Written evidence submitted by Harding Evans LLP (NLR0035)

I am a Partner in the specialist Medical Negligence team at Harding Evans LLP.

Harding Evans is a full service law firm based in Newport, South Wales. We act for claimants from all over England and Wales in relation to medical negligence claims.

We are members of AVMA and APIL and having been previous members of SCIL we are in the process of renewing our membership with them. We hold a contract with the Legal Aid Agency.

There are 10 fee earners in the department making it one of the largest departments in Wales.

The department Head Ken Thomas is member of the AVMA panel and is an APIL specialist panel member. I am a senior litigator with APIL and have recently submitted by AVMA panel application.

Ken and I have over 50 years of clinical negligence experience acting solely for claimants through our respective careers.

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

The financial sustainability of the NHS and the provision of patient care is a multifactorial issue that has presented problems for Governments for many years. It cannot be said that the current cost of litigation is the only impact on the financial sustainability of the NHS. We have a growing population year on year. We have an ageing population which places never before seen demands on the NHS. We have an NHS that is laden with levels of management. We have ageing hospital buildings that need rebuilding; to name but a few issues facing the NHS. The financial issues facing the NHS cannot be laid at the feet of claimants.

To put this into perspective spending on clinical negligence was forecast to consume 4% of total trusts' income in 2020.

•What are the key changes the Government should consider as part of its review of clinical negligence litigation? In particular: ◦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?

The principle behind compensation has and always should be to put the injured person in the position that they would have been if the negligence had not occurred. This must remain the overarching purpose of compensation.

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

A no fault based system of compensation; one in which accidents and injuries are regarded as inevitable, and the emphasis is on compensating victims for related expenses would allow patients to receive redress more quickly; but what about compensating victims for pain and suffering?

Such a scheme also has many pitfalls; it would potentially be administered by Government and may not be seen by patients as being independent. Such a scheme could also lead to more claims, problem medics would not be identified, and system failings would not be discovered. Incidents of medical negligence may potentially never improve.

In Scandinavia they make decisions based on the concept of “avoidability” — that is, whether an injury could have been avoided by good medical practice. Allegations of poor professional performance are dealt with by separate assessment and disciplinary procedures. This would however involve a complete overhaul of our legal principles of Bolam negligence.

We have a very good protocol in place for the resolution of clinical disputes however rarely are those time limits stipulated within the protocol complied with by defendants trust. The protocol requires lawyers to send letters of notification as soon as possible after a potential medical negligence claim is discovered. The Letter of Notification gives the Defendant a ‘heads up’ that the Claimant is likely to bring a claim however defendant trusts do not seem to act upon these letters and only start their own investigations of the claim when they receive the letters of claim.

Compliance by the defendant with the time limits stipulated in the protocol would mean that patients receive redress more quickly.

There are also too many law firms purporting to be expert in clinical negligence claims but they are not. This means that they clog the system with fruitless claims and claims that do have merit progress slowly because they are not familiar with the protocol.

Clinical negligence is a specialist field of work that should only be carried out by firms who can demonstrate that they have the necessary expertise in the area with having panel members (either AVMA or Law Society).

The clinical negligence claims process cannot be simplified. These claims do not fit into a “one size fits all” box. There must be a process of due diligence on behalf of trust in investigating these cases as there must be public accountability. However access to early funds by way of interim payment would assist victims gain early rehabilitation were appropriate. The introduction of a similes code to the current Rehabilitation Code used for personal injury claims would be enormous benefit to victims. Access to early rehabilitation would have the potential to maximise recovery early thus potentially reducing the final award of damages.

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

In any clinical negligence claim the burden falls on the claimant to prove their case even when the defendant trust has undertaken its own enquiries which detail negligence and injuries caused. In these cases, why is the claimant is still put to proof. The defendant trust should be making early admissions in these cases based on their own investigations.

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

In my experience the current Early Notification Scheme is not fit for purpose. I have one case were we are almost 3 years down the line and the full response under the Early Notification Scheme has still not been received. The defendant trust are simply investigating the case as they would if the Scheme was not in place.

Many trusts are not even engaging with the scheme.

◦**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?**

We have previously made representations to the Clinical Negligence Fixed Costs Review in April 2017.

We would wish to reiterate the points made therein as they still apply. We would wish to point out in particular that as a firm based in Wales we have now had experience of the Welsh Government's Putting Things Right (Redress) Scheme, for cases under £25,000, for over 10 years. That Scheme set up in 2011 should be looked at closely in any Inquiry whereby a fixed fee scheme is proposed by the H & SCC. Our firm view based on 10 years working with that scheme is that introducing a FRC will mean fewer, not more, lessons are learnt to promote patient safety.

As for the appropriate level for FRC, £25,000 is too high a limit. Such a scheme is suitable only for very low value matters, our considerable experience would suggest £5,000. Beyond that level, there can be causation complexities and a need for two or more experts, meaning any fixed scheme that "cut corners" is not appropriate. In any event, any FRC scheme at whatever level should not include child cases, stillbirths or elderly deaths.

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

It is inevitable that a "blame" culture exists because harm has been caused by somebody's error and it is human nature to want to "blame" someone.

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

It is vitally important that any clinical negligence system encourages lesson learning and commitment to change as the result of any action. Claimants want to know that others will not suffer as they have suffered. We do not want to see more lives ruined as a direct result of negligent medical care. When mistakes are made there must be openness and communication with patients.

I have seen many cases were despite a very damning Root Cause Analysis Report or Duty of Candour letter the claimant is still put to proof to obtain independent medical evidence in respect of issues of breach of duty and causation.

•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?

This is an issue for those in charge of running the NHS.

•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?

The HSIB has no authority to implement change within the health sector so it is difficult to see how they could impact patient safety incidences.

•What legislative changes would be required to support these changes?

This is an issue for legislators.

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