Written evidence submitted by Stewart's (NLR0041)

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Introduction

Stewarts is an international litigation firm specialising in complex high value disputes. Our practice areas include Personal Injury, Clinical Negligence, International Injury and Aviation.
Our specialisms are recognised by top-tier rankings in the leading legal directories: Chambers and Partners, the Legal 500 and the Times.

In relation to clinical negligence, our exclusive focus is on claims of the utmost severity, usually those involving brain or spinal injury, but also include fatal accidents, significant injuries arising from the mismanagement of mental health claims and obstetric cases.

Stewarts welcome the opportunity to respond to the Health and Social Care Committee's call for evidence and welcome the acknowledgement that reform is required to encourage a learning culture within the NHS.

Executive Summary

In 2010, it was estimated by the King's Fund that the NHS undertook 1 million patient interventions every 36 hours. The latest data suggests that this has now risen to 1.5 million interventions per day.[1] Against that backdrop, data from the NHS Litigation Authority annual reports (subsequently NHS Resolution) reveals that the total number of claims notified to the NHS has remained relatively static. The most recent data reveals that the legal costs of bringing those claims is also reducing. The opportunity to reduce litigation costs is, in our view, most likely to be achieved through an enhanced programme to learn from claims and near misses, rather than a further overhaul of the legal environment.

We do not consider that any reform of the litigation system is necessary to improve patient care; nor should negligently injured patients be required to accept anything less than full compensation for their losses. Improved patient safety leading to a reduced rate of clinical negligence claims requires a well-funded NHS. That is the financial responsibility of the government and all taxpayers, not the small cohort of people who are injured through substandard care.

Frame of Reference

Upon launch of this enquiry, the Health and Social Care Committee confirmed:

"Figures show that in 2020/21, £2.26bn was spent from the NHS budget to settle claims and pay legal costs arising from clinical negligence claims. The total potential liabilities arising from all negligence claims made up to the end of 2020/21 was £82.8bn, increasing by about £5.7bn every year."

We consider that this brief paragraph misstates NHS Resolution ("NHSR") data and does not accurately reflect our experience as a Claimant clinical negligence firm. It is our understanding and experience that the number of newly notified claims each year has remained largely consistent, with claimant costs reducing. The modest increase in claims numbers over the last year can be reasonably attributed to the inclusion of new and historic GP liabilities, previously indemnified outside the NHS.

[1] The King's Fund – Activity in the NHS 23/10/2020 https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/NHS-activity

Whilst it is correct that the NHSR accounts provide for an £82.8bn reserve for all potential liabilities, (i.e. to include those that may never arise) this does not reflect the wider data in the report, which reveals that the cost of those potential liabilities has markedly reduced as follows:

- *Liabilities arising from claims under all of our indemnity schemes at the end of this financial year have* ***decreased by £1.3 billion.***[2]

- *The cost of settling claims in 2020/21* ***reduced across all schemes by £120 million****, to £2.26 billion.*[3]

It is unclear on what basis it is suggested that total potential liabilities are increasing by nearly £6bn per year.

Whilst it is accepted that NHSR provision for *potential* liabilities is substantial (£82.8bn), it should be noted that this is an accounting principle i.e. a provision for potential settlement value of all notified claims, to include both past and future claims where damages are paid with periodical payments. It relates to claims for clinical incidents dating back over many years (birth injury claims which tend to attract the highest levels of compensation usually take in excess of 10 years to resolve). It is our view that this cost will never be fully incurred, for the following reasons:

1. Many cases are wholly defended after first notification. For example, the most recent data (2020/21) demonstrates that 43.8% of claims were settled with no payment of damages.[4]

2. A significant number of claims will be resolved for a lesser sum than the anticipated reserve/amounts sought by the claimant.

3. Awards paid by instalment (periodical payment orders) will not infrequently be terminated early if the claimant has a shorter life expectation than anticipated.

For these reasons, it would be incorrect to regard the total potential liabilities of NHS Resolution as a sum which is likely to be incurred or which is a liquid sum or an amount taken out of the NHS budget in any one year. To inform the debate on whether claims costs are increasing, decreasing or static it would be more informative for NHSR to quote the additional liabilities incurred by claims resolved each year, rather than in this potentially misleading past accumulated liabilities format.

It is our view that the key to reducing the annual future costs of litigation and the number of clinical negligence claims is for the NHS and NHSR to adopt a uniform, organisational approach in terms of reporting, investigating and sharing between NHS trusts as to adverse outcomes so as to reduce the occurrence of future harm.

Investigation reports should be provided to claimants early on, early disclosure should be encouraged, with the claimant involved in the investigation process. We also suggest than any successful clinical negligence claims are followed up with trust staff at all levels (i.e. beyond management) to enable wider learning for the trust concerned. Where procedures are changed, whether pre or post-settlement, this should be notified to the claimant and their legal representatives to instil confidence that there is a process of learning and to avoid future harms.

Our response to the below questions is given with the above in mind.

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[2] NHS Resolution: Annual Report and Accounts 2020/21, 16

[3] Ibid, 73

[4] Ibid, 18

Response

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

We do not seek to express a view on the financial sustainability of the NHS, which is difficult to place into context without accountancy expertise and where there are significant other commercial demands on the budget, to include *inter alia*, the expense of PFI and property projects and the premium costs of procurement. Fundamentally, the proper funding of the NHS is a question for the government. The widespread vocal support for the NHS during the COVID pandemic reinforces the long-standing impression that the public strongly support a well-funded and fully functioning NHS.

The expansion of NHS indemnification to general practice prevents direct comparison of case numbers over a longer period. On our analysis and once the addition of new and existing GP liabilities are accounted for and excluded, the NHSR data suggests that there is a trend of reducing claims, in addition to which greater collaboration between claimant and defendant firms will serve to reduce costs. A significant number of claims are concluded without any damages payment made at all, reflecting the general complexity of bringing a successful clinical claim.

Whilst changes to the litigation process could limit the recovery of costs or damages, that approach would inevitably involve a departure from the principles of full compensation and access to justice, without any clear benefit to patient safety. It is our view that the changes brought about by the Jackson/LASPO reforms since 2013 have already taken effect to manage costs. The focus should now be on claims prevention rather than claims outcomes. The central theme to this response will be that NHS learning and collaboration in relation to claims generally is the key to a significant reduction in the NHSR outlay on legal costs. This can be achieved with benefit to both the NHS and its patients.

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?

This question combines the entitlement to compensation for negligently inflicted injury with the aim of improving future patient safety through learning from past errors. These are two distinct issues that ought not to be conflated:-

1. The litigation process is undertaken to secure vital compensation for claimants, who require those sums to meet their losses including costs of essential care and support. The litigation process is conducted by legal professionals and the NHSR in their capacity as indemnifier. Those parties are not generally healthcare professionals and are not able to implement practical changes in the healthcare system. The process is backward looking, focussing on individual claimants and the specific incidents that led to their injury.

2. The promotion of learning from mistakes and errors within the NHS is an essential mechanism to prevent future mistakes of a similar type. This learning should be disseminated across each hospital, NHS Trust and the organisation as a whole.

The Courts of England and Wales do not perform any role in requiring system change or procedure review by litigants. That is not their role, nor are they resourced to do so.

If a Claimant is successful in litigation then damages will be awarded to that individual; it is then entirely for the defendant party and NHS Resolution to disseminate what has been learned from the expert reports obtained by both parties. That process can take place within the defendant institution and beyond. Whilst NHSR will have access to the information for each claim, it is unclear how widely that information is disseminated or available to other healthcare professionals. Publication is a key component, which is why other industries, such as aviation, do so widely – in relation to both adverse events and near misses. Claimants are rarely if ever informed of what changes have been made following the litigation process and their injury.

We do not believe that the process of awarding compensation needs to be reviewed, nor would any such review lead to less adverse incidents or improved patient safety. What is required is a more robust and open system of investigation and dissemination of lessons learnt to avoid repeated or similar incidents throughout the NHS.

In relation to healthcare investigations outside the litigation process (e.g. after a "near miss" or serious incident) one of the key challenges is the compartmentalisation of the NHS into individual hospital trusts. The effect of this division is that individual trusts investigate their own incidents and claims and do not routinely always share data and learnings to the wider NHS organisation to prevent repeated problems in other areas. Our suggestions as to how to enable this are outlined later in our response.

Duty of Candour

The changes brought about by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 should not be underestimated. As recognised by the Ockenden Report[5], one of the key wishes of those affected by clinical negligence is to have their questions answered to allow them to understand what went wrong with the treatment.

Indeed, the Pre-Action Protocol for the Resolution of Clinical Disputes also clearly sets out:

"It is important that each party to a clinical dispute has sufficient information and understanding of the other's perspective and case to be able to investigate a claim efficiently and, where appropriate, to resolve it. This Protocol encourages a cards-on-the-table approach when something has gone wrong with a claimant's treatment or the claimant is dissatisfied with that treatment and/or the outcome."

We consider that this is particularly important in the context of lower value and fatal injury claims, without significant injuries nor related future needs. Studies have found that a full and frank disclosure of an adverse incident to a patient reduces the incidence of litigation. Full disclosure, together with an appropriate apology, would assist in ensuring that the concerns of patients are addressed in a meaningful way, at an early stage. In the absence of early, meaningful engagement from an NHS Trust, the patient is often left with no option but to start the litigation process. That process, in the absence of an admission of fault, can take several years, during which, the patient will have no access to the financial assistance for treatment, rehabilitation nor care they need.

Our experience is that some hospital trusts, have in recent years, improved their response to the duty of candour. A number of our clients have been invited to detailed duty of candour meetings in which identified errors have been explained, generally, as part of a serious incident investigation. An apology is much less frequent, afforded to few clients notwithstanding the efforts of NHSR to communicate to staff that an apology is not an admission of liability. Unfortunately, it is still in the majority of cases in which there has been an adverse outcome, that no investigation is undertaken at all. For greater learning across

[5] Ockenden Report, Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust, 10 December 2020

the NHS, we would welcome and suggest a uniform approach to the duty of candour across the organisation and its staff.

We consider that NHSR has taken positive steps in recent years to improve openness, candour and learning in the field of obstetrics, demonstrated by the introduction of the national Early Notification Scheme for the early reporting of infants born with a potential severe brain injury. The potential applicability and suitability of the scheme to improve transparency in wider clinical negligence disputes is explored later in this response.

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

Rehabilitation Code

It is our view that a key failing of the current system is the NHSR's reluctance to engage with The Rehabilitation Code[6]. The Code, which is primarily used in personal injury claims at present, facilitates early rehabilitation on a balanced risk basis to the defendant insurer(s). Whilst the Code is voluntary, its consideration is mandatory under the Pre-Action Protocol for the Resolution of Clinical Disputes[7]. Para 1.3 of the Rehabilitation Code expressly recognises the need to commence therapeutic input to optimise recovery even prior to admissions of liability.

Where there is no agreement on liability, the parties may still agree to use the Code. The health and economic benefits of proceeding with rehabilitation at an early stage, regardless of agreement on liability, may be especially strong in catastrophic and other severe cases. Compensators should consider from the outset whether there is a possibility or likelihood of at least partial admission later on in the process so as not to compromise the prospects for rehabilitation.

Our experience in practice is that NHSR are unwilling or unable to implement the Rehabilitation Code, even on an ad hoc basis, notwithstanding the fact that rehabilitation could significantly reduce the amount of damages ultimately paid to claimants. For example, in cases involving a psychological element, the parties could work proactively together to organise an early evaluation of a claimant's needs and to provide psychological rehabilitation. In doing so, it is likely the claimant's recovery would be accelerated. Similarly, early neuro-physiotherapy treatment may, in some cases, avoid muscle wastage or contractures. Such input could substantially reduce the amount of compensation payable by NHSR. We suggest that immediate needs assessment reports should be considered in all serious injury matters, which would also assist NHSR in particular to understand at an early stage the Claimant's level of disablement, home environment and daily challenges.

Early Settlement

Our own data suggests that over the past three years, joint settlement meetings have proved an effective method for settlement. More than half of those settled clinical negligence cases were settled at joint settlement meetings (JSMs). Whilst it is promising to see that so many claims settle without incurring the final costs of proceeding to trial, we would encourage a shift towards earlier disclosure, earlier admissions of negligence leading ultimately to earlier resolution. Of those cases that settled at JSM, 20% of those took place within 3 weeks of trial, often following multiple years of dispute. In contrast, only 12% of our cases settled prior to the Case Management Conference, or to look at the flip side, 88% of our cases that ultimately settle with damages paid are "fought" by the NHSR beyond this stage. We recognise that this is an area where NHSR are continuing to address resource.

[6] 2015

[7] Para 3.9

Where liability is denied, early JSMs or mediation can only be effective with appropriate exchange of liability witness evidence and preliminary expert evidence available to enable parties to assess risk. The earlier admissions are made and/or JSMs can be (appropriately) fixed within the lifespan of each claim, the greater the prospect of reducing costs for the NHS.

We have also seen a rise in mediations in recent years, with 10% of our cases that settled in the same period, settling via mediation. Where appropriate, mediations can facilitate outcomes that the Court cannot, such as interaction between the clinician and the claimant and/or to deliver a meaningful apology. However, the parties must be prepared with adequate expert evidence and be able to take instructions regarding settlement offers if they are to be successful at the earliest stages of the litigation.

We were reassured to learn from the NHSR Annual Report that almost 75% of the claims settled in 2020/21 were settled without any court proceedings at all and only 0.3% of claims proceeded to trial.[8] In catastrophic injury claims, rehabilitation treatments can often delay first instruction of legal teams by a year or more. Similarly, the desire for a judgment order for periodical payments, and/or need for a large interim payment will often necessitate court involvement.

NHSR own data[9] confirms that in year 2020/21, there were 8802 claims with damages paid and of those 3,172 (20.24%) resulted in proceedings. We would suggest that in each of those claims there were likely to be opportunities to reduce the costs of the claim by earlier investigations, disclosure, admissions and settlement.

Further, of that cohort of claims during 2020/21, 3914 resulted in proceedings, with only 780, or around 5%, resolving without damages being paid. This data shows that NHSR successfully defended less than 25% of claims that year. It is our view that this NHSR data demonstrates there is still plenty of scope to identify those cases that will result in damages payments much earlier, and engage in negotiations more readily prior to issue of proceedings.

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

We repeat our comments above on engagement between parties in terms of settlement meetings or mediation.

We would like to see earlier disclosure of internal investigation reports, policy documents and, where a defence relies strongly on robust evidence from clinicians, consideration given to early mutual exchange between the parties on a without prejudice basis. That is particularly important where costs budgeting is typically delaying the progress of claims by 6 months or more.

By the claimant voluntarily providing early evidence, the NHSR can consider the position of the claimant at an early stage, and engage with the claimant as to potential rehabilitation or treatment needs in line with the Rehab Code. A collaborative approach over the issues in line with the Pre Action Protocol by NHSR would save costs; both parties should consider an exchange of evidence as soon as possible.

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

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[8] NHSR Annual Report and Accounts 2020/21, 18

[9] NHSR Annual Report and Accounts 2020/21, figure 16

We agree that Early Notification scheme is an effective model for speeding up the resolution of cases thereby reducing costs following systemic failures, such as those experienced at Shrewsbury and Telford NHS Trust between 2000 and 2012. We believe that the requirement to report early, identify and swiftly address incidents are of paramount importance to reduce the reoccurrence of failures. More resourcing would be required within the NHS to facilitate an expansion of the Early Notification scheme system-wide, but we would support the scheme being extended. In addition to expansion of the scheme, the government might consider potential for increased and improved use of the Healthcare Safety Investigation Branch (HSIB) in cases involving serious outcomes. At present, its remit is limited and there is no onus on the Trusts to implement any recommendations made by HSIB.

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?

As specialists in serious injury claims which tend to be of high value, we acknowledge that the proposal for fixed recoverable costs falls outside of our core area of work. We have made a series of observations below, but defer to responses submitted on behalf of representative bodies, such as the Association of Personal Injury Lawyers ("APIL") and the Society of Clinical Injury Lawyers ("SCIL").

The Civil Justice Council ("CJC") report on fixed recoverable costs in lower value clinical negligence claims[10] highlights at para 3.84 that not all lower value clinical negligence claims are suitable for a fixed costs process. Specifically, the CJC observe that 'complexity' elements, such as multi-defendant claims; or sensitivity, such as for stillbirth claims, should be excluded from a fixed costs regime. We agree and would also suggest that a fixed costs regime should exclude child cases, cases involving protected parties, international and fatal claims.

We do not consider a scale akin to the personal injury regime can easily transfer to clinical negligence, where costs of expert reports are somewhat higher and disclosure more extensive. Clinical claims are, matters of professional negligence which require expert interpretation (often from multiple experts) and are rarely clear-cut. It will still require expert solicitors to conduct the matter to ensure the claimant has access to fair compensation and access to justice. A proposed percentage increasing scale in terms of increased costs as the case progresses may be a way to address that issue.

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

In our view any "blame culture" does not stem from the clinical negligence litigation system, but rather is a longstanding systemic problem that has developed in the NHS.

For the vast majority of our seriously injured clients, their aim is not to 'blame' or seek retribution from those who have been negligent. The decision to bring a clinical negligence claim is often not taken lightly. It is frequently the realisation by claimants and families that they need funds to cover loss of earnings and/or to access rehabilitation, care or treatment which motivates them to pursue a claim. It is important to

[10] https://www.judiciary.uk/wp-content/uploads/2019/10/Fixed-recoverable-costs-in-lower-value-clinical-negligence-claims-report-141019.pdf

claimants who experienced negligence that they receive an apology, and they might hope lessons will be learnt to prevent future patients from experiencing the same negligence and adverse outcome. The fact that the majority of claims are brought against hospital trusts as corporations rather than against named individuals assists to de-personalise the process. Our experience is that claimants simply wish failures of care to be identified and accepted as a component of proving their claim rather than to attribute blame to any one individual.

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

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?

We respond to the above questions as one and repeat our responses above in relation to lesson learning within the NHS. We do not consider that the clinical negligence system created a 'blame culture' within the NHS. As stated above, the NHS should review and implement better processes to learn from mistakes, disseminate learning around those mistakes and commit to making changes. We repeat our above comments regarding the duty of candour and use of the Rehab Code in relation to claims.

However, in order to move away from a blame culture and towards a learning culture within the NHS, we propose the investigation of all adverse incidents is conducted in an external setting, by external investigators from another trust, for example. It is difficult for clinicians to properly identify system failures, to identify any additional training needs or changes in procedure when conducting an internal investigation. The separation should mean that the investigator can feel more comfortable in analysing and reviewing the performance of those involved and can therefore make more informed and robust recommendations. It would result in more robust learning from outcome events at an earlier stage. In all adverse incidents, data should be collected as early as possible and irrespective of whether any claim is made.

In May 2021, Getting it Right First Time and NHS Resolution published the guide "*Learning from Litigation Claims: Getting It Right First Time (GIRFT) and NHS Resolution best practice guide for clinicians and managers*". It was highlighted that frontline clinical staff often did not know about the claims arising from care and treatment provided in their own hospital department, let alone in other hospitals. In response to this, GIRFT proposes reviews (whether serious incident, serious untoward incident or patient safety incident) should take place in respect of all claims to ensure no opportunity for learning is missed. The findings from the learning should then be disseminated to all front line clinical staff in a structured format, which does not just filter into the highest level doctors and managers, but all of those within the department. Any significant findings ought to be disseminated wider, for instance through regular training to relevant staff at other hospitals.

Crucially, the GIRFT guide recognises the need for patients and their families to be involved in the learning process and recommends that trusts should work in partnership with patients, families and carers. If the NHS is committed to learning from the litigation system, we suggest that trusts write to patients who have experienced serious adverse outcomes to explain the measures put in place to prevent the same mistakes from occurring again. In our experience, claimants (and/or their families) would seek real comfort from this and it would demonstrate that lessons had been learned as a result.

Pertinent findings from the thematic study commissioned by NHS Resolution 'Learning from Suicide Claims'[11] was that there were

[11] NHS Resolution: Learning from Suicide Claims, A thematic review of NHS Resolution data (September 2018)

- Low quality investigations, which were generally based on a root cause analysis model, which did not lead to an understanding of 'why' incidents occurred.

- Recommendations were made that are unlikely to prevent recurrence due to a lack of focus on systemic changes.

- Little reference to the sharing of learning across organisations and the wider sphere to promote systemic improvement'[12].

Whilst it is not suggested those issues pervade *all* internal investigations within the NHS, it seems clear that there is more that can be done to learn from episodes of harm both prior to and after litigation. There should be particular emphasis on the sharing of key findings both within the trust and between trusts to ensure best practice and consistency regardless of location.

Those who criticise the current system appear to call for a 'no-fault' or 'no-blame' system, which would enable patients who have been harmed to access a fund for financial support as is required without the need to prove negligence. In a recent, similar review in Ireland[13], an Expert Group considered in detail the introduction of a no fault system and concluded it was not appropriate for a number of reasons, but most importantly, because it recognised a no fault system could in fact increase the likelihood of important patient safety lessons not being learned. It is important to accept that error is human and will, inevitably, occur within the context of complex healthcare provided to the UK population. The Expert Group expressly recognised that *where fault is identified, it can lead to prevention of such events occurring again.*

The litigation process itself should not be a barrier to internal learning and information sharing from Trust to Trust. NHSR may need to be more active in sharing relevant data between trusts to enable further discussion on adverse outcomes and future avoidance of harm.

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?

It is very rare in our experience for clinical negligence litigation to be commenced as a means to obtain non-financial remedies[14]. The decision to bring a claim can be linked to the handling of an incident by the trust concerned, but is more readily linked to the need of the negligently injured patient to secure compensation for their injury related needs and losses.

Our proposal would be that the remit Healthcare Safety Investigation Branch (HSIB) be appropriately resourced and expanded to enable the body be invited to investigate all serious incidents where there is significant and life changing injury. Those cases are:

- Of maximal severity and therefore likely to cause additional costs to the NHS healthcare budget;

- Likely to yield highest damages if a negligence claim is established

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[12] Ibid, 91

[13] https://www.gov.ie/en/publication/6fa6b-submissions-and-papers-submitted-to-the-expert-group-to-review-the-law-of-torts-and-the-management-of-clinical-negligence-claims/

[14] Very few claimants could afford to fund such litigation on a non-financial point of principal. Since the restriction of legal aid virtually all clinical negligence claims rely on law firms risking their legal fees under a conditional fee agreement (CFA). CFAs are only commercially viable if there are reasonable prospects that damages will be recovered.

- Fewer in number than other types of injury/litigation such that HSIB is unlikely to be overwhelmed where their resources are presently limited.

When a serious safety incident has occurred the patient should not need to wait until they have instructed solicitors for an investigation into their treatment to begin.

There is no requirement for Trusts to implement HSIB recommendations, but such recommendations should be shared amongst Trusts particularly if HSIB is seeing a pattern of outcomes upon which similar recommendations might be made.

What legislative changes would be required to support these changes?

Whilst we do not propose major legislative change, we reiterate our comments above that systemic reform is required within NHS (and NHSR). These changes do not warrant any legislative reform of the litigation system nor the rights enshrined in all truly civilised societies to access to justice and full compensation.

We support and echo FOCIS' submissions on this question that clinical negligence legal costs are a symptom of a failure to learn from past mistakes within the trust/NHS, and also that a true intention to investigate, learn and disseminate learning should assist in reducing both the number of claims and costs of litigation.

Oct 2021