Written evidence submitted by RCOG and RCM (NLR0061)

Introduction and key points

The RCOG and the RCM support the Government's commitment to tackling the rising costs of clinical negligence and the consultation on a revised approach to clinical negligence announced in the 2020 Spending Review.[1]

The underpinning issues for the rising costs of clinical negligence are complex, but the cost of damages awarded has increased recently[2] without a rise in the total number of claims itself. With this in mind, we understand the necessity to consider revisions to limit the cost of damages as part of reforms, and will consider and respond to the Government's proposals once they are published.

However, **we believe the ultimate aim of the Department for Health and Social Care and NHS Resolution should be to reduce preventable harm first and foremost, thereby reducing the number of claims.** Improving patient safety and reducing avoidable harm is the best way to reduce litigation costs, because it addresses the root cause of the costs, notwithstanding the clear moral imperative to reduce harm itself, rather than the resultant cost of harm.

It is the RCOG and RCM view that any approach to clinical negligence must be based upon the following principles:

1. Better care costs the system less, and the primary route to reducing litigation should be to invest in better, safer care.

2. There is a reasonable balance struck between adequate compensation for claimants and levels of funding needed to deliver high-quality, safe services across the NHS.

3. The system enables and encourages a culture of learning

Clinical negligence costs constitute a threat to the sustainability of the NHS

Spending on clinical negligence litigation in the NHS continues to escalate and constitutes a threat to the sustainability of the NHS. Spending on clinical negligence is increasing much faster than funding for the NHS, tripling in the decade from 2009.[3]

Maternity cases account for 11% of the total number of all clinical negligence claims but now represent 59% of the total costs of litigation by value[4]. For the year 2020-21, maternity claims were valued at approximately £4.2 billion, this figure has almost doubled since 2016/17, when it was £2.2 billion[5].

The Public Accounts Committee identified that increasing damages for the small but stable number of high-value maternity claims was one of two main factors responsible for the increasing overall costs[6]. Every baby born in the NHS in England now incurs indemnity costs of £1100. With roughly 600,000 births annually, the NHS pays roughly £12.7 million a week for the costs of obstetric harm.[7] **It is clear that a clinical negligence system that more effectively reduces costs from maternity**

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[1]HM Treasury, Spending Review (2020)
[2] NHS Resolution, Clinical negligence numbers steady, but rising costs remain a concern (2019)
[3] National Health Service Litigation Authority, Report and Accounts (2009)
[4]NHS Resolution, Annual report and accounts (2021)
[5]NHS Resolution, Annual report and accounts (2017)
[6] House of Commons Committee of Public Accounts, Managing the costs of clinical negligence in hospital trusts (2017)
[7] Christopher Wai Hung Yau et al, The BMJ, Clinical negligence costs: taking action to safeguard NHS sustainability (2020)

services would have a significant impact on reducing the overall cost of clinical negligence claims across the NHS, and should be a key focus of the Government's upcoming proposals.

Clinical negligence claims in gynaecology account for 9% of the total clinical negligence claims, and 3% of the total value of claims. NHS Resolution has reported a continued increase in cases relating to gynaecology in recent years, of which a large percentage are associated with vaginal mesh incidents.[8]

Due to the nature of a publicly-funded healthcare system, funding for clinical negligence reduces available funding for NHS care, and the rapidity with which costs have risen over the last decade in clinical negligence has not been replicated elsewhere in NHS spending on services. **The proportion of NHS resource going to litigation instead of into delivering safer care is worsening, and this needs to be addressed.**

Better care costs the system less

Reform to the clinical negligence system in relation to the rising costs of claims clearly has value, and has the potential to form part of the solution to both reducing the burden of cost to the NHS, and consequently allowing a higher proportion of the NHS overall budget to be invested in patient safety. However, it is not and should not be the primary route to reducing the costs of litigation.

The ultimate aim of the NHS in relation to clinical negligence should be to reduce the number of adverse incidents by improving patient care and reducing preventable harm, resulting in a reduction in the costs of litigation. The 2017 Public Accounts Committee report recommended that urgent and coordinated action be taken to reduce patient harm, especially in maternity care, in order to reduce the costs of litigation[9], and the recent NHS Patient Safety Strategy suggested the potential to reduce claims provision by around £750 million a year by 2025[10].

There is clear evidence that improvements to patient safety in health systems reduces the level of avoidable harm and is associated with reduced litigation and costs generally in healthcare[11][12][13], and also for maternity[14].

Investing in 'better care' is not simple, however. In a recent BMJ article on clinical negligence[15] RCOG Vice President for Clinical Quality Tim Draycott and others argued that the benefits of evidence-based work to improve safety have often been missed as a result of poor implementation. The paper outlined four foundational principles for safer care: dealing with structural problems, a real commitment to learning, learning from high performance, and facilitating system-wide improvements.

There have been multiple patient safety initiatives across the NHS, including maternity care, in recent years. However, so far these have lacked a cohesive approach that addresses key issues at all the levels required. A joined up system-based approach to patient safety is being increasingly

[8] Ibid
[9] Ibid
[10] NHS England and Improvement, The NHS Patient Safety Strategy (2019)
[11] Bernard S Black et al, American Journal of Health Economics, The association between patient safety indicators and medical malpractice risk: Evidence from Florida and Texas (2017)
[12] Qian Yang et al, CMAJ, Improved hospital safety performance and reduced medicolegal risk: an ecological study using 2 Canadian databases (2018)
[13] Michael D Greenberg et al, RAND, Is better patient safety associated with less malpractice activity? Evidence from California (2010)
[14] Ibid
[15] Ibid

recommended in order to enable real improvement[16]. Work undertaken at the University of Cambridge identified the features of very safe maternity units and showed that there are six mechanisms that appear to be important for safety in the unit studied[17], including collective competence, insistence on technical proficiency, clearly articulated and constantly reinforced standards of practice, behaviour and ethics, and a highly intentional approach to safety and improvement.

In our joint written evidence submission to the maternity safety inquiry[18], the RCOG and RCM outlined key actions required to improve maternity safety and reduce harm, including the need to address lack of resource and capacity, improving personalisation of care, improving collection and use of data, identifying and improving areas of clinical practice, and improving culture and leadership within services. **Adequate investment in key targeted areas should be prioritised by the Government to reduce the number of adverse incidents, and thereby the cost of litigation on the NHS.**

More funding has been directed towards improving maternity safety in recent years, with the Government announcing £9.4 million for pilot schemes on birth-related injuries in the 2020 Spending Review.[19] Some of this funding has been awarded to the RCOG, in collaboration with the RCM and the THIS Institute at the University of Cambridge, for the Avoiding Brain Injuries in Childbirth (ABC) collaboration. The programme is currently in its first phase, piloting a standardised approach to intrapartum fetal surveillance as well as developing best practice to reduce harm at impacted fetal head during a caesarean section. The potential benefits are significant: preliminary analysis provided for the Department of Health has identified that the ABC programme has the potential to reduce cases of cerebral palsy in England by >80 per year, representing a cost saving of between £860 million and £1.4 billion per year in avoided litigation alone. **It is the availability of sustainable, long-term funding to pilot, evaluate and roll out improvement programmes such as ABC that will achieve significant return on investment to reduce litigation costs in maternity care.**

It is clear, however, that further targeted investment is needed, with clear evidence that there remains a gap between the funding required and the funding provided to deliver safe, high-quality care.[20]. In its recommendations to Government following the maternity safety inquiry[21], the committee called for an increase of £200-300m per annum for maternity services, yet the Government has so far only committed to the £95.6m investment in NHSE/I in response to the Ockenden findings[22]. A recent parliamentary question identified that many Trusts have to date received more than a million pounds less than they applied for to deliver an adequate response to the findings of the Ockenden report into maternity safety. **If the Government does not commit to the additional annual spending recommended by the committee in the upcoming Spending Review, we encourage the committee to use this inquiry to reiterate its call for the additional funding required to improve maternity safety, outlining the impact this could have in reducing the costs of NHS litigation by reducing claims.**

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[16] Christopher Wai Hung Yau, University of Bristol Better care costs less: a system-based approach in maternity care (2019)
[17] Liberati et al, Social Science & Medicine How to be a very safe maternity unit: An ethnographic study (2019)
[18] RCM and RCOG, Written evidence to the Health and Social Care Committee Inquiry on the safety of maternity services in England (2020)
[19] HM Treasury, Spending Review policy paper (2020)
[20] UK Parliament, Question for DHSC from Justin Madders MP on Maternity Services: Finance (2021)
[21] Ibid
[22] HM Government, The Government's response to the Health and Social Care committee report on the safety of maternity services in England (2021)

Understaffing and its pervasive effects on the ability to provide compassionate and safe care, effect on workplace morale and risks to burnout, is clearly implicated in patient safety. Despite this, there is limited action to tackle workforce shortages, with the former health minister admitting to the health select committee earlier this year that there was a shortage of nearly 2000 midwives alone. There are also workforce shortages in obstetrics, with a 2018 survey finding that 90% of obstetrics and gynaecology junior doctors reporting rota gaps in their units[23]. A recent survey of RCM members also showed a worrying picture in relation to retention, with over half of midwives surveyed considering leaving the profession, with two-thirds of those who had left or were considering leaving not satisfied with the quality of care they were currently able to deliver.

A reasonable balance between adequate compensation for claimants and funding to deliver services

In a publicly-funded healthcare system such as the NHS, the cost of litigation is derived from the same budget as services. It is therefore necessary to ensure that any approach to clinical negligence claims finds a reasonable balance between fairly compensating those who have been affected by clinical negligence, whilst ensuring sufficient NHS funding to deliver high-quality, safe patient care.

The report following the committee's inquiry into maternity safety recognised how high claims and damages are in maternity care, and the impact this has on available funding for service delivery. The committee posed that legal redress and financial compensation is one of a few motivations for families pursuing litigation, alongside the need for an explanation and an apology, and the importance of accountability[24].

It is imperative that any revision of the clinical negligence system ensures that families who have been affected by adverse incidents are compensated adequately and fairly. However, the concern that the significant growth in damages in recent years is unsustainable is founded, when it is seen in the context of the NHS overall budget. **The Government's proposals on clinical negligence reforms must strike a reasonable balance between compensating claimants and protecting funding to deliver services. This should further support an ambition to improve patient care and reduce preventable harm, by investing money saved through litigation into programmes of work to improve safety.**

A culture of learning

There is strong evidence about the importance of team working and developing positive cultures in improving services. The 2020 Each Baby Counts report[25] identified that 'lasting cultural changes in learning, leadership and multi-professional working are the key to tackling the number of incidents in our maternity services'.

There must be a real commitment to learning across systems in order to deliver high-quality, safe maternity care[26]. The clinical negligence system must enable and encourage learnings from incidents, not prevent them. The committee identified in its inquiry into maternity safety[27] that the approach to clinical negligence has cultivated a culture of defensiveness and blame, and despite the fact that the legal defendant is always the trust and not an individual clinician, this did not prevent it from contributing to a 'culture of blame'. The committee also heard evidence that the current

[23] RCOG, O&G Workforce Report: Update on workforce recommendations and activities (2018)
[24] House of Commons Health and Social Care Committee, The Safety of maternity services in England (2021)
[25] RCM, RCM responds to Each Baby Counts (2020)
[26] Ibid
[27] Ibid

mechanism for awarding compensation being based on proving clinical negligence perpetuates the need to apportion blame, rather than promoting openness and learning. There is evidence that blaming individuals for systemic failures may be implicated in poor practice[28].

A revised approach to clinical negligence should be geared towards creating a culture of learning at every level of the system, and not perpetuating 'blame' cultures that can be damaging to maternity safety.

We support the current progress and aspiration for appropriate early admission of liability as well as enabling learning from litigation through sustained and genuine engagement with staff and families.

The Early Notification Scheme, which requires reporting within 30 days all maternity incidents when babies have had severe brain injuries diagnosed, has introduced several benefits. It avoids lengthy litigation processes where early liability is admitted, and increased use of mediation and other forms of dispute resolution is helping to avert claims going to formal court proceedings. It also pools clinical information as to causes of poor outcomes, which should help to reduce injuries caused to babies.

The RCM Solutions Series, which has been designed to support a move towards a learning culture, is an example of how a focus on learning is essential to stop services repeating the same mistakes. It looks at issues such as improving leadership[29] and designing systems to reduce the risk of human error[30], and starts from a point of service improvement, rather than reducing litigation or damages. Both the RCM and the RCOG, working side by side, also have a role in creating a culture of learning across maternity care at every level, and supporting good practice.

[28] NHS Resolution, Five years of cerebral palsy claims - A thematic review of NHS Resolution data (2017)
[29] RCM, Effective and inclusive leadership a key factor in improving safety, says RCM (2021)
[30] RCM, Designing systems to reduce individual errors will improve maternity safety says RCM (2021)