Informing Progress - Shaping the Future

FOIL UPDATE 3rd May 2022

House of Commons Health and Social Care Committee report on NHS litigation reform

This report was published on 28th April and has already received widespread publicity.

It addresses government concern that every year in England the NHS spends over £2 billion compensating patients who suffered harm during their treatment, but through a claims process that is slow and inefficient. There is particular concern about the rate and speed of claims inflation, which it is believed will double over the next decade to £4.6 billion, but with around a quarter of such costs going to lawyers. On top of all this there are accumulating future liabilities, put at £8.3 billion in 2021/22 alone.

As the existing Health Service Safety Investigations Body (HSSIB) loses responsibility for 1,000 of the most serious maternity incidents which will not, therefore, benefit from no blame investigations, the government feels that a system is urgently needed 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 by the new body should prioritise the identification of system changes that can be disseminated across the NHS to prevent mistakes being repeated. Even if the threshold for compensation is not

IN BRIEF

A House of Commons Committee has suggested a wholesale reform of the way in which compensation is paid to patients suffering harm while undergoing NHS treatment.

Proof of negligence would no longer be the benchmark and compensation would be calculated on different bases.

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.

The central recommendation is 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. As discussed below, this will initially focus on obstetric cases. An independent administrative body should be made responsible for investigating cases and determining eligibility for compensation in the most serious cases.

It is felt that reconstituting the new Special Health Authority, which will take over maternity investigations from HSSIB, would be an efficient way for the government to implement these recommendations.

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 the report encourages the government to adopt.

First, 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.

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. 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 the health system and should be scrapped for all NHS-related clinical negligence claims involving children under 18 years of age.

Before any court case there should be compulsory use of alternative dispute resolution mechanisms (ADRs).

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.

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.

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.

As the most complex and expensive cases are those related to birth injuries which leave children seriously disabled, it may be appropriate to pilot new changes in this area. Once established, and having proven its value, the administrative system should then be expanded to accommodate all claims for compensation made against the NHS.

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.

In support of its proposals, the report cites examples of schemes in other jurisdictions around the world.

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. However, based on evidence from abroad, the report believes that, when given the choice, patients and families prefer the simpler administrative process. It also recommends that the new body would be the mandatory first port of call for anyone who thinks they are entitled to compensation

The proposed administrative body should be empowered to change the way compensation is awarded. At present compensation is awarded on a ‘once and for all’ basis, but the report recommends that awards be made with periodical review built in so that they can become responsive to the changing needs of patients.

The full report may be viewed at: NHS litigation reform (parliament.uk)

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