Written evidence submitted by Clyde & Co's (NLR0048)

This submission is made by Clyde & Co's UK Healthcare department. Clyde & Co is a leading global law firm, and our healthcare department in the UK provides advice to a wide range of healthcare clients. We are on NHS Resolution's panel of law firms, so act for NHS healthcare organisations including NHS Trusts and GPs. We do not act for Claimants.

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

About £2.2 billion in damages and costs was paid by NHS Resolution in respect of its clinical schemes in 2020/21. That is £2.2 billion less in one year available to be spent on delivering patient care. The National Audit Office has said that the cost of clinical negligence claims is rising at a faster rate year on year than NHS funding. Clearly, that is a worrying prospect. The impact of litigation on NHS services, both in financial terms (damages and costs) and also-just as importantly-in human terms (impact on patients and staff) simply cannot be overestimated.

It is imperative that patients who have suffered harm are compensated fairly but there is also a need to ensure that vital resources are preserved for patient care. There is also a further need to support staff who are involved in incidents and claims and a moral obligation to ensure that learning is disseminated to ensure, so far as is possible, that mistakes are not repeated.

Whilst meritorious claims should be settled swiftly, there is a need to guard against claims which are fraudulent or exaggerated (though we acknowledge that these are in the minority). NHS Resolution is clear that unmeritorious claims will be robustly defended.

There is a need to minimise legal costs and the most effective way to achieve that is by keeping claims out of litigation and settling meritorious claims as near to the index event as possible. There is also a clear advantage in identifying the learning from claims and ensuring that that learning is embedded and disseminated as near to the point of harm as possible.

Clinicians have a statutory duty of candour and are actively encouraged to offer apologies when things go wrong – see for example NHS Resolution's "Saying Sorry" leaflet. That is the start of an increasingly collaborative process which flows through to the complaints system, internal investigation or HSIB investigation, and into claims. There has been a concerted and effective move towards a less adversarial approach, which has largely been welcomed by patients, families and claimant solicitors, and an increasing willingness to mediate or consider other forms of dispute resolution. Initiatives such as NHS Resolution's Early Notification Scheme, the COVID 19 Protocol and the Mediation Project are all examples of ways in which resolution is being moved upstream to deliver compensation to patients and families more swiftly and at reduced cost, with the benefit of costs savings having the potential to be used to fund patient safety initiatives.

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****?*

NHS Resolution recognises the importance of Learning from Claims both on a micro and macro scale. It has a unique set of data from claims which it harnesses to drive the patient safety agenda. Safety & Learning is now a key element of its services - supporting the NHS to better understand and learn from claims, concerns and disputes; to target safety activity while sharing learning across the NHS.

In connection with this there is a recognition that if lessons are to be learned, there needs to be a move towards a blame free environment where clinicians feel supported and able to engage in the debate about what went wrong and how best to avoid a recurrence. We query the extent to which clinicians "on the ground" receive detailed feedback from Trust legal departments, particularly in respect of the expert evidence received during the claims process and suggest that more work could be done to ensure that direct feedback is given, as soon as possible, within a supportive learning environment.

In primary care, learning from claims is a challenge given that GP practices are numerous and widely dispersed across the country. NHS Resolution is already analysing data from GP claims showing trends in types of claims e.g. mis-prescribing and missed cancer cases. It is imperative that this is disseminated to GP practices, which could be achieved via Local Medical Committees with practices incentivised to attend regular CPD meetings to learn from claims and to actively address common failings. Incentivisation schemes referable to primary care funding may encourage a reduction in repetition of errors and an appetite for continued learning from claims.

We also consider regulators such as the GMC and NMC should continue to encourage clinicians to make early admissions when mistakes have been made, so as to demonstrate insight, and to encourage early remediation and learning from errors which may avoid the requirement for a full fitness to practise hearing.

We consider that local learning is key. It is imperative for investigations to be concluded swiftly, resolution delivered as soon as possible post incident, and learning to be fed back and changes implemented at the earliest opportunity. This further supports the drive towards early, pre action settlements as opposed to resolution occurring some years down the line when the learning and feedback may be perceived to be less relevant to current practice.

Mediations have increased significantly since the launch of NHS Resolution's mediation scheme, and the focus is firmly on pre litigation mediation/ADR at the earliest possible opportunity.

59% of NHS Resolution's CNST payments relate to maternity claims. NHS Resolution's Early Notification Scheme is proving a great success in investigating/resolving maternity incidents at an early stage (even before a legal claim has been intimated) and promoting vital learning much nearer to the event.

In short, we think things are going in the right direction but more needs to be done to encourage earlier resolution – see below.

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

Often patients will make a claim, not because they seek compensation, but because they see it as the only way to obtain an explanation about what has happened to them and what will be done to prevent a recurrence. Patients often make a complaint before they make a claim, and only elect to

then proceed with a claim due to dissatisfaction with the response they have received to their complaint or the way the complaint has been handled. A focus on robust complaints management at local level could mean that patients receive the answers they seek more quickly without needing to resort to litigation. Often, the problem with the complaints system is that complaints are handled by very junior staff and responses can be delayed, inaccurate and may fail to address the patient's concerns or demonstrate (where appropriate) that learning has been disseminated and embedded within the organisation.

One option to ensure that patients receive financial redress more quickly might be to allow payments of up to £10,000 to be made at a local level. Acceptance would not prevent a patient bringing a claim, but any payment made would be deducted from any damages subsequently agreed or awarded. It may be that a significant number of modestly valued claims could be resolved locally without any legal costs being incurred.

If a claim does ensue, the Pre-Action Protocol should include a preliminary requirement for patients to have exhausted Trusts/GP Practices' complaints handling protocols before a Letter of Notification is issued. This should include early meetings with patients and their families with apologies where appropriate at an early stage to reduce the number of claims even entering the Pre-Action Protocol stage.

Under the Pre-Action Protocol, claimants' solicitors are encouraged to serve Letters of Notification when they are confident that a claim will ensue but prior to them being in a position to serve a formal Letter of Claim with detailed allegations of negligence. NHS Resolution will commence investigations following service of a Letter of Notification and this provides an opportunity to identify cases where early admissions are appropriate and legal costs of can be minimised. Learning can be identified and fed back at that early stage. A greater willingness to provide Letters of Notification, rather than serving a Letter of Claim at the outset would enable earlier investigation and, in appropriate cases, earlier resolution.

Exchange of expert evidence prior to the issue of court proceedings could be introduced into the Pre-Action Protocol to encourage resolution before claims are formally issued.

Trusts are encouraged to notify NHS Resolution of incidents which may lead to high value claims before a claim has been intimated so that investigations can be undertaken at that early stage. We suggest that earlier notification by Trusts of a broader range of potential claims would assist in streamlining the process.

The majority of claims are now settled prior to the issue of court proceedings or, where the claim is in proceedings, by some form of ADR. We suggest that where liability has been denied in Pre-Action protocol correspondence, there should be a requirement for a pre litigation meeting before proceedings are issued with an outcome report to be sent to court with the claim form and supporting documents. A mandatory pre action settlement meeting is likely to reduce still further the number of cases which proceed to litigation and help increase the amount of early and swift settlements for patients.

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

The Pre-Action protocol generally works well and there is a significant and growing degree of collaboration between Claimant and Defendant communities, as evidenced by the COVID19 and Mediation Protocols. Extension of the current pre-action protocol to formalise steps which would

aim to foster greater collaboration and engagement, without recourse to proceedings, would assist. As above, this could include the requirement for a pre litigation meeting and/or provision for early without prejudice exchange of liability evidence.

NHS Resolution has a panel of highly experienced law firms, and increasingly, those who advise Claimants are highly experienced, specialist law firms. In our view, claims are much more likely to reach an early conclusion if both sides are experienced and adopt a collaborative and co-operative approach. For example, many Claimant and Defendant firms, including ourselves, have arranged settlement meetings where a large number of cases being dealt with by 2 firms are discussed over the course of the day with a view to settling as many as possible during the one meeting. This initiative has proved very successful and similar resolution forums should be encouraged with the aim of covering a broader range of claims.

We also consider there is scope for a Clinical Negligence working party consisting of representatives from Claimant and Defendant law firms to increase this collaboration, meeting quarterly to discuss issues arising and developing and further refining protocols to reflect best practice.

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

The Early Notification scheme is not enforceable, and it is a matter of voluntary participation. We do not advocate making it mandatory. However, its ethos should be encouraged – behaviours to ensure patients, claimants, and their families obtain settlement as early as possible and at a stage when learning from the claim is still relevant. Earlier, at point of incident learning is the key issue and contributes hugely to the ability to have constructive discussions with and feedback to Trusts in real time rather than there being a significant time lag.

- ***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 are strongly supportive of a fixed recoverable costs regime as the current system is out of step with the remainder of the market. We think this regime should apply to the vast majority of cases which settle for up to £25,000, and indeed, there may be scope in due course to extend the scheme so that it applies to settlements at a higher level than that. Specific provision could be made for enhanced costs in appropriate cases, for example those requiring judicial approval of settlements or where Claimants do not have the requisite capacity to litigate.

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

With the introduction of the duty of candour legislation, requiring clinicians to be open and honest with patients and provide them with explanations when treatment does not go as expected, there has been a shift in the way clinicians approach patient safety incidents and the patients involved in them. Whilst the adversarial nature of litigation does mean that clinicians are at times individually criticised, much of the concern about "blame culture" and its potential effect can be mitigated by providing clinicians with training and guidance on how to approach patients when something goes

wrong, including how to maintain good relationships (which is largely contingent on effective communication skills). Training to Trusts and GP Practices in "saying sorry" at the early complaints stage may help alleviate a blame culture and prevent defensive practice. This is important in primary care where the doctor-patient relationship is likely to continue after the complaint/claim has resolved.

It should be made clear to clinicians that in providing apologies and explanations, they do not need to fear the potential for a claim being made. Initiatives introduced by NHS Resolution (e.g. Being Open; Saying Sorry) have positively reinforced this message. The key issue is to ensure that clinicians are educated about the claims process and given reassurance around being involved in a claim. This can be done by ensuring all clinicians receive training on the claims process (and any disciplinary/regulatory issues arising), what a claim means for them professionally and personally, how they will be supported and how to best approach the claims process from the outset. We find that often clinicians lack this key knowledge and it is this fear of the unknown and lack of understanding which causes them the greatest stress and concern. Simple but effective measures could be implemented to alleviate this.

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

We consider this to be vital from both a financial and moral perspective.

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

Work has already been carried out to address the challenge of the rising cost of clinical negligence in response to the recommendations of the National Audit Office report and subsequent Public Accounts Committee findings in 2017.

Patients who have been negligently harmed must be compensated. The current law (S2(4) of the 1948 Law Reform Act) requires the NHS to provide funds for private as opposed to NHS care. We consider its repeal is long overdue. This could result in significant costs savings and funds that could be kept within the NHS for the benefit of all patients**.**

Similarly, we consider the Discount Rate calculation mechanism needs to be reconsidered to reflect the reality of how damages are invested. The current negative discount rate in our view does not reflect the real world, is effectively overcompensating Claimants, and has hugely increased the financial burden on the NHS.

The NHS could purchase care packages from public providers on the basis that the same level of care should be available to everyone with the same injury or disability. Funds would not be diverted away from NHS services and could be used to improve health and care services.

Changes could also be implemented to prevent Claimants from claiming the cost of private education except in exceptional circumstances.

When organisations (e.g. GIRFT) are trying to influence the patient safety environment, there is currently no mechanism for implementation of their recommendations. Some formal recognition of best practice and implementation of the same would help.

As discussed above, the complaints process could allow compensation payments of up to £10,000. Acceptance would not prevent a patient bringing a claim, but any payment made would be deducted from that claim.

Oct 2021