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

Contents

Synopsis by H N Whitfield

The Report is entitled 'NHS Litigation Reform 'and is based on the recent consultation by the House of Commons Select Committee on Health and Social Services to identify ways to reduce the costs of medical litigation. The title of the Report does not identify this.

During the consultation process the Committee received some 70 written submissions. Subsequently, there were three meetings of the Committee, to which a total of 18 witnesses were called. None of the witnesses held GMC registration.

The first 54 pages of the Report consist of:

1. A review of historical attempts to change medical education,
2. A review of the written submissions.
3. Thirty-four Conclusions and Recommendations that were drawn up by professional Committee Staff and approved by the Committee.

At their Meeting on 20 April 2022 , at which the Report was approved, there were three of the eleven members of the Committee present, Rt Hon Jeremy Hunt, Chair, (Conservative, South West Surrey), Lucy Allan MP (Conservative, Telford) and Dr Luke Evans (Conservative, Bosworth).

I believe that the length of the report will deter some from reading it. There are important recommendations. I wrote the synopsis to highlight these.

Executive Summary Pages 3-6

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. 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.

Introduction Pages 7-52

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.” The Medical Protection Society (MPS) said the current system is “neither equitable nor appropriate”

37. We heard that the system, which requires patients to prove fault, is inherently adversarial. 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".

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."

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 "clinical negligence litigation is a commercial activity like most civil litigation" and for law firms " an important driver is the pursuit of legal fees; litigation is only indirectly related to compensation, patient safety, and professional regulation." 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".

62. 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." 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." Scott Morrish *(bereaved parent)*concluded that clinical negligence cases "generating lessons 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".

<u>The blame culture</u>

74. Academics at Manchester Metropolitan University reported in their written evidence that the "adversarial nature of the clinical negligence system perpetuates the 'blame culture'.

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.

166. The Government said that "since NHSR's mediation scheme was first launched on 5 December 2016, over 1,200 claims have been mediated up to 31 March 2021." 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. In 2020 NHSR reported success in those cases that were mediated, highlighting "74% of cases mediated are settled on the day of mediation or within 28

days of mediation date" and the Government concluded that mediation is now "a regular feature in health claims." 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." They called for NHSR to demonstrate "increased willingness" to "enter into early ADR."

Mediation

167 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, 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."

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". Lauren McGuirl (*CEDR*) 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. Scott Morrish (*bereaved parent*) 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."

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.

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.

189. 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.

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.

Conclusions and recommendations. P 55

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.

2. Clinical negligence cannot and does not inform or disseminate learning or systematically contribute to patient safety improvements.

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. 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.

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.

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.

6. We recommend that, in the first instance, the new administrative patient compensation system should be focused on obstetric cases 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.

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.

An Affordable System

8. We note that those that gain most from the present system are its most staunch defenders and the greatest critics of any administrative alternative.

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.

10. We recommend that the Government should consult widely at home - and evaluate best practice from abroad - to ensure that the bar is set appropriately.

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.

12. 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

13. Compensation should be based on the additional costs necessary to top up care available through the NHS and social care system. 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.

14. The assessment of parental earnings in the calculation of damages for children under eighteen years of age is unfair.

15. 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.

A Learning System

16. Maintaining a costly and adversarial litigation system is evermore at odds with our understanding of how the NHS should respond to failures in care.

17. 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.

18. We also believe that the investigatory system should be reformed. 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.

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.

20. 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.

Access to Justice

22 An independent administrative system ...s*hould be set up*.. in the first instance to provide compensation in birth injury cases.

23. Provide initial compensation within weeks of a claim and then be adapted to meet the individual child's requirements as they grow and develop.

24. We believe that the administrative system should be the mandatory first port of call for injured patients and their families.

25. 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.

26. 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.

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.

28 More can be done to resolve cases early.

29 We recommend that before any court case there should be compulsory use of alternative dispute resolution mechanisms.

30. 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.

31. 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.

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.

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.

34. 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.

Hugh N Whitfield 10 May 2022