Written evidence submitted by Russell-Cooke LLP (NLR0038)

Russell-Cooke LLP is a London based firm with a well-established Personal Injury and Clinical Negligence department. The department attracts a broad-range of Claimant work and regularly represents clients in claims related to treatment undertaken within the NHS.

The questions raised by the Committee directly concern our clients, and the Government's intention to extend fixed recoverable costs will have a significant impact upon the landscape in which we operate.

Russell-Cooke LLP is a member of the Society of Clinical Injury Lawyers ('SCIL'). We welcome SCIL's response to the Committee's call for evidence, and use this opportunity to reiterate the views expressed by SCIL in their response to the Committee.

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

  This question is flawed: the question should be whether the failure of the NHS to learn from errors and therefore to reduce those errors, unnecessary harm to patients and the resulting cost of litigation is sustainable. An NHS taxpayer-funded at approximately £148bn last year excluding the extra costs of COVID, has to be fully and openly accountable to the public who pay for it. The costs of litigation versus that budget also has to be put into context – as a percentage of budget the claims ratio is in fact far below the level of indemnity required in other professional sectors. To truly debate the issues, openly and honestly, they have to put into their actual context (see further below).

  More than 20 years ago the Chief Medical Officer published a report entitled "An Organisation with a Memory", which urged the NHS to learn from its mistakes, including to identify and remedy the causes. That report rightly identified litigation as a rich source of data from which the NHS should learn.

  Learning did not happen. In 2016 alone, the Care Quality Commission published two separate reports pointing to the failure of NHS investigations to identify the cause for accidents; in 2017 the National Audit Office was critical of the failure of the NHS to used data gathered from claims.

  The cost of current litigation, that is damages and Claimant legal costs, is in any event reducing as detailed in the NHSR Annual Reports of 2020 and 2021. This is despite increasing Defendant costs.

- ***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?***

    Our well-established system of common law provides that the wrongdoer pays compensation which puts their victim in the same position, so far as money can, that they would have been in had the negligence not occurred. It is a system that we should be proud of. It is a principle of 100% compensation which the Government is

on recent written record as intending to uphold e.g., the Lord Chancellor's last discount rate review summary.

We should not undermine the rights of harmed individuals to reduce the cost of harming them to the wrongdoer – especially when that wrongdoer happens to be controlled by the Government itself, as that is a clear abuse of constitutional power to try to insulate oneself from full and proper claims.

Change should start at the heart of the NHS by looking at how patients can be kept safe which in turn will promote better care and reduce the need for redress. It should be remembered that claims are not the cause of NHS negligence – they are the result of it – and therefore the correct approach is to look at why there are failures of patient safety learning (including from claims themselves) across the whole of the NHS, i.e., what is it about the structure of the NHS which means separate Trusts repeatedly make the same errors and how can there be structural reform of the NHS to overcome that?

Finally, tort reform in respect of clinical negligence cases only cannot be allowed – it there is to be reform, it has to be across the whole of the civil justice system and will require primary legislation to achieve. Most importantly it will also not achieve any costs savings and will in fact achieve an increase in Government spending because:

- People will be undercompensated and therefore their recovery and return to work will be delayed thereby reducing the Government's tax income and increasing/prolonging State benefits payments;
- NHS funding would have to increase yet further beyond that allowed for by the current NI tax levy to match/top-up the difference between private care and therapy and that provided by the NHS currently;
- Social care funding would have to further increase beyond that allowed for by the current NI tax levy, to again make up the difference between what under-compensated Claimants receive by way of damages and their actual needs.

It is further noted that the recent recommendations of the Select Committee, including for no-fault compensation, are not costed and incomparable as between the funding and demographics of the different countries concerned and England and Wales.

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

  There is encouraging evidence that a collaborative approach between Claimant and Defendant lawyers is reducing costs and a prime example of that approach is the Covid 19 Clinical Negligence Claims Protocol 2019 negotiated by NHSR, AVMA and SCIL, which has resulted in savings of many millions of pounds.

  To improve the efficiency of the administration of lower value claims (NB lower value does not equate to lower patient safety learning potential and in fact probably the reverse), SCIL has developed the SCIL Scheme which suggests a way to improve

the system and also allow for learning without the fear of recrimination for clinicians and to avoid future harm.

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

  SCIL, AvMA and NHSR are currently working well together. As the majority of lawyers dealing with this work are either AvMA or Law Society Panel members, being specialists ensures continuity when talking with Defendants such as MDU, MPS, NHSR and their panel firms. The SCIL Scheme further encourages collaborative working and resolution of claims without the need for Court proceedings.

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

  More resources would be required for this to work, including to make the scheme more independent of the NHS itself. Clinicians still fear recrimination from their employer or regulator as per the Select Committee's own recent findings in respect of maternity services. There also appears to be a lack of training about the system which means that many Trusts do not engage with it, or families are unaware that their child's birth has been referred to this scheme. It is also concerning that families are not being signposted to organisations such as AVMA at any stage of the ENS process so that they can obtain independent advice on the process and its outcome. This in itself currently undermines the transparency and any semblance of independence in the scheme, and therefore its credibility generally.

- ***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?***

  SCIL has already responded extensively to the Government's FRC proposals and await the consultation. They have provided the Government with the SCIL Scheme which offers a solution to lower value claims, without the associated fixing of costs, and have suggested a pilot of the scheme over a trial period.

  However, they remain of the view that the assumption that the solution to the cost of clinical negligence litigation, is to cut costs rather than to reduce harm is completely the wrong approach. That is why patient safety and learning is at the heart of the SCIL Scheme. It also ignores the last 2 NHSR annual reports which clearly show that costs and damages are reducing.

  SCIL would welcome meeting and discussing matters with the Select Committee to address the misconceptions and incorrect assumptions being made. It should also be accepted, as the Government has publicly supported the 100% compensation

principle, that when harm has occurred, a patient should be properly compensated for the harm caused.

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

  The Committee has presumed that the system creates a blame culture. As per the recent Select Committee's report into maternity services, there is no good-quality, hard, independent evidence to support litigation adversely affecting the running of the NHS – there is only supposition and anecdotal information. In recent years there has been a change in stance at NHSR, with a greater emphasis on resolving claims and learning, which SCIL welcomes. The NHSR annual report for 2021 highlighted the increased collaboration with SCIL and AvMA, and reported decreasing legal costs, which is also to be welcomed.

  Unfortunately, as per research for the outgoing Labour Government over 11 years ago, there is in fact no such thing as a "compensation culture" in injury law – there is only a perception of one, which is perpetuated by the media and politicians talking about it as if it does exist.

  There is certainly however something that appears to be at the heart of some Trusts with reports of bullying, discrimination, and fear of whistleblowing. There was £27m paid in claims by NHS employees that they were stressed or bullied in the previous 5 years in a recent NHSR report (see link below). That report found no evidence that clinical negligence litigation was part of the "blame culture".

  https://resolution.nhs.uk/wp-content/uploads/2019/07/NHS-Resolution-Being-Fair-Report.pdf

  SCIL shares the view of Mathew Syed and others that "black box thinking", to analyse the causes of errors, which are rarely individual errors, is the way to improve patient safety and reduce the cost of litigation. Preventing unnecessary harm to innocent patients is the key, rather than incorrectly focusing upon the result of that i.e., clinical negligence claims – or to put it another way, looking at it from the wrong end of the telescope and so distorting the picture. The SCIL Scheme has Patient Safety at its core, with the proposal of Patient Champions (similar to the Patient Safety Commissioner proposed by Baroness Cumberledge) and could be utilised across the NHS and other health care systems. By working with specialist lawyers at SCIL and with AVMA, lessons can be learnt and patient safety maintained and improved.

  Lord Edward Garnier was reported as saying on the proposed reforms about the "delay, deny and defend" culture and this is what needs to change. It should be remembered that 90% of potential clinical negligence cases are investigated by lawyers and do not proceed. The ones that are progressed are tested as per the very high legal thresholds which currently exist at common law, supported by like for like independent medical experts and are not pursued lightly but after much investigation and assessment. Clients/patients do not come to pursue medics for revenge, and if they did, we would not pursue those matters, but do so in order to receive compensation for the harm caused or as most clients will say to us, to avoid it from happening to someone else. Remove the specialist lawyers, as the current proposals may in fact do, and NHSR's costs of dealing with Litigants in Person will increase at least 900% i.e., the opposite of any costs savings will be achieved.

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

  SCIL views it as imperative that patient safety is at the heart of litigation and that lessons should be learnt without fear and recrimination for clinicians. It is why we say that claims are important patient safety learning opportunities in their own right.

  There have already been too many health scandals to show where there are problems in the system such as Telford, Patterson, Shipman etc. Many of those scandals have only been exposed because of the work of specialist Claimant clinical negligence lawyers. Specialist lawyers often recognise trends, but a Patient Safety Champion, as recommended by the SCIL Scheme, would provide even greater opportunity to identify and learn from errors and to share learning across the whole of the NHS.

- ***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?***

  The NHSR Report referred to above does not find any evidence of a blame culture caused by clinical negligence litigation, rather the blame culture (if it exists) is one within NHS organisations. It is simply wrong to lay the blame for that at the door of the innocent victims of clinical negligence.

- ***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 short answer is that it will involve a lot more funding for it to increase the breadth, most importantly the depth to capture all patient safety learning points, and speed of its investigations.

  External investigation of incidents is to be welcomed as internal investigations are, for obvious reasons, carried out by the colleagues and employees of the organisation which creates a risk of defensive investigation. It is true that many patients would not resort to litigation if they received a full and honest apology together with an explanation of what went wrong and confirmation of the steps that are being taken to prevent the same thing from happening to another patient.

  However, financial circumstances and the provision of care, equipment and therapies in the NHS sector means that many will be left with no choice but to seek compensation. For those patients, an apology is the starting point but not the end point.

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

  The current tort system works well and has adequate tests in place to ensure that matters are looked at properly and properly compensated. As above, any tort reform would have to be across the whole of the civil justice system to avoid a very easy judicial review of its reasonableness, and so would require primary legislation to alter the common law and it's long-established 100% compensation principle which the Government is on recent public record as

supporting. Given that targeting clinical negligence claims is to approach the issues from the wrong end, it is difficult to see how there would be legislative appetite for this non-solution to the actual issue of failure of patient safety learning across the whole of the NHS - which in fact probably needs better-spent scrutiny of meaningful NHS structural reform instead. If we make the NHS safer, we have no need of other reform.

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