Written evidence submitted by Hempsons Solicitors (NLR0014)

Hempsons is a law firm with extensive links with the healthcare professions. Hempsons came to the Panel of the NHS Litigation Authority having been legal advisors to the MDU, the BMA and several of the Royal Colleges for 100 years before the liabilities were nationalised in 1990. We retain deep links with healthcare professions, providing an unusual viewpoint. In essence we advise:

1. **The cost of most litigation against the NHS is sustainable, in the sense that it is a burden that it can carry. That does not make it right or sensible, but you can continue to divert 2% of NHS turnover to the consequences of unlawful damage to patients if you so choose without destroying the Service.**

2. **The exception is maternity services where staff are demoralised, burned out and replaced by less experienced colleagues.**

3. **We advocate an expansion of the local Duty of Candour responses as a means of engaging with the victims of accidents in seeking non-financial remedies. It has the priceless advantage of being owned by the Trusts and necessitating a joint exploration of issues without destroying the therapeutic alliance between patient and provider. Local investigations must be properly resourced and moderate harm identified at the outset.**

4. **We do not agree with your focus on speed once a claim is in the legal process. Most disputes are resolved reasonably promptly, and the delays are generally caused by other factors such as the need to assess claimants' needs.**

5. **There is much more of a problem with legal costs. The legal profession has ceased to provide a service at a price that the public can reasonably be expected to pay. The courts could easily devise a cheaper system if they so choose.**

6. **We applaud and are proud to support NHS Resolution's attempts to feed back the lessons of their claims, these provide anecdotal evidence of things that could be improved. Much more will be achieved if you were to support and expand the systematic reviews what the NHS is actually doing that are undertaken by the professions, through things such as NCEPOD, MBRRACE and GIRFT. We recommend a national programme using AI to review electronic fetal monitoring and outcome.**

7. **We have a crisis in education and training. We will need to undo the damage that has been done over the last 25 years. Pending that you need to support rigorous training. We need a stable midwifery workforce with high morale.**

8. **So far HSIB has yet to demonstrate that it can command the confidence of clinicians or the Service in producing anything more robust than local SI investigations. There is also a limit to what can be achieved through exhaustive investigation of individual cases.**

Question 1

What is the impact of the current costs of litigation on the financial sustainability of the NHS and the provision of Patient Care?

a. This raises a number of different questions because the impact varies on different sectors. The most important single distinction is between the impact on obstetrics and all the rest: the total amount spent by Commissioners is about £3 billion a year on all obstetrics services. Half of this is diverted at the beginning of the year to meet subscriptions to the CNST so that about £1.5 billion is paid by Commissioners for the provision of obstetrics, including all staff employment. However, the real cost of litigation arising from these services in year is over £6 billion. That figure is insulated from the NHS, by being added to the provision on HM Treasury's Balance Sheet in respect of these liabilities. The provision for claims against the secondary care system in England has gone up from about £25 billion to £82.8 billion over the last 6 years and NHS managers are able to regard it as someone else's problem because they never appear on the individual Trust's Balance Sheet.
b. It may fairly be said that much of this is attributable to an increase in the cost of money to finance long-term liabilities, but that does not mean that this is anything other than "real money." Whenever HM Treasury is asked to approve any sort of capital expenditure it inevitably considers the capital account.
c. The resulting pressure on capital expenditure over the last 10 years is seen all over the NHS. Individual Trusts now have a liability for a backlog of servicing of buildings and so on of £9 billion pounds: those are buildings and equipment that should have been replaced and the resulting inefficiency of lifts not working and theatres not being able to be used at optimum capacity impacts on the running costs of the service.[1] We have also had restrictions on the provision of equipment, so that this country (which invented MRI scanners) had fewer per capita than any other country in western Europe before we were hit by COVID, and of those that we do have a large number are obsolete.[2]
d. So, the capital liabilities of the Service have a day to day impact on the efficiency going forward and the distinction between capital and current expenditure is deceptive.
e. Since the discount rate changed in 2017 we see individual claims made on the NHS for over £30 million as a regular part of our work and these present an extraordinary disproportion. The midwife who will have caused the damage, through some action that we cannot defend may earn £30,000 per year (the midwifery scale runs from £24,000 - £38,000 per annum) so that we regularly see claims by individual patients for more than the midwife who is held to blame would have earned if she worked for 1,000 years.
f. This degree of disproportion has a devastating effect on the morale of the service. The only intervention that has been shown to reduce the incidence of obstetric mishap, and the lifetime of appalling disability that may follow, is the presence 1:1 of an experienced midwife who has been through a recent PROMPT training course alongside the obstetric staff with whom she works. In other words, to achieve this we need a stable workforce with high morale. The morale amongst midwives is appalling: if you Google "Midwife burnout" you will see a litany of stories describing a profession in crisis. It does no good to invest in more aggressive recruitment: the NHS does not have a recruitment problem. It will not solve the problem by attracting

[1] See ERIC: https://digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection/england-2019-20

[2] [2] https://www.rcr.ac.uk/posts/nhs-must-do-more-future-proof-its-mri-capacity-say-imaging-expert

more bright-eyed enthusiasts at the start of their careers who will do little to make parturition safer. The issue is that the NHS has an appalling retention rate, and it will only fix that by making the profession more congenial.

g. We see the same thing in obstetrics. The RCOG surveys its Members, and they report that there are significant rota gaps amongst middle grades. These are handled by asking the existing trainees to work out of hours: there is no training out of hours, so the future skills of the profession are being compromised to keep the lights on now.[3] Many Middle-grade trainees report that they regularly consider leaving the profession.[4]

h. All of this means that in obstetrics the present situation is not sustainable. We note that a law reform aimed at reducing damages is not one of the questions on which you have sought submissions and so we will only trouble you briefly with proposals on this occasion, although we hope that this is a topic to which you will return.

i. In any calculating system, by which we mean one in which the financial sustainability is allowed to dictate decisions about practice, providers of healthcare services would get out of obstetrics altogether. Indeed, virtually all such providers have already done so where they are in a position to choose. There is a tiny group of private practitioners who are clinging on by their fingernails to a few cases in London.

j. The only reason why individual Trusts are able to continue to provide obstetric services is because they are insulated from the fiscal consequences of their actions by the CNST and NHS Resolution who administer it on behalf of the Secretary of State who is himself the Administrator of the scheme. If NHS Resolution were buying insurance in the marketplace for obstetric liabilities they would be being charged at least £7 billion a year.

k. Non-Obstetric Claims

The rest of the NHS litigation scene is broadly speaking sustainable. The liabilities are accumulating at about £2.5 billion to £3 billion a year which is certainly more than the Trusts are paying, but it is something that society is free to choose to spend and therefore to that extent it is sustainable. We may hope that the price of long-term money will fall so that the rate at which the provisions increase will fall. That does not make it a wise or appropriate use of the insufficient resources that Parliament has chosen to devote to this area of our life. If there is one thing we have learnt from Covid it is that healthcare service is not an optional extra. Covid has taught us that absent an effective healthcare system, everything else in our society – the economy, education and our cultural life, are all at risk. If that is right, then society has no choice but to increase the money devoted to healthcare to levels that were not proposed, even at the height of the Wanless debate 20 years ago.

l. However, subject to the caveat that the sustainability of the NHS is something that society has not yet begun to grapple with, the cost of litigation which runs at about 2% of the total expenditure on healthcare plainly does not threaten the sustainability of the service beyond the maternity department. If the Queen in Parliament so chooses, we can obviously afford to divert 2% of NHS spending to the cost of unlawful failures of our duty of care to people who have turned in their hour of need to use the Service they have paid for.

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[3] RCOG Workforce Review 2017: https://www.rcog.org.uk/globalassets/documents/careers-and-training/workplace-and-workforce-issues/rcog-og-workforce-report-2017.pdf.

[4] RCPCH Rota Gaps and Vacancies 2017: Survey: https://www.rcpch.ac.uk/sites/default/files/2018-02/paediatric_rota_gaps_and_vacancies_survey_wingsan_final.pdf

Question 2

What are the key changes the Government should consider as part of its review of clinical negligence litigation in particular?

(1) What changes should be made in the way in which compensation is awarded in clinical negligence claims to promote learning and avoid the same problem being repeated elsewhere in the system?

a. It is hard to see how there can be any very effective relationship between the way compensation is awarded and the process of learning lessons. Indeed, the connection that was proposed in the "Swedish graph" which seemed to reveal a dramatic fall in Cerebral Palsy rates as a result of a more candid approach from the insurers was always illogical and unpersuasive. The real reason why the number of claims fell was probably the result of the introduction of neonatal cooling at about the same time, as Swedish researchers have now identified.

b. Certainly, claims handlers and lawyers can spot patterns and should point them out to the Service. NHS Resolution has taken a leading role in doing this and is planning to do more. The CNST can also use its enormous data and financial power to advocate for change in dangerous practices: the Maternity Incentive Scheme for Trusts is a good example how this can achieve a formative effect on policy within Trusts, but this works because it is based as much on the authoritative advice that it receives from senior clinicians as it is on the data derived from claims. The primary business of the CNST (and now CNSGP) is the management of claims: training is the province of Health Education England and senior clinicians. Practice policy is the province of NICE, which acts on the advice of the RCOG in obstetrics. You should not expect the claims system to play a primary role in either training or the drafting of protocols.

c. What you should do is to promote the other mechanisms of learning which are well established within the healthcare professions and have achieved dramatic results. It is they who should be using the data and lessons that the CNST/CNSGP is able to identify. In 1946 the incidence of mortality from anaesthesia alone was about 1 in every 1,000 anaesthetics. [5] Today the incidence of mortality from anaesthesia alone is immeasurably rare. This was achieved as a result of a sustained process of professional review and self-criticism. It is true that in anaesthesia it has been helped by contributions from the equipment makers and big pharma, so that the condition of the unconscious patient can now be monitored by pulse oximeters in a way that was simply not possible in 1946. But this was in response to demands from clinicians and the process by which these have been driven is the same as the process by which the profession has become safer. Endless learning and re-learning have been accompanied by the formulation of rules of practice by clinicians and their professional bodies.

d. Obstetric anaesthesia is a particularly good example. In 1946 a caesarean section was an extremely hazardous process, largely because of the anaesthetic and the danger of regurgitation of stomach contents at induction. When the first Confidential Enquiry into Maternal Mortality was launched in the early 1950's this was identified, and the incidence of obstetric anaesthetic death steadily increased as caesarean section under general anaesthesia became more

[5] Beecher & Todd Annals of Surgery 1954

popular. In the 1970s we always had two or three such inquest files open. Now it is so rare that we cannot remember the last case.

e. One of the major changes that brought this about was the introduction of epidural and then spinal anaesthesia so that the general anaesthetic is a comparative rarity on the obstetric ward. In this respect, litigation proved to be positively detrimental to progress. In 1954 the Court of Appeal found in the case of *Roe and Woolley v Ministry of Health* that a patient had probably suffered spinal cord damage as a result of hairline cracks in the glass file that enabled the local anaesthetic agent to be contaminated with a sclerosant, phenol that was used to store it in sterile conditions.[6] Whatever the merits of that decision (and it is now thought to have been mistaken[7]) it put back the cause of spinal and epidural anaesthesia in this country by 40 years. Until the 1970's epidural anaesthesia was rare and spinal anaesthesia did not become commonplace until the 1990's. This was largely due to the adverse impact of a generation attempting to learn the lessons of litigation when our cases are best seen as anecdotal illustrations of danger, rather than presenting a template for safe practice based on the sort of evidence that medicine now demands.

f. What you should do, as a Parliamentary Committee, is to advocate strongly for support for an expansion of the work of the ways in which the profession advocates for safer practice. GIRFT has achieved great things, simply by using recognised senior doctors with authority to present comparative data about their outcomes to individual teams.

g. The Confidential Enquiries, such as NCEPOD, perform a vital role in pursuing ways of improving clinical services. At present NCEPOD publishes only two reports a year and does little to publicise them because it runs on a budget of about £1 million a year. It is able to achieve this because it harnesses the enthusiasm of the medical profession who are anxious to criticise what they and their colleagues are doing and to identify ways of improving it. It should be reinforced and given the resources to promote its lessons, however inconvenient they may be. Its independence should be guaranteed by reporting directly to Parliament.

h. Similarly, the oldest confidential enquiry in the world, MBRRACE has been reviewing cases of maternal mortality since 1952. During that period there has been a transformation in the rates of mortality for both mothers and babies. Recently it has concentrated on drawing attention to the extraordinary increased dangers faced by mothers and babies from a BAME background.

i. Furthermore, we would doubt the wisdom of looking at claims alone as a source of proposals to improve the service or to make it safer. Certainly, the amount of damages involved can give our lessons a persuasive cogency that belies the anecdotal nature of our evidence, but they are rare. The CNST gets less than 10,000 claims a year, the NHS deals with 560 million patient interactions a year, 1.5 million a day.[8] So one in 50,000 interactions results in a claim.

j. The vast majority of adverse events do not result in claims. There are over 200 million medication errors a year.[9] There are about 1.5 million adverse events.[10] Those mishaps which result in serious damage and a claim being made are a tiny

[6] ***Roe v Minister of Health*** [1954] 2 All ER 131

[7] *Hutter (October 1990). "The Woolley and Roe case. A reassessment". British Journal of Anaesthesia.* ***84*** *(10): 859–864. doi:10.1111/j.1365-2044.1990.tb14573.x. PMID 2240503. S2CID 24506166.*

[8] https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/NHS-activity
[9] https://www.sheffield.ac.uk/news/nr/200-million-medication-errors-occur-nhs-every-year-1.765781
[10] https://www.health.org.uk/sites/default/files/IsTheNHSGettingSafer.pdf

minority. The difference is largely down to luck and you would do much better to study the larger denominators to look for likely causes of damage in the future.

Training

k. Much of what we need demands an improvement in healthcare education and training. For example, we see a steady stream of cases where sepsis is not recognised by inexperienced doctors. NCEPOD published a study as a result of surveying the performance of doctors in Trusts up and down the country.[11] It found that there were similar delays in about 50% of the cases that they selected for scrutiny.

l. There is not much point in picking on the few cases that come to litigation other than for anecdotal illustration. NCEPOD studied 500 cases and produced a quiver full of proposals. The core problem is that we have so undermined medical training that we have a generation of junior doctors who find it very difficult to recognise the sick patient because such people are rare in their experience. The role of the doctor is usually to be with the sick patient for a short period of time. The continuity of care that used to be the hallmark of medical training has gone, as has the continuity of training that used to be provided by the firm structure in which one consultant supervised the work of their own trainee.

m. The NCEPOD study identified ways in which patients suffering from sepsis could be recognised and the very simple 6 measures that needed to be taken at once that would be sufficient to treat the vast majority of such cases. It looked at the whole clinical journey and identified all the ways in which patients are habitually failed. Overall, less than 50% of such patients were found to have received good care which means that most of them would have had an arguable claim if they had chosen to complain about their outcome. Any learning process that is owned by the healthcare professions and added to ordinary routine training is far more likely to be effective and infinitely more likely to be cost effective than something ordained from above. Seeking to use the handful of cases of sepsis that come to litigation as a basis for learning is unlikely to help very much and may distort things, as happened with spinal injections after Roe and Woolley's cases. Where individual cases do have an anecdotal power that is obvious to the handlers, this is publicised through the NHS Resolution's Annual Report and through lectures that we give in hospitals up and down.

n. We are all proud to support the advocacy and learning processes of NHS Resolution because clinicians are prepared to listen us as a result of their fear of the legal process. But it is can only be a very small part of an adequate way to address a learning deficit. Picking on cases for anecdotal reasons is no substitute for rigorous training across the piece.

(2) How can clinical negligence processes be simplified so that patients can receive redress more quickly?

a. The short answer is that once again you have to break up the problem into its component parts – what causes delay and will a simplification of the process

[11] *Just Say Sepsis!* :https://www.ncepod.org.uk/2015report2/downloads/JustSaySepsis_FullReport.pdf

reduce that? As lawyers we probably look at the time to resolution starting from our instruction. For patients we envisage this starts far earlier and before any of what we recognise as the clinical negligence process begins. For this reason, we repeat our view that there needs to be investment in the duty of candour process. Redress comes in a number of forms – not just financial compensation. An injured patient who has had their experience acknowledged and explained without having to instigate the procedure themselves is likely to view their experience far more positively than one who has battled through a complaints process and needed to instruct solicitors before a satisfactory response is received.

b. Cases worth under £50,000 are on average disposed of by NHS Resolution within 16 months of a claim being made and lawyers instructed. That is the present figure and it has been impacted by the pandemic. One of the KPIs by which NHS Resolution manages its panel of lawyers and its own claim handlers is the interval that it takes to settle a claim from when we are instructed and so most panel lawyers close such cases remarkably quickly. The time interval involved is comparable with the time interval that it takes to dispose of such cases in New Zealand under their no-fault system – it may not be quite as fast, but the timescales are comparable.[12] The present period of 16 months is an average that includes the tiny minority of cases where the parties do not agree that there is liability so that they have to go to trial. It does not measure the time from the date of incident or when the candour procedure has been concluded.

c. Nevertheless, we would not suggest that all is for the best in the best of all possible worlds. The objection to the present tort system for such cases is not primarily because of its delay but because of the costs. Very few such claims are disposed of without spending more on legal costs than the damages at stake if lawyers are involved. Sometimes the difference is obscene. This could be controlled if the courts wished to do so. A contested claim about a case worth £20,000 may well result in a bill of costs from the Claimant's lawyers of £300,000 and such bills are approved by the courts. For the same trial the defendant's budget will probably be 20-30% of the claimant's figure. Indeed, the courts now approve those estimates in advance and have no compunction in authorising the expenditure. This results in us trying to close files even faster because it is the only way to protect our client's funds.

d. Obviously, it is not within the scope of your work to suggest how the courts should be forced to reduce claimant's costs so that the legal profession provides a service at a price that the public may be expected to pay. There is for example no justification for the courts to approve costs based on hourly rates that are more than double the average paid by NHS Resolution to its own lawyers for cases of a similar value. They do so on the basis that they are awarding the market rate, when the reality is that there is no other market. 90% of clinical negligence rates are set by the courts and the rest conform to those figures.

e. However, if it is not within the ambit of your report to comment on the actions of the court in regulating lawyers' costs, you could propose how the whole system could be replaced. Any claim of less than say £30,000 could be taken out of the litigation process altogether and dealt with through the complaints system. Parliament did enact a Redress system some 15 years ago, but it was not well thought out and it has never been brought into effect. We confess that

[12] https://www.acc.co.nz/im-injured/how-we-manage-your-claim/

we were not great fans of it at the time but then the Claimant lawyers had not so comprehensively priced themselves out of the market. Any alternative to litigation, such as no-fault liability or redress through an administrative rather than a legal process looks more attractive as the legal alternative has become progressively more unaffordable.

f. So, the answer to your question about how things can be handled more swiftly is:

(i) Justice is not significantly delayed as it is, so long as uncontested claims are on average being dealt with at a speed that is roughly comparable with the New Zealand system. We do not think it is reasonable to complain of delay once the formal legal process has been commenced.

(ii) We are already running as fast as we can, mainly in order to stop the Claimant lawyers spending money that the NHS cannot afford, and which is utterly disproportionate to the damages at issue.

(iii) Things might not be done more swiftly under an administrative process where you would still have to assess the extent of the injury, the cost of the remedies and whether it satisfied whatever causation test was chosen.

(iv) Require Claimants to serve a protocol compliant letter of claim supported by expert evidence and signed by a statement of truth - unless they rely on a Trust/general practice investigation or candour response that effectively concedes liability. This would prevent costs being incurred on investigating speculative claims and compel Claimant firms to investigate properly.

(v) Require Trusts and general practice to report to NHS Resolution every case where the duty of candour process has identified moderate harm. For lower value cases allow fixed Claimant costs which will incentivise speed of pushing the claims through the system.

(vi) As redress is about more than compensation look at the introduction of a specific Rehabilitation Code for clinical negligence claims

g. In any sensible system that was trying to provide a service at a price that the public could reasonably be expected to pay, as soon as a claim was made the court would summons both parties and decree that the total amount of costs that might be available would be, say 30% or 40% of the claim for each side in a small claim, if it went to trial. So, if the damages are £50,000 the courts could tell the parties that there is £15,000 or £20,000 available to be spent in recoverable costs and invite the parties to make submissions as to how they would like that money to be spent. The parties would probably agree on a design that included one expert on each side for liability and one on quantum. Each should be required to write a short report for the sort of fee that the defence obtain screening reports, say £1,000 each. So that would be £2,000 a side. They could have another £2,000 for taking instructions from the claimant and any other witnesses – a surprising amount can be done on the telephone as we have all learned in lockdown. There could be £2,000 for all inter-parties' correspondence and £2,000 for preparing for court. That would amount to about £8,000 a side. There could then be £5,000 for a barrister for the trial and £5,000 for witnesses if they really need them. Any economies made in any of

these areas could be transferred to another area, but the envelope of recoverable costs would be known from the outset and the lawyers might occasionally find themselves doing a bit pro bono. It would be very easy for the courts and parties to design a system on a case-by-case basis that would deliver justice at a proportionate price.

h. Inevitably, such a lack of expense would result in the parties designing a swift system. Nobody wants files sitting around their office which cannot earn them recoverable fees. As it is, the parties go to court to describe a process that is obviously disproportionately expensive, and no-one turns a hair. Since we now have one-way costs shifting, the Claimant will almost never have been at risk of having to pay the costs of either side.

(3) How can collaboration between legal advisors be strengthened to encourage early and constructive engagement between parties?

a. One answer is simple, link payment of costs to adherence to a non-adversarial format. When you have the lawyer's wallet in your hand, their heart and mind will surely follow. In most cases there is reasonably constructive engagement between the parties in litigation and this has improved during the pandemic because the courts have made it clear they expect it and will expect to see a more co-operative attitude to extensions of time. The trouble is that if flexibility becomes an end in itself, it may result in more ill-founded claims being settled. Alternative Dispute Resolution (ADR) is how the overwhelming majority of cases are resolved – obviously since only 2% go to trial and many are now resolved before proceedings are even issued. ADR may be the result of a simple offer and acceptance or a bit of telephone negotiation. In the vast majority of cases a mediator is not needed. The trick is to settle them earlier without increasing the proportion where you pay damages and disproportionate Claimant's costs. This is an adversarial process and those who appeal for amity tend to overlook this.

b. Many potential claims received by Claimant firms are not pursued - there may be data held that could be used to help local healthcare providers learn about their complaints and candour processes. Claimant and Defendant firms working together to support the NHS to improve would for some patients be another form of redress.

(4) What role could an expanded Early Notification Scheme play in improving transparency and efficiency systemwide?

a. What is unusual about the EN Scheme is that the Service identifies the cases before any claim has been made, using the criteria devised by the RCOG in its study of SI reports, Each Baby Counts. It was never designed as a basis for identifying claims or cases where compensation might be payable, and it has proved to be broader than is appropriate for that purpose. One of the criteria was that it included every baby sent for cooling as a result of evidence of metabolic acidosis at birth. The overwhelming majority of such children proved not to have permanent damage and we have since narrowed the criteria so as catch fewer children who do not have identified damage.

b. This reveals one problem inherent in any expanded Early Notification Scheme. The criteria used for the statutory duty of candour include any case where moderate harm has been sustained by a patient and that includes any return to theatre or unexpected prolongation of a stay in hospital. These events are not likely to sound in damages, or at least not to any significant extent, so we would need something narrower. We can see more scope for learning – if the data is shared across the Service and analysed in the way GIRFT works.

c. Leaving aside the precise criteria for identifying such cases, there is a second objection which is that the majority of people who have suffered harm as a result of the mistaken efforts of doctors and nurses to help them, have no desire to make a claim for financial compensation. It is different where the clinician has been unkind or tried to deceive the patient about what has happened, but if the therapeutic alliance between patient and clinician has not been broken, most of us would not wish to make a claim and we would deprecate any desire to change that attitude. You do not want to shoehorn people into a model devised by the civil law in which people seek to monetise every delay or disappointment at the expense of those who have tried to help them.

d. The duty of candour already requires Trusts to level with patients who have suffered harm and to explain what has happened. At the moment, where it is thought that they may have a claim they are encouraged to engage lawyers to represent them. Any alternative to that is fraught with hazard because it will put the service in the position of having to be careful not to take advantage of the unrepresented litigant. It is very difficult for the defence to quantify a claim because the vast majority of the damages that are payable are case specific. The general damages payable for the physical injury are a modest component of a claim where a much larger amount is due to probable loss of earnings or the cost of care. Under the present system, we do not know how much care someone really needs, and it is difficult for us to guess at what their loss of earnings is likely to be.

e. Our own view, for what it is worth, is that we should replace awards for the purchase of care by the provision of care itself through what might be called a National Health Service, that the payment of damages is inconsistent with the existence of an adequate NHS. At the moment the NHS is so strapped for resources that it cannot provide the sort of care at home that people need. We would advocate the repeal of Section 2(4) of the 1948 Law Reform Act which requires the courts to disregard the availability of services from the NHS or another public authority when quantifying claims, but at the moment it is of academic importance because such services are in such scarce supply from the NHS. Nevertheless, we should include a statutory assumption that people will use the NHS unless it can be shown not to be available.

f. We recommend a nationwide project to examine, with AI learning, how and why staff respond in the way that they do to GTG traces during labour. This should run for all deliveries, so a range of outcomes are included – those with a pathological trace and no brain damage as well as those with no obvious warning but a catastrophic outcome. This would allow for improved training for obstetric and midwifery staff. It could also lead to incentives for manufacturers to develop improved monitoring equipment.

(5) The Government has reiterated its intention to extend fixed recoverable costs, which limit the amount that can be paid out to legal costs, to clinical negligence cases with settlements of less than £25,000. At what level should these fixed recoverable costs be set, and are there any circumstances in which they should not apply to low value clinical negligence cases?

a. As we have said, we think that a proportionate sum to be spent on costs is 40% of the damages in smallish claims. In other words, £10,000 on a £25,000 claim. However, we would suggest that was a maximum figure and in case specific circumstances where the liability is obvious it should be much less.

b. For example, the death of a member of the family attracts an award for bereavement which at present is £15,120. The mechanism by which this was fixed by Parliament was a desire to replace nominal awards for loss of expectation of life. It is not at all obvious that any civilised society would monetise bereavement at all. How anyone can think that a sum of money can compensate for the loss of a child points to such a vulgarity that is hard to describe. Indeed, we know from cases of wrongful birth that children are extremely expensive to bring up so that financial compensation is inappropriate. But, in its wisdom Parliament adopted the Irish idea of a fixed figure for bereavement, what Irish lawyers used to call "tear money." It was said that having such a fixed sum would avoid undignified disputes about one person being more bereaved than another. However, since then lawyers have found a way round this by getting psychiatrists to certify that their clients have what is called a pathological grief reaction. In practice this means that they are encouraged to be rather more bereaved than other people. If Parliament said that the damages in respect of a death were going to be the bereavement damages plus a fixed sum for a funeral of £5,000 and no other claim would be entertained, then you would reduce the damages to £20,000 and you could say that the costs would be fixed at £2,000.

c. Incidentally this is not a new debate. In 1995 we did propose that all claims of under £10,000 should be taken out of the tort system altogether and dealt with by the complaints system, in our submission to Lord Woolf's report. It did not catch on then, but today we suspect the tide of opinion has turned with the failure of Lord Woolf and thereafter Sir Rupert Jackson to find ways to reduce costs effectively.

d. It will be said there are circumstances in which fixed recoverable costs should not apply to low value clinical negligence cases and it is worth considering the principal contenders for such a badge.

(i) Testing a point of law

There will be some cases where both sides want to test a point of law because it has other repercussions for the service. Any Claimant who wished to maintain that their case was so novel as to raise a new point of law should have to make their submission to the courts. Such cases are very rare, but they do come up. For example, the question of whether blood was a product and so caught by the strict liability for dangerous products, which lay at the heart of the Hepatitis C litigation in the 1990's was a good example.

(ii) Group actions

Group actions raise their own problems. We have acted in a number of large group actions such as

- whether or not prisoners should have a claim for insufficient methadone being prescribed when they were opiate dependent.
- the retained body parts following the Alder Hey scandal where we acted in the nationwide litigation that followed. The parties wished to know whether or not a body part could be capable of ownership and whether a relative had a right to possession of the parts of the body that were removed by the Pathologist.[13]
- where the patients of the deceased gynaecologist Rodney Ledward claimed to have been sexually assaulted by him.

In those cases, apparently low value individual cases were linked by a group action order so that the court could take a view of the greater claim. We would agree that such cases should not be caught by the same cap, but experience shows that those cases tend to be owned by the lawyers rather than the litigants and run in the interests of the lawyers. The costs were vast, and the courts were forced to act in the organ retention and Ledward cases because the litigation had become mainly concerned with the issues of costs. In both cases the litigation settled very soon after those cost capping orders were made.

Question 3

To what extent does the adversarial nature of the current clinical negligence system create a "blame culture" which affects medical advice and decision making?

a. The answer we would suggest is little or not at all. The adversarial nature of the litigation system is not responsible for the blame culture, which comes from more broadly based causes in our society.
b. The blame culture comes from the fact that society's tolerance of suboptimal medicine is so diminished that it is not prepared to resolve such matters merely on the basis of a payment from the State to the individual. The blame culture comes from a dysfunctional attitude to medicine on the part of broader society. One part of this is certainly that patients are intolerant of failure by a service that they are not prepared to finance properly. There has been a decline of deference to clinicians that is most vividly seen in the present "anti-vax" movement. Doctors who get it wrong are more likely to experience complaints to the General Medical Council and their employers take an intolerant attitude to their failures so that we are regularly handling difficult clinical disciplinary cases.
c. Whether the blame culture affects medical advice and decision making is another matter. We doubt it. It is true that fear of complaints and disciplinary action does make doctors more risk adverse, but these things are hard to distinguish from the general tenor of events in society. For example, 40 years ago the decision to perform a skull x-ray after a closed head injury that had not resulted in detectable signs or symptoms of intercranial damage was regarded as defensive medicine. It is

[13] Incidentally the furore around the discovery that hospitals were storing body parts and tissue samples contributed to the demise of the hospital post mortem. That has been a real setback in the struggle to learn from medical mistakes.

now routine, not only to do a skull x-ray, but also a CT scan in circumstances where it would simply not have been thought appropriate in 1980. As a society we are more risk averse, as the increase in the wearing of seatbelts in cars and the demand for lower vehicle speeds in cities demonstrate. We do not think that blame culture affects medical advice and decision making very much.

d. The idea that the blame culture is a product of litigation or its fear is also mistaken. Indeed, the impetus to encourage apologies came from the indemnifiers and lawyers long before it was adopted by the GMC or the DH. It was first suggested by Dr Kate Allsop in the first edition of the MDU Journal in 1986,[14] and by Lord Donaldson MR in a celebrated case.[15] Almost the first circular of the NHS Litigation Authority endorsed the principle. The statutory Duty of Candour was also proposed by a lawyer, Sir Robert Francis QC in the Mid Stafford Report. This pressure is up against an understandable fear amongst doctors and nurses that they will lose their careers if they admit to having caused harm, something that GMC and NMC proceedings reinforce every day.

Question 4

How important is it that any clinical negligence system encourages lesson learning and commitment to change as a result of any action?

a. We hope we have made it clear that we think that it is essential that the NHS learns lessons and a commitment to change as a result of adverse events. However, we have also said that we think that the tiny minority of such cases that come to litigation does not mean that they provide an especially valuable resource. The clinical negligence system has got quite enough on its plate in trying to deliver a service at a price that the public can be expected to pay without it being given a responsibility for lesson learning. It is useful for our lawyers to go round the hospitals lecturing to healthcare professionals for all sorts of reasons. It helps them to understand what is happening and to be less frightened when they get a claim. We are able to explain to them how catastrophic events occur. It helps to get them to discuss common traps for the unwary. But there is nothing unique about the cases that we handle.

b. Take for example a very common cause of major litigation, which is delay in the diagnosis of Cauda Equina Syndrome. Handling this sensibly demands a recognition of the following propositions:

1. Lower back pain is very common.
2. Most of us experience it 10 times as often as we present it to our GP or the emergency department.
3. Of those who do seek professional help, 90% do not have an injury that merits an MRI scan.
4. Of those that do merit an MRI scan, the vast majority will prove negative.
5. Of those that prove positive, in the sense of revealing an operable lesion that corresponds to the symptoms, the vast majority will recover without any damage if there is no surgery. More will be managed by an epidural injection.
6. Such surgery is fraught with hazard and best avoided wherever possible.
7. Of those that do not get a complete recovery without permanent damage, a significant minority will do so because they present too late, when they are already in urinary retention and earlier surgery would probably have made no difference.

[14] Don't be Afraid to Say Sorry
[15] *Lee v South West Thames RHA* [1985] 2 All EWR 385 (CA);

8. Most of the claims we lose involve allegations around consent, patients claim they were not warned of the dangers of surgery or the need to return promptly if symptoms became worse. In these cases, doctors who are short of time have failed to make the notes we need to refute the claims about what was said.

c. All of these lessons are, or should be, drummed into junior hospital doctors who have to sort the sheep from goats at every stage. The idea that there is anything to be gained by distorting their education so as to concentrate on the very few cases where breach of duty, damage and avoidable causation of that damage can all be proved, is counter intuitive. What is needed is a sophisticated ability to examine patients, so as to elicit and test for the well-known Red Flags and we have no particular ability to help them to do this. We can help by pointing out that they also need support in making IT based records of the counselling process, as we have repeatedly explained to the Service.[16]

d. The reality is that it is hard enough for doctors to learn how to practice medicine as it is, and they have very little time to do so. The time they have is not used effectively because they play little or no part in continuity of care so they do not see the outcomes and cannot learn from their own decisions. The ST2 who sees a patient in the ED and sends them for an MRI may see the report if they are lucky: the rest of the patient journey will be obscure to them.

e. In most cases that we see the records of the history taken and the physical examination are incomplete: these are familiar faults brought on by overwork and lack of training, exactly like the obstetric disasters where we see the same mistakes being made every year for the same reasons.

f. We think the duty of candour system provides better scope for learning and commitment to change but that this needs to be on a national level.

Question 5

What changes should be made to clinical negligence claims to enable a move away from a blame culture and towards a learning culture in the NHS?

a. It will already be plain to you that we doubt the wisdom of the propositions underlying this question. The institution of which doctors are most frightened is the GMC and to a lesser extent the disciplinary processes of their employer. In nurses' cases they may be more afraid of their employers than the NMC. We do think that they should be less aggressive in a lot of the things they do, declaring our interests as we must that we defend before both the GMC and the employers, although we also act for employers in these processes.

b. We see little or no evidence that negligence claims cause a blame culture in the NHS. Things are slightly different in the private sector where indemnifiers now have a low tolerance of an adverse claims record. This is because the cost of such liabilities has become prohibitively high.

[16] See for example: Leigh B. Progress Towards A Decision Record Is Lamentable. *Clinical Risk*. 2016;22(1-2);16-20 ; Consent in the Post-COVID-Era ://www.boa.ac.uk/resources/knowledge-hub/consent-in-the-post-covid-19-era.html 20 May 2020

Question 6

How can the Healthcare Safety Investigation Branch work to improve short term responses to patient safety incidents and therefore reduce the number of those who are forced to pursue litigation as a means of obtaining non-financial remedies?

a. Again, there are a number of questions wrapped up in this. First, we think that there are problems with the concept that HSIB are going to resolve things without claims. It is more likely that they are going to increase the number of claims. Mostly we have come across their work in the context of birth injuries where there is little or no prospect that people are going to settle for non-financial remedies.
b. We suggest that non-financial resolution is far more likely to be achieved through the Trust dealing directly with patients well through the duty of candour process. An investigation by a third party like HSIB is unlikely to preserve the therapeutic alliance. Increased investment in local complaints handling and the candour process is required.

Question 7

What legislative changes would be required to support these changes?

a. First and foremost, we think you need radical legislation to reduce the cost of claims. Obstetric claims are made unsupportable because it is now regarded as *de rigueur* to set up a one patient institution even where the patient requires round the clock care from two people. It is as though someone were proposing to set up an in-house ITU. There are fundamental disadvantages of such an institution:

    (1) The patient has no peers and never meets anyone who is not concerned with their own care.

    (2) There are no economies of scale so that where the patient may need a piece of equipment once a week it has to be bought and left idle for the other 6 days.

    (3) Where the patient needs round the clock care, it has to be provided on a 1 to 1, sometimes even 2 to 1 basis even though they may need such help less than once a night. In a National Health Service such care would naturally be provided in the context of a small institutional setting such as The Meath in Godalming.

    (4) Where there is a one patient institution there is no prospect for career progression for the carer and it is very hard to provide the sort of supervision which will ensure that care is delivered conscientiously to a high standard and the risks of abuse are minimised. Such small teams are intrinsically unstable.

    (5) Houses have to be bought that are large enough to house the team of carers and the equipment.

    (6) The benefit is confined to those who can demonstrate a causative breach of duty, when the need may be just as great in cases who have no such right to damages. As Mahatma Ghandi pointed out, the measure of a civilised society is how it treats its most vulnerable members, and it is folly to identify them on the basis of how they acquired their disability.

b. Primary legislation should direct the courts not to award the costs of a one patient institution or home care where that care can be provided by the NHS or Local Authority in a small institutional setting. In other cases, much can be done with therapeutic communities where individuals will live in individual homes/shares homes but where there will be a number of such homes in an area, so you have a pool of skilled staff, adapted houses that can be used repeatedly for people with similar needs and a wider community used to dealing with people with disability – schools, specialist teachers to taxi's equipped with ramps and skilled drivers who know how to use them. However, these matters should be left to the experts who plan services for their communities as part of the NHS: they should not be invented on a one-off basis by the courts.

c. That is the one major cost saving that you could introduce, and it would make a massive difference as far as damages are concerned.

d. Linked to this, the statutory assumption in s2(4) of the Law Reform Act 1948 should be reversed. It is absurd that the courts should be required to ignore the availability of state services and the court should act on the assumption that they will be used wherever possible.

e. Fixed capped costs should be imposed. The Government's scheme is a reasonable start, but it should go much further. No claim against the NHS should attract costs of more than £100,000 or 40% of the damages whichever be the lower. The small claims fixed costs scheme proposed by the Government should be seen as an exception to this rule. If the parties were told by the court that there was a fixed sum then the court and the parties would have to work together to design a process for disposing of the dispute between the parties at a price that the public can be expected to pay.

f. . Those who recover damages to meet a clinical need should lose the right to demand those services from the NHS or Social Services. We have cases where the recipients of Periodic Payment Orders to pay for clinical care have applied to be assessed by their local provider of services, expecting their needs to be assessed without reference to their means.

g. Parliament should by primary legislation guarantee the independence of the Confidential Enquiries and have them reporting directly to Parliament every year. They should have substantially increased budgets, say £5,000,000 a year each and be required to produce more and larger reports, to promote them publicly and to present their findings and business plans to the Health Select Committee.

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