From the Permanent Secretary
Sir Chris Wormald

Department of Health & Social Care

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Dame Meg Hillier MP
Chair of Public Accounts Committee
House of Commons
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Sent via email to: pubaccom@parliament.uk

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Dear Chair

Progress on the implementation of agreed recommendations by the Government to the Committee of Public Accounts: Session 2017-19

Fifth Report of Session 2017-19 Department of Health and Social Care / Ministry of Justice HM Treasury - Managing the costs of clinical negligence in hospital trusts

Following on from my letter of 1 December 2022, I am writing to provide the Committee with an update from the Department of Health and Social Care on progress against the outstanding recommendation in the above-named report.

Recommendation 2: The Department, the Ministry of Justice, and NHS Resolution must take urgent and coordinated action to address the rising costs of clinical negligence. This includes reviewing whether current legislation remains adequate, and reporting back to the Committee by April 2018; continuing to focus on actions to reduce patient harm, in particular, harm to maternity patients; and appraising further measures to reduce the legal costs of claims, for example whether mediation should be mandated for certain types of claims.

The Department continues to work with the Ministry of Justice, HM Treasury, Cabinet Office and NHS Resolution to understand cost drivers and explore possible solutions to address rising costs. This is an important issue and Ministers are currently considering next steps. I would like to update you on the work the Department has done to make progress on this issue.

The government and the NHS have taken significant steps forward. In January 2022, the department published a consultation on the introduction of fixed recoverable costs for lower value clinical negligence claims to address high legal costs and streamline the claims-handling process. Responses are currently being considered and the department plans to publish its response to the consultation shortly.

Patient Safety remains a priority for the government. In September 2022 the first Patient Safety Commissioner began her role as a champion for patients, leading a drive to improve the safety of medicines and medical devices. The Health Services Safety Investigations Body (HSSIB) will be established in October 2023 to investigate patient safety incidents in the NHS and

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independent sector. The delay in establishing HSSIB, originally planned for April 2023, will enable the smooth transition of the Healthcare Safety Investigations Branch (HSIB) to the new independent body. HSIB's maternity investigations programme will continue, but be hosted by the CQC from October 2023. This instead of forming a Special Health Authority, as announced in a Written Ministerial Statement on 30 March. In 2022, NHS England invested £127 million towards the maternity NHS workforce and improving neonatal care. We have taken steps to improve maternity safety within the NHS. This is evidenced by a 19% reduction in stillbirths in 2021 and 30% reduction in neonatal mortality rates for babies born over the 24-week gestational age of viability in 2020, when compared to the 2010 baseline. We are also strengthening the quality of perinatal services and safety surveillance across all maternity services. Services requiring improvement are receiving hands-on support from senior midwives and obstetricians through the Maternity Services Support Programme.

Finally, we are currently assessing the findings of the Health and Social Care Select Committee (HSCSC) report following its inquiry into litigation reform. We welcome the HSCSC's focus on this important issue and expect to respond later this year. In the Department's response we also plan to address the residual points from this recommendation and in doing so conclude its implementation. As such, we will need to push the implementation date back to Autumn 2023.

Yours sincerely,

Chris Wormald

SIR CHRIS WORMALD
PERMANENT SECRETARY