Written evidence submitted by Irwin Mitchell (NLR0031)

About Irwin Mitchell

Irwin Mitchell provides legal and financial services to both businesses and individuals and incorporates the leading complex personal injury and claimant medical negligence practice in England.

We support more patients and families in respect of their claims than any other law firm and we work with several patient safety charities to support their work in learning from harm and campaigning for change. Wherever possible we share our experiences with medical and other healthcare professionals through training, study days and conferences.

The information provided is based on our extensive experience in the sector.

Executive Summary

- The best way to tackle the cost of clinical negligence is to prevent harm from occurring in the first place and we agree with the Committee's July 2021 report on the "Safety of maternity services in England" that staffing and resourcing, leadership and better early responses to patient safety incidents are crucial to learning lessons.

- Reports into 'blame culture' identify the key contributors as poor leadership, staffing, workload and resourcing. There is no evidence that clinical negligence claims per se are a driver of blame culture.

- All of the families we represent would much rather that they had never suffered any negligence. The imperative for all those who consider the cost of clinical negligence claims is to focus on reducing harm and reducing the human impact which will have the desired benefit of reducing financial costs.

- Recent law reforms have already begun to reduce the costs of medical negligence. In the 2020/21 NHSR Annual Report it is apparent that claims numbers have fallen and the combined cost of damages and legal costs have reduced.

- All costs and damages associated with clinical negligence cases are either agreed with the defendant or decided by the court based on the evidence put before them. This can result in large payments because the costs associated with living with a severe disability can be significant and can include adapting their home, the costs of equipment and specialist care and therapies they need for the rest of their lives.

- When assessing litigation reform in clinical negligence cases the approach should be to look for the opportunities to improve the experience of litigants, reduce timescales and find cost efficiencies, rather than simply looking to reduce the amount of damages provided to some of the most vulnerable in our society.

- The bar to establishing liability in clinical negligence is high. Only around 10% of patients who make a clinical negligence enquiry with us will be advised to investigate; of those, approximately 30% will not result in a claim. This screening process carried out by specialist claimant firms such as ourselves prevents the significant costs NHS Resolution (NHSR) would incur in investigating and defending this huge number of initial enquiries.

- Amongst the thousands of avoidable patient safety incidents that occur each year, there remains an ever-growing list of national healthcare scandals, many of which were only highlighted following the litigation process which not only flagged issues missed by internal reviews but also provided the appropriate redress for those patients harmed.

- Irwin Mitchell and other specialist claimant clinical negligence firms are already engaged with NHS Resolution (NHSR) in trying to improve the claims process, for example increasing the use and earlier engagement of Alternative Dispute Resolution methods and in establishing protocols to process any multiple claimant group claims more efficiently to save time and costs.

- If early admissions of liability are made in part or in full this enables the parties to work on resolving the claim sooner. With better initial investigations and greater use of the information available to a healthcare organisation, including access to clinical analysis, early admissions ought to be more forthcoming in many more cases. Empowering an NHS Trust or NHSR to admit cases early would go a long way to speeding up the process, facilitating learning closer to the event and reducing the time and expense involved in unnecessary legal investigations. We do not necessarily see the need to generate more data and investigations, just a need to improve the investigation process, act more quickly with what is produced and more consistently across all NHS Trusts. HSIB and ENS reports often contain recommendations to improve clinical practice but it's unclear whether those recommendations are followed through.

Introduction

1. When something goes wrong in a healthcare setting, the human cost is significant for the injured party but also the clinicians involved. Assessing what happened and why is essential for all involved – patients are entitled to answers and clinicians want to understand and learn from the events. However, investigating and reconstructing events to analyse what happened, what should have happened and the difference between the two is a complex and lengthy process which means that there are unavoidable costs involved. Negligence is a serious allegation and must be afforded due process to protect both claimant and defendant.

2. The financial impact for someone who has suffered an injury can in many cases be significant. Over the years the courts have determined what is reasonable compensation. The courts will hear from Claimants and Defendants and determine what is reasonable

based on the evidence put before them. This can result in large damages payments but this is because often the costs associated with living with a disability are significant.

3. The system needs to be properly resourced and requires the input of professional expertise in law and medicine; anything else risks preventing injured people from receiving the redress they need. When an individual is injured, damages payments attempt to put them back in the position they would otherwise have been in; their entitlement under the law to full compensation is a vital part of ensuring that this can happen as far as possible.

4. When assessing potential litigation reforms in clinical negligence cases, the approach should be to look for the opportunities to improve the experience of litigants, reduce timescales and find cost efficiencies, rather than simply looking to reduce the amount of damages awards to some of the most vulnerable in our society. Our current system already provides patients with independent advice and redress for those who have suffered avoidable harm as a result of negligence and serves to highlight failings in standards of care from which lessons can be learned and patient safety improved.

Irwin Mitchell's response to the Specific Inquiry Questions

- **What is the impact of the current cost of litigation on the financial sustainability of the NHS and the provision of patient care?**

5. The starting point must always be that all in society hold a duty of care not to injure our fellow citizens. That duty is at least as applicable to the state as it is to individuals and if not more so. As Lady Justice Hale observed in her judgment in Parkinson –v- St James and Seacroft University Hospitals NHS Trust [2002] QB 266 para 56 "the right to bodily integrity is the first and most important of the interests protected by the law of tort".

6. Justice therefore requires those who are injured to receive satisfaction through the civil justice system. That satisfaction takes the form of establishing liability (fault) as well as damages calculated to reflect the losses arising from the established wrong.

7. There is a high hurdle to clear when establishing liability in clinical negligence. The effect of this is that around 90% of those who enquire with us as to whether they have a claim will be advised not to investigate; of those who do proceed with an investigation approximately 30% will not result in a notified claim and will be closed at that stage but the patient goes away having gained further answers as why things went wrong. The screening process carried out by specialist claimant firms such as ourselves prevents the significant cost NHSR would incur in investigating and defending this huge number of initial enquiries and also protects clinicians from exposure to more potential claims which do not have a solid basis in law.

8. Insofar as the way in which damages are calculated in clinical negligence cases, those losses deemed recoverable by the court follow strict criteria established through judicial consideration from 1880[1] through to the present day. Any attempt to vary these principles and make an exception for a state funded entity must be approached with great caution, not least for fear of restricting an individual's access to justice. The response of civil litigation is to ensure those harmed are compensated to remedy the injury that ought not to have been sustained and, where necessary, to support injured patients as long as the effects persist.

9. Amongst the thousands of avoidable patient safety incidents that occur each year, there remains an ever-growing list of national healthcare scandals, many of which were only highlighted following the litigation process which not only flagged issues missed by internal reviews but also provided the appropriate redress for those patients harmed. Restraining the ability of private individuals to seek legal remedy could materially alter the focus and drive that is brought to bear on serious lapses in medical care.

10. It is sometimes suggested that claims against the NHS should be treated differently from other areas of personal injury. Any such approach or adjustment would be contrary to fundamental principles of justice and equality. Why should someone who has suffered a life-changing injury as a result of negligence on the part of an NHS provider be left in a worse position than someone who has suffered a similar injury due to negligence on the part of their employer or in a road traffic accident for example? Would the same 'alternative' legislation and restrictions apply if an employee of the NHS was injured as a result of the negligence of their employer, or would it only apply to the duty of care owed to patients? In addition, how would treatment in private hospitals and/or by private doctors be approached? Will any proposed adjustment to the clinical negligence claims be limited to claims against the NHS, thereby creating a 2-tier system? In this instance, the response to a scandal such as that involving the breast surgeon Ian Paterson would be to compensate his private patients fully but not his NHS patients. Or will the private sector stand to benefit from any adjustment to the system simply because they operate in the same sector as the NHS? Taking clinical negligence cases out of the existing framework of the law of tort is a recipe for injustice.

11. It is worth remembering that all of the families we represent would much rather that they had never suffered any negligence and had cause to pursue a claim; they certainly would not want other people to suffer the same harm. The imperative for all those who consider the cost of clinical negligence claims is to focus on reducing harm and reducing the human costs which will have the desired benefit of reducing financial costs.

12. Recent law reforms have already begun to reduce the costs of medical negligence. In the 2020/21 NHSR Annual Report it is apparent that claims numbers have fallen and damages have reduced due to the adjustment to the PI Discount Rate (PIDR). The Jackson reforms implemented in 2013 have succeeded in shifting a portion of the costs burden from NHSR

[1] Livingstone –v- Rawyards Coal Company [1880] 5 App Cas 25 @ 39

onto Claimants which are met through the damages they recover, thus reducing the legal costs paid out to Claimants by NHSR:

- Claims in respect of established clinical negligence schemes reduced by 607[2]
- Damages paid to claimants including PIDR expenditure decreased by £73.4m[3]
- Claimants' legal costs have decreased by £49.4m[4]
- There has been a reduction in the number of high value claims[5]

According to that report, the combined costs of the process and damages paid have overall fallen by £114.9[6] million since the previous year, These combined costs represent 1.5% of NHS England's total annual budget[7], comparing favourably with the costs of indemnity for other professional sectors.

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

13. Litigation has a valuable and necessary role to play in resolving medical disputes. From our perspective as a leading claimant law firm, there are some improvements that could be made in respect of the efficiency of the process, the costs involved and its contribution to preventing future harm or promoting patient safety. However, in order to make those improvements, there needs to be a better understanding of the underlying causes of those issues which cannot be attributed to any one particular party to litigation. Because those are not well understood, the response can be to question the system as a whole and look for alternatives rather than to work on improving the existing process, which we consider is still fundamentally fit for purpose.

14. The best way to tackle the rising cost and other consequences of medical negligence will always be to prevent harm from occurring in the first place and the Committee is urged to concentrate its work on staffing and resourcing, leadership and better early responses to patient safety incidents as identified in its July 2021 report on the "Safety of maternity services in England".

15. We address the Committee's specific questions below:

    - **What changes should be made to the way that compensation is awarded in clinical negligence claims in order to promote learning and avoid the same problem being repeated elsewhere in the system?**

[2] P40 2020/21 NHSR Annual Report
[3] P43 2020/21 NHSR Annual Report
[4] P43 2020/21 NHSR Annual Report
[5] P43 2020/21 NHSR Annual Report
[6] P43 2020/21 NHSR Annual Report
[7] Based on figures obtained from P15 The Government's 2021-22 mandate to NHS England and NHS Improvement

16. This question conflates two issues: the payment of damages on the one hand and learning from harm on the other. Whether or not damages are paid, it is essential that the healthcare system has the framework within which learning can be properly captured and shared, not just within the organisation where the incident occurred but across the healthcare sector. The payment of damages does not and should not influence whether that occurs.

17. Damages are not in any way intended to be punitive against an organisation or individual, nor are they aimed at encouraging patient safety learning. Those payments are designed to put the claimant, as far as possible, back in the position they would have been but for the negligence. That might mean allowing a patient who can no longer work to pay their bills and put food on the table; it might mean providing them with access to vital therapies or care. Each payment is carefully calculated and either agreed with the healthcare organisation through its lawyers or adjudicated on by an impartial judge.

18. Similarly, there is no reason why clinical negligence cases or the level of damages paid should in any way inhibit the process of learning. The improvements to be made in this regard are to consider how the incidents are investigated and learning points are shared. Independent, properly funded investigations putting patients and their families at the heart of the process will vastly improve that learning. Further, there is much more to be done to ensure that the Duty of Candour is being applied consistently across the health service. Incident investigations can be used as a gateway to earlier financial redress, for example through the Early Notification Scheme considered below. If further learning points have been elicited by the litigation process then there ought to be a formal mechanism by which that is captured but it would be particularly important to require that this is followed up to ensure implementation. However, fundamentally it is those investigative processes in the aftermath of incidents which are best placed to promote learning and that is sadly where the system has been lacking.

- **How can clinical negligence processes be simplified so that patients can receive redress more quickly?**

19. Investigations into clinical negligence cases take time but it is important to understand why that is so. Whether or not a case proceeds is almost entirely dependent on whether an independent expert (often more than one) supports the case, i.e. that the standard of care was such that it was negligent and that, with adequate care, there would have been a better outcome. The cases are naturally complex because they involve allegations of professional negligence and the process has to account for the needs of both the injured patient and the clinician (or its indemnifying organisation) and a higher burden of proof. Of the enquiries that we receive, we estimate that we only accept 10% of those as having reasonable grounds to investigate and approximately 30% of those will be discontinued after investigation and never result in a claim against the NHS Trust or clinician.

20. If the case proceeds then the defendant organisation is rightly afforded time under the Pre-Action Protocol to investigate for themselves before court proceedings are commenced and decide whether they wish to defend the case either in full or in part.

21. Of those that do proceed, the answer as to how the process can be accelerated in part lies in the response of the Defendant organisations; clearly if early admissions of liability are made in part or in full this enables the parties to work on resolving the claim sooner. With better initial investigations and greater use of the information available to a healthcare organisation, including access to clinical analysis, early admissions ought to be more forthcoming in many more cases. We still see healthcare organisations ignoring their own self-critical investigation reports in the context of litigation, forcing claimants to undertake their own investigations at extra cost and causing delay. However, even when admissions of liability are made, the onus will still be on the claimant to prove his or her injury and losses flowing from the incident, often with the need to obtain witness evidence, documentary evidence and expert evidence on both sides.

22. There is perhaps a lack of understanding outside the legal profession that there are considerable efforts underway by lawyers on both sides to improve the culture of collaboration and, in its Annual Report for 2020/21, NHS Resolution made a particular point of attributing the reduction of legal cost to *"a greater cooperation between the parties"*. For specialist lawyers, there is great value in good working relations with their counterparts. The advantage of early and constructive engagement means that cases are dealt with more quickly and efficiently, at less cost and provide further opportunities for patient safety learning.

23. The mainstream use of other forms of dispute resolution is important, such as mediation and settlement meetings, not just for the case as a whole but for single specific issues. Delays and costs can increase as soon as the claim is issued at Court; better resourcing for the civil justice system including a specialist list for medical negligence claims would go a long way to resolve this where litigation is necessary. However, we can save time and expense by specialist lawyers facilitating earlier resolution of issues before the Court is involved, leaving Court for those cases which require judicial intervention and in turn improving the Courts' backlogs. Alternative Dispute Resolution (ADR) has long been a part of the process and in all but a rare few cases it is successful in resolving the claim before a trial. However, for a variety of reasons traditionally it has been seen as an adjunct to the court process, often deep into litigation. There is a growing emphasis on early ADR, for example pre-action or at an early stage of proceedings. Litigation is a valuable tool for resolving disputes but it should be considered one of the many routes to resolution. Specialist lawyers will explore all those options and agree a suitable roadmap on a case by case basis as there is no 'one size fits all' solution. We would be willing to give consideration to the use of ADR of different methods, at different times and on different issues. Because some of the approaches are novel, all stakeholders need to be given the opportunity to pilot new approaches to see whether they work otherwise there is a risk of adding a further layer of cost or of committing to processes which result in injustice. Any recommendations

flowing from those pilots can be fed into the existing Pre-Action Protocol for Resolution of Clinical Disputes.

24. Speeding up the process of redress is therefore not necessarily a question of "simplifying processes"; in fact the reverse can be true. It will require expert and collaborative work between specialist solicitors and barristers on both sides to understand the issues between them and work through them in a sensible and timely manner.

25. It should be borne in mind that it is not always desirable for a patient to rush through the process for early redress because it can take time, sometimes a number of years, for the full consequences of an injury to become apparent. For example, in some birth injury cases where a child has learning difficulties as a result of their brain damage, it may be necessary to wait until that child is of secondary school age before the full extent of their needs become clear.

    - **How can collaboration between legal advisors be strengthened to encourage early and constructive engagement between parties?**

26. Where specialist firms deal with the legal claims, the process is not as adversarial as might be imagined. Often there is a relationship of trust between large Claimant firms and those on the NHS Resolution panel due to working together repeatedly, encouraging a constructive approach to resolving claims. However, to build on this Irwin Mitchell has worked on various initiatives with NHSR in recent years to further improve the working relationship between lawyers, encourage a more open dialogue and change the culture behind the litigation process. As part of this, we have explored ways to improve the time taken to resolve cases and look for alternative means of resolution outside the Court process.

27. The litigation process has to afford both sides the opportunity to advance or defend their case so neither side is disadvantaged. Whilst it is an adversarial process which requires case management and a robust framework to ensure that justice is served for both parties, collaboration ensures that the litigation process supports effective and efficient resolution of claims, whilst avoiding needlessly aggressive (and therefore expensive) litigation.

28. Consideration could be given to fixed points in the case where the parties are required to meet or discuss the case, for example:
    a) Pre-issue of proceedings
    b) Once the parties have exchanged formal Particulars of Claim and Defence
    c) Post-exchange of liability evidence

29. These methods only work through collaboration and trust between the legal advisors but have the potential to significantly reduce delays and costs. For example, a claim may be capable of resolution prior to court proceedings following an early meeting of the experts, when this would ordinarily taking place deep into the court process, as the legal advisors can take an early view of how a Judge would view the evidence of that expert in determining the

case. Where the parties can see the positive results of such collaboration it helps to strengthen the relationship between those legal advisors so that these methods are considered again in future cases.

30. Above all, such is the complexity of clinical negligence cases that claimants need access to advice from specialist lawyers who can advise them as to the full range of dispute resolution methods for any particular case.

    - **What role could an expanded Early Notification scheme play in improving transparency and efficiency system-wide?**

31. From 1 April 2017, maternity units have been required to notify NHSR within 30 days of all babies born at term who have had a potentially severe brain injury diagnosed in the first 7 days of life, based on the following criteria aligned with the RCOG Each Baby Counts programme:
    - Diagnosed with grade III HIE
    - Actively therapeutically cooled
    - Decreased central tone and were comatose and had seizures of any kind

32. ENS leans heavily on an established framework which provides a gateway to providing an initial steer on liability. The Each Baby Counts criteria provide a unique gateway to ENS for those particular cases. If this was to apply to other types of clinical negligence cases, thought will need to be given to whether similar gateways could be created, for example through early identification of avoidable adverse incidents highlighted by internal or external investigations. If frameworks similar to ENS can be expanded to other areas of clinical negligence then this will reduce the number of cases where breach of duty needs to be investigated or debated and will help injured parties to focus on establishing causation of harm and the associated damages. It is always in an injured party's interests to have access to interim payments as soon as possible and efficiency in the system that facilitates this would be welcomed.

33. However, at the moment, there seems to be no shortage of responses to adverse incidents (Root Cause Analysis reports, Serious Untoward Investigations, HSIB involvement, etc.) and yet early admissions of liability are not always forthcoming. Establishing a system that empowered the Trust or NHSR to admit cases early would go a long way to speeding up the process, facilitating learning closer to the event and reducing the time and expense involved in unnecessary legal investigations. We do not see the need to generate more data and investigations, just a need to improve the quality of investigations and act more quickly and consistently with what is produced. HSIB and ENS reports often contain recommendations to improve clinical practice but it's unclear whether those recommendations are followed through.

    - **The Government has reiterated its intention to extend fixed recoverable costs, which limit the amount that can be paid out to meet 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?

34. Irwin Mitchell was represented on the CJC Working Party which produced a Report on Fixed recoverable costs in lower value clinical negligence claims in October 2019, looking at how costs in low value claims could be reduced. We are firmly of the view that in order to streamline costs in lower value cases the legal process also needs to be streamlined. The CJC report sets out an alternative framework for resolving cases with a value of less than £25,000 and sets out the reasons why that framework is not suitable for cases with a higher value.

35. Certain types of case are not suitable for a streamlined process because of their complexity and would need to be excluded from any scheme:

    - Cases with a value in excess of £25,000
    - Claims involving more than one Claimant
    - Claims involving more than one Defendant
    - Claims involving more than two medical experts
    - Protected parties (children to be included but with a "bolt on" for the approval hearing)
    - Fatal claims

36. Costs set in a low value scheme up to £25,000 will need to be at a level where specialist firms do not exit the market which would result in costs being driven up significantly, with NHSR having to investigate non-meritorious claims.

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

37. To our knowledge, there is no evidence that the adversarial nature of clinical negligence claims creates a 'blame culture' within a healthcare setting or that the fear of claims affects clinical advice and decision-making. From our experience of dealing with these cases each year we see no evidence of poor decision-making being driven by "blame culture" or "defensive medicine". We have no cases where harm was done as a result of a decision that was led by defensive practice for example in maternity care, clinicians rushing to carry out caesarean sections unnecessarily.

38. The clinical negligence system provides financial redress to patients injured as a result of negligence. Litigation itself is not the cause or a contributing factor for the failings or errors made in the first place. If the culture of the NHS is to be improved it needs to be held accountable for mistakes and the litigation process is a valuable and independent part of that.

39. We consider that a "blame culture" does impede lessons being learned where harm has resulted but the evidence points to this emanating within the healthcare system itself, rather than from any fear of litigation. Rather than colleagues or institutions coming together after an adverse incident, there often appears to be a rush between nursing/midwifery staff and clinical staff to blame each other for the outcome. We also recognise that a number of parents are signposted to us by staff from within the relevant hospital, reflecting perhaps a fear of retribution if they speak out publicly. Inadequate treatment of whistleblowers is a familiar theme, for example the recent situation at West Suffolk Hospital[8].

40. The NHS England Just Culture guide has been adopted by all healthcare organisations, patient groups and professional bodies. It recommends developing a learning culture within healthcare organisations, to avoid perpetuating a 'blame culture' but this depends on leadership. The King's Fund[9] highlights the need to develop collaborative, inclusive and compassionate leadership to deliver the highest quality care for patients and tackle deep-seated cultural issues in the NHS, including unacceptable levels of work-related stress, bullying and discrimination.

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

41. The primary purpose of clinical negligence is to compensate victims of medical negligence who have suffered injury, which in the higher value cases is often devastating for them and their families with lifelong consequences. We believe that lessons can be learned from the outcomes in those cases whether in identifying themes for learning or identifying more systemic problems within healthcare. The work of the Safety and Learning team at NHSR has been a recent welcome development in achieving some of those aims. However, that analysis will by definition be retrospective, often many years later.

42. We know that it was only through the efforts of patients or relatives bringing litigation cases or by pursuing Inquests, that scandals such as those at Mid-Staffordshire, Morecambe Bay, Shrewsbury & Telford and East Kent came to light and by the time those scandals were officially recognised, the families affected had endured prolonged suffering and heartbreak.

43. We would submit that in order to respond quickly to areas of concern, regulatory bodies such as the CQC, HSIB and NICE as well as Datix analysis by NHS Resolution, play a much more important role in lesson learning and early identification of problems. There is evidence within the maternity sector that those bodies are having a positive impact on standards of care.

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[8] https://www.theguardian.com/society/2020/jan/28/urgent-inquiry-ordered-into-witch-hunt-at-west-suffolk-hospital

[9] https://www.kingsfund.org.uk/projects/positions/NHS-leadership-culture

- **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?**

44. Litigation reform does not hold the key to a transformation from a blame culture to a learning culture; the real question is what more can be done to support a culture of openness and learning from mistakes regardless of litigation. Reports into 'blame culture' as set out above including a BMJ survey of 2018[10], identify the key contributors to that culture as poor leadership, staffing, workload and resourcing. In the NHS Staff Survey 2020, the good news was that two thirds of NHS staff felt well supported within their setting and would be able to speak up about unsafe clinical practice without fear of retribution. However, nearly one third of the 595,000 respondents said that they would not feel safe speaking up in those circumstances. There is no evidence that clinical negligence claims per se are a driver of blame culture and if anything, the evidence which does exist points to a culture of poor leadership.

45. We also note the findings and conclusions of the Committee's Report on 'Workforce burnout and resilience in the NHS and social care'[11] and the contributions from HSIB and The British Society for Rheumatology amongst others reflecting that patient safety would "*gain more by looking at organisational resilience than staff resilience*" and suggesting that the focus be on "*addressing current rota gaps and unsustainable workloads*" to build resilience at a system level.

46. The King's Fund in its analysis of leadership challenges within the NHS, points out that leaders at all levels play an important role in improving the culture of the organisations in which they work and that the attractiveness of leadership roles has been heavily affected by inter alia, attribution of blame by regulators, other national bodies and politicians. The importance of leadership has also been noted by the new Secretary of State and we welcome the recent announcement of a Review into NHS Leadership by Sir Gordon Messenger[12].

47. Our primary focus is on supporting the injured clients who approach us for help and for too long, they faced a lengthy process with an uncertain outcome. We welcome the culture shift in recent years with NHSR taking a much more collaborative, less adversarial approach to the resolution of claims.

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

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[10] BMJ 20 September 2018
[11] Published 18 May 2021
[12] https://www.gov.uk/government/news/government-launches-landmark-review-of-health-and-social-care-leadership

48. In most clinical negligence cases damages payments are absolutely essential; it may be that the harmed patient can no longer work or requires specialist care, equipment and rehabilitation. As noted above, where there has been established or accepted negligence the process of fairly compensating that person for a potentially life changing injury is a separate consideration from the issue as to how wider lessons can be learned from what happened to that individual.

49. However, it is also fair to acknowledge that some patients feel forced to go down the path of litigation in order to seek answers and explanations as to what happened to them or to a loved one. At times they feel there is a closed door and that as a family they are on the outside of any investigation into what has gone wrong in their care.

50. In addition, patients or their families are often confused by the various investigations being undertaken, particularly following an injury at birth. There may be a Serious Untoward Incident report being prepared; a Root Cause Analysis being undertaken; an Early Notification Scheme being initiated; and/or an HSIB investigation taking place. It can be utterly overwhelming. Whilst all of the investigations are welcomed as an important part of responding to adverse events, it is not uncommon, sadly, to hear that families have approached solicitors because the complaints or investigation processes did more harm than good, made them feel alienated and pushed the family to seek legal advice. In our experience, patients come to us having had unsatisfactory experiences with NHS complaints or internal investigations. They perceive that healthcare professionals have "closed ranks" and feel compelled to initiate a legal claim in a bid to gain answers, seek change and achieve justice. It is therefore essential that an independent body for patient safety incidents exists.

51. The creation and expansion of HSIB has helped improve the quality of investigations and subsequent learning and reinforces the long held view that external scrutiny avoids many of the pitfalls of internal investigations, such as issues of bias, lack of insight and the sharing of best practice. We would therefore welcome the expansion of the role of HSIB, with a requirement that there is better engagement with families from the outset and that they understand what is happening and feel included rather than on the outside. Some ways to achieve this could include:

(i) A clear framework for how the incident is to be investigated with timescales shared with the patient or their family from the outset to include the terms of reference of what is being investigated
(ii) A requirement for the patient or their family to be able to provide their account to HSIB at the earliest opportunity to ensure their concerns are taking into consideration and they feel included in the process
(iii) The early use of mediation or face to face meetings between the patient and relevant clinicians to ensure an open and non-hierarchical discussion
(iv) The introduction of a dedicated adverse events manager, akin to a police family liaison officer. Additional support through in this way would benefit the family when they are at their most vulnerable and would help them to navigate their way through what is

often overwhelming and confusing process. Someone in this role may also help the internal culture to overcome the defensive medicine issues.

(v) Increased funding and resourcing for HSIB to ensure thorough and prompt investigation of all incidents.

- **What legislative changes would be required to support these changes?**

This would need to be a matter for Parliament and the relevant advisory bodies once there has been a thorough analysis of whether there is a need for any fundamental changes to NHS litigation.

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