."[59] The Government's analysis was informed by a 2017 National Audit Office study which reported no "evidence yet that the rise in clinical negligence claims is related to poorer patient safety."[60]

49. The Government's position is that the cost to the taxpayer of clinical negligence is rising because "payments for compensation and, until recently, claimant legal costs have been growing at rates far above inflation."[61] To substantiate their argument they identified evidence that there has been no significant growth in claims which relate to cerebral palsy and brain injury (CP/BI) caused by injury at birth:

50 Department of Health and Social Care (NLR0070), Annexe B, para 22
51 Department of Health and Social Care (NLR0070), para 31
52 Medical Protection Society (MPS) (NLR0032), p 4
53 Medical Protection Society (MPS) (NLR0032), p 4
54 Department of Health and Social Care (NLR0070), Annexe B, para 23
55 Department of Health and Social Care (NLR0070), Annexe B, para 23
56 The Centre for Socio-Legal Studies (NLR0063)
57 FOCIS (The Forum of Complex Injury Solicitors) (NLR0042), Society of Clinical Injury Lawyers (SCIL) (NLR0011)
58 Mrs Victoria Beel (Principal Lawyer at Slater and Gordon) (NLR0024)
59 Department of Health and Social Care (NLR0070), para 26
60 NAO, Managing the costs of clinical negligence in trusts,, September 2017, HC 305, Para 16
61 Department of Health and Social Care (NLR0070), para 26

> the absolute volume of settled CP/BI claims has fallen steadily since 2006/07 and growth in numbers of claims across maternity claims more broadly has been considerably lower than total claims. This underlines the point that for these claim types, volume has not been the key driver of cost rises. Considering there is no evidence that the severity of injuries has worsened, this suggests that compensation for a harmed patient today would be significantly higher than for an identically harmed patient 15 years ago.[62]

50. We received evidence which suggested that commercial motives could shape the behaviour of clinical negligence solicitors and, consequently, the legal costs incurred. Academics at Manchester Metropolitan University, currently investigating Cauda Equina Syndrome (CES) and litigation, concluded in their written evidence that the NHS is "paying vast amounts of tax payers' money to cover legal costs with relatively little money going to the patient" and "the main beneficiaries of the current system are the legal profession."[63]

51. Michael Powers QC and Anthony Barton, both qualified legal and medical practitioners and the authors of the legal text, Clinical Negligence, cautioned in their evidence that "[c]linical negligence litigation is a commercial activity like most civil litigation" and for law firms "[a]n important driver is the pursuit of legal fees; litigation is only indirectly related to compensation, patient safety, and professional regulation."[64] Furthermore, we were told that even if cases clear a law firm's initial legal test "some cases will be rejected as uneconomic if the law firm assess the financial return as insufficient compared to the outlay required".[65]

Clinical negligence takes too long

52. Over the course of our inquiry we heard an abundance of evidence that the clinical negligence process fails patients and the families of those who have been harmed because it takes far too long to resolve cases.[66] The Medical Defence Union highlighted that it can take many years for a patient to even initiate a case and the NAO's 2017 study found that on average it takes two to three years for a patient or their representative to notify NHS Resolution of a claim following a clinically negligent event.[67] The Centre for Socio-Legal Studies emphasised how long it can take to settle cases connected to the most serious events, noting that "in 2017 the average time period from a birth related brain injury in a baby occurring to full quantification of a settlement was 11.5 years."[68]

53. Helen Vernon, Chief Executive of NHS Resolution, observed that in England "the claim comes very much at the end of a series of other processes" and the Government's evidence acknowledged that the "system is complex and can often take years to reach a conclusion." The Bar Council illustrated the practical legal implications of cases taking so

62 Department of Health and Social Care (NLR0070), Annexe B para 12
63 Dr Gillian Yeowell (Associate Professor at Manchester Metropolitan University); Dr Sue Greenhalgh OBE (Consultant Physiotherapist Bolton NHS FT & Clinical Fellow Manchester Metropolitan University at Bolton NHS FT & Manchester Metropolitan University); Professor James Selfe (Professor of Physiotherapy at Manchester Metropolitan University) (NLR0010), para 1.2
64 Michael Powers QC; Anthony Barton (NLR0004), p 1
65 The Centre for Socio-Legal Studies (NLR0063)
66 Department of Health and Social Care (NLR0070), para 47
67 The Medical Defence Union (MDU) (NLR0019), para 18
68 The Centre for Socio-Legal Studies (NLR0063)

long to resolve, commenting that the requirement in clinical negligence cases to "establish factual causation also causes practical difficulties for defendants whose employees may have moved on or whose memories have faded over time."[69]

54. Sir Robert Francis connected the combative nature of clinical negligence to the time it takes to resolve cases, noting that "adversarial litigation system always takes far too long", the time taken to settle a case "will involve a struggle" and, for long periods patients and families will receive no support.[70]

55. Jill Edwards, whose daughter Kirsty suffered an injury at birth in 1983, described to us the challenge she faced in finding legal representation and then fighting for recognition of the injuries that Kirsty suffered and her entitlement to compensation. Mrs Edwards did not engage a solicitor until 1996 and the NHS did not admit liability and causation until 2004, and even then it was another three years before the case was settled and Kirsty was awarded compensation.[71] Scott Morrish explained that a lengthy complaints and litigation process "traps everybody involved for a ridiculous period of time" and has "lots of negative consequences, not just emotional and psychological" which can place a strain on marriages and employment.[72]

56. There is evidence, however, that NHS Resolution (NHSR) has had some success in resolving cases early to prevent them reaching court, thus shortening the period it takes to settle cases. Helen Vernon told us that only 0.3 per cent of cases which NHS Resolution receive end up going to trial and Simon Hammond, Director of Claims Management at NHSR, said that "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."[73] The Government's written evidence explained that cases settled without formal court proceedings "were resolved via correspondence, at settlement meetings or via forms of dispute resolution, including formal mediation."[74]

57. The Early Notification scheme (EN) introduced in April 2017, for early reporting of infants born with a potential severe brain injury following term labour has helped to reduce the time it takes to settle some of the most serious cases.[75] The scheme requires hospital Trusts to notify NHSR, via the Healthcare Safety Investigation Branch (HSIB), of these maternity incidents. The Government said that the scheme's purpose includes "the early admission of liability or breach of duty where appropriate."[76]

58. Rather than waiting for a formal claim for compensation to be commenced, within 30 days Trusts are now required to report to the EN incidents which align with criteria defined by the Royal College of Obstetricians and Gynaecologists (RCOG) Each Baby Counts programme.[77] The Government said that the EN has substantially reduced the

69 The Bar Council (NLR0069), para 47
70 Q25
71 Q120, Q124
72 Q44
73 Q105
74 Department of Health and Social Care (NLR0070), paras 51–52
75 A brain injury that happens when a baby's brain doesn't receive enough oxygen during delivery.
76 Department of Health and Social Care (NLR0070) para 53
77 Each Baby Counts was the RCOG's national quality improvement programme to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour.

time taken for NHSR to become aware of an incident and concluded that "the scheme has already reduced the time between an incident occurring, an investigation into eligibility for compensation being initiated and admissions of liability being made".[78]

59. Sir Robert Francis acknowledged that NHSR's initiatives could achieve positive outcomes in terms of quickly pulling together resources to evaluate a serious case and achieving swifter resolution.[79] Sir Robert added that "most of these cases could be solved very quickly indeed" and, referring to his own experiences, explained:

> the speed at which it is possible to gather together a team of experts to talk to the family about their concerns, to be quite transparent with them about what is being looked into, to meet all the relevant doctors and nurses, to come to an early expert view as to what the situation was and to be able, first, to explain that to the family and, secondly, immediately, where it is appropriate, to start looking at what compensation or support they need is a remarkable thing to witness.[80]

Clinical negligence does not promote learning

60. In their written evidence, the Centre for Socio-Legal studies said that law firms "tend to operate initial stringent screening processes which on average reject over 90% of potential cases raised with them" because they will not meet "the threshold for proving legal negligence" or because "they are out of time or not about a matter which is actionable."[81] The law firm, Irwin Mitchell, said that the "screening process" specialist law firms undertake "prevents the significant costs NHS Resolution (NHSR) would incur in investigating and defending" a much greater number of inquiries.[82]

61. Overall, the Centre for Socio-Legal Studies estimated that litigation is initiated in "only around 3%-5% of potential cases" and "this percentage is significantly biased towards matters where the value of the claim is likely to be high".[83] The implication of law firms filleting cases to such an extent before they reach NHSR is that the clinical negligence cases investigated "cannot offer a broad evidence base for the NHS to learn from when the vast, vast majority of the information is received by, and discarded by, claimant lawyers".[84]

62. In any case, witnesses to our inquiry argued that litigation is not set up to deliver learning outcomes and "it is not the intention of a clinical negligence claim to investigate or make findings about any wider implications."[85] The Bar Council said that to suggest that clinical negligence should generate learning "is to misunderstand the purpose of tort law which is to compensate the victim and not to punish or prevent recidivism by the tortfeasor."[86] Scott Morrish concluded that clinical negligence cases "generating lessons

78 Department of Health and Social Care (NLR0070), para 53
79 Q36
80 Q36
81 The Centre for Socio-Legal Studies (NLR0063)
82 Irwin Mitchell (NLR0031), p 2
83 The Centre for Socio-Legal Studies (NLR0063)
84 The Centre for Socio-Legal Studies (NLR0063)
85 The Medical Defence Union (MDU) (NLR0019), para 15
86 The Bar Council (NLR0069), para 21

is a fantasy" and Sir Robert Francis made the case that the clinical negligence process cannot generate learning to solve problems within the health system because it is too adversarial and the process "always takes far too long".[87]

63. The Society of Clinical Injury Lawyers noted that over 20 years ago the then Chief Medical Officer "rightly identified litigation as a rich source of data from which the NHS should learn."[88] However, the Government's evidence was clear that "claims are not the primary source of learning for the NHS, which is best undertaken at source and as close in time to the event as possible". Echoing Sir Robert Francis's analysis, the Government said that the time lag "between incident and claim may curtail the scope for many individual claims to have much impact on system-wide learning."[89]

64. Evidence from academics at Manchester Metropolitan University emphasised the difficulties associated with sharing learning gathered from clinical negligence cases across the NHS. They found that "it is very difficult for NHS trusts to be able to share experiences" and "whilst one trust may learn from reflection on the litigation incident this learning is then not shared with other trusts, who may repeat the same mistakes."[90] In fact, we received evidence which argued that attempting to take learning from clinical negligence cases can impede rather than support learning because individual incidents observed through the lens of clinical negligence litigation may misrepresent overall levels of risk. Hempsons Solicitors noted the implications of a clinical negligence case in the 1950s "had put back the cause of spinal and epidural anaesthesia in this country by 40 years" and there is risk attached to seeking learning from litigation "when our cases are best seen as anecdotal illustrations of danger, rather than presenting a template for safe practice based on the sort of evidence that medicine now demands."[91]

65. We heard repeatedly that many people who bring clinical negligence claims have very little desire to enter into litigation and are not motivated by monetary compensation. Action against Medical Accidents (AvMA) said that people see litigation as a "last resort" and the majority of people "want to understand what happened to them or their loved ones and to make sure that avoidable harm is avoided in the future, so others do not need to suffer in the same way."[92] In essence, people who have suffered harm want the NHS to learn from events and not repeat its mistakes.

66. Joanne Hughes, whose daughter Jasmine died aged 20 months after errors in her care, said that after the death of her daughter she learnt that discovering the truth about what happened is central to acceptance for bereaved families because "you cannot process what has happened until you understand what has happened. You cannot figure out how you are going to learn to live with loss until you understand why the loss has occurred".[93] Sue Beeby described to us the circumstances which led to her son, Jasper, suffering a serious brain injury at birth and said that she and her family "wanted to ensure that what

87 Q25
88 Society of Clinical Injury Lawyers (SCIL) (NLR0011), p 1
89 Department of Health and Social Care (NLR0070)
90 Dr Gillian Yeowell (Associate Professor at Manchester Metropolitan University); Dr Sue Greenhalgh OBE (Consultant Physiotherapist Bolton NHS FT & Clinical Fellow Manchester Metropolitan University at Bolton NHS FT & Manchester Metropolitan University); Professor James Selfe (Professor of Physiotherapy at Manchester Metropolitan University) (NLR0010), para 2.1.1
91 Hempsons Solicitors (NLR0014), section 1, e
92 Action against Medical Accidents (NLR0021), p 4
93 Q22

had happened to Jasper could never happen to another baby."[94] However, two years after Jasper's birth, Sue Beeby and her family had no confidence that the implications of Jasper's case were fully understood "so we felt that we had no choice but to continue with the litigation."[95] Joanne Hughes said that the process of litigation and settling her claim did not lead to learning or even a full explanation because, although the case was settled in her favour, the expert evidence that she accumulated was not accepted by the hospital in question, the harm Jasmine suffered was not fully acknowledge and the reality of Jasmine's death was not recognised by all parties.[96]

67. Dr Sarah Devaney, a Senior Lecturer in Healthcare Law and Regulation at the University of Manchester, pointed to academic evidence which supported the view that most people who pursue clinical negligence claims do so to find out what happened and to prevent it happening again.[97] Dr Devaney identified a relationship between the desire of patients to see that lessons were learned from the harm they suffered and the limited capacity of clinical negligence cases to inform learning. Dr Devaney said that "it is only compensation that is a guaranteed outcome of a successful claim, thus denying many patients and their healthcare providers the improvements in safety that is the desire of all of them."[98]

68. The Centre for Socio-Legal studies at the University of Oxford observed that access to compensation for negligence "hinges on the circumstances in which the harm occurred, not the needs of the injured person".[99] They explained that although only a very small proportion of all cases ever reach court and a settlement, "a substantial proportion of those who litigate do not engage with other ways that the NHS could obtain information on their grievances".[100]

Culture and blame

69. Our terms of reference invited witnesses to discuss whether litigation promotes defensive medicine and a blame culture within the NHS, rather than encouraging clinicians to share their experiences to support learning. To succeed in a claim for clinical negligence, amongst other legal criteria a claimant must establish fault. In litigation cases the fault is personalised to an individual practitioner. Blame is therefore a necessary component part of success for a claimant.[101]

70. In 2018, the British Medical Association surveyed 8,000 members about what impacted on their working lives and found that nearly half of doctors (45%) were often fearful of making a medical error in their daily workplace and over half (55%) said they were more fearful than they were five years previously. Additionally, over half of doctors (55%) said they worried that they wiould be unfairly blamed for errors that were due to system failings and pressures.[102] The Government, however, said that they are "not aware

94 Q16
95 Q16
96 Q22
97 Dr Sarah Devaney (Senior Lecturer in Healthcare Law and Regulation at University of Manchester) (NLR0039), para 2
98 Dr Sarah Devaney (Senior Lecturer in Healthcare Law and Regulation at University of Manchester) (NLR0039), para 2
99 The Centre for Socio-Legal Studies (NLR0063)
100 The Centre for Socio-Legal Studies (NLR0063)
101 Bevan Brittan LLP (NLR0058)
102 FOCIS (The Forum of Complex Injury Solicitors) (NLR0042)

of direct evidence that fear of the current claims process is discouraging NHS staff from disclosing incidents."[103] Furthermore, they said that, whilst claims can be "stressful and upsetting" for clinicians, they do not believe that there is evidence which points to clinical negligence encouraging a blame culture within the NHS.[104]

71. The Government's perspective was supported by Guy Forster, from the Association of Personal Injury Lawyers, who said that "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."[105] AvMA said that it is not the fear of litigation which contributes to a blame culture but the attitude of NHS Trusts for whom "it is all too easy […] to point the finger of blame at an individual clinician who is cited in a clinical negligence claim".[106] Sue Beeby said that in her case the hospital were complacent in their attitude to errors that had been made and were "inclined to believe that one doctor had made a very stupid mistake."[107] As a consequence, the hospital supposed that all they needed to do would be "to reflect on the fact that they had made that mistake and then the hospital could continue" as normal.[108]

72. Nevertheless, there is evidence that the threat of litigation and all it entails can undermine the confidence and behaviour of health professionals. In 2016 Baroness Cumberlage's Better Births review found that the threat of litigation and the high cost associated with it could encourage obstetricians and midwives to practise in a risk-averse way, inhibiting their ability to support some of the choices that women may want to make, and undermined multi-professional working.[109] Similarly, Academics at Manchester Metropolitan University reported that medical professionals responded to the risk of clinical negligence litigation by taking more detailed notes and lowering the threshold for referral and to order investigations.[110] Dr Sarah Devaney cited evidence which called into question the concept of defensive medicine (practising in a risk averse way), calling it a "jaded cliché", however Dr Devaney acknowledged that "the prospect of claims being brought, which have blame at their centre, may deter reporting concerns and therefore learning from error."[111]

73. Sir Robert Francis QC argued that a breakdown of trust can result from "an instinctive defensive reaction of clinicians who, regardless of whether or not the outcome was actually avoidable, feel upset, guilty, and fearful."[112] Sir Robert described the impact on medical professionals when a case arises:

> When a claim is made they can feel singled out, unsupported and worried about possible sanctions. Clinical negligence claims tend not to be discussed

103 Department of Health and Social Care (NLR0070), para 29
104 Department of Health and Social Care (NLR0070), para 40
105 Q95
106 Action against Medical Accidents (NLR0021), p 10
107 Q18
108 Q18
109 National Maternity Review, Better Births Improving outcomes of maternity services in England A Five Year Forward View for maternity care, para 3.32
110 Dr Gillian Yeowell (Associate Professor at Manchester Metropolitan University); Dr Sue Greenhalgh OBE (Consultant Physiotherapist Bolton NHS FT & Clinical Fellow Manchester Metropolitan University at Bolton NHS FT & Manchester Metropolitan University); Professor James Selfe (Professor of Physiotherapy at Manchester Metropolitan University) (NLR0010), para 3.2
111 Dr Sarah Devaney (Senior Lecturer in Healthcare Law and Regulation at University of Manchester) (NLR0039), para 3
112 BMJ Blog, Sir Robert Francis, Why clinicians need to change their approach to litigation, May 7 2021, [Accessed 12 April 2022]

> with colleagues and little help is offered about what to do. Consequently, concern for repercussions of any apology or admission of error can override their duties to the patient.[113]

74. Academics at Manchester Metropolitan University reported in their written evidence that the "adversarial nature of the clinical negligence system perpetuates the 'blame culture'."[114] A 2013 study of midwives' experience of clinical negligence in England included quotes from some midwives which highlighted how difficult the process can be. One midwife said the process was "awful" and, referring to meetings to simply discuss the case said they "can't describe to you how intimidating those meetings are[…] terrifying is the only word."[115] Drs Yeowell and Greenhalgh and Professor Selfe said that clinical staff had responded to the culture that clinical negligence perpetuates by changing careers, specialities, clinical settings and, in some cases, even choosing to retire.[116]

Safety science

75. AvMA has said that improved investigations would help to resolve cases more quickly, improve learning and reduce costs within clinical negligence.[117] However, evidence we took illustrated that the requirement within clinical negligence to demonstrate individual fault stands in stark contrast to best practice in terms of patient safety. The Health Safety Investigations Branch (HSIB), which undertakes "independent investigations of patient safety concerns in NHS funded care across England", has pioneered investigations "which identify the contributory factors that have led to harm or the potential for harm" and "never seek to attribute blame or liability." HSIB said that safety science is not focused on identifying individual error and because the "negligence process focuses on the actions of individual clinicians, even the learning and commitment to change as a result of action will likely be focused erroneously on individuals rather than the systemic factors".[118]

76. Dr Sarah Devaney underlined that it is "only error caused by fault" with which clinical negligence is concerned and that evidence demonstrates that this outcomes-based approach is flawed because "errors which do not fall below the required standard of care, but nevertheless have or could have caused harm are not learned from within this system."[119] Sir Robert Francis said the techniques used by HSIB "should be widespread" a view also expressed by Scott Morrish who made a clear distinction between safety investigations and investigations which related to compensation for injured patients.[120] The extent to which people within the NHS understand how systems can influence their behaviour

113 Ibid
114 Dr Gillian Yeowell (Associate Professor at Manchester Metropolitan University); Dr Sue Greenhalgh OBE (Consultant Physiotherapist Bolton NHS FT & Clinical Fellow Manchester Metropolitan University at Bolton NHS FT & Manchester Metropolitan University); Professor James Selfe (Professor of Physiotherapy at Manchester Metropolitan University) (NLR0010), para 3.2
115 Robertson JH and Thomson AM, A phenomenological study of the effects of clinical negligence litigation on midwives in England: The personal perspective. Midwifery 30 (2014) e121-e130
116 Dr Gillian Yeowell (Associate Professor at Manchester Metropolitan University); Dr Sue Greenhalgh OBE (Consultant Physiotherapist Bolton NHS FT & Clinical Fellow Manchester Metropolitan University at Bolton NHS FT & Manchester Metropolitan University); Professor James Selfe (Professor of Physiotherapy at Manchester Metropolitan University) (NLR0010), para 3.3.
117 Action against Medical Accidents (NLR0021), p1, p4
118 Healthcare Safety Investigation Branch (NLR0037)
119 Dr Sarah Devaney (Senior Lecturer in Healthcare Law and Regulation at University of Manchester) (NLR0039), para 3
120 Q14

and practice was questioned by Sir Robert, who said that when a failure occurs "there is limited understanding that the reason that what, in retrospect, looks like a stupid mistake was actually due to pressures that people have been put under."[121]

77. Highlighting the distinction between clinical negligence litigation and a process that can genuinely contribute to enhanced patient safety Sir Robert concluded:

> your average medical negligence lawyer, whether a solicitor or a barrister, is not necessarily the best equipped person to decide what the safety learning should be in relation to a particular incident.[122]

An opportunity for change

78. An opportunity now exists for the Government to implement a better system for compensating injured patients. Maria Caulfield MP, Minister for Patient Safety and Primary Care, said that "she was not against any scheme" and that she was willing "to look at every single option".[123] The Government acknowledged a fundamental difference between clinical negligence litigation and administrative compensation schemes which operate in other countries. They said that "[t]ort law systems can be seen as more adversarial" and when the two sides cannot reach agreement "they will ultimately go to trial in the courts." In contrast the Government characterised alternative compensation schemes as "more inquisitorial" with claims evaluated by "an administrative body which decides on eligibility and compensation, with much-reduced use of the courts and legal representation."[124]

79. It important that the Government are ready to examine a new way of compensating injured patients as other initiatives being introduced in parallel could complement and underpin proposals for reform. In January 2022 the Government announced that it would create a Special Health Authority (SHA) to assume responsibility from Healthcare Safety Investigation Branch (HSIB) for "independent investigations relating to intrapartum stillbirth, early neonatal death, or severe brain injury diagnosed in the first seven days of life and also maternal deaths."[125] The purpose of the SHA will be to undertake family-centred investigations, share safety concerns and provide system-wide learning beyond those cases which are captured by the Early Notification scheme and with the intention of investigating "the cases where there is the greatest potential for learning across the system."[126]

80. Focusing on birth injury is significant, as the most complex and expensive clinical negligence cases are those related to obstetrics. They account for almost three fifths of cash payments, and the Government's evidence said that 79% of high value awards relate to obstetric claims.[127] Hempsons Solicitors illustrated the scale of the cost by arguing that the "only reason why individual Trusts are able to continue to provide obstetric services is because they are insulated from the fiscal consequences of their actions by the CNST and

121 Q30
122 Q41
123 Q132
124 Department of Health and Social Care (NLR0070), para 17
125 HCWS560, Special Health Authority for Independent Maternity Investigations, Statement made on 26 January 2022
126 Q182
127 NHS Resolution, HC 387, Department of Health and Social Care (NLR0070), Annex B, para 11

NHS Resolution".[128] In the United States of America, the original purpose of the Virginia state Birth-Related Neurological Injury Compensation Program "was to take the most expensive cases out of the system".[129]

Conclusions

81. **In 2005 the New Zealand Parliament made a conscious choice to alter the legislation underpinning their system of clinical negligence because they wanted to change from a punitive system to one that would encourage the co-operation of hospitals and medical professionals. This is the lesson we need to learn in England. If NHS Trusts, medical professionals, patients and their families are to engage in a thorough investigation into what is often a traumatic and tragic event, the whole investigation cannot be premised on a search for individual blame.**

82. **Clinical negligence cannot and does not inform or disseminate learning or systematically contribute to patient safety improvements. It is not its purpose and too much information is filtered out at an early stage to ever make this a realistic prospect. Demonstrating individual fault is fundamental if compensation is to be awarded, but this is not a process consistent with contemporary safety-focused investigations. Whilst there is a strong case for improving the techniques used to investigate mistakes made in the NHS these techniques would not align with the evidence gathering process for a successful clinical negligence claim.**

83. **Some claimant organisations said the screening process, as carried out by specialist claimant firms, prevents a significant cost that NHS Resolution would otherwise incur. Claimant costs, however, account for a fifth of all cash payments associated with clinical negligence and witnesses highlighted that law firms gravitate towards higher value cases, reject those that require a significant initial outlay, and are driven by the pursuit of legal fees. Given the skill with which law firms appear to have leveraged income from the clinical negligence market, we are not convinced that the real cost of screening cases is not eventually passed on to the taxpayer.**

84. ***The system for compensating injured patients in England is not fit for purpose. It is grossly expensive, adversarial, and promotes individual blame instead of collective learning. We recommend that when a patient is harmed, they or their family should be able to approach an independent administrative body which would investigate their case and determine whether the harm was caused by the care they received and if, in the ordinary course of events, it was avoidable. The investigation would be inquisitorial, it would look at the facts of the case, and it would focus on how all parts of the system delivered care to the patient in question. Should it be found that the patient suffered harm because of their care, they would receive compensation.***

85. **We recognise that our recommendations would radically change the principles which underpin the way injured patients are compensated and the Bar Council said that to introduce a new statutory administrative scheme would be "a project of phenomenal ambition." Given the scale of the undertaking, and the cultural change**

128 Hempsons Solicitors (NLR0014)
129 Q57

we are asking the system to make, the new system would be best implemented in stages with an initial focus on the most complex and expensive cases, which are those related to birth injuries.

86. ***As it becomes embedded within the framework of the NHS, we recommend that, in the first instance, the new administrative patient compensation system should be focused on obstetric cases which align with the Each Baby Counts criteria. Once established, and having proven its value, the independent administrative compensation system should then be expanded to accommodate all patient injury claims made against the NHS in England.***

87. ***The Government is creating a new Strategic Health Authority (SHA) to investigate serious incidents and improve safety in maternity care. We believe that reconstituting the SHA to investigate claims, establish the causes of harm and determine eligibility for compensation would be an efficient way for the Government to implement our recommendations. However, reconstituting the SHA should be undertaken in such a way as to create an administrative compensation body whose independence is recognised by the Courts.***

88. In the following chapters we explain why an administrative compensation system would be better for patients, families and clinicians, and how it could be achieved. We also set out the evidence which shows that the system we recommend would be fairer, cheaper and safer.

2 An affordable system

89. In this chapter we explore the costs of an administrative compensation system. We discuss if moving away from clinical negligence litigation to an administrative system would open the floodgates to additional cases and consider the threshold that would need to be established within a non-adversarial system for compensation to be awarded. This chapter looks at the costs of administrative systems which operate in other countries and how they compare with the clinical negligence system in England. We also examine features of the system for calculating damages and modifications which could be made to bring costs under control.

Opening the floodgates

90. Perhaps the most common argument we heard against moving to a non-adversarial statutory system was that it would open the floodgates to claims which, otherwise, would not be compensated. The Medical Defence Union (MDU) said an alternative scheme "would simply be unaffordable", a point repeated by the Association of Personal Injury Layers (APIL) and the Forum for Clinical Injury Solicitors (FOCIS), who pointed to economic modelling published in the mid-2000s related to the NHS Redress Act 2006.[130]

91. The 2006 Act was meant to introduce a redress scheme to cover lower value clinical negligence cases and provide an alternative to litigation. However, successive Governments never brought forward the necessary regulations to implement it in England (a redress scheme for low-value cases does operate in Wales). The scheme set out in the Act could not be regarded as a direct forerunner of a comprehensive administrative scheme as it did not contain many of the essential features of an administrative scheme, such inquisitorial investigations which avoid individual blame, and was "concerned with liability in tort" which meant that "it is essentially about negligence".[131] FOCIS warned that Government projections in 2005 showed that, even for the low-value cases the 2006 legislation was intended to cover, costs could increase by £46 million against a total clinical negligence spend of £500 million and argued that this means any shift to a scheme outside the strictures of tort litigation would place too great a burden on the taxpayer.[132]

92. Nevertheless, as we have already illustrated, legal costs and the value of awards have grown rapidly since the mid-2000s and whether changing the system would, in reality, immediately drive additional cost is worthy of closer inspection. The Government's evidence indicated that costs are already rising very rapidly with annual cash payments set to more than double from £2.2 billion in 2020–21 to £4.6 billion in 2030–31.[133] Sir Robert Francis said the risk of opening the floodgates was a decreasingly relevant point "because we only have to look at how much it is costing now."[134] Sir Ian Kennedy said that he did not believe that an administrative system would "cost as much as the current

130 The Medical Defence Union (MDU) (NLR0019), para 38, Association of Personal Injury Lawyers (APIL) (NLR0016), FOCIS (The Forum of Complex Injury Solicitors) (NLR0042)
131 Michael Powers QC; Anthony Barton (NLR0004), p 3
132 FOCIS (The Forum of Complex Injury Solicitors) (NLR0042)
133 Department of Health and Social Care (NLR0070), Figure C
134 Q32

litigation system", noting that multi-million pound settlements in birth injury cases can be awarded years after the birth of child who, by the time of the settlement, may already have received over a decade's worth of publicly funded care and support.[135]

93. In our examination of administrative systems which operate across the globe, Michael Mercier, Principal Solicitor at the New Zealand Accident Compensation Corporation, told us that even in the New Zealand scheme, which awards compensation on no-fault basis, almost a third of claims that are made are not accepted.[136] Furthermore, Mr Mercier said that claims which carry most cost are decreasing and although their claim volume has increased "serious claims seem to be going down".[137] In New Zealand more people can access compensation without needing to enter a protracted legal battle but that has not unleashed a tide of expensive claims that their system is compelled to settle. Similarly, authorities in Virginia, which operates a birth injury compensation plan completely removed from the tort system, have found that, since they introduced an administrative no-fault system based on clear eligibility criteria, entry into the programme has been steady with no major increase in almost two decades.[138]

94. The Centre for Socio-Legal studies noted in its evidence that legal firms believe that "the clinical negligence market provides an opportunity with significant untapped potential" because the "proportion of people who make a claim after an adverse incident is very low."[139] It is notable that our witnesses from New Zealand and the US said that the bulk of the opposition to administrative schemes in other countries came from legal groups that worked within the field of clinical negligence.[140] Furthermore, it was the representatives of the legal profession in England that argued most vehemently in response to our call for evidence that administrative alternatives to clinical negligence would be unaffordable. Guy Forster, representing APIL, told us, however, that self-interest within the legal profession did not make it resistant to change.[141]

Cost comparisons

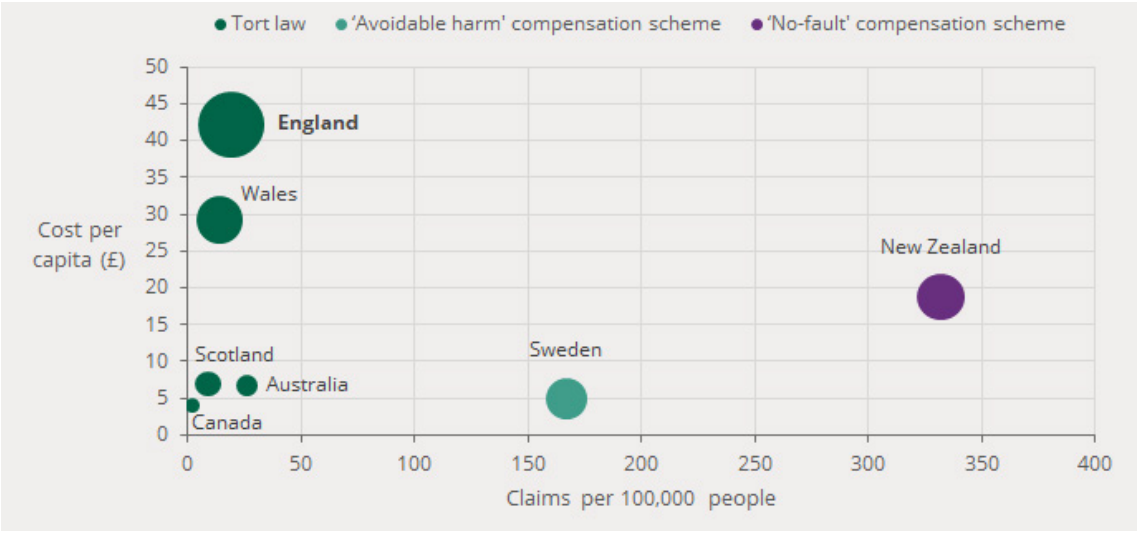
95. An important feature of any administrative compensation system would be the extent to which it would be affordable to operate. Capsticks Solicitors said it should not be assumed that the costs of an alternative administration system would "be less than the costs associated with the current Tort based system" and Guy Forster from APIL said that "the costs involved to administer" an administrative scheme" were "likely to be much greater than what we are dealing with."[142] However, the Centre for Socio-Legal studies offered a very different analysis: they reported that, in contrast to approximately one quarter of all expenditure being swallowed up by legal fees within clinical negligence litigation, in international administrative schemes "administrative costs average between 12–18% of the spend with the rest being compensation payments."[143] This means that "far more of the money paid is going to compensate victims."[144]

135 Q34
136 Q52
137 Q52
138 Q54
139 The Centre for Socio-Legal Studies (NLR0063)
140 Qq73–75
141 Q102
142 Capsticks Solicitors LLP (NLR0060), Q91
143 The Centre for Socio-Legal Studies (NLR0063)
144 The Centre for Socio-Legal Studies (NLR0063)

International comparisons

Figure 1: England has the highest cost per capita for clinical negligence

(Size of bubble represents spending on clinical negligence as a proportion of health spending)



96. Most significantly, the Government's own evidence showed that in comparison to the expense of clinical negligence, all the international administrative systems for which there is data are cheaper in terms of their cost per capita, their cost as a percentage of GDP and their cost as a percentage of total health spend. Not all the international schemes are the same, they have different thresholds for compensation and some entirely replace recourse to the courts whilst others act as an alternative option, however none prove to be more expensive despite recording a higher volume of claims.[145]

Table 1: Clinical negligence claims and costs data across jurisdictions

System	Country	Population (2018, million)	Claims / 100,000 (2018/19)	Cost per capita (£) (2018/19)	% of GDP (2018/19)	% of Health Spend (2018/19)
Tort law	England	56	19	42.1	0.1%	2%
	Wales (2017 data)	3.1	14	29.2	0.1%	1%
	Scotland	5.4	9	6.9	0.02%	0.3%
	Canada	37	2	4.1	0.01%	0.1%
	Australia	25	26	6.8	0.02%	0.2%
'Avoidable harm' compensation scheme	Sweden	10	167	5.0	0.01%	0.8%
	Denmark	6	183	-	-	-
'No-fault' compensation scheme	New Zealand	4.9	332	18.7	0.1%	1%

Source: Department of Health and Social Care (NLR0072), Table A

145 Department of Health and Social Care (NLR0072)

97. The Government attempted to provide us with a broad context in which to view international cost comparisons. They warned that the figures should be "viewed as illustrative" and "the figures cannot be compared on a straightforward like-for-like basis."[146] In particular, making a comparison between England and Sweden is difficult because of the differences in social care provision between the two nations. In England, 58% of the cost of awards over £3.5 million cover the costs of social care alone, whilst in Sweden "social care costs are excluded from compensation awards because they are covered entirely by the social security system."[147] Furthermore, the Government said loss of income is not typically included in Swedish compensation awards whereas it forms "7% of total compensation costs in England."[148] In Sweden, however, loss of future earnings can be included in compensation awards and are calculated on the basis of the average national wage.[149] Nevertheless, the difference in the cost of compensating patients in Sweden as compared to England is far from marginal and there is an order of magnitude difference between the two systems.

98. George Deebo, Executive Officer of the Virginia (USA) Birth-Related Neurological Injury Compensation Program, commented that legal input is rarely required even to determine care for children in complex birth injury cases. He said that the way in which the Virginia programme operates means that "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". Because it is an administrative process approximately only one in ten cases would require any form of hearing.[150] In England, however, a quarter of all that is spent on clinical negligence claims finds its way to lawyers, whilst countries such as Sweden and Japan which have administrative systems "tend to involve low or minimal legal representation".[151]

Thresholds

99. The threshold for the award of compensation within administrative schemes which do not rely on proving clinical negligence can vary. Some systems are based on the principle of compensation being provided for avoidable harm whilst others will adopt a 'no fault' principle. Some systems can combine the two principles.

Table 3: Thresholds for compensation in administrative systems

'Avoidable harm' Compensation Scheme	A scheme or framework that includes a notion of 'avoidable harm' as a threshold for deciding compensation, as opposed to e.g. a negligence threshold. Definitions of avoidable harm vary.
No-fault	The principle that injured persons are entitled to receive compensation for their injuries, without proving fault against the opposite party. A 'no fault' compensation scheme is based on this principle.

Source: Department of Health and Social Care

146 Anastasia Watson (Parliamentary Clerk and Parliamentary Affairs Lead at Department of Health and Social Care) (NLR0073), para 7
147 Anastasia Watson (Parliamentary Clerk and Parliamentary Affairs Lead at Department of Health and Social Care) (NLR0073), para 14
148 Anastasia Watson (Parliamentary Clerk and Parliamentary Affairs Lead at Department of Health and Social Care) (NLR0073)
149 Oral evidence taken before the Health and Social Care Committee on 3 November 2020, HC (2019–21) 677, Q124
150 Q56
151 Anastasia Watson (Parliamentary Clerk and Parliamentary Affairs Lead at Department of Health and Social Care) (NLR0073), para 11

100. The Centre for Socio-Legal Studies noted that the specific thresholds and definitions can be central in determining the number of claims that are accepted and settled. They said that:

> when New Zealand shifted from 'Medical Malpractice' to 'Treatment Injury' [i.e. an injury occurred as a consequence of medical treatment] claim numbers went up by 42% and the proportion that were paid went from 38% to 64%. In contrast in Sweden an avoidable harm threshold is used and around 40% of cases are paid.[152]

101. Establishing the correct threshold could carry with it a degree of legal complexity and the Bar Council warned that ""[a]voidable" injury is a problematic term in the context of clinical negligence as causation is the most contentious issue and very often the reason many claims will fail."[153] They argued that any new scheme must carefully decide its eligibility criteria and be clear if it would "apply a concept like breach of duty or award compensation on a "no fault" basis" as if causation were to be a consideration problems associated with delay and cost may not be avoided.[154] Sir Robert Francis, however, made the case that avoidability is an important component of devising a test which moves away from individual negligence but that "an avoidability test […] would be lowering the threshold."[155]

102. Sweden operates a threshold based on avoidable harm which has proved successful, and we heard that of the 18,000 claims each year that are made just 20–25 would result in a court case.[156] Michael Mercier explained New Zealand's "very low" threshold based around the concept of treatment injury which asks if the injury suffered by a patient was "not an ordinary consequence, was not a necessary part and was not wholly or substantially due to your underlying condition" then the patient will receive entitlements within the compensation programme.

103. Despite setting a low threshold, Michael Mercier noted that the ACC's provisions which relate to treatment injury and eligibility are "extremely complex."[157] Mr Mercier reflected the concerns highlighted by the Bar Council that a challenging aspect of any system is establishing causation and said that determining whether an injury is "an ordinary consequence, or the extent to which something is wholly or substantially due to an underlying condition" is the most complex aspect of New Zealand's system.[158]

104. The Government's evidence emphasised that claim volumes in countries with broader eligibility criteria tend to be much higher and the Centre for Socio-Legal Studies said that "widening the pool of eligible claimants widens the possible compensation bill".[159] Nevertheless, as we have shown, far from all claims in countries with lower thresholds are accepted and in systems such as the birth injury programme in Virginia, the criteria

152 The Centre for Socio-Legal Studies (NLR0063)
153 The Bar Council (NLR0069), para 15
154 The Bar Council (NLR0069), para 15
155 Q29, Q33
156 Anastasia Watson (Parliamentary Clerk and Parliamentary Affairs Lead at Department of Health and Social Care) (NLR0073), para 14
157 Q70
158 Q70
159 Anastasia Watson (Parliamentary Clerk and Parliamentary Affairs Lead at Department of Health and Social Care) (NLR0073), para 11, The Centre for Socio-Legal Studies (NLR0063)

are deliberately narrow and specific.[160] Moreover, the provision of compensation for birth injury in England is a lottery as "those who are able to prove fault will have access to compensation while the ones who aren't able to, will not get any support at all."[161] Although their eligibility criteria can be complex, administrative systems can offer a much more equitable approach.

Damages in an administrative system

Parity of awards

105. An important aspect of designing a new administrative compensation system would be establishing the mechanism for making awards. Central to this would be determining whether the administrative system would award damages of the same value as the courts in clinical negligence cases. The Government's evidence said that awards in both New Zealand and in the Japanese Obstetric Compensation System for Cerebral Palsy (JOCS-CP) have caps and tariffs attached to them which limit the total compensation which can be awarded to an injured patient.[162] For example, in Japan an injured a child is entitled to "a single rate of fixed compensation" which amounts to "a lump sum of c. £195,000 and annual instalments of c. £8,000 for 20 years."[163]

106. Damages awarded as a consequence of clinical negligence "are designed to put the claimant, as far as possible, back in the position they would have been but for the negligence" and England does "not have a culture of exemplary or punitive damages."[164] We should not ignore the fact that financial compensation is an essential component of supporting injured patients, particularly children who suffer birth injuries. Sue Beeby told us that it was a consultant at Addenbrooke's hospital who "stressed the importance of the financial settlement for Jasper's lifelong care needs".[165] As the Association of Personal Injury Lawyers highlighted an award "is not a windfall."[166]

107. Commenting on the application of caps within administrative schemes, the Bar Council said they "are significantly lower than common law damages" and claimants have a right to "fair and equitable compensation".[167] Therefore, it would be "difficult to support any scheme in which a claimant's right to compensation would be significantly reduced."[168] The Bar Council explained that in the early 1990s the House of Lords established an "essential principle" of the way in which an assessment of damages is made, which is that "the claimant is entitled to 100% of their damages".[169]

108. Peter Walsh argued that it would be "intolerable" for awards to be subject to any form of cap and that even top slicing awards to fund administrative costs would be an unacceptable breach of the principle that compensation is awarded to restore someone

160 Q56
161 Medical Protection Society (MPS) (NLR0032), p 5
162 Anastasia Watson (Parliamentary Clerk and Parliamentary Affairs Lead at Department of Health and Social Care) (NLR0073), para 14
163 Anastasia Watson (Parliamentary Clerk and Parliamentary Affairs Lead at Department of Health and Social Care) (NLR0073), para 14
164 Irwin Mitchell (NLR0031), The Centre for Socio-Legal Studies (NLR0063)
165 Q16
166 Association of Personal Injury Lawyers (APIL) (NLR0016)
167 The Bar Council (NLR0069), para 17
168 The Bar Council (NLR0069), para 17
169 The Bar Council (NLR0069), para 49

to the position in which they would have been barring the negligence.[170] Professor Shin Ushiro, Director of the Division of Patient Safety at Kyushu University Hospital, told us, however, that the main complaint in relation to the system in Japan is not the tariff-based compensation but that the scheme's criteria are quite narrow and the families of some children with cerebral palsy must still rely on social security for support as they cannot be entered into the scheme and receive compensation based on the tariff.[171]

109. Any discussion of the way in which damages in clinical negligence cases are determined must acknowledge the relationship between successful claims and the income of legal firms. Successful clinical negligence cases carry with them a substantial success fee for claimant solicitors which is top sliced from the damages which are awarded to the claimant. The Centre for Socio-Legal studies explained:

> Almost all clinical negligence claims are bought using a conditional fee agreement aka 'no win, no fee'. These allow a solicitor to charge a success fee (additional to their basic costs, which are also recovered in the event of a claim succeeding) of up to 100% of their fees capped at 25% of the damages awarded. For lower value claims the claimant usually gets 75% of the value of the court award.[172]

To make up for "the fact that the success fee (of up to 25%) is taken from their damages" successful claimants may receive an uplift of up to 10 per cent to their general damages which will also cover non-pecuniary loss such as pain and suffering.[173] An enhancement of 10% of general damages does not, however, off-set a 25% loss.

110. In the administrative compensation system we recommend there would be no caps applied to the awards and there is no reason why an administrative scheme should be any less generous than the courts. Stripping away legal costs and, specifically, the swingeing success fees which directly reduce the value of awards could, however, allow for a more cost-effective system whereby the damages received by the claimant are not reduced by the entitlements of claimant solicitors.

The provision of NHS care

111. Section 2(4) of the Law Reform (Personal Injuries) Act 1948 provides that defendants who pay for the future healthcare and treatment of damaged patients must do so on the presumption that such care will be provided by the private sector and not the NHS. Michael Powers QC and Anthony Barton noted that the provision "is a limited statutory exception to the common law rule that expenses are reasonably incurred."[174] They said that the provision is "legally anomalous" and claimants have a duty to mitigate their loss, which means that the cost of private health care should not be covered when NHS services are available.[175]

112. The Medical and Dental Defence Union of Scotland (MDDUS) said that the 1948 Act does not reflect the reality of how such care can or should be provided and that many

170 Q113
171 Q72
172 The Centre for Socio-Legal Studies (NLR0063)
173 The Centre for Socio-Legal Studies (NLR0063)
174 Michael Powers QC; Anthony Barton (NLR0004), p 3
175 Michael Powers QC; Anthony Barton (NLR0004), p 6

claimants who receive damages for future healthcare continue to utilise NHS services.[176] The Medical Defence Union also said that it is not clear that the Government has evidence on what investment decisions are made by claimants with their compensation settlements, nor what proportion of that is spent on their care.[177] The Government said there is a lack of data to understand the extent to which patients who receive damages continue to use the NHS for their care, but noted that, overall, NHS services "account for a small proportion of payments for compensation" (approximately 3% of the highest value awards).[178]

113. Ward Hadaway LLP, which is a member of NHSR's Legal Panel, said that repealing section 2(4) would "at a stroke reduce the bill to the exchequer" and Hempsons Solicitors said it is "absurd that the courts should be required to ignore the availability of state services."[179] Discussing reforms that could limit the cost to the taxpayer, Sir Robert Francis highlighted the 1948 legislation and said it is an area that requires "urgent change."[180] The British Medical Association said the provision should be repealed so that defendants can "buy NHS and local authority care packages" which would "ensure those who experienced harm are appropriately cared for while simultaneously keeping the costs within the NHS for the benefit of all patients".[181]

114. However, claimant organisations expressed strong opposition to any repeal of Section 2(4) of the 1948 Act. The Association of Personal Injury Lawyers (APIL) argued that any repeal could have "catastrophic consequences both for injured patients and the NHS".[182] APIL said that, in the aftermath of a medically negligent event, the most effective rehabilitation happens soon after an injury, and "the NHS can be notoriously slow to provide treatment, especially in the current covid-19 crisis and the consequential backlog of cases". Arguing that patients who have been through clinically negligent events can often experience a loss of trust in the NHS, APIL said "it cannot be right that their only hope of further treatment is from the same defendant who caused the injury in the first place.[183]

Future earnings

115. The calculation of damages is partly based on an assessment of any loss of potential future earnings—a calculation that can be highly significant in birth injury cases where damages may need to meet care costs for many decades to come. The Medical Defence Union was highly critical of the way in which a child's lost future earnings are calculated on the basis of parental income, they said the system is "perverse" because it maintains "the notion that the child of an investment banker should receive a higher compensation settlement than the child of a refuse collector."[184]

116. The Medical and Dental Defence Union of Scotland agreed that the calculation of future earnings is unfair and said that other countries have a system in which "awards for high earning claimants are reduced by way of a formula that is not susceptible to

176 Medical and Dental Defence Union of Scotland (MDDUS) (NLR0065)
177 The Medical Defence Union (MDU) (NLR0019)
178 Department of Health and Social Care (NLR0070), Annexe B, para 21, Annexe A, Table B
179 NLR0045, Hempsons Solicitors (NLR0014), para 7 d
180 Q33
181 British Medical Association (NLR0040)
182 Association of Personal Injury Lawyers (APIL) (NLR0016)
183 Association of Personal Injury Lawyers (APIL) (NLR0016)
184 The Medical Defence Union (MDU) (NLR0019), para 23

manipulation."[185] This is achieved by implementing "a cap on what can be recovered as loss of earnings in a clinical negligence context, for example, in Australia awards are capped, typically, a multiple of two or three times the national average wage".[186]

117. In line with the MDDUS's arguments, our July 2021 report into Safety of Maternity services argued that compensation should be based entirely on need, not circumstance, and recommended that awards should be "standardised against the national average wage to prevent unjust variability in compensation payments."[187]

Conclusions

118. **We are concerned only with the dynamics of the legal market in so much as they affect the ability of injured patients and their families to access compensation, and the system to learn and improve safety. However, we note that those that gain most from the present system are its most staunch defenders and the greatest critics of any administrative alternative. The evidence than an administrative system would open the floodgates to new and expensive claims is patchy at best and any examination of the impact on costs must be undertaken with the knowledge that, left unchecked, the cost of settling clinical negligence cases will more than double in the next ten years.**

119. **The advantage of an administrative system is that criteria can be established to remove uncertainty and turn what otherwise would be an adversarial process into one concerned only with the facts of the case. Compensation should be based on agreement that correct procedures were not followed and the system failed to perform, rather than the higher threshold that there has been clinical negligence by a hospital or clinician. Whilst this widens the pool of people entitled to compensation, the evidence from countries that have adopted such an approach is that overall costs will be lower not higher.**

120. ***Establishing the precise criteria for an administrative patient injury compensation system based on system error is a complex task. We have taken evidence from various successful international schemes that each use a different threshold and we do not seek to be prescriptive over which threshold should be used in England. We recommend that the Government should consult widely at home - and evaluate best practice from abroad - to ensure that the bar is set appropriately.***

121. **In our July 2021 report examining the safety of maternity services, we recommended that the Government remove the disregard of NHS care in the award of damages. We have seen no evidence to change our recommendation. To argue that patients injured by errors in their NHS care would not want further care or treatment from the NHS is to mispresent the way healthcare is provided in England. The NHS is not a single entity, but a complex and comprehensive system made up of multiple organisations all dedicated to providing care at the point of need. An injured patient receiving private care in a private hospital is likely to be under the care of an NHS-trained clinician who continues to practise within the health service. Should the NHS in England injure a patient it should be incumbent on the NHS to provide the necessary care to restore the injured party, as closely as possible, to good health.**

185 Medical and Dental Defence Union of Scotland (MDDUS) (NLR0065), para 4
186 Medical and Dental Defence Union of Scotland (MDDUS) (NLR0065)
187 The safety of maternity services in England, HC 19, July 2021, para 105

122. **There is no reason why an administrative scheme should be any less generous in the compensation it awards than the courts, not least because damages would not be top sliced to meet claimant legal costs. Within the administrative compensation system, no caps would be applied to the awards, but a mechanism would be required to establish the cost of care that may need to be provided privately in addition to state funded support.**

123. ***Compensation should be based on the additional costs necessary to top up care available through the NHS and social care system, rather than the current assumption that all care will be provided privately. Whilst we recognise that additional care costs are difficult to calculate, we recommend that they should be modelled using practice established in international patient injury compensation schemes. We further recommend that Section 2(4) of the Law Reform (Personal Injuries) Act 1948 should be repealed for clinical negligence cases brought against NHS organisations in England.***

124. ***The assessment of parental earnings in the calculation of damages for children under 18 years of age is unfair. It undermines the principle that damages should be calculated to meet a person's needs and contradicts the principle of equality that sits at the heart of our health system. We recommend that the assessment of future earnings based on parental income should be scrapped for all NHS-related clinical negligence claims involving children under 18 years of age. We also recommend that such compensation is standardised against the national average wage to prevent unjust variability in compensation pay-outs.***

125. **There is strong evidence that an administrative compensation scheme would provide better value for money to the taxpayer than clinical negligence litigation. There is significant potential to strip away the vast legal costs which account for over a quarter of all that is paid and introduce a system which is cheaper to administer. Furthermore, allowing NHS care to be included in the calculation of damages and basing calculations of loss of earnings on the national average wage would help to moderate the value of awards. An administrative compensation scheme introduced with the reforms we recommend would be more cost effective and more responsive to the needs of patients and families.**

3 A learning system

126. This chapter builds on the evidence and arguments discussed in chapter 1 and explores how inadequate investigations into serious incidents affect injured patients and their families. We examine the relationship between investigations and clinical negligence litigation and illustrate how administrative systems have greater capacity to learn from failures in care. The importance of learning is highlighted by experience from systems in other countries and we discuss the extent to which international administrative systems have enhanced patient safety.

Poor investigations

Patient and family experience

127. Scott Morrish said that reform of clinical negligence should be viewed in the context of failures to properly investigate cases where patients are injured, observing that in his own experience it had taken six months for the original investigation into Sam's death to reach a series of inaccurate conclusions.[188] Sue Beeby said that it was the diligence of her solicitors, rather than the NHS's investigation into the injuries that Jasper suffered, which "established the full catalogue of errors in Jasper's maternity care" adding that the entire NHS investigation took place without her or her family being contacted.[189]

128. Joanne Hughes explained that key aspects of Jasmine's death were never investigated, she saw "no evidence of learning" and there was never an opportunity to learn from the tragedy because the circumstances had "not been properly understood, recognised and acknowledged" by the NHS.[190] Guy Forster from the Association of Personal Injury Lawyers said that the dissemination of learning across the NHS can be "ad hoc" and there is no "cohesive way of pulling learning together."[191]

An inability to learn

129. Discussing the flaws that can afflict investigations which relate to clinical negligence cases, the Bar Council said there have been instances where "substantial compensation is awarded or agreed where the preliminary clinical governance assessment has been not to proceed beyond a 72-hour report."[192] Commenting on the quality of these reports, the Bar Council said they represent a "failed opportunity to review and learn" because the reports "are not even completed by or with regard to the relevant clinicians and may be superficial, inaccurate or incomplete."[193] Whilst the Early Notification scheme for infants born with a potential severe brain injury following term labour was designed to drive down cases of neonatal mortality and birth injury, we heard that it remains "blame focussed" and, whilst mortality has reduced, it has not delivered "a clear decrease in brain injuries."[194]

188 Q7, Q1
189 Q16, Q18
190 Qq23–24
191 Q90
192 A 72-hour report is an initial review that an NHS Trust must complete within three working days of serious incident occurring. It forms the basis of a subsequent more substantial investigation. The Bar Council (NLR0069), para 24
193 The Bar Council (NLR0069), para 24
194 Department of Health and Social Care (NLR0070), Annexe D, para 2, The Centre for Socio-Legal Studies (NLR0063)

130. It was clear from the evidence we heard that clinical negligence investigations subjugate learning in favour of building cases to either prove clinical negligence or defend accusations of individual blame. Joanne Hughes said that finding out what happened to Jasmine descended into a process of each side seeking out competing expert opinions which muddied any focus on discovering the factors which led to her daughter's death.[195] The Bar Council described a "fundamental split" between processes which support "good clinical governance" such as root cause analysis, which does not focus on blame and looks at systematic problems, and the demands of the clinical negligence litigation which analyses "duty, breach, causation and loss and contributory negligence".[196] They concluded that to try and build system-based learning into litigation "would be a radical change to what civil justice means" but it could be a feature of an administrative system.[197]

Learning in administrative systems

Enhancing safety

131. Administrative systems are more able to gather useful data which can be used to enhance learning and patient safety. The Centre for Socio-Legal studies said that administrative systems "have been more successful" in creating the necessary conditions to extract as much data as possible to support learning.[198] In New Zealand healthcare providers became more comfortable in submitting claims to the Accident Compensation Corporation (ACC) after it adopted a no-fault threshold.[199] Michael Mercier acknowledged that New Zealand's claim volumes are high, but in contrast to England, New Zealand has a large amount of data from cases gained via inquisitorial investigations to support their patient safety work. The experience in New Zealand indicates that administrative systems generate less fear and defensiveness amongst medical professionals, which enhances learning and patient safety. The Centre for Socio-Legal Studies concluded that "without the barriers to success of a litigation-based model, administrative schemes centralise the reporting of potential cases, providing a far richer source of data and therefore learning."[200]

132. Examining the relationship between compensation systems, learning, and safety, the Government addressed neonatal mortality and said they "cannot see any clear associations between neonatal mortality rates and differences in the type of compensation scheme."[201] Dr Pelle Gustafson, Chief Medical Officer, at the Swedish patient insurer Löf, however, said that their compensation scheme based on avoidable harm was "a major contributor" to improving patient safety. Dr Gustafson noted decreasing numbers of "both baby injuries and maternity injuries—mostly pelvic floor injuries" as areas where learning from the system had translated into improved patient outcomes.[202]

195 Q22
196 The Bar Council (NLR0069), para 22
197 The Bar Council (NLR0069), para 22
198 The Centre for Socio-Legal Studies (NLR0063)
199 Q62
200 The Centre for Socio-Legal Studies (NLR0063)
201 Anastasia Watson (Parliamentary Clerk and Parliamentary Affairs Lead at Department of Health and Social Care) (NLR0073), para 32
202 Q46

133. Professor Shin Ushiro told us that the Japanese birth injury compensation scheme had a formal process for disseminating learning and an illustration of its success was that it had recorded a reduction in the number of cases coming into the system.[203] In 2009, its first year of operation, 419 cases were entered into the Japanese Cerebral Palsy scheme, by 2014 that figure had reduced to 326 and even when the eligibility criteria were widened the following year eligible cases only increased to 376.[204] Professor Ushiro added that investigative reports into Cerebral Palsy cases increasingly find that cases have resulted from unknown genetic causes and there has been a decline in cases related to error or malpractice.[205]

Improving culture

134. An attractive feature of administrative compensation systems is that they support a restorative culture and do not serve to further widen the fissure between patient and clinician. Dr Pelle Gustafson said that the Swedish compensation model provided a mechanism by which individual clinicians could assist patients in cases where errors had been made and patients experienced harm. This, Dr Gustafson explained, provided clinicians with an additional degree of confidence and reassurance that they can help provide support to harmed patients:

> 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.[206]

135. Dr Gustafson described a sense of relief in knowing that patients are supported by the administrative scheme, and the Centre for Socio-Legal studies concluded that the Swedish model's avoidance of individual blame and capacity for clinicians to help patients make claims had enabled "better learning".[207] Even though healthcare professionals may feel ashamed when an error occurs, we heard that in Japan it has become easier for clinicians to be open about their mistakes because, in addition to compensation, a no-fault investigative report is shared with families.[208] The positive aspects of administrative schemes for healthcare professionals were underlined by Matthew Style, the Department of Health and Social Care's Director General for NHS Policy and Performance, who had "met colleagues from Japan and Sweden to discuss their schemes" and had been "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".[209]

Investigations and regulation

136. An important feature of international administrative systems is the separation of their inquisitorial, no-blame investigations from any wider professional or system-wide regulatory activity. In New Zealand, compensation has been separated from regulation

203 Q59
204 Professor Shin Ushiro (Professor and Director at Division of Patient Safety Kyushu University Hospital, Executive board member Japan Council for Quality Health Care) (NLR0077)
205 Q59
206 Q67
207 Q67, The Centre for Socio-Legal Studies (NLR0063)
208 Q65
209 Q139

which means that since 2005 the ACC has no longer been obliged to report concerns about individual practitioners. Michael Mercier said that in 2005 the ACC assumed 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."[210]

137. Similarly, Dr Gustafson said that in Sweden they "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". Dr Gustafson said "[t]he issue at the systemic level is to separate compensation from supervision, and not having leakage between those two systems."[211] Outlining his vision for an administrative system, Sir Ian Kennedy concluded that the most effective system is one where patient need is considered separately from the failures of institutions or individuals because this would help to eliminate "harmful consequences, not least the tendency to cover up."[212]

138. Precedents exist in the UK whereby information gathered in investigations is held in a 'safe space' and not shared with any other parties. The statutory basis for bodies that investigate air, rail and marine accidents restricts the sharing of information between the investigatory body and other regulatory and legal agencies.[213] The Health and Care Act 2022 contains provisions which ensure that information gathered by the Health Services Safety Investigations Body in the course of its safety investigations could only be shared in very limited circumstances. The main exemption to the 'safe space' would be when it "is necessary to address a serious and continuing risk to the safety of any patient or to the public", but information could also be released by order of the High Court.[214] Originally the Bill contained provisions which allowed information to be released at the request of a senior coroner but the Government has agreed to amend this aspect of the Bill to protect the integrity of the 'safe space.'[215]

Conclusions

139. **Clinical negligence litigation stands in stark contrast to best practice in terms of patient safety. Gains are made by careful system-wide analysis rather than the search for individual blame. The creation of the Health Services Safety Investigations Body as a statutory body which will undertake no-blame safe space investigations maps out the direction of travel for reducing harm and improving patient safety. Maintaining a costly and adversarial litigation system is evermore at odds with our understanding of how the NHS should respond to failures in care. The administrative body's investigative process would generate a rich, more usable source of data which could be returned to the NHS to improve patient care.**

140. **It is not within the scope of clinical negligence litigation to encourage the culture, or support the mechanisms, to identify learning from serious incidents. Neither can the process of litigation disseminate learning and enhance patient safety. Moreover, the experience of those who gave evidence to our inquiry illustrated that investigations after serious incidents are often inadequate and the looming threat of clinical negligence**

210 Q63
211 Q67
212 Sir Ian Kennedy, Clinical negligence reform is an ethical and financial necessity, 9 August 2021 [Accessed 12 April 2022]
213 Health and Care Bill, Explanatory Notes, July 2021, para 130
214 Health and Care Bill, Explanatory Notes, July 2021, para 130, Schedule 14
215 HC deb, 30 March 2022, col 863 [Commons Chamber]

for providers and healthcare professionals does not encourage thorough investigations which can provide injured patients and families with a comprehensive account of what happened in their care.

141. ***Aside from the substantive reform of clinical negligence litigation that we have recommended, we also believe that the investigatory system should be reformed. After any tragedy involving medical error there should be a standardised process of investigation which focuses on the overriding priority to learn from mistakes and prevent tragedies being repeated. We recommend that, at a minimum, such investigations should:***

- ***last a maximum of six months,***
- ***be independently-led involving both families and the Trust in question,***
- ***include implementation of any safety recommendations that are made,***
- ***communicate lessons across the NHS.***

142. ***We further recommend that, in parallel, an investigation by an independent administrative body responsible for alternative dispute resolution should be completed and a determination on liability for compensation released to the family, the Trust and NHS Resolution. The Trust and NHS Resolution would decide whether to accept liability for a mistake or negligence and to commence payments. If at the end of the six-month window liability for cases relating to maternity care has not been accepted these cases would fall within the remit of the Early Notification scheme and NHS Resolution.***

143. **In the longer term, an administrative compensation system would address problems associated with inadequate investigations by undertaking inquisitorial, system-focused investigations with no examination of individual blame. This would build greater confidence amongst healthcare professionals that they could be open and forthright when contributing to investigations. However, to further support healthcare professionals, we believe that there should be formal separation between the administrative body's investigative process and external regulatory processes.**

144. ***We recommend that information obtained by the administrative body in its investigations should not be shared with any other professional or system regulator unless it constitutes unlawful activity or identifies an immediate danger to patients. We also recommend that the administrative body should agree a memorandum of understanding with the Office of the Chief Coroner to ensure consistency of investigation and provide transparency as to the process for the disclosure of information for inquests.***

4 Access to justice

145. In this chapter we explore how administrative systems respond to the needs of injured patients and illustrate evidence which shows that administrative systems can compensate more quickly than clinical negligence litigation. This chapter discusses whether the introduction of an administrative system should mean that injured patients lose their right to recourse via the courts and we examine how this aspect of the administrative compensation process operates in other countries. We also consider reforms that could be introduced to enhance access to justice within the existing legal framework which includes the greater use of alternative dispute resolution techniques in advance of legal proceedings. Finally, we examine the Government's proposals to limit the legal costs that can be charged in some low-value clinical negligence cases.

146. The central feature of a statutory administrative scheme for compensating injured patients would be enhanced access to justice. Action against Medical Accidents cautioned that "it would be abhorrent if people injured by the NHS had lesser access to justice than those caused personal injury in other parts of society" noting that tort law applies to all personal injury claims and not only clinical negligence.[216] However, evidence we received illustrated that an administrative system could resolve cases more quickly and be more responsive to the needs of injured patients. The Centre for Socio-Legal Studies said that when the Accident Compensation Corporation (ACC) in New Zealand, "shifted from 'medical malpractice' (individual fault-based) to 'treatment injury' (an avoidable harm threshold that looks at systemic issues as well as individual errors), the average decision time for a claim fell from over 5 months to 13 days."[217]

Administrative systems are more responsive

147. Discussing the benefits to families of the swift resolution of cases, Dr Sonia Macleod, a researcher into Civil Justice Systems based at the Centre for Socio-Legal Studies within the University of Oxford and Specialist Adviser to this inquiry, highlighted the birth injury scheme introduced in Virginia in the 1980s. Dr Macleod said that "[i]n Virginia, eligibility for compensation is determined for every single child entered on that scheme within four months of the scheme becoming aware of it."[218] The Centre for Socio Legal Studies said that despite improvements to birth injury litigation as a consequence of the Early Notification scheme, England is "nowhere near the timeframes that international administrative schemes operate" and "there is a plethora of evidence from other schemes, such as ACC in New Zealand and the Nordic countries, which indicates that administrative schemes have much faster claim processing times."[219]

148. As a consequence, an administrative system could be more responsive in the way that payments are made to successful claimants. Simon Hammond, Director of Claims Management at NHS Resolution, explained that some international administrative systems are able to review needs on an ongoing basis whereas in England claimants receive "a once-and-for-all settlement."[220] Simon Hammond told us that delay can be built in because children have to reach "developmental milestones" before a full assessment of

216 Action against Medical Accidents (NLR0021)
217 The Centre for Socio-Legal Studies (NLR0063)
218 Q38
219 The Centre for Socio-Legal Studies (NLR0063)
220 Q94

their life-long needs can be made.[221] Irwin Mitchell said that in birth injury cases a brain injured child may be at secondary school before "the full extent of their needs become clear."[222]

149. Bevan Brittan LLP, which sits on NHS Resolution's clinical negligence legal panel, were very critical of the once-and-for-all approach. They acknowledged that periodical payment orders (PPOs)[223] are now used in high value cases to make life-long payments but said the process for determining damages is inherently inadequate because "the assessment of the cost of care will inevitably be unsatisfactory either over compensating or under compensating the Claimant."[224] The Government's evidence said that the use of PPOs in high value awards had "risen at an average rate of 7% to 8% per year over the last decade", but Browne Jacobson LLP, which is on NHS Resolution's legal panel, cautioned that high value awards may need to be reviewed "at key stages to check that the assumptions on which they were based remain valid" and doing so could encompass additional administrative cost.[225]

150. Helen Vernon, Chief Executive of NHS Resolution (NHSR), said that in birth injury cases NHSR does have the ability to make "small interim payments that might support the family in the early years".[226] Nevertheless, Sir Robert Francis highlighted "long periods of time" when no support is available to injured patients and Sue Beeby told us that because "it took two years for the hospital to admit liability" her family did not receive "the funding that we wanted to use to improve Jasper's outcomes."[227] The Centre for Socio-Legal Studies highlighted the glaring difference in performance between England and countries with administrative systems, pointing to evidence which showed that "the average time period from a birth related brain injury in a baby occurring to full quantification of a settlement was 11.5 years", in contrast "international non-adversarial schemes could determine eligibility and quantification for all claimants within a year."[228]

151. It is welcome that Matthew Style, Director General for NHS Policy and Performance at the Department of Health and Social Care, acknowledged that international evidence illustrated the importance of families receiving early support and that this is something that would be examined within "the current statutory framework."[229] However, Sir Robert Francis observed that it is the adversarial nature of litigation which breeds delay so any attempt to improve processes within the existing statutory framework is constrained by the demands of demonstrating clinical negligence and determining legal liability.[230] The system in England stands in stark contrast to the birth injury schemes in Virginia and Florida, which have statute-defined timeframes and can begin to provide certainty to the families of severely injured children within a matter of weeks.[231]

221 Q94
222 Irwin Mitchell (NLR0031), para 25
223 A continuing series of regular instalments paid to the injured person for the rest of their life instead of a single lump sum payment.
224 Bevan Brittan LLP (NLR0058)
225 Browne Jacobson LLP (NLR0051), para 24
226 Q173
227 Q19
228 The Centre for Socio-Legal Studies (NLR0063)
229 Q172
230 Q25
231 The Centre for Socio-Legal Studies (NLR0063), para

Retention of legal rights

152. A notable aspect of some, but not all, of the administrative systems which operate around the world is that the schemes replace a patient's right to seek redress via the courts. In New Zealand, for example, a person who is harmed as a consequence of medical treatment cannot sue for any costs that relate to an injury the Accident Compensation Corporation (ACC) covers because "it is an exclusive system, in that it takes away civil litigation rights."[232] The systems in Sweden and Japan, however, offer an alternative to legal routes and Professor Shin Ushiro noted that when the Japan Obstetric Compensation System for Cerebral Palsy was introduced there was "a decrease in the number of lawsuits related to obstetrics and gynaecology by 75%."[233]

153. The Bar Council said that "one of the positive features of the tort law system in that it is able to develop the law in relation to new circumstances and novel claims" and that it would be "hard to see how a statutory [administrative] scheme can retain the same or similar ability to develop the law or achieve just satisfaction for an injured claimant."[234] To mitigate this problem they said that "part of the answer to this issue would be retaining the claimant's right to bring a civil claim."[235]

154. Examining how an administrative system could co-exist with the continued right to bring a civil claim, the Centre for Socio-Legal studies said that there are two ways this could be achieved. The first is for the two systems to operate in parallel and the second is for litigation to become an option only once a claimant has been through the administrative system.[236] If the former were to be implemented, they said that for the system to function efficiently the administrative option would have to be more attractive to claimants.[237] This was achieved in Sweden because the administrative system run by Löf, the Swedish patient insurer, "is non-adversarial, faster and offers parity of compensation."[238]

155. In the UK, however, there are already systems of redress which limit the right to bring legal proceedings until after an alternative route has been explored. The Centre for Socio-Legal Studies said that UK Ombudsman Schemes "do not choke off the possibility of court access entirely but litigants are usually required to have gone to the Ombudsman before being granted access to the courts."[239] Sonia Macleod said that the advantage of an Ombudsman system is that the inquisitorial nature of their investigations "takes out the adversarial nature from the get-go."[240] Furthermore, the courts regard properly constituted, independent Ombudsman as an acceptable model of justice, typically endorse their decisions and Ombudsman often have their powers set out in primary legislation.[241]

156. In practice, when given the choice, injured patients tend to prefer non-adversarial administrative systems and we know that in England it takes claimants between two and three years to bring a clinical negligence claim.[242] The Government's evidence reported

232 Q51
233 Q58
234 The Bar Council (NLR0069), para 16
235 The Bar Council (NLR0069), para 16
236 The Centre for Socio-Legal Studies (NLR0063)
237 The Centre for Socio-Legal Studies (NLR0063)
238 The Centre for Socio-Legal Studies (NLR0063)
239 The Centre for Socio-Legal Studies (NLR0063)
240 Q38
241 The Centre for Socio-Legal Studies (NLR0063)
242 NAO, 2017, para 1.9

that the number of people in Sweden who choose to seek redress via the courts instead of through the administrative systems is very low, noting that "around 20–25 cases go into the court system per year as compared to c. 18,000 claims that go through the administrative scheme".[243]

157. Professor Uhsiro told us that when Japan's Cerebral Palsy Scheme was introduced there was a fear that families would use part of their compensation to fund further litigation, but instead lawsuits decreased because the scheme was able to provide investigative reports to families which explained what when wrong in their care.[244] The Professional Standards Authority for Health and Social Care (PSA) highlighted research from the USA which found that when a hospital in Michigan changed the way it responded to patient injuries and medical malpractice claims there was a reduction in legal cases brought against the hospital. The PSA concluded that "no-fault compensation schemes lead to fewer claims" in the courts because "defensive organisational response to avoidable harm tends to encourage rather than discourage patients and families from taking action."[245]

158. We also heard that the administrative schemes may be more attractive to patients because they have the capacity to be more compassionate. This is because patients and clinicians are not immediately divided into separate camps and in practice means that "the doctor or nurse will sit down with the patient in the hospital" to discuss with them what went wrong and help them begin the process of seeking compensation.[246]

Advocacy

159. We heard that the relationship between the injured patient and solicitor was a central aspect of ensuring access to justice for claimants. Sue Beeby told us that her family had "an exceptional solicitor" and it was the diligence of their legal team that meant she and her husband eventually had the opportunity to participate in a mediated discussion with the senior team at the hospital where her son, Jasper, was injured.[247] Joanne Hughes said that following the death of her daughter, Jasmine, she had numerous questions and with an inquest looming realised that she required an advocate "who could offer me the advice, support and advocacy that I needed both to try to establish the truth and to represent me at the inquest."[248]

160. Sir Ian Kennedy told us that it should not require good lawyers to ensure that patients and their families have mediated discussions which provide an honest account of what happened in their case.[249] Sir Ian added that people are "lucky to get good lawyers sometimes" and we heard that advocacy can extend beyond making a claim and even beyond the award of damages. Discussing her path to receiving damages following the birth injuries suffered by her daughter, Kirsty, Jill Edwards said that it was 13 years before she found a solicitor who was able to take her case and even then "he said he could not make any promises." Even today, 39 years on from Kirsty's birth, and with damages awarded in 2007, problems persist with Mrs Edwards' legal representation. Mrs Edwards

243 Anastasia Watson (Parliamentary Clerk and Parliamentary Affairs Lead at Department of Health and Social Care) (NLR0073), para 22
244 Q76
245 Professional Standards Authority for Health and Social Care (NLR0047), para 2.2
246 Q39
247 Q21, Q16
248 Q22
249 Q27

said that she had been forced to change solicitors because of difficulties in making use of the damages awarded to Kirsty and that she absolutely dreads "walking into a solicitor's office because I and my daughter are made to feel like we are powerless".[250]

Reforms to the existing system

Alternative Dispute Resolution

161. Our recommendations would not immediately alter the system for making a claim for all claimants as the new system would, initially, only apply to birth injury cases. Therefore, we examined aspects of the existing system which could be improved to streamline litigation and tackle costs, delay and the adversarial nature of clinical negligence.

162. Central to improving the experience of claimants and defendants within litigation is enhancing the role of alternative dispute resolution (ADR) which includes mechanisms for resolving disputes which do not require court proceedings. Action against Medical Accidents (AvMA) said that ADR "offers a good way of resolving some claims in a more constructive and economical way" and can deliver both a financial settlement and collective understanding of what went wrong which can be powerful in achieving closure for injured patients and their families.[251] The Association of Consumer Support Organisations, which represents the interest of consumers in the civil justice system, said mediation (a structured conversation between parties in a dispute facilitated by a neutral mediator) is useful because many claimants do not pursue a clinical negligence claim purely to seek financial compensation, but because they desire an apology from the person or organisation that caused harm and seek reassurance that the error will not occur again.[252]

163. Joanne Hughes, who is training to be a mediator, discussed mediation in the context of a restorative approach which focuses on the needs of everybody involved in an event which caused serious harm. Mrs Hughes argued that amongst patients and families, and within the NHS, there is a greater need for understanding about how the restorative approach evaluates harm that has been suffered by all parties, which can extend beyond the injured patient and include medical professionals.[253] Mrs Hughes said this restorative approach complements a just culture which should recognise harm, understand how it came about, takes collective responsibility, and asks how the harm can be repaired.[254] Helen Vernon, Chief Executive of NHS Resolution, told us that healthcare staff need greater training in understanding how clinical negligence operates so that there is no fear in admitting error and so that they can be "open and transparent right from the off."[255]

164. The Centre for Socio-Legal studies said that, when subject to a complaint, healthcare professionals have "some concerns such as damage to professional reputation and employability" and experience "a disconnect between the professional's perception of themselves as a caring professional and the adverse event outcome".[256] Sir Robert Francis noted that when adverse events occur health professionals will often, unreasonably, "feel

250 Q127
251 Action against Medical Accidents (NLR0021), p 6
252 The Association of Consumer Support Organisations (ACSO) (NLR0028)
253 Q42
254 Q42
255 Q146
256 The Centre for Socio-Legal Studies (NLR0063)

deeply that it is their responsibility."[257] Joanne Hughes said that after a serious incident healthcare professionals suffer "moral injury" and this needs to be acknowledged within the process of resolution.[258]

165. NHS Resolution has emphasised that mediation, which is the main form of ADR, can provide claimants, patients and their families with a platform to articulate concerns. They said it enables NHS staff to listen and respond to concerns because it "puts the patient/claimant at the heart of the claim" and addresses concerns beyond financial compensation which "would otherwise not be possible to address in any other dispute resolution setting such as a meeting with just the lawyers."[259]

166. The Government said that "[s]ince NHSR's mediation scheme was first launched on 5 December 2016, over 1,200 claims have been mediated up to 31 March 2021."[260] To put this figure in context, in 2020–21 NHS Resolution received 12,629 clinical negligence claims and in that year 74% of claims were resolved without formal proceedings.[261] In 2020 NHSR reported success in those cases that were mediated, highlighting that "74% of cases mediated are settled on the day of mediation or within 28 days of mediation date"[262] and the Government concluded that mediation is now "a regular feature in health claims."[263] However, the Forum of Complex Injury Solicitors (FOCIS) were critical of NHSR's approach, observing that "ADR is still often refused by NHSR if liability is in dispute [or] until evidence obtained."[264] They called for NHSR to demonstrate "increased willingness" to "enter into early ADR."[265]

Mediation

167. The legal firm, Irwin Mitchell, were positive about ADR saying that "in all but a rare few cases it is successful in resolving the claim before a trial", but cautioned that "traditionally it has been seen as an adjunct to the court process, often deep into litigation."[266] A number of witnesses called for the expanded early use of mediation and face-to-face meetings between the claimant and defendant.[267] Sir Robert Francis advocated the benefits of mediation and agreed that it happens "too late in the process, after a great complexity of litigation and the litigation process has started."[268] Explaining when mediation should take place, Sir Robert said it should begin:

> right at the outset, when there are angry people on one side and scared doctors on the other, that is exactly the sort of situation where trained mediators and conciliators can have an enormous effect on getting people to focus on the issues and to come to an outcome that is mutually satisfactory.[269]

257 Q30
258 Q42
259 NHS Resolution, Mediation in healthcare claims – an evaluation, 12 February 2020 [Accessed 25 March 2022]
260 Department of Health and Social Care (NLR0070), Annex E
261 Department of Health and Social Care (NLR0070), para 51
262 NHS Resolution, Mediation in healthcare claims – an evaluation, 12 February 2020 [Accessed 25 March 2022], p 4
263 Department of Health and Social Care (NLR0070), para 51
264 FOCIS (The Forum of Complex Injury Solicitors) (NLR0042), p6
265 FOCIS (The Forum of Complex Injury Solicitors) (NLR0042), p6
266 Irwin Mitchell (NLR0031), para 23
267 For example: Irwin Mitchell (NLR0031), The Association of Consumer Support Organisations (ACSO) (NLR0028), The Charlie Gard Foundation (NLR0023)
268 Q37
269 Q37

Sue Beeby said that it was two years after Jasper died that she and her family had an opportunity to be heard and found out what happened, but early mediation might have brought swifter resolution and prevented the case from extending beyond Jasper's death.[270]

168. Lauren McGuirl, Director for Commercial Services, at the Centre for Effective Dispute Resolution (CEDR) which established and serviced the pilot mediation scheme initiated by NHSR, said that starting mediation early may not achieve "complete resolution" but "will result overall in more engagement and more resolution remedy for the patients".[271] Furthermore, early mediation "will also reduce costs because claims that would have been filed are not."[272]

169. We considered whether mediation should be a compulsory feature of any clinical negligence claim. As outlined above, there are some circumstances in the UK whereby legal cases can only be brought after attempts at resolution via the Ombudsman have been exhausted so precedent exists for restricting access to legal routes until alternatives have been utilised. Helen Vernon, Chief Executive of NHSR, however, was sceptical, arguing that "because of its nature" mediation "is best carried out on a voluntary basis".[273] Lauren McGuirl said that cases would have to be reviewed "on a case-by-case basis" but that there could be merit in introducing compulsory mediation of clinical negligence cases.[274] Scott Morrish said it was "staggering" that mediation is not used more widely and it "should be a compulsory part of the aftermath of any harm event."[275]

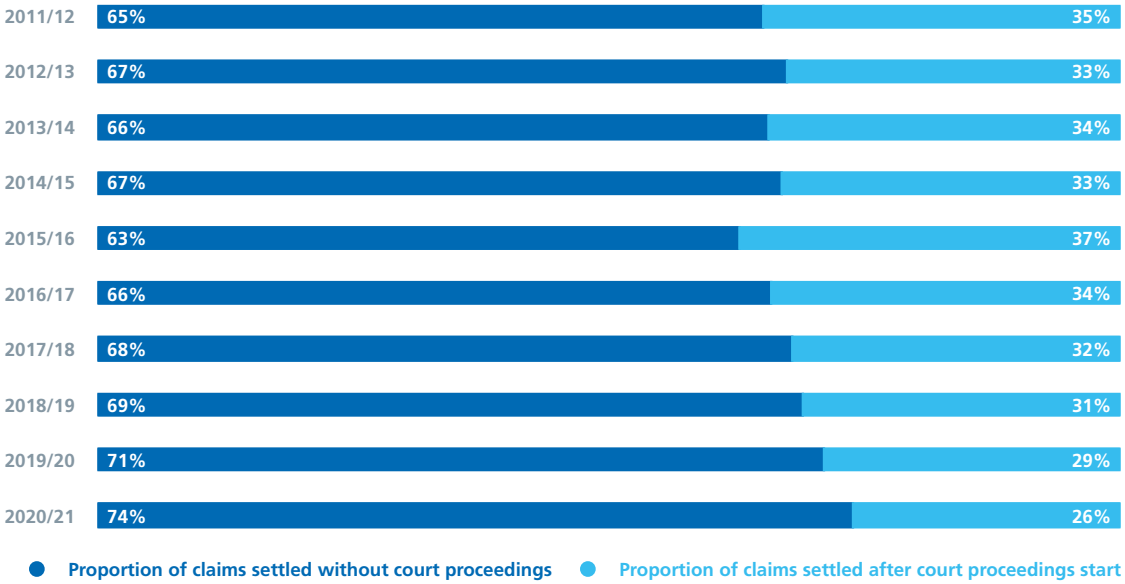
Early resolution of cases

170. The majority of clinical negligence claims are resolved without formal court proceedings (pre-action) with both parties reaching agreement about liability and damages, or acceptance by the claimant that there was no negligence. Settlement can be achieved through a Pre-Action Protocol (PAP)[276] but, even using PAP, the time to resolution can still vary significantly and complex claims can take several years.[277]

171. Commenting on the process by which clinical negligence claims are managed, the Government said that "a desire for speedy resolution and a smooth claimant experience must neither cut across access to justice and appropriate redress for claimants" nor "dilute the requirement to ensure value for money for the NHS and the taxpayer".[278] The Government's evidence emphasised the role NHSR has played in resolving cases early to prevent them reaching court which has included a "more collaborative approach with claimant solicitors". This has included working with "claimant law firms and their own panel firms" on "various innovative dispute resolution techniques focused on improving resolution meetings and changes to process."[279] AvMA, however, called for improved "co-

270 Q45
271 Q92
272 Q92
273 Q168
274 Q92
275 Q44
276 The Pre-Action Protocol sets out conduct that the court would normally expect prospective parties to follow prior to the commencement of proceedings
277 NHS Resolution (2021). Annual Statistics (Supplementary Annual Statistics, Table 17.A). London, NHSR. Available online at:
278 Department of Health and Social Care (NLR0070), para 48
279 Department of Health and Social Care (NLR0070), paras 51–52

operation between defendant and claimant solicitors and rigorous application of the clinical negligence 'Pre-Action Protocol'"[280] Nevertheless, data published by NHSR indicated that progress has been made in settling cases without court proceedings:



Source: NHS Resolution, Annual report and accounts 2020/21, 15 July 2021, HC 387, Figure 17

172. We heard that early settlement of cases may reduce costs within the process of litigation. The Association for Personal Injury Lawyers said that collaboration with NHSR had generated "greater efficiency" resulting in "lower costs, without removing the injured patient's need for, and right to, full and fair compensation."[281] AvMA said that "most of the legal costs can be avoided" if "offers of compensation are made early", although this would require fault to be "recognised and admitted."[282] Irwin Mitchell said that "facilitating learning closer to the event and reducing the time and expense involved in unnecessary legal investigations" could be achieved if "a system that empowered the Trust or NHSR to admit cases early" was introduced. Peter Walsh told us that because the NHS is liable, as opposed to individual clinicians, it should be possible to quickly settle cases "without the need for litigation."[283]

173. Although academics at Manchester Metropolitan University "found that claims are settled out of court even where clinical negligence has not been found" the legal constraints and implications of clinical negligence make it difficult for the system to respond in the way envisaged by AvMA.[284] Helen Vernon was adamant that NHS Resolution works within the framework of clinical negligence and "can only make a payment where we are satisfied that there is a case of negligence, as opposed to an avoidable harm threshold".[285]

280 Action against Medical Accidents (NLR0021), p4
281 Association of Personal Injury Lawyers (APIL) (NLR0016)
282 Action against Medical Accidents (NLR0021), p 2
283 Q101
284 Dr Gillian Yeowell (Associate Professor at Manchester Metropolitan University); Dr Sue Greenhalgh OBE (Consultant Physiotherapist Bolton NHS FT & Clinical Fellow Manchester Metropolitan University at Bolton NHS FT & Manchester Metropolitan University); Professor James Selfe (Professor of Physiotherapy at Manchester Metropolitan University) (NLR0010), para 1.2
285 Q165

174. The law does not appear to provide scope for cases to be settled on any basis other than clinical negligence, which means individual fault. Dr Sarah Devaney said that tort litigation "does not go beyond the actions of the clinician involved, whether this reached the required professional standard, and whether this failure to meet the standard caused the injury concerned."[286] The Bar Council observed that the Bolam test focuses on the question of whether "no reasonable clinician would have done what the Defendant did or failed to take steps which should have been taken."[287] In contrast, rather than concentrating on individual fault, the test in New Zealand is influenced by the overall performance of the system that provided care to a patient. Michael Mercer told us that this is an important feature of their no-fault approach as it enabled a degree of buy-in and cooperation from health professionals which otherwise would not have been achievable.[288]

Fixed recoverable costs

175. Fixed recoverable costs (FRCs) in clinical negligence may have the potential to curb rising costs but there are concerns that they may inhibit access to justice. Fixed recoverable costs set the amount of legal costs that the winning party can claim back from the losing party in civil litigation and give certainty in advance about the maximum amount that the losing party will have to pay. However, they mean that the amount that can be reclaimed may not cover the actual costs of the case, which can be hard to predict.

176. Fixed recoverable costs already apply in most low-value personal injury cases and in January 2017 the then Department of Health consulted on introducing FRCs for clinical negligence cases with a value of up to £25,000 in damages. In parallel with the Department of Health's consultation, in July 2017, Lord Justice Jackson published a review examining the options to extend fixed recoverable legal costs for all personal injury claims with damages up to £250,000. Whilst clinical negligence claims were not originally within the scope of his review, Lord Justice Jackson said that a "working party with both claimant and defendant representatives" should be established by the Department of Health and the Civil Justice Council "to develop a bespoke process for handling clinical negligence claims up to £25,000."[289] In their consultation response the Government acknowledged Lord Justice Jackson's recommendations but noted that even organisations supportive of FRCs in clinical negligence were cautious about their introduction. The Department of Health agreed to set up a working group to further develop the proposals.[290]

177. On 31 January 2022 the Government "published a consultation proposing FRCs and a streamlined claims process for clinical negligence claims up to £25,000 in damages."[291] In their evidence the Government said that for lower value claims the "average claimant legal costs in 2019/20 were five times those of defendant legal costs" and the Minister said the proposals to cap recoverable costs "will save something like £454 million over the next 10 years."[292]

286 Dr Sarah Devaney (Senior Lecturer in Healthcare Law and Regulation at University of Manchester) (NLR0039), para 1
287 The Bar Council (NLR0069), para 38
288 Q51
289 Judiciary of England and Wales, Review of Civil Litigation Costs: Supplemental Report Fixed Recoverable Costs, the Right Honourable Lord Justice Jackson, July 2017
290 Department of Health and Social Care, Consultation on Introducing Fixed Recoverable Costs in Lower Value Clinical Negligence Claims Summary of Consultation Responses, February 2018
291 Department of Health and Social Care (NLR0074), para 17
292 Department of Health and Social Care (NLR0070), para 31, Q131

178. Organisations that represent defendants in clinical negligence cases expressed strong support for FRCs. The Medical Protection Society (MPS) said it is not unusual for claimant lawyers' costs to exceed the damages awarded to claimants in lower value clinical negligence claims, even where claims are settled at an early stage.[293] The MPS said they would support FRCs for all clinical negligence claims up to a value of £250,000, highlighting data published by the Government in 2017 which showed that for "claims with damages payments between £50,001 and £100,000 in 2015/16, the total defence costs were 19% of the damages - whereas the claimant costs were 99%."[294] Furthermore, for claims which have a value of between £100,001–£250,000 «the total defence costs were 15% of the damages, whereas the claimant costs were 72%.»[295] The MPS concluded that FRCs would "[i]ncrease transparency and proportionality for all parties" and would also "benefit both parties financially, as it would no longer be necessary to prepare and then agree or dispute budgets in claims that fall under the regime."[296] In July 2017, however, Lord Justice Jackson concluded that FRCs would not be suitable for most clinical negligence claims above £25,000.[297]

179. The Bar Council's evidence cautioned that "the complexity of issues such as breach of duty and causation bear no necessary relationship to the level of financial loss suffered" and therefore cases "settled for a modest amount of damages may incur the same or very similar levels of costs as larger claim[s]".[298] Action against Medical Accidents (AvMA) said the failure to recognise that low-value cases may still be very complex was a "fundamental flaw" with the Government's proposals and the Bar Council pointed out that very serious cases such as neonatal death may require expert evidence and investigation but only result in "modest damages."[299] In 2017, the Medical Defence Union, said "it is possible to recognise the additional complexity of clinical negligence claims within a fixed costs regime" and they would not "support any exceptions for clinical negligence […] as that would open the way for legal challenges that would undermine the whole point of fixed costs.[300] Hempsons Solicitors, however, said that exceptions to FRCs should be made in group actions or cases where claimants are testing a point of law.[301]

180. The Minister told us that the FRC scheme proposed in the Government's 2022 consultation would make "the process faster, quicker and fairer for patients, so that they are able to reach a settlement as quickly and easily as possible."[302] AvMA, however, said that there is little evidence to support the idea FRCs can reduce the costs of litigation. Instead, they argued that reducing costs in this way will diminish the "public's ability to access justice", a claim also made by the Association of Consumer Support Organisations.[303]

293 Medical Protection Society (MPS) (NLR0032), p 4
294 Medical Protection Society (MPS) (NLR0032), p 4
295 Medical Protection Society (MPS) (NLR0032), p 4
296 Medical Protection Society (MPS) (NLR0032)
297 Judiciary of England and Wales, Review of Civil Litigation Costs: Supplemental Report Fixed Recoverable Costs, the Right Honourable Lord Justice Jackson, July 2017
298 The Bar Council (NLR0069), para 12d
299 Action against Medical Accidents (NLR0075), The Bar Council (NLR0069), para 12d
300 The Jackson Review, fixed-recoverable-costs-supplemental-report-online-2–1.pdf (judiciary.uk)
301 Hempsons Solicitors (NLR0014), p 11
302 Q158
303 The Association of Consumer Support Organisations (ACSO) (NLR0028), p 2, Action against Medical Accidents (NLR0021), p 7

181. AvMA's main concern was that "many law firms" will "decline to represent clients with lower value claims because it is hard to recover their costs and to make a profit."[304] The Society of Clinical Injury Lawyers (SCIL) said that "a recent 'straw poll' of SCIL members found 70% of member firms would be forced to withdraw from working in the field if these proposals were to be introduced."[305] SCIL said that should this happen the poorest claimants would be disproportionately affected as they would not be able to ""top up" inadequate levels of fixed costs".[306] AvMA claimed that they have already "seen a marked increase in people coming to us for help because they are finding it hard or impossible to find a solicitor" and the "imposition of fixed recoverable costs in the way proposed by the Government would make this problem much worse."[307] AvMA expressed concern that defendants would have a "perverse incentive" to increase costs "in the knowledge that the claimant solicitor simply will not be able to continue as they would not be able to recover their costs."[308]

182. Discussing the impact on the legal market, the Bar Council offered a broader view. They pointed out that financial implications for claimant law firms have already been considered, and whilst in some cases the fixed costs may be insufficient, in others they could be generous relative to a legal firm's outlay:

> An important aspect of the fixed costs regime emphasised by the senior members of the judiciary who have had to adjudicate on its operation is that it works on a 'swings and roundabouts' basis: there will be some cases where fixed costs do not adequately compensate the claimant and their legal representatives for the time spent on the case, however, there will be other instances when the level of fixed costs is generous as the time spent is minimal.[309]

183. The Centre for Socio-Legal studies was sceptical that the introduction of FRCs would fundamentally change the commercial landscape for claimant law firms. They said solicitors "are savvy commercial enterprises and there will be an analysis of the stage a claim needs to get to in the FRC processes which maximises returns."[310] Addressing concerns about access to justice they concluded that if "the only available route to justice is denied then the judiciary will take action to correct this."[311]

Cost shifting

184. It is standard practice in civil litigation that the loser pays the winner's costs. However, an exception to this applies in clinical negligence actions so that in most cases a losing claimant does not have to meet the defendant's costs, an exception known as Qualified One-Way Costs Shifting (QOCs).[312] The Government said that, in combination with other reforms such as the introduction of Conditional Fee Arrangements, this has "minimised the financial risk borne by claimants bringing clinical negligence claims."[313]

304 Action against Medical Accidents (NLR0075)
305 Society of Clinical Injury Lawyers (NLR0076)
306 Ibid
307 Action against Medical Accidents (NLR0075)
308 Action against Medical Accidents (NLR0075)
309 The Bar Council (NLR0069), para 56
310 The Centre for Socio-Legal Studies (NLR0063)
311 The Centre for Socio-Legal Studies (NLR0063)
312 The Bar Council (NLR0069), para 54
313 Department of Health and Social Care (NLR0070)

185. Michael Powers and Anthony Barton said that claimants should not "enjoy completely risk-free litigation" and should be "liable for fixed, capped, or a proportion of successful defendant's costs."[314] They said that QOCs has put claimants in a risk-free, no-lose position whilst defendants are encouraged to settle in order "to limit irrecoverable costs rather than according to the merits" of a case.[315] Part 36 of the Civil Procedure Rules which govern clinical negligence allows each party to make offers to settle a claim without going to trial. The Bar Council noted that this provision rebalances the effect of QOCs because "defendants can protect their position by making offers which place the claimant at significant costs risk and encourage the parties to settle the claim in advance of trial."[316] They concluded that this aspect of the Civil Procedure Rules "operates extremely well" because "Part 36 plays a huge role in the settlement of most clinical negligence claims."[317]

Conclusions

186. **An independent administrative system designed in the first instance to provide compensation in birth injury cases would be much more responsive to the needs of patients and families. Without a contentious legal battle, eligibility would be established quickly and support provided to injured patients within weeks rather than years. The administrative body could be tasked with ensuring that compensation meets a child's requirements as they grow and develop so regular reviews could be built into the process. Moving away from once-and-for all settlements would aid this process and provide a more realistic response to the needs of children with severe brain injuries.**

187. ***The most effective system would be one that can provide initial compensation within weeks of a claim and then be adapted to meet the individual child's requirements as they grow and develop. We recommend that awards be made with periodical review built in so that they can become responsive to the changing needs of patients.***

188. **Although our system would be no less generous in its awards than the courts, patients would still retain the option of pursuing clinical negligence cases and seeking redress via litigation. Evidence from abroad indicates, however, that when given the choice, patients and families prefer the simpler administrative process. We believe that the administrative system should be the mandatory first port of call for injured patients and their families.**

189. ***Therefore, we recommend that litigation should become an option for claims covered by the administrative system only after the claimant has pursued their case through the administrative system.***

190. **We heard powerful testimony from people who have been through litigation about how they valued the support from solicitors who become their advocates and guides within the labyrinthine process. Whilst we do not doubt that there are many excellent solicitors who act in the best interests of people who have suffered terrible trauma, the fact that their guidance, advocacy and compassion is so valued only underlines the**

314 Michael Powers QC; Anthony Barton (NLR0004), p 5
315 Michael Powers QC; Anthony Barton (NLR0004), p 2
316 The Bar Council (NLR0069), para 55
317 The Bar Council (NLR0069), para 55

necessity for change. Legal professionals will only take commercially viable cases with a prospect of success, meaning many people who have suffered harm will never benefit from expert advocacy.

191. **In the system we recommend, someone with a claim would not need intensive legal support as their claim would be evaluated inquisitorially without months or years of toil to demonstrate clinical negligence. It is also important to note that there is no guarantee that someone will find a solicitor equipped to provide them with the support and guidance they need. By moving away from litigation to an administrative system, patients and families would not have to enter a lottery of legal representation.**

192. **Settling cases without court proceedings is positive but does not necessarily mean that injured patients will not experience an adversarial, complex and expensive process. The most serious cases still take years to settle rather than weeks or months. NHS Resolution's efforts to reduce the number of cases that reach court are welcome, but more can be done to resolve cases early and provide a sense of closure for both injured patients and healthcare professionals.**

193. ***We recommend that before any court case there should be compulsory use of alternative dispute resolution mechanisms. This often happens before the start of a trial but should happen before the issuing of any court proceedings. We recommend that the Government consult on the format of alternative dispute resolution and whether it should include mediation or be structured around an inquisitorial, ombudsman-style process.***

194. **It is understandable that representatives of injured patients should wish to see fault admitted and cases settled early, but the statutory framework on which clinical negligence is based makes this very difficult. Clinical negligence is focused on individual blame, therefore, it is unsurprising that within this process individual clinicians will seek to defend their actions, protect their reputations and expect support from their employers in doing so.**

195. ***NHS staff, injured patients and families need greater support in dealing with the fallout from clinical negligence cases. We recommend that every hospital should have adequate numbers of staff trained in "just culture" practices to reduce confrontation and relationship breakdown between injured patients, their relatives, and bereaved families.***

196. ***We heard that there is no leeway for NHS Resolution to concede cases on any basis other than clinical negligence, but this was challenged by academic evidence we received. In response to this report, the Government should provide an explanation which addresses the evidence we have cited which shows that some clinical negligence cases have been settled even when negligence has not been found. The Government should explain how frequently cases are settled without negligence being established and whether negligence is the appropriate test if it is not being applied in actuality.***

197. ***We are concerned that the Government's proposal to introduce Fixed Recoverable Costs in clinical negligence cases below £25,000 may compromise access to justice for the poorest claimants. The Government is right to try and rein in excessive legal costs, but until the administrative scheme we are recommending is introduced in full it must ensure that all injured patients retain access to adequate legal representation. In***

response to this report the Government should set out the safeguards it will introduce to ensure that fixed recoverable costs do not restrict access to legal representation for the poorest and most vulnerable injured patients.

198. ***Once an administrative scheme is established for all clinical negligence claims the future of Qualified One-Way Costs Shifting (QOCs) in clinical negligence cases against the NHS should be considered. The Government has said the purpose of QOCs is to minimise the financial risk to claimants, but, as the administrative system will provide risk free access to compensation which is no less generous than that awarded by the courts, QOCs will become redundant. We believe that any claimant who pursues litigation having been offered compensation by the independent administrative body should have to pay the defendant's costs if they subsequently lose their case. Part 36 offers will remain vital. We recommend that NHS Resolution should consider using the quantum of compensation made by the independent administrative body as a part 36 offer.***

Conclusions and recommendations

Clinical negligence - how it fails

1. In 2005 the New Zealand Parliament made a conscious choice to alter the legislation underpinning their system of clinical negligence because they wanted to change from a punitive system to one that would encourage the co-operation of hospitals and medical professionals. This is the lesson we need to learn in England. If NHS Trusts, medical professionals, patients and their families are to engage in a thorough investigation into what is often a traumatic and tragic event, the whole investigation cannot be premised on a search for individual blame. (Paragraph 81)

2. Clinical negligence cannot and does not inform or disseminate learning or systematically contribute to patient safety improvements. It is not its purpose and too much information is filtered out at an early stage to ever make this a realistic prospect. Demonstrating individual fault is fundamental if compensation is to be awarded, but this is not a process consistent with contemporary safety-focused investigations. Whilst there is a strong case for improving the techniques used to investigate mistakes made in the NHS these techniques would not align with the evidence gathering process for a successful clinical negligence claim. (Paragraph 82)

3. Some claimant organisations said the screening process, as carried out by specialist claimant firms, prevents a significant cost that NHS Resolution would otherwise incur. Claimant costs, however, account for a fifth of all cash payments associated with clinical negligence and witnesses highlighted that law firms gravitate towards higher value cases, reject those that require a significant initial outlay, and are driven by the pursuit of legal fees. Given the skill with which law firms appear to have leveraged income from the clinical negligence market, we are not convinced that the real cost of screening cases is not eventually passed on to the taxpayer. (Paragraph 83)

4. *The system for compensating injured patients in England is not fit for purpose. It is grossly expensive, adversarial, and promotes individual blame instead of collective learning. We recommend that when a patient is harmed, they or their family should be able to approach an independent administrative body which would investigate their case and determine whether the harm was caused by the care they received and if, in the ordinary course of events, it was avoidable. The investigation would be inquisitorial, it would look at the facts of the case, and it would focus on how all parts of the system delivered care to the patient in question. Should it be found that the patient suffered harm because of their care, they would receive compensation.* (Paragraph 84)

5. We recognise that our recommendations would radically change the principles which underpin the way injured patients are compensated and the Bar Council said that to introduce a new statutory administrative scheme would be "a project of phenomenal ambition." Given the scale of the undertaking, and the cultural change we are asking the system to make, the new system would be best implemented in stages with an initial focus on the most complex and expensive cases, which are those related to birth injuries. (Paragraph 85)

6. *As it becomes embedded within the framework of the NHS, we recommend that, in the first instance, the new administrative patient compensation system should be focused on obstetric cases which align with the Each Baby Counts criteria. Once established, and having proven its value, the independent administrative compensation system should then be expanded to accommodate all patient injury claims made against the NHS in England.* (Paragraph 86)

7. *The Government is creating a new Strategic Health Authority (SHA) to investigate serious incidents and improve safety in maternity care. We believe that reconstituting the SHA to investigate claims, establish the causes of harm and determine eligibility for compensation would be an efficient way for the Government to implement our recommendations. However, reconstituting the SHA should be undertaken in such a way as to create an administrative compensation body whose independence is recognised by the Courts.* (Paragraph 87)

An affordable system

8. We are concerned only with the dynamics of the legal market in so much as they affect the ability of injured patients and their families to access compensation, and the system to learn and improve safety. However, we note that those that gain most from the present system are its most staunch defenders and the greatest critics of any administrative alternative. The evidence than an administrative system would open the floodgates to new and expensive claims is patchy at best and any examination of the impact on costs must be undertaken with the knowledge that, left unchecked, the cost of settling clinical negligence cases will more than double in the next ten years. (Paragraph 118)

9. The advantage of an administrative system is that criteria can be established to remove uncertainty and turn what otherwise would be an adversarial process into one concerned only with the facts of the case. Compensation should be based on agreement that correct procedures were not followed and the system failed to perform, rather than the higher threshold that there has been clinical negligence by a hospital or clinician. Whilst this widens the pool of people entitled to compensation, the evidence from countries that have adopted such an approach is that overall costs will be lower not higher. (Paragraph 119)

10. *Establishing the precise criteria for an administrative patient injury compensation system based on system error is a complex task. We have taken evidence from various successful international schemes that each use a different threshold and we do not seek to be prescriptive over which threshold should be used in England. We recommend that the Government should consult widely at home - and evaluate best practice from abroad - to ensure that the bar is set appropriately.* (Paragraph 120)

11. In our July 2021 report examining the safety of maternity services, we recommended that the Government remove the disregard of NHS care in the award of damages. We have seen no evidence to change our recommendation. To argue that patients injured by errors in their NHS care would not want further care or treatment from the NHS is to mispresent the way healthcare is provided in England. The NHS is not a single entity, but a complex and comprehensive system made up of multiple organisations all dedicated to providing care at the point of need. An injured patient

receiving private care in a private hospital is likely to be under the care of an NHS-trained clinician who continues to practise within the health service. Should the NHS in England injure a patient it should be incumbent on the NHS to provide the necessary care to restore the injured party, as closely as possible, to good health. (Paragraph 121)

12. There is no reason why an administrative scheme should be any less generous in the compensation it awards than the courts, not least because damages would not be top sliced to meet claimant legal costs. Within the administrative compensation system, no caps would be applied to the awards, but a mechanism would be required to establish the cost of care that may need to be provided privately in addition to state funded support. (Paragraph 122)

13. *Compensation should be based on the additional costs necessary to top up care available through the NHS and social care system, rather than the current assumption that all care will be provided privately. Whilst we recognise that additional care costs are difficult to calculate, we recommend that they should be modelled using practice established in international patient injury compensation schemes. We further recommend that Section 2(4) of the Law Reform (Personal Injuries) Act 1948 should be repealed for clinical negligence cases brought against NHS organisations in England.* (Paragraph 123)

14. *The assessment of parental earnings in the calculation of damages for children under 18 years of age is unfair. It undermines the principle that damages should be calculated to meet a person's needs and contradicts the principle of equality that sits at the heart of our health system. We recommend that the assessment of future earnings based on parental income should be scrapped for all NHS-related clinical negligence claims involving children under 18 years of age. We also recommend that such compensation is standardised against the national average wage to prevent unjust variability in compensation pay-outs.* (Paragraph 124)

15. There is strong evidence that an administrative compensation scheme would provide better value for money to the taxpayer than clinical negligence litigation. There is significant potential to strip away the vast legal costs which account for over a quarter of all that is paid and introduce a system which is cheaper to administer. Furthermore, allowing NHS care to be included in the calculation of damages and basing calculations of loss of earnings on the national average wage would help to moderate the value of awards. An administrative compensation scheme introduced with the reforms we recommend would be more cost effective and more responsive to the needs of patients and families. (Paragraph 125)

A learning system

16. Clinical negligence litigation stands in stark contrast to best practice in terms of patient safety. Gains are made by careful system-wide analysis rather than the search for individual blame. The creation of the Health Services Safety Investigations Body as a statutory body which will undertake no-blame safe space investigations maps out the direction of travel for reducing harm and improving patient safety. Maintaining a costly and adversarial litigation system is evermore at odds with our

understanding of how the NHS should respond to failures in care. The administrative body's investigative process would generate a rich, more usable source of data which could be returned to the NHS to improve patient care. (Paragraph 139)

17. It is not within the scope of clinical negligence litigation to encourage the culture, or support the mechanisms, to identify learning from serious incidents. Neither can the process of litigation disseminate learning and enhance patient safety. Moreover, the experience of those who gave evidence to our inquiry illustrated that investigations after serious incidents are often inadequate and the looming threat of clinical negligence for providers and healthcare professionals does not encourage thorough investigations which can provide injured patients and families with a comprehensive account of what happened in their care. (Paragraph 140)

18. *Aside from the substantive reform of clinical negligence litigation that we have recommended, we also believe that the investigatory system should be reformed. After any tragedy involving medical error there should be a standardised process of investigation which focuses on the overriding priority to learn from mistakes and prevent tragedies being repeated. We recommend that, at a minimum, such investigations should:*

    - *last a maximum of six months,*
    - *be independently-led involving both families and the Trust in question,*
    - *include implementation of any safety recommendations that are made,*
    - *communicate lessons across the NHS.* (Paragraph 141)

19. *We further recommend that, in parallel, an investigation by an independent administrative body responsible for alternative dispute resolution should be completed and a determination on liability for compensation released to the family, the Trust and NHS Resolution. The Trust and NHS Resolution would decide whether to accept liability for a mistake or negligence and to commence payments. If at the end of the six-month window liability for cases relating to maternity care has not been accepted these cases would fall within the remit of the Early Notification scheme and NHS Resolution.* (Paragraph 142)

20. In the longer term, an administrative compensation system would address problems associated with inadequate investigations by undertaking inquisitorial, system-focused investigations with no examination of individual blame. This would build greater confidence amongst healthcare professionals that they could be open and forthright when contributing to investigations. However, to further support healthcare professionals, we believe that there should be formal separation between the administrative body's investigative process and external regulatory processes. (Paragraph 143)

21. *We recommend that information obtained by the administrative body in its investigations should not be shared with any other professional or system regulator unless it constitutes unlawful activity or identifies an immediate danger to patients. We also recommend that the administrative body should agree a memorandum of*

understanding with the Office of the Chief Coroner to ensure consistency of investigation and provide transparency as to the process for the disclosure of information for inquests. (Paragraph 144)

Access to justice

22. An independent administrative system designed in the first instance to provide compensation in birth injury cases would be much more responsive to the needs of patients and families. Without a contentious legal battle, eligibility would be established quickly and support provided to injured patients within weeks rather than years. The administrative body could be tasked with ensuring that compensation meets a child's requirements as they grow and develop so regular reviews could be built into the process. Moving away from once-and-for all settlements would aid this process and provide a more realistic response to the needs of children with severe brain injuries. (Paragraph 186)

23. *The most effective system would be one that can provide initial compensation within weeks of a claim and then be adapted to meet the individual child's requirements as they grow and develop. We recommend that awards be made with periodical review built in so that they can become responsive to the changing needs of patients.* (Paragraph 187)

24. Although our system would be no less generous in its awards than the courts, patients would still retain the option of pursuing clinical negligence cases and seeking redress via litigation. Evidence from abroad indicates, however, that when given the choice, patients and families prefer the simpler administrative process. We believe that the administrative system should be the mandatory first port of call for injured patients and their families. (Paragraph 188)

25. *Therefore, we recommend that litigation should become an option for claims covered by the administrative system only after the claimant has pursued their case through the administrative system.* (Paragraph 189)

26. We heard powerful testimony from people who have been through litigation about how they valued the support from solicitors who become their advocates and guides within the labyrinthine process. Whilst we do not doubt that there are many excellent solicitors who act in the best interests of people who have suffered terrible trauma, the fact that their guidance, advocacy and compassion is so valued only underlines the necessity for change. Legal professionals will only take commercially viable cases with a prospect of success, meaning many people who have suffered harm will never benefit from expert advocacy. (Paragraph 190)

27. In the system we recommend, someone with a claim would not need intensive legal support as their claim would be evaluated inquisitorially without months or years of toil to demonstrate clinical negligence. It is also important to note that there is no guarantee that someone will find a solicitor equipped to provide them with the support and guidance they need. By moving away from litigation to an administrative system, patients and families would not have to enter a lottery of legal representation. (Paragraph 191)

28. Settling cases without court proceedings is positive but does not necessarily mean that injured patients will not experience an adversarial, complex and expensive process. The most serious cases still take years to settle rather than weeks or months. NHS Resolution's efforts to reduce the number of cases that reach court are welcome, but more can be done to resolve cases early and provide a sense of closure for both injured patients and healthcare professionals. (Paragraph 192)

29. *We recommend that before any court case there should be compulsory use of alternative dispute resolution mechanisms. This often happens before the start of a trial but should happen before the issuing of any court proceedings. We recommend that the Government consult on the format of alternative dispute resolution and whether it should include mediation or be structured around an inquisitorial, ombudsman-style process.* (Paragraph 193)

30. It is understandable that representatives of injured patients should wish to see fault admitted and cases settled early, but the statutory framework on which clinical negligence is based makes this very difficult. Clinical negligence is focused on individual blame, therefore, it is unsurprising that within this process individual clinicians will seek to defend their actions, protect their reputations and expect support from their employers in doing so. (Paragraph 194)

31. *NHS staff, injured patients and families need greater support in dealing with the fallout from clinical negligence cases. We recommend that every hospital should have adequate numbers of staff trained in "just culture" practices to reduce confrontation and relationship breakdown between injured patients, their relatives, and bereaved families.* (Paragraph 195)

32. *We heard that there is no leeway for NHS Resolution to concede cases on any basis other than clinical negligence, but this was challenged by academic evidence we received. In response to this report, the Government should provide an explanation which addresses the evidence we have cited which shows that some clinical negligence cases have been settled even when negligence has not been found. The Government should explain how frequently cases are settled without negligence being established and whether negligence is the appropriate test if it is not being applied in actuality.* (Paragraph 196)

33. *We are concerned that the Government's proposal to introduce Fixed Recoverable Costs in clinical negligence cases below £25,000 may compromise access to justice for the poorest claimants. The Government is right to try and rein in excessive legal costs, but until the administrative scheme we are recommending is introduced in full it must ensure that all injured patients retain access to adequate legal representation. In response to this report the Government should set out the safeguards it will introduce to ensure that fixed recoverable costs do not restrict access to legal representation for the poorest and most vulnerable injured patients.* (Paragraph 197)

34. *Once an administrative scheme is established for all clinical negligence claims the future of Qualified One-Way Costs Shifting (QOCs) in clinical negligence cases against the NHS should be considered. The Government has said the purpose of QOCs is to minimise the financial risk to claimants, but, as the administrative system will provide risk free access to compensation which is no less generous than that awarded by the*

courts, QOCs will become redundant. We believe that any claimant who pursues litigation having been offered compensation by the independent administrative body should have to pay the defendant's costs if they subsequently lose their case. Part 36 offers will remain vital. We recommend that NHS Resolution should consider using the quantum of compensation made by the independent administrative body as a part 36 offer. (Paragraph 198)

Formal minutes

Wednesday 20 April 2022

Members present:

Jeremy Hunt, in the Chair

Lucy Allan

Luke Evans

Draft Report (*NHS litigation reform*), proposed by the Chair, brought up and read.

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

Executive summary agreed to.

Paragraphs 1 to 198 agreed to.

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

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

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

Adjourment

Adjourned till Tuesday 26 April 2022 at 9.45 am

Witnesses

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

Tuesday 16 November 2021

Sue Beeby, lived experience witness; **Scott Morrish,** lived experience witness; **Joanne Hughes,** lived experience witness; **Sir Robert Francis QC,** Chair, Healthwatch England; **Sir Ian Kennedy QC,** Emeritus Professor, Health Law, Ethics and Policy, University College London; **Dr Sonia Macleod**, Researcher, Civil Justice Systems, The Centre for Socio-Legal Studies, University of Oxford — Q1–45

Tuesday 11 January 2022

Michael Mercier, Accident Compensation Corporation; **Dr Pelle Gustafson**, CMO, Swedish Patient Insurer; **George Deebo**, Executive Officer, Virginia Birth-Related Neurological Injury Compensation Program; **Professor Shin Ushiro**, Professor and Director, Division of Patient Safety Kyushu University Hospital, Executive board member Japan Council for Quality Health Care — Q46–83

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; **Simon Hammond**, Director of Claims Management, NHS Resolution — Q84–114

Tuesday 1 February 2022

Jill Edwards, lived experience witness — Q115–129

Maria Caulfield MP, Parliamentary Under-Secretary of State (Minister for Patient Safety and Primary Care), Department of Health and Social Care; **Matthew Style**, Director General for NHS Policy and Performance, Department of Health and Social Care; **Helen Vernon**, Chief Executive, NHS Resolution — Q130–196

Published written evidence

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

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

1 Action against Medical Accidents (NLR0021), (NLR0075)

2 Association of Optometrists (NLR0057)

3 Association of Personal Injury Lawyers (APIL) (NLR0016)

4 Beel, Mrs Victoria (Principal Lawyer, Slater and Gordon) (NLR0024)

5 Bevan Brittan LLP (NLR0058)

6 Bolt Burdon Kemp (NLR0054)

7 Boyes Turner LLP (NLR0030)

8 British Medical Association (NLR0040)

9 Browne Jacobson LLP (NLR0051)

10 Bunch, Mr Nathan (Solicitor, Slater and Gordon) (NLR0026)

11 CEDR (Centre for Effective Dispute Resolution) (NLR0036)

12 Capsticks Solicitors LLP (NLR0060)

13 Clarke Willmott LLP (NLR0013)

14 Clayton, Mr Neil (Partner , Lime Solicitors (A Trading name of Ampa LLP)) (NLR0017)

15 Clyde & Co LLP (NLR0048)

16 DAC Beachcroft (NLR0052)

17 Day, Leigh (NLR0029)

18 Department of Health and Social Care (NLR0070), (NLR0072), (NLR0073), (NLR0074)

19 Derry, Dr T (General Practitioner, NHS) (NLR0025)

20 Devaney, Dr Sarah (Senior Lecturer in Healthcare Law and Regulation, University of Manchester) (NLR0039)

21 DisputesEfiling.com Limited (NLR0049)

22 FOCIS (The Forum of Complex Injury Solicitors) (NLR0042)

23 Fitton, Dr Richard (Retired GP, British Medical Association) (NLR0003)

24 Fletchers Solicitors (NLR0012)

25 Gent, Ben (Lawyer, Slater & Gordon) (NLR0033)

26 Harding Evans LLP (NLR0035)

27 Healthcare Safety Investigation Branch (NLR0037)

28 Hempsons Solicitors (NLR0014)

29 Hibbins, Ms Joy (CEO, Suicide Crisis (a registered charity which provides crisis services to individuals who are experiencing a suicidal crisis)) (NLR0020)

30 Hodge Jones and Allen LLP (NLR0055)

31 Hurlbut, Ms Julia (NLR0043)

32 Independent Fetal Anti-Convulsant Trust (NLR0006)

33 Independent Healthcare Providers Network (NLR0044)

34 Independent Medical Negligence Resolution (NLR0053)

35 Irwin Mitchell (NLR0031)

36 Kennedys (NLR0056)

37 LGB Alliance (NLR0009)

38 Latif, Mr Shire (NLR0027)

39 Lawyers, Forum of Insurance (NLR0066)

40 Marhoon, Mr Ayad (Student, Kings College London) (NLR0001)

41 Medical Protection Society (MPS) (NLR0032)

42 Medical and Dental Defence Union of Scotland (MDDUS) (NLR0065)

43 Pagination Accredited Group of Experts (NLR0050)

44 Patient Safety Learning (NLR0059)

45 Penningtons Manches Cooper (Solicitors) (NLR0046)

46 Powers QC, Michael; and Barton, Anthony (NLR0004)

47 Professional Standards Authority for Health and Social Care (NLR0047)

48 Ross CBE, Nick (NLR0068)

49 Royal College of Obstetricians and Gynaecologists (RCOG) (NLR0061)

50 Royds Withy King Solicitors (NLR0015)

51 Russell-Cooke LLP (NLR0038)

52 Stevenson, Mr Edward (Self Employed Company Owner, C E Stevenson Motors) (NLR0002)

53 Stewart's (NLR0041)

54 Seibert, Mrs Madeline (NLR0008)

55 Society of Clinical Injury Lawyers (SCIL) (NLR0011), (NLR0076)

56 Tees (NLR0062)

57 The Association of Consumer Support Organisations (ACSO) (NLR0028)

58 The Bar Council (NLR0069)

59 The Centre for Socio-Legal Studies (NLR0063)

60 The Charlie Gard Foundation (NLR0023)

61 The Medical Defence Union (MDU) (NLR0019)

62 Thompsons Solicitors (NLR0018)

63 Ushiro, Professor Shin (Professor and Director, Division of Patient Safety Kyushu University Hospital, Executive board member Japan Council for Quality Health Care) (NLR0077)

64 Vaughan, Dr Jenny (NLR0071)

65 Wake Smith Solicitors Ltd (NLR0034)

66 Ward Hadaway LLP (NLR0045)

67 Weightmans LLP (NLR0064)

68 Yeowell, Dr Gillian (Associate Professor , Manchester Metropolitan University); Greenhalgh OBE, Dr Sue (Consultant Physiotherapist Bolton NHS FT & Clinical Fellow Manchester Metropolitan University, Bolton NHS FT & Manchester Metropolitan University); and Selfe, Professor James (Professor of Physiotherapy , Manchester Metropolitan University) (NLR0010)

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website.

Session 2021–22

Number	Title	Reference
1st	The Government's White Paper proposals for the reform of Health and Social Care	HC 20
2nd	Workforce burnout and resilience in the NHS and social care	HC 22
3rd	Pre-appointment hearing for the Chair of the Food Standards Agency	HC 232
4th	The safety of maternity services in England	HC 19
5th	The treatment of autistic people and people with learning disabilities	HC 21
6th	Coronavirus: lessons learned to date	HC 92
7th	Supporting people with dementia and their carers	HC 96
8th	Children and young people's mental health	HC 17
9th	Clearing the backlog caused by the pandemic	HC 599
10th	Pre-appointment hearing for the position of Chair of NHS England	HC 1035
11th	Pre-appointment hearing for the position of Chair of the Care Quality Commission	HC 1091
12th	Cancer services	HC 551
1st Special	The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of maternity services in England	HC 18
2nd Special	The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of mental health services in England	HC 612
3rd Special	Supporting people with dementia and their carers: Government Response to the Committee's Seventh Report	HC 1125
4th Special	Expert Panel: evaluation of the Government's commitments in the area of cancer services in England	HC 1025

Session 2019–21

Number	Title	Reference
1st	Appointment of the Chair of NICE	HC 175

Number	Title	Reference
2nd	Delivering core NHS and care services during the pandemic and beyond	HC 320
3rd	Social care: funding and workforce	HC 206
4th	Appointment of the National Data Guardian	HC 1311