Written evidence submitted by Penningtons Manches Cooper (NLR0046)

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

The question appears to suggest that the cost of litigation has a direct impact on the financial sustainability of the NHS and the level of care. This question avoids acknowledging the primary cause of injury arising out of errors in treatment, which is the failure of the NHS to learn from mistakes, over many years. Neither does it consider the importance of access to justice for patients who have been injured and their right to recover damages as a remedy.

The principle that an individual can claim damages against a wrongdoer for harm caused is well established with many checks and balances to ensure that only legitimate claims are successful. This is not a system where individuals successfully bring claim without merit. Those who bring clinical negligence claims are patients who have generally never been involved in litigation before, are vulnerable and who need an award of damages to recover monies lost such as earnings and pay for future needs. Substantial sums are only paid when life changing injuries have been caused by errors in treatment that should not have happened. We should be proud of a legal system which supports individuals to regain their independence and are put back, as far as possible, to the position they would have been in but for errors in medical care. A robust legal process requires appropriate funding otherwise there will be a negative impact on access to justice.

The cost of litigation will reduce if failures in care are avoided. Therefore, rather than looking to reduce an individual's legal rights by limiting the standard of legal representation the focus should be on continuing to improve patient safety which will involve learning lessons from errors.

In recent years we have seen an acknowledgment that resources should be committed to practical and consistent learning from errors. It seems to us that this new approach is at a relatively early stage and needs to be consolidated into everyday practice. This is the single most important issue to address. Reducing errors will, most importantly, avoid harm to many patients, reduce the impact on clinicians and this will lead to a reduction in litigation costs as the number of claims reduce. The recent Ockenden investigation into maternity care, for example, brings up the same errors which were highlighted in the investigation into Morecambe Bay, several years earlier – significant funds are also spent on these investigations and there needs to be a focus to make sure the same known errors do not continue to be made.

Fundamentally we consider that the present litigation process works well and does what it should do, which is to represent vulnerable individuals allowing them to seek and recover damages when they have been injured through no fault of their own.

However, we have made suggestions below on areas of litigation which could be improved.

- **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 problems being repeated elsewhere in the system?**

      We do not agree that the way compensation is awarded in clinical negligence claims has a significant impact on learning. However, it is very clear to us that there are many lessons that could be learnt as a result of the litigation process and there has been a failure to make use of the information available for the benefit of patients.

      Example: A recent example, in our practice, is a case we settled in September 2021 relating to a hospital failing to prescribe the correct 10-day course of anti-coagulant medication to a lady after her c-section. She was told upon discharge she didn't need to go home with any more medication. She suffered a blood clot and sustained injury. The Trust admitted breach of duty. They said that lessons had been learned and practices changed. We were saddened to hear, just days after we settled this claim, of another case where the same thing happened, some time after our client's case at the same hospital. This client wasn't prescribed the correct 10-day course of anticoagulant medication after a c-section and suffered a blood clot. She was told upon discharge that she didn't need to go home with any more medication. This is a prime example of how the costs involved in this second case and an injury to a patient could have been avoided had there been appropriate learning by the Defendant Trust in our first case

      There are opportunities to learn from mistakes during the course of the litigation, for instance:

      - Letter of Notification: letters have not been acted upon with a view to improving patient safety and learning lessons at an early stage, the only focus has been litigation.

      - Letter of Claim: letters have not been acted upon with a view to improving patient safety and learning lessons at an early stage. In addition, there is a worrying rise in the number of Letters of Response we receive where there is a complete denial of liability despite a subsequent complete admission of liability at the Defence stage. We think any investigation needs to consider the reasons why admissions made at the Defence stage are not being made earlier on in the Letter of Response. There are clear savings to be made here where the costs of issuing and serving a claim could be avoided. Perhaps there should be an internal reporting system for when cases are denied in the pre-action stages and then

admitted in full at Defence and the Claimant asked for a breakdown of the costs incurred between Letter of Response and Defence for this to be reported back to an internal system where this data can be collected and analysed.

- Receipt of defendant expert reports by the litigation team and the exchange of expert reports between the parties appear to be dealt with purely with a focus on litigation rather than feeding back for the purposes of patient safety.

- Mediation – in recent years we have noted more frequent involvement by the trust when a representative has been sent to observe mediation and/ or settlement meetings with a view to acknowledging errors and learning from mistakes. This is a welcome development and we believe it is an attempt to deal with the criticism that trusts (and/ or members of staff) have made, that they have not been involved in the litigation process or informed of the outcome meaning that the opportunity to learn lessons has been missed.

- Claimant solicitors are rarely asked to provide their assistance in relation to patient safety even after litigation has concluded. This is a missed opportunity.

In conclusion we do not consider that the way compensation is awarded in clinical negligence claims should change but we do consider that litigation can promote learning if medical evidence available during the course of litigation or at conclusion is analysed independently.

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

  The *COVID-19 Clinical Negligence Claims Protocol 2019* is an example of a helpful collaborative approach between claimant and defendant lawyers.

  The *SCIL scheme* prepared to encourage efficiency of the administration of lower value claims will assist to simplify the process of litigation, where appropriate.

  No fault Compensation Schemes - compensation remains to put the injured person back into the position they would have been in but for the negligence, as far as possible. Any suggestion that there should be a discount to the damages paid (which would be inevitable in a "No Fault" scheme) is inconsistent with this principle.

  In our day-to-day practice, we have noted a number of points which would, however, improve the litigation process:

- Defendants need to engage with claims at an earlier stage, commencing their own investigations promptly and responding within protocol timescales or agreed extensions. They should not wait until court proceedings have been issued, and the court fee incurred, to engage with the case and properly investigate it. Appropriate attention given at the outset would lead to early resolution of many cases without the need to issue court proceedings and without the associated time and costs.

- When early investigations do take place, for instance HSIB investigations, these should lead to earlier admissions by NHSR, where appropriate. An offer to settle a claim should be explained and supported by evidence and explanation. Too often an offer to settle, with a detailed explanation of the value of the claim by the claimant, is met with a Part 36 Offer which is considerably lower and without any explanation or comment on the claimant's evidence. This is a cynical tactic when it is clear that evidence is available to the defendant but it chooses not to enter into negotiations "on a level playing field". This often leads to delay in reaching a settlement because the defendant fails to enter into dialogue.

- Independent experts should be instructed at an early stage and asked to consider all relevant evidence with necessary fees paid and their time should not be capped unreasonably. Using a fixed grid for fees encourages incomplete analysis and leads to the provision of unreliable evidence. Appropriate fees paid at an earlier stage will reduce costs in the long term. It is false economy to cap expert fees in this way and leads to increased costs at a later stage.

- Use of mediation is helpful. However, more often than not, evidence from the defendant is provided very late in the day – sometimes a day or so before the mediation is due to take place. In addition, it is not unusual for a mediation to be postponed if the defendant is not able to comply with an agreed timetable. This causes additional costs and delay.

We have, of course, experienced very helpful and collaborative approaches by defendants and this inevitably increases the prospects of resolution and reduces costs. Our impression is that a collaborative approach is achieved when specialist and experienced solicitors are instructed on each side.

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

SCIL, AvMA and NHSR and APIL are working together, when it is appropriate to do so.

On individual cases, collaboration is considerably hampered if those making decisions do not have sufficient expertise and considerably improved if they do. The majority of claimant solicitors dealing with this work are either AvMA or Law Society panel. The defendant panel firms appear to have less consistency of fee earner and we observe solicitors running cases who either do not have sufficient experience or authority to make decisions on the progress of a case. In addition, there appears to be duplication when a fee earner has to refer decisions to a case handler. Removing layers of decision making would assist.

It is important that defendant panel solicitors are instructed as early as possible with adequate instructions and authority to settle. Panel solicitors should have the ability to engage with the case and understand issues so that productive discussions can take place early on. The current protocol of engaging by email and being as collaborative as possible is assisting.

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

  ENS is a litigation tool and therefore not a scheme set up to improve systems. It can and should provide examples of systems failure but it is not independent as it is operated by NHSR. HSIB is intended to provide independent investigation. It is better placed to work to improve transparency and efficiency. However, there are delays in the investigation and analysis of lessons learned should be available more quickly and communicated more widely to senior managers and those involved in day-to-day care.

  HSIB needs funding and the power to follow up when recommendations are made to ensure they are implemented. HSIB will require more funds in order to do this work and needs to remain independent of NHSR.

- **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?**

  The SCIL scheme, offers a solution to lower value claims without the associated fixing of costs. It is suggested that a pilot of the scheme is necessary and arguments have been set out as to why a fixed costs scheme would not lead to access to justice.

  Points made previously are that fixed costs are unworkable because the rates proposed are inadequate to provide access to justice. This is a complex area of work relating to criticism of professional practice. The costs involved in establishing a successful claim are not necessarily linked to the damages awarded; they will reflect the complexity of medical and legal issues. Limiting

the reasonable time taken to prepare a case means that cases with merit will be at risk. Furthermore, the level of costs incurred is impacted hugely by the conduct of the defendant, namely the liability stance taken, how quick defendants are to respond and engage appropriately and how co-operative and pragmatic they are generally. Fixed costs for cases of £25,000 or under significantly impacts access to justice for the most vulnerable members of society, and often in situations where the outcome has been the most harm. Where young children, the elderly or disabled die because of negligent care, claims are often of low financial value, but are of great importance to their families and to the public, to gain an understanding of what went wrong and to ensure that such significant harm does not happen again. Limiting costs in these claims will make it more challenging for them to be brought, for necessary detailed investigations to be undertaken and, therefore, for lessons to be learnt as a result of the litigation and for families to receive justice.

A fixed costs scheme could easily be abused by defendants deliberately not cooperating thereby running a claimant into the field of cost disproportionality such that they cannot proceed and are then denied access to justice.

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

A "blame culture" is not a concept that specialist solicitors recognise. Blame culture suggests cases are brought without justification and this does not reflect the day-to-day practice of specialist solicitors who investigate claims and would not accept instructions to pursue a case unless it has been carefully considered and is supported by expert evidence. Claimant's solicitors would not benefit financially from a "blame culture" as unmeritorious claims do not succeed and costs are not then recovered. The process is not about apportioning "blame" but recognising what has gone wrong and compensating individuals for their injury. As stated throughout this document it also has the potential to encourage lesson learning and improve patient safety if alerts to errors in treatment are acted upon quickly.

Focusing on individual blame is not productive, mistakes happen and those mistakes should be acknowledged and learnt from so that they are avoided going forwards. Many claims are against Trusts, not individuals, and this fact also goes against the suggestion of a "blame culture" in litigation. Our approach to claims acknowledges that where harm occurs it is very rarely as a result of one individual error.

There have been instances of adverse reaction to "whistleblowing" within the NHS leading to bullying and discrimination and it is our impression that clinicians are much more concerned about the response of the GMC and the reaction of their employers when an error has occurred and not the litigation process itself.

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

  The purpose of litigation is to compensate individuals and place them in the position they would have been in, as far as possible, but for the negligence. The purpose is not to encourage lesson learning however it has been evident for many years that the outcome of litigation can have a positive impact on patient safety, provided the NHS takes note and is willing to listen. Patients say that they would not want anyone else to go through what they have been through, so learning and training is important, but this is separate and distinct from the award of damages.

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

  See above. We do not agree that a blame culture arises as a result of the management of clinical negligence litigation.

- **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?**

  Patients do not pursue litigation for non-financial remedies. If injured they seek damages to assist them gain a reasonable quality of life after negligent injury or death, which frequently also causes financial hardship for the family. Those entitled to compensation should be able to pursue a claim. It is of course true that lessons can be learnt from "near misses" where an error has taken place but damage has not been caused. Suggestions to improve HSIB's role are set out above, including funding to follow up on recommendations made.

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

  The current tort system, not limited to clinical negligence cases, is robust. A fundamental change is not needed. However, any suggestion that clinical negligence cases should be singled out could not be justified when it appears the primary purpose is to reduce the justifiable costs of the litigation process, and fair compensation to injured parties, rather than focusing on the cause of litigation claims which is the failure to learn from mistakes and improve patient safety.

- **Fixed recoverable costs in low value clinical negligence claims: at what level should fixed recoverable costs be set and in what circumstances should FRC not apply to low value clinical negligence claims?**

We oppose FRC for the reasons set out in response to previous consultations and specifically support piloting the SCIL Scheme provided to the government.

Penningtons Manches Cooper

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