Written evidence submitted by DAC Beachcroft's (NLR0052)

Introduction and reason for submitting evidence.

DAC Beachcroft is a member of NHS Resolution's panel of legal advisers for both clinical and non-clinical claims. We also provide legal advice to a Medical Defence Organisation and a number of private medical malpractice insurers. We also act for numerous insurers in non-clinical negligence personal injury claims.

The Committee's call for evidence sets out the financial cost of clinical negligence and rightly highlights the fact that this money is diverted from patient care. In addition to the financial cost is the human impact on the patients involved and their families. Healthcare professionals are motivated by a desire to help patients and to provide the best possible care. They are also deeply affected when care does not achieve the planned or expected outcome. We offer this evidence in the hope that our experience of working within the current framework will assist the Committee.

What are the key changes the Government should consider as part of its review of clinical negligence litigation?

To identify areas for change clinical negligence litigation has to be seen as part of the wider process of healthcare delivery. Patients enter the healthcare system to receive advice and treatment and to be part of a therapeutic relationship with those providing care. No patient enters that system with an eye on being part of the 'clinical negligence litigation' process. However when things go wrong or expectations are not met it may become relevant and necessary. It is vital changes are targeted at minimising the number of patients who need that process. Where it is required the process must be efficient, achieving the right outcome as quickly as possible whilst maintaining the therapeutic relationship and utilising the right proportion of the health budget.

Fundamentally the clinical negligence litigation process is there to determine:

1. whether a patient is entitled to financial compensation because the care provided failed to meet the legally required standard and caused harm.
2. The amount of compensation that should be provided.

Disputes centre around entitlement to and the amount of compensation. There is a sense however that some patients enter this system, not because of a need to obtain financial compensation, although for some that is vitally important, but because earlier stages in the healthcare process have failed to maintain the relationship between patient and healthcare provider and have not provided information and explanations in the right way at the right time.

To identify and evaluate areas for possible reform it is essential that the reasons why patients enter the compensation process are properly understood. The clinical negligence litigation process has to be seen alongside other processes and the quality of the relationship that exists between healthcare providers and their patients. Identifying areas for change in the clinical negligence system alone would be too restrictive without having regard to:

- The quality of discussions and process of providing information about the patient's condition, available treatment options and possible outcomes.
- Minimising adverse outcomes in the care delivery process.
- The quality of discussions which take place following episodes of care about outcomes and future care.

- The ability of the NHS complaints process to address concerns about care delivery, provide explanations and maintain the therapeutic relationship.
- The ability of the system to proactively identify, investigate, share information about and learn from episodes of care which result in unexpected or unplanned outcomes.
- The ability of the system to provide relevant information and assist the patient access the compensation process whilst maintaining the therapeutic relationship when the outcome is indicative of unacceptable care.

In all claims our approach is to assess the relationship between the patient and healthcare provider and consider whether there is a need to provide more information about what happened and why. Sometimes this is all that is needed to resolve the claim.

At the core of our approach is to work collaboratively with those helping the patient to resolve the dispute. This involves a recognition that there is a shared objective of resolving the dispute as quickly as possible minimising the level of NHS resources diverted from patient care.

Litigation has to be seen as the option of last resort. Its function is to be there as a means of achieving resolution when there remain intractable differences between the parties as to entitlement or the appropriate amount of compensation.

The resources and remedial options of Her Majesty's Courts and Tribunal Service are limited. There is a place for litigation when, despite everyone's best efforts, the dispute has not been resolved. However the time and cost involved together with the impact on individuals mean it must be used sparingly and only when absolutely necessary.

A key development in recent years has been the introduction of the **Early Notification scheme for maternity incidents**. This has played a vital role in driving improvements in maternity services and supporting families whose babies suffer injuries at birth. The scheme has brought forward significantly the point of investigation and engagement with families. The Scheme:

- Provides full and open explanations about care at a much earlier stage.
- Ensures early admissions and apologies are made where appropriate at a much earlier stage and far closer in time to the birth.
- Provides early financial support to affected families.
- Provides support to NHS staff involved.
- Feeds learning and guidance back into the service at a much earlier stage.

Early notification ensures that the NHS maintains its involvement with the family following the incident and through proactive investigation and openness the NHS is able to take responsibility for the incident and do what it can to maintain or repair relations with the family involved. In the past this responsibility may have been passed back to the family requiring them to find legal advisers to conduct an investigation on their behalf. For understandable reasons, this may have taken time, caused further distress and resulted in significant costs being incurred which may ultimately have formed part of the legal costs associated with the claim.

Through early reporting and proactive investigation the Early Notification Scheme has saved significant time, costs and fed back learning into the service. For these reasons introducing earlier incident reporting into other clinical areas should be carefully considered.

Improvements and reforms need to focus on reducing the incidents and circumstances which give rise to claims and maintaining relationships between patients and healthcare providers when things

do not go as planned. Other changes can be considered which will remove cost from the system but key changes should be driven by a desire to reduce incidents of harm.

Areas which should be considered are:

- Can the process of providing information to patients about their condition, treatment options and possible outcomes be improved?
- It is vital that healthcare providers are open and available to talk to patients when the outcome of treatment is not as planned or expected. Such discussions about what has happened, why and what can be done may maintain relationships and provide information which may otherwise be sought through a claim.
- If an NHS complaint is brought then there must be candour and a focus on maintaining relationships and providing explanations and information.

Within the Claims process it is vital that the **Pre-action Protocol for the Resolution of Clinical Disputes** is used properly. Areas for possible improvement are:

- Encouraging greater use of Letters of Notification to bring forward the point where care providers and indemnifying bodies are aware that a claim is been seriously contemplated.
- There needs to be better awareness of and engagement with section 5 'Alternative Dispute Resolution' of the protocol and its opening sentence which states 'Litigation should be a last resort'.
- There needs to be better awareness of and engagement with the 'stocktake' process contained within section 6 of the protocol.
- Greater use of the Court's powers to impose sanctions when there has been a failure to comply with the Protocol especially refusals to engage properly with sections 5 and 6 or the commencement of proceedings without prior compliance with the Protocol.

In summary therefore key changes need to have 3 core objectives:

1. Reduce adverse incidents causing harm.
2. Reduce the circumstances where patients need to use the clinical negligence process for reasons other than obtaining financial compensation.
3. Ensure that the clinical negligence process is as efficient as possible, uses litigation as the mechanism of last resort and pays fair compensation utilising the right amount of the health budget.

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

and

<u>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?</u>

Whilst the current legal framework involves an adversarial process significant strides have been made to operate that system in a less adversarial manner working collaboratively towards dispute resolution. There will be examples where this hasn't happened but there is a definite trend towards a less adversarial approach and the pace of development in this area has quickened appreciably in recent years. This can be seen through:

- The significant increase in the use of mediation (119% increase in around 2 years).
- Constant annual increases over 10 years in the number of claims resolved outside litigation.
- Collaboration between NHS Resolution and those who speak for and help patients.
- The creation and use of other forms of dispute resolution notably regular meetings between NHS Resolution, the firms on its panel and leading Claimant firms to review and seek to resolve claims outside litigation (Resolution meetings).
- Increased collaboration during the pandemic to ensure claims continued to be progressed without inappropriately taking up clinical time. NHS Resolution's COVID protocol encouraged and facilitated collaborative working between legal representatives. We anticipate the culture this fostered and the practical arrangements introduced will continue and be formalised beyond the pandemic.

There is increasing recognition of the interaction between systems and individuals in the incidents which cause harm and give rise to claims. Learning from incidents to prevent recurrence of harm has been at the core of incident investigation within the NHS for some time. We look forward to the roll out of the Patient Safety Incident Response framework (PSIRF) and in the meantime continue to work with NHS organisations using the Serious Incident Framework. This approach has encouraged root cause analysis aimed at finding underlying systemic issues and this must feed through into the claims process. Focusing on the conduct of individuals can often mask underlying systemic issues which if identified and tackled may have a greater impact on future patient safety. Such an approach should be encouraged by all involved, including those investigating possible claims on behalf of patients and the experts they instruct.

NHS Resolution encourages a just and learning culture (**Being Fair guidance**). When investigating and responding to clinical negligence claims it is vital that all involved take on board the need to strike a fair balance between fairness and responsibility without discussion of blame.

It must also be recognised that the clinical negligence system is not alone in grappling with the interaction between individual and systemic issues and how to achieve fair accountability without inappropriate blame. Similar issues run through employment and regulatory processes which carry potentially greater personal jeopardy for the practitioners involved. These must be considered alongside the clinical negligence process when considering whether a 'blame culture' exists and whether it affects medical advice and decision making. Further research may be needed to understand the impact of these processes on clinical decision making and attitudes.

Significant progress has been made in recent years in reminding all involved about the human impact of claims on patients, their families and those providing care. NHS Resolution has facilitated very powerful sessions with Nadine Montgomery, families affected by suicide and clinicians involved with birth injuries. These had a significant and lasting impact on those who attended. Such sessions highlighting the personal impact of claims are important and reinforce the need for all involved to do whatever they can to reduce incidents of harm. They also promote compassion and fairness reminding everyone that at the heart of the dispute are individuals whose lives have been affected by these events and who now share an interest in achieving early resolution without an unnecessarily adversarial attitude inflaming the situation or apportioning blame.

This attitude and culture must be carried into the claims process and reconciled with the adversarial nature of the system. It must be borne in mind when claims are presented ensuring that the role played by individuals is placed in the context of the system delivering care. The fact that the legal Defendant in a CNST claim is the NHS Trust needs to be remembered and claims should where possible focus on systemic rather than individual issues.

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

Learning lessons from the clinical negligence system is of vital importance and is at the core of NHS Resolution's approach and that of its panel. There is a huge repository of data available about the circumstances giving rise to claims. Significant progress has been made gathering, analysing and sharing that data across the service. Learning lessons from claims can be seen in a number of recent initiatives which may all inform further developments.

NHS Resolution's **Maternity Incentive Scheme** supports the delivery of safer maternity care through introducing an incentive element to trust contributions to the CNST. NHS organisations are encouraged and incentivised to meet ten key safety actions. This has brought together key partners from across the maternity system and provided an achievable and measurable process requiring the sign off of the Trust Board.

For our part we work with NHS Resolution and NHS Trusts to promote this Scheme and assist with gathering data supporting Trusts as they prepare submissions to the Scheme.

This Scheme also dovetails with and supports the Early Notification Scheme which is referred to elsewhere in this document.

Getting It Right First Time (GIRFT) - NHS Resolution has worked closely with GIRFT for several years driving improvements in care and reducing incidents of harm and costs notably in orthopaedic surgery and emergency medicine. We have assisted and supported NHS Resolution and Trusts in gathering and analysing data in relation to claims feeding into the work carried out by GIRFT. We were also pleased to work with NHS Resolution and GIRFT in producing the practice guide **'Learning from Litigation Claims'** which provides clear guidance on how learning from claims can drive patient safety improvements and so reduce costs.

Claims scorecards - NHS Resolution provide updated 'claims scorecards' annually for CNST members to help them better understand their value and volume of claims by specialty and cause, and to help target interventions aimed at improving patient safety. We regularly discuss this information with NHS Trusts to add our insight into the source of claims and how we can help reduce risk for example through the provision of further information or providing training on risk management, incident investigation and how the claims process can feed into patient safety initiatives.

We routinely provide data and analysis to NHS Trusts about the claims we work on. We analyse and report the data we hold to identify sources of claims and the steps that can be taken to minimise risk of recurrence.

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?

As set out elsewhere in this submission it is vital that incidents are investigated at the earliest possible stage and that patients are fully consulted about the issues that matter to them and assisted in gaining an understanding about what has happened and why. This plays an important part in limiting the claims process to assessing entitlement to compensation as set out above.

What legislative changes would be required to support these changes?

Section 2(4) of the Law Reform (Personal Injuries) Act 1948 should be amended to require

consideration of the provision of future treatment by the NHS and limiting or removing the ability to recover private treatment costs. Consideration should be given to whether repealing section 2(4) is sufficient or whether other areas of private provision should be limited where state funded alternatives may be possible, notably nursing care, other therapies and equipment.

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