SUBMISSIONS TO PUBLIC ACCOUNTS COMMITTEE ON

"MANAGING THE COST OF CLINICAL NEGLIGENCE IN THE NHS"

30TH OCTOBER 2017

Brief Introduction to AvMA

1.1. Action against Medical Accidents (AvMA) was originally established in 1982. It is the UK patient safety charity specialising in advice and support for patients and their families affected by medical accidents. Since its inception AvMA has provided advice and support to over 100,000 people affected by medical accidents.

1.2. AvMA offers specialist services to the public, free of charge. AvMA's specialist services are its Helpline, pro bono inquest service and advice and information services.

1.3. Through our work we have observed how the public are driven by the need for the truth about what has happened in relation to an incident or a death and to ensure that lessons are learned so that future mistakes are prevented.

1.4. The demand for our services invariably outstrips what we can supply and has generally increased, not diminished in recent years.

2. Executive Summary

2.1. We are concerned that whilst National Health Service Resolution (NHSR), Ministry of Justice (MoJ) and Department of Health (DH) identifies that one of the key contributors to clinical negligence cost are liabilities incurred for brain injured children as a result of negligent obstetric care, the solutions offered are hollow and insubstantial.

2.2. A lot of emphasis has been put on the number of low value cases coming through to the NHS, rather than examining how cases can be resolved at the earliest opportunity and without litigation. We are concerned that their approach puts too much emphasis on outcomes arising from imposing a system of Fixed Recoverable Costs (FRC), rather than taking an objective look at the issues that give rise to claims.

3. Background to AvMA's Response

3.1. In preparing these written submissions we have been particularly mindful of the focus on "how" the NHSR, DH and MoJ are exploring the impact of rising costs, tackling those costs while providing a quick and efficient service for claimants.

4. Neurological injury in newborns as a result of negligent care

4.1. When giving evidence to the Public Accounts Committee (PAC) on 16th October, Sir Chris Wormald (CW) acknowledged that 83% of damages relate to 8% of cases and that maternity safety cases are the big driver of costs. He commented that the only long term solution is to have fewer of those incidents.

4.2. AvMA does not disagree with CW assessment.

4.3. However, the NHS has long been aware of the key areas of weakness in this area. In October 2012 the NHS Litigation Authority (NHSLA) published **"Ten years of maternity claims an analysis of NHS Litigation Authority Data"**

http://www.nhsla.com/Safety/Documents/Ten%20Years%20of%20Maternity%20Claims%20-%20News%20Release%20-%20October%202012.pdf

4.4. That report highlighted that in the period 1st April 2000 – 31st March 2010 there were 5,087 maternity claims with a total value of £3.1 Billion. The report also identified that the issues related to management of labour, cerebral palsy and CTG interpretation accounted for 70% of all the maternity claims brought.

4.5. The core themes to emerge from the report included: the need to engage with the risk management process at all levels; suitable learning and training; ensuring the availability of appropriate supervision and support; having in place up to date protocols and guidance which staff were familiar with and learning lessons from claims.

4.6. The report recognised that "***the most effective way to reduce the financial and human cost of maternity claims is … focusing on preventing incidents involving the management of women in labour, including the interpretation of CTG traces"***

4.7. In September 2017, NHS Resolution produced a further report entitled **"Five years of cerebral palsy claims – a thematic review of NHS Resolution data"** (The Five Year Report)

http://resolution.nhs.uk/wp-content/uploads/2017/09/Five-years-of-cerebral-palsy-claims_A-thematic-review-of-NHS-Resolution-data.pdf

4.8. The Five Year Report identifies that avoidable errors within maternity still occur; these errors contribute significantly to the £1.7 billion costs for clinical negligence in 2016/17. It confirms that the number of cerebral palsy claims (the most devastating and expensive injuries) ***"has remained relatively static over the last ten years"***

4.9. The ambition to reduce the number of brain injuries that occur during or soon after birth by 50% is laudable and fully supported by AvMA. However, we are concerned that there is no real and effective means of demonstrating how the NHSR, DH and MoJ are going to do this.

4.10. Certainly, learning when things go wrong and identifying areas for improvement are fundamental to eliciting change, but this has been common knowledge for years. It is an approach that would reduce the number of claims received by the NHS across the board, not just maternity claims.

4.11. The 5 year report identifies at page 8 that the serious incident and root cause analysis reporting in those cases were of "…***poor report quality, the recommendations were unlikely to reduce the incidence of future harm".***

4.12. The report also looks at the recurring themes and areas for improvement, which includes fetal heart rate monitoring, it concludes at page 9 ***"Unfortunately, the evidence suggests there has been little improvement in these areas in recent years"***.

4.13. When forming its conclusions the report says it has taken "***into account the work currently ongoing within the wider maternity system. This includes, implementation of the recommendations set out in better births, the forthcoming review of the serious incident framework due in 2018 and the development of local maternity systems (LMS)…"***

4.14. The recommendations in the Five Year Report (see page 10 of the report) include:

(i) Appointing a working party to create a national standardised and accredited training programme for all staff conducting serious incident investigations;

(ii) That all cases of potential serious brain injury, still birth and early neonatal death should be subject to an external or independent peer review

(iii) That all staff alongside their obstetric and midwifery leads undergo locally led, multi-professional training, including integrating clinical skills with teamwork

(iv) CTG training to incorporate risk stratification, timely escalation of concerns and the detection and treatment of deteriorating mother and baby

(v) That the effectiveness of a Trust's training should be linked to clinical outcomes.

(vi) Improved emotional support for staff throughout an investigation

4.15. During the PAC meeting a question was asked by Gillian Keegan about what had been done to deal with the factors that have given rise to increased costs. The response was that the NHSR has "***had a focus on claimant legal costs for some time" (Helen Vernon's (HV) response to question 4).*** It was explained that there are two elements to this, one is controlling the volume of claims coming through, and the second is controlling the incidents that lead to the claims. Particular emphasis was put on the work done to reduce the reporting time associated with obstetric claims from "***about five to six years…we have reduced the time lag to***

30 days" ((HV's) response to Question 5). This step was only implemented on 1st April 2017.

4.16. It is of considerable concern that NHSR did not seek to discuss implementing some or all of the recommendations set out in the 5 Year Report.

4.17. The need to reduce these high value, devastating injuries is being recognised but no substantive plan of action has been offered. There needs to be a plan and a commitment to actually deal with the incidences that lead to claims.

4.18. It is not disputed that reducing the reporting time will influence when the incident is brought to the knowledge of NHSR. It will provide an opportunity to put in place action more swiftly. However, the opportunity will be lost if there is no clear pathway for rolling out the learning and identifying who will be responsible to making changes.

4.19. The NHSR's response ignores the fact that basic steps such as serious incident reporting are of such poor quality that they currently do not contribute to reducing the incidence of harm. NHSR did not indicated whether this is going to be addressed, and if so, how. There was no reference to the suggestion that a working party be set up to look at this, no indication of whether this is going to be adopted to help improve this core skill.

4.20. When discussing what will be done to address expensive and devastating injuries arising from obstetric care nothing was said about what, if anything is going to be done to address problems with reading CTG traces and fetal heart rate monitoring. These are key problems that give rise to claims in negligence, they are problems that were identified years ago but persist and have not improved.

4.21. There will be no future improvement unless and until a strategic, properly considered and funded plan of action is put in place. Basic changes are required for learning to be properly identified and disseminated nationwide. The culture within the NHS does have to change but a clear direction of travel to address these weaknesses needs to be identified and committed to without delay.

4.22. Even without the Five Year Report the NHS has missed opportunities to improve maternity care and reduce their own exposure to costly claims. We refer to the work of Mr Tim Draycott, Consultant Obstetrician at Southmead Hospital who in 2000 founded Practical Obstetric Multi-Professional Training (PROMPT), a method of training based around team working. More details of the PROMPT method and Mr Draycott's work can be found in the following link:

http://patientsafety.health.org.uk/sites/default/files/resources/prompt.pdf

4.23. Mr Draycott's findings were that less than 50% of working midwives and obstetricians could employ anything more than basic care in an emergency situation. To address this he implemented better training, which resulted in a significant reduction in harm (50 -100% reduction depending on the type of obstetric complication being considered).

4.24. Mr Draycott's improvements were made in an NHS trust, without additional funding but with commitment and determination. The lessons learned at Southmead could and should be followed elsewhere. The PROMPT method has been around for some 17 years and has been adopted overseas with equal success. However it is still not mandatory for NHS maternity units to consider his methods and findings and adopt them.

4.25. It is difficult to see why NHSR and its predecessor NHSLA have not been more proactive about these findings which have been proven to make a significant difference and which would almost certainly have reduced the number of obstetric claims and consequently the compensation payable.

4.26. CW says in response to Question 12: ***"…the only answer to those big value cases is to have fewer incidents."*** In his response to question 15 he says "***we are focused on how we do the things that we can control"***. It does appear that the recommendations made in the Five Year Report and lessons from PROMPT are both within the NHSR's control and could be adopted.

4.27. Unless there is a concrete plan of action that draws on some of the recommendations and established learning from PROMPT and necessary funding made available, nothing will change. The rate of injury will continue to remain static and the compensation which needs to be paid in these cases will remain unaltered. Accordingly, the opportunity to substantially reduce the costs involved with this category of claim will again be missed and the incalculable human cost will continue.

5. Increase in lower value claims

5.1. The NHSR has identified that the other key driver of costs is the "***expansion in the number of much smaller cases"*** (CW response to PAC, question 2). Helen Vernon's (HV) response to PAC question 4, is that this issue is being addressed by having a "**focus on claimant legal costs"** which "**have become increasingly disproportionate"**

5.2. The NHSR have not suggested that the increase in the number of lower value claims being made is down to spurious claims being made. It is worth noting that Claimant solicitors will only be paid for cases where they have successfully proved the claim, it is not in their financial interests to bring claims that are lacking in merit.

5.3. If improvements were made to both the NHS complaints and early investigation processes this would enable trusts to identify cases where negligence occurred at the earliest possible opportunity. NHSR needs to organise itself and its trusts to ensure that where appropriate, cases are

settled at this early stage. This would avoid the need for litigation and lessons could be learned as soon as possible to prevent a repetition of the incident.

5.4. In the report following the inquiry into Mid Staffordshire NHS Foundation Trust, Sir Robert Francis QC said: ***"A health service that does not listen to its complaints is unlikely to reflect its patient's needs. One that does will be more likely to detect the early warning signs that something requires correction, to address such issues and to protect other from harmful treatment"***

5.5. If there is a genuine commitment to capturing incidences at the earliest opportunity, resolving claims as soon as possible, openness, honesty, transparency and making changes where appropriate then there has to be a commitment to improving the complaint process and other investigations at this level.

5.6. A great deal has been written on the complaints process, particularly in recent years although in practice little appears to have changed.

5.7. Lord Justice Jackson is the architect of FRC, in his recent Supplementary Report on Civil Litigation Costs, July 2017, he discussed clinical negligence costs in detail. His report can be found here:

https://www.judiciary.gov.uk/wp-content/uploads/2017/07/fixed-recoverable-costs-supplemental-report-online-2-1.pdf2017

5.8. Jackson commented that whilst he is unable to reach any conclusion on the issue of defendant conduct ***"…nevertheless I am bound to say that there is some evidence in this regard which warrants investigation by the NAO." (page 116, para 3.2)***

5.9. The NAO did not address this point in their report. Poorly managed cases cause delays in settling proceedings and costs money. However, the NAO has identified at page 44, paragraph 3.16 of their report that NHSR is taking longer to resolve claims – in 2011 it took an average of 300 days to resolve a claim, in 2016/17 it took 426 days, an increase of 126 days. The NAO puts the cost of delaying settlement at £40/day. This means that the average delay is costing an extra £5,040/case.

5.10. The NHSR needs to look objectively and critically at defendant conduct. Improving early stage investigative processes means there will be a greater chance that the issues will be identified early on; in turn this increases the chance of early settlement where appropriate. This approach also meets the patient's needs as they do not want to be locked into litigation, most want to know what went wrong, why and what has been done about the defects identified to ensure they don't happen again.

5.11. The NHSR announced an intention to work with the Parliamentary Health Service Ombudsman (PHSO) on the issue of complaints. However, it is not clear whether that intention will develop into actual working together.

In any event, the PHSO is the second tier of the NHS complaints process; the intervention is really required at the earlier, NHS Complaints investigation stage.

6. Fixed Recoverable Costs:

6.1. At the PAC meeting, the NHSR and MoJ discussed how they are working together to bring costs down. They are relying on the introduction of a fixed recoverable costs (FRC) regime to do this – Refer Richard Heaton's response to PAC Question 10 and his comment ***"I am very optimistic that we can get a decent FRC regime in here".***

It is notable that if FRC are not introduced there is no apparent alternative plan for reducing costs. Mr Heaton comments ***"The traditional view has always been that that has been too difficult in this area…a grid of costs will not work. That was the public response to the consultation…The Civil Justice Council say it is too rough and ready and will get in the way of access to justice".***

6.2. The above view is shared by others who specialise in clinical negligence claims. Specialist clinical negligence Masters in the High Court have publically stated that many clinical negligence claims are not suited to FRC as it fails to take into account complexity. It remains a strongly held view that the value of a clinical negligence claim is not a good indication of what it will cost to run the case.

6.3. Lord Justice Jackson has recommended that a working party of both claimant and defendant representatives be set up to develop a bespoke process for handling clinical negligence claims valued at less than £25,000. It is expected that the working party will examine a number of options, not just FRC. There has been no proper assessment of the impact of LASPO. Is FRC needed? is it a good solution to the concern about clinical negligence costs? or will it damage access to justice and hide negligent treatment costing the NHS more in the long run?

6.4. Jackson identifies two ways to avoid runaway litigation costs. FRC is one option the other is to impose a budget for individual cases. In relation to the latter a cost budgeting system already exists for claimant clinical negligence costs.

6.5. Cost budgeting is considered to be effective by all the major groups (Before the event insurance and liability insurers; High Court Masters specialising in clinical negligence; claimant solicitors and the bar). However, there are issues around the costs incurred before the costs budget hearing. This could be addressed and may be a suitable issue for the Jackson working party to consider. Improved complaints and early stage investigation would assist in keeping those pre issue costs down.

6.6. The fact that no successful FRC scheme has yet been designed is indicative of the difficulties involved in applying this scheme to clinical negligence claims.

7. Cost effective approaches:

7.1. The NHSR should be urged to commit itself to improving the way it carries out its internal investigations and its use of the complaint process. If it will commit to this then it must set out how and when it proposes to introduce those changes. Improvements in these processes will encourage greater confidence in the NHSRs willingness to be accountable when things go wrong.

7.2. It will make the issues more readily identifiable for the purposes of facilitating early settlement. This will help to manage the conduct of parties involved in litigation and it will save costs in all claims, not just the lower value claims.

7.3. As Lord Justice Jackson commented at p73, paragraph 15.3 of his Supplementary Report, July 2017, the best way to reduce litigation costs is to: settle meritorious claims early or admit liability early, too many claims are settled after the issue of proceedings and claims which are seriously contested generate substantial costs.

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