Written evidence submitted by Browne Jacobson LLP (NLR0051)

Opening remarks

1. Browne Jacobson LLP is a national law firm with a team of over 120 health and social care lawyers acting across both the private and public sectors. We have a national reputation for healthcare, providing services across all areas of healthcare law to health and social care providers, commissioners and regulators. We are a trusted advisor to over 100 NHS bodies, more than 150 local authorities and many independent providers. We have over 25 years' experience in defending health organisations involved in litigation.

2. We have chosen to address some of the questions set out in the call for evidence. Our experience in assisting healthcare providers and supporting clinicians with investigations into patient safety incidents, inquiries, complaints, clinical negligence claims, inquests and disciplinary investigations informs our submissions to this inquiry.

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

3. The NHS remains one of the safest healthcare systems in the world but when things go wrong, the best way to learn lessons and improve safety is to investigate as soon as possible after the event. In our view system reforms need to focus on improving the early response to harm rather than the clinical negligence litigation process, which can follow some years after the incident.

4. The primary role of the compensation system is the financial compensation of patients harmed as a result of negligent treatment, yet it is very clear that financial compensation is often not the only or primary reason for pursuing litigation. We often hear at the end of a claim that if the right action had been taken at the very start, putting the family at the heart of the matter and communicating with them in an open and honest way, providing evidence that learning has been identified and actioned, a claim for clinical negligence would never have been brought. System reforms should focus on empowering people to feel confident that they can take the resolution of their concerns outside of the claims process to achieve a fair and just resolution.

5. Although the clinical negligence system is ostensibly adversarial there is a growing trend towards co-operation between parties in order to reduce friction and cost. We have worked hard to build collaborative relationships with claimant lawyers, facilitating exchange of information, allowing us to identify the key drivers behind the claim, maximising the prospect of an early, just and fair resolution but also ensuring the needs of the patient are met. For example, we have held mediations with families just to look at the learning from the case or to provide an apology. We use a range of dispute resolution platforms such as "Resolution Rooms" to efficiently resolve a number of cases with the same firm of solicitors at one meeting, through to specific group action protocols and the use of joint experts. In our experience, the parties' motivation and engagement with dispute resolution processes will be affected by the legal representatives who represent, advise and participate in the ADR process. Whilst there are positive levels of co-operation and engagement between claimants and defendants, there is no doubt that collaboration is easier and more cost-effective when dealing with firms that really understand clinical negligence litigation.

6. In our experience there is considerable variation in culture and response to criticism from one organisation to another. Our perception is that a number of factors influence whether there is a blame or a learning culture, including:

    - Organisational culture and leadership

    - Experience of the inquest, litigation, disciplinary and regulatory processes across the organisation and by individual clinicians

7. We are not convinced there is a universal "blame culture" which hampers medical advice and decision-making, but any form of criticism and close scrutiny of clinical care and advice causes considerable stress for clinicians, and litigation is only part of the picture. The idea that the NHS should simply "learn from claims" and then all claims will be prevented is a fallacy. Review of the number of claims reported to the Compensation Recovery Unit shows that over the last 10 years to 2020, claims in respect of clinical negligence, employer, motor, other and public liability have remained fairly consistent in number. There will be consistent themes and causes for all of these accidents. Learning from the past to change the future is easier said than done.

    https://www.gov.uk/government/publications/compensation-recovery-unit-performance-data/compensation-recovery-unit-performance-data

8. Medicine is complex, and sometimes it is a question of finding the least worst option for a patient, rather than there being one right way to treat them. Sometimes claims appear to arise out of the blue, without any prior indication that a patient feels they have suffered an adverse outcome or anything to prompt an internal investigation. Some claims only arise when a patient reflects on their treatment years later or they learn that the side-effects they experienced were not inevitable. Sometimes changes in the law (such as that brought about by *Montgomery v Lanarkshire Health Board*) result in retrospective changes to the law, widening the scope of claims.

9. Organisational culture is key. It is vital that healthcare providers embed a just and learning culture, where staff are supported to raise concerns about patient safety, where audits are undertaken and the nature of concerns recorded in the register of concerns are assessed to see how well Freedom to Speak up procedures are working and if there are barriers to this. Changing organisational culture however requires a whole system approach. Leadership within the organisation, at all levels, is critical, as is training from the board to the ward to embed and understand the approach. With strong leadership and a culture of candour, patient concerns are responded to promptly and openly. Well-led organisations understand that being open and honest with patients does not result in more claims, and sometimes a claim is avoided with a candid explanation of what went wrong and why, and, crucially, the relationship of trust between patient and healthcare provider remains intact.

10. Healthcare professionals are often acutely aware of the potential for referral to their regulatory body. Whilst claims against NHS Trusts are made against the organisation, this is not the case with GPs, for whom an admission of fault can feel very personal, and for whom it can have more profound consequences for their registration. It is, perhaps, not surprising that healthcare professionals feel vulnerable when an adverse incident can potentially result in any combination of a complaint, an inquest, a claim and a regulatory referral. These processes are independent of each other but, inevitably, interlinked.

11. There can sometimes be concerns amongst healthcare professionals that being open and candid at the outset could be used against them at some point in the future. We are seeing this with HSIB reports being put to witnesses at inquests as evidence of previous inconsistent statements, and cases where the inquest process is leading to referrals to professional bodies based upon failings admitted in an internal investigation. Consideration could be given to legislative reforms so that evidence given to an HSIB investigator could not be used against the maker of the statement in any regulatory proceedings against that individual or an inquest relating to the same matter. The regulatory investigation or inquest should be independent and reach its own conclusions. We believe it is these sorts of reforms which will better encourage transparency and learning from adverse incidents, rather than changes to the clinical negligence regime.

Complaints process and readability of written information

12. In our view the handling of complaints is an area requiring investment and training, as the quality of complaints handling can directly influence whether a clinical negligence claim proceeds. Good communication early on is key. Healthcare providers need to demonstrate that they engage meaningfully with patients and provide clear information following an incident and in particular in response to a complaint.

13. The Behavioral Insights Team (Behavioral Insights into Patient Motivation to Make a Claim for Clinical Negligence; August 2019) identified a number of themes around complaint handling in the NHS, including that communications were "incomprehensible to lay people" and "lacked appropriate tone and compassion". Correspondence with patients needs to meet duty of candour requirements and provide a full and easy to understand explanation for what has happened. If drafted well, with appropriate tone and empathy, it can prevent a claim being subsequently pursued and is therefore a key driver to reducing future claims and their costs.

14. Browne Jacobson is working with the University of Nottingham and NHS Resolution to undertake research on the "readability" of written information provided to patients by NHS organisations. This research has involved the use of eye tracking technology to understand how clear the written information provided to patients and their families who have concerns about their care or treatment really is, and whether written responses provided are meaningfully understood. Through this work it is hoped it will be possible to improve the standard of complaint responses, to resolve complaints effectively and compassionately without the time and resource costs of claims. There are a number of areas where healthcare organisations could benefit from improving the clarity of written information provided to patients and this project has obvious potential extensions, for example to the analysis of incident responses.

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?**

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

15. Our role is clearer, and the length of litigation and costs associated with it are reduced, when the healthcare provider has already fully investigated the incident. That investigation can take many forms: a complaint may have been made, an incident investigation triggered or the investigation may be for the Coroner or by HSIB. "Redress" can take many forms – sometimes it is about addressing financial need but often the patient's primary need is to understand what has happened and why, and feel confident that their treatment is now on the right track and others won't suffer. It helps if we can then work constructively with claimant lawyers to resolve the claim, and in many instances court proceedings are never required. The "Covid protocol" has accelerated collaborative working during the pandemic, providing reassurance on both sides that litigation will be seen as a last resort.

16. Change needs to focus on the point of incident, encouraging early intervention through a patient-centred approach to support healthcare providers and families to resolve concerns in a holistic and empathetic way at reduced cost. This includes having a strong system for local incident investigations which take a system-wide approach and are centred around learning and improvement rather than blame. The quality of that investigation is the critical factor. Often those investigations are limited by the resource the healthcare provider has available for that function and investment and training are needed. It is also important that staff are supported in this process and receive training on how to respond to incidents, including having difficult conversations with families and how to deliver duty of candour in practice. Arguably, the current establishment of integrated care systems to support greater local collaboration provides a good opportunity to embed this approach across the NHS.

17. Patient engagement needs to be central to the early response to harm. It is very clear that resolution of concerns goes beyond compensation. Patients need to feel heard and to have their questions answered. There need to be processes for meeting patients' needs, including emotional and psychological needs, outside of the legal process framework. Early meetings between the healthcare team and families to provide explanations and apologies are often useful and can be cathartic for all concerned, but one size does not fit all. In our experience mediation can be a constructive forum, providing a confidential space to explore issues, and for exploring non-monetary forms of resolution. A willingness to find common ground provides the best incentive for success.

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

18. Collaboration is built on relationships of mutual trust and this is easier for defendant clinical negligence specialists or in-house advisers to establish with claimant law firms who are equally experienced in healthcare claims. We have noticed a number of new entrants into the claimant market following the introduction of the Legal Aid, Sentencing and Punishment of Offenders Act 2012. Under the previous Legal Aid system, only lawyers who met the Legal Aid Agency's standards were granted a franchise to act for claimants in clinical negligence cases. Whilst we try and take the same approach with all, inevitably it is easier to establish a relationship of mutual trust with a firm with whom one has regular dealings.

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

19. We do not consider the role of the clinical negligence system is to encourage learning and commitment to change; this needs to happen closer to the incident and should just be part

of the driver for improvement in patient care. There needs to be continued support for healthcare providers to analyse claims data, triangulating this with other data sources including the data from Getting It Right First Time.

Changes to the way compensation is awarded

20. It is challenging to settle any personal injury claim where there is any element of uncertainty. That uncertainty can relate to prognosis, for example how a claimant will respond to treatment, whether they will be able to continue working despite their injury or how their care or future treatment will be funded. Considerable cost is spent on anticipating needs, trying to assess the risk that a particular outcome will materialise and compensating for that risk. Some claimants will fare better than expected, others will not.

21. Potentially there is double recovery and this is an area that would benefit from review. On the face of it Section 2(4) of the Law Reform (Personal Injuries) Act 1948 can create injustice, as it allows claimants to claim private care when NHS care is available. Section 2(4) allows a claimant to recover compensation to cover the cost of private treatment to remedy the damage suffered. For example, a claimant suffering a hip injury may require a hip replacement in 20 years followed by 3 revision operations every 10 years after that. Each of those 4 operations might cost £10,000 in the private sector. Section 2(4) allows the patient to recover those sums from the NHS. However, that award just forms part of the overall compensation award. There is no obligation for the claimant to use those funds for the purpose for which they have been paid. Patients may in fact subsequently elect to undergo such treatment through the NHS. This means the NHS has paid twice. It has paid the claimant to have the treatment privately, but then subsequently funds the surgery as part of the usual NHS activity free at the point of delivery.

22. However, any review of this area needs to be evidence-based. Section 2(4) does not prevent defendants arguing that a claimant is unlikely to opt for private care; traditionally this argument has been run where NHS care provides a better solution for the patient, for example in relation to specialist cancer follow-up. If there is a presumption that a claimant has to mitigate their loss by pursuing NHS care first then we will see arguments about provision in a particular geographical area, which will create a new aspect of costs.

23. Potentially there are other examples of double recovery, which defendants try to address through indemnities when settling large claims. For example NHS Continuing Care eligibility is determined by clinical need rather than financial means. This creates an anomaly where the NHS may have paid significant sums in compensation to a patient who is seriously injured as a consequence of clinical negligence. Following settlement of that claim the claimant might apply, and be awarded, funding for ongoing care under the NHS Continuing Care framework, notwithstanding the fact that the NHS is already funding that claimant's care needs.

24. Any reform in this area needs to be holistic and needs to balance the injustice of the taxpayer potentially paying twice for care or treatment needs, or over-settling a claim based on a pessimistic prognosis which does not materialise, versus creating additional stress for claimants who have been injured by clinical negligence. However, in an era when many large value claims are settled via periodical payments, which require families to provide evidence that the claimant is still alive on an annual basis, it is worth considering whether it makes sense for high value settlements to be reviewed at key stages to check that the assumptions on which they were based remain valid. It needs to be acknowledged that this

might result in additional cost, both in terms of damages and administrative cost, which perhaps highlights the need for quality research in this area.

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