Written evidence submitted by Kennedys (NLR0056)

About Kennedys

Kennedys is a global law firm with expertise in dispute resolution and advisory services. Founded in 1899, we have a rich history of delivering straightforward advice, even when the issues are complex.

With over 2,300 people and 43 offices around the world, including 12 offices across the UK, we are a fresh-thinking firm and are not afraid to bring new ideas to the table beyond the traditional realm of legal services.

Our lawyers handle both contentious and non-contentious matters, and provide a range of specialist legal services, for many industry sectors. We have particular expertise in litigation and dispute resolution, especially in defending insurance and liability claims.

Healthcare practice

Our national healthcare practice, spread across four locations (Birmingham, Cambridge, London and Sheffield) has over 35 years' experience representing medical malpractice insurers in England. We have also been working in the public sector acting on behalf of the NHS since 1998 when we were appointed on to NHS Resolution's clinical panel. We have one of the largest and widely respected specialist teams in this sector.

We also currently act for a number of this country's largest independent Hospital groups and specialist independent hospitals and their insurers. We are also instructed by the insurers of large professional healthcare schemes for surgeons, dentists, rehabilitation practitioners and physiotherapists. We also act for private beauty and eye clinics.

We have extensive GP experience having represented Medical Protection's GP Members. We continue to act for GPs and Allied Health Professionals through NHS Resolution's Existing Liabilities Scheme for General Practitioners (ELSGP) and Clinical Negligence Scheme for General Practitioners (CNSGP).

We provide support for all healthcare professionals before their regulatory bodies including the General Medical Council, General Dental Council and Nursing & Midwifery Council. We act for all healthcare providers at inquests.

Our global healthcare practice spans 24 of our offices and associated offices across 19 countries, with 31 healthcare partners and 153 healthcare lawyers in total.

We are committed to playing an active and constructive role in the development of policy on behalf of our clients and the wider healthcare industry. By way of example, we have coordinated indemnifiers response to the various consultations involving the personal injury discount rate.

Taking into account our extensive experience of clinical negligence claims both on behalf of NHS Resolution and the independent sector and their insurers we provide a response to the Health and Social Care Committee's call for evidence.

Response to questions

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

  We consider the evidence points to the NHS being one of the safest healthcare systems in the world. The Commonwealth Fund rated the UK first overall in respect of care process compared to 11 international countries, including the US, Canada, New Zealand, Norway and Australia in their Mirror, Mirror 2017 report.

  We observe whilst there has been a historic increase in litigation costs since 2007, total payments relating to NHS Resolution clinical schemes (excluding administration costs) decreased by £114.9 million to £2,209.3 million, compared to £2,324.2 million in 2019/20 and this in turn was a year on year reduction. Notwithstanding this reduction the sum still equates to about 1% of the entire budget for the NHS in England (Kings Fund suggesting Department of Health and Social Care planned spending in 2020/21 being £212.1 billion).

  Whilst some of this year on year reduction may be attributable to significant measures employed by NHS Resolution to resolve claims quicker and maintain matters outside of proceedings, there remains the concerns highlighted in the National Audit Office (NAO) report of 7 September 2017 – 'Managing the costs of clinical negligence in trusts'. The NAO concluded the Department of Health and Social Care and NHS Resolution had only "limited control over many of the factors influencing those claims" and suggested a coherent cross-government strategy underpinned by policy was required to tackle the rising costs of clinical negligence litigation.

- **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?**

    Alongside promoting the importance of a just culture within organisations, removing blame from any failure, we consider greater collaboration between patients who have been

harmed, their legal advisers, compensators and the organisations or individuals providing the care is vital to promote learning and avoiding the same problems being repeated.

We endorse a move away from the adversarial litigation process, encouraging more mediation and dispute resolution. This should also include, crucially, the patients, their relatives and the clinical leads from the treating organisations, jointly scrutinising the evidence to establish not only what went wrong but how it can be improved for the immediate future.

We promote the drafting of an agreed 'outcome report', setting out lessons learnt, including an audited roadmap of next steps which highlights changes required, where appropriate. This outcome report should be reviewed after six months, with evidence to be provided of improvements and changes where relevant. This is similar to the Regulation 28 reports which can be requested by Coroners following an inquest although the difference here is they are drafted and agreed by the key stakeholders in the case. The report should then be shared within the organisation and, where appropriate, wider – such as to the Royal Colleges and Universities. Issues which have wider relevance across healthcare providers should be shared. There is no mechanism for doing this on claims (for example, similar to National Reporting and Learning Systems).

One of the crucial requirements to promote learning is early intervention. The ability to prevent repetition of adverse incidents is diluted if the incident being investigated is historic (say, over two years old) as the systems may have changed since then; memories will have faded; and the medical professionals involved may have moved on. Accordingly, to effectively promote learning, we endorse the expansion of the Early Notification Scheme (ENS), currently being utilised by NHS Resolution for incidents involving injuries at birth. We recommend an expansion of this scheme to include incidents concerning catastrophic injuries and those involving some fatalities (see below).

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

We propose a more effective and better managed complaints process could potentially avoid claims if patients received adequate explanations to their complaints. We do not think NHS Trusts have sufficient resources to manage complaints as effectively as they could, which leads to patients seeking legal redress.

Equally, a better complaints process where a patient is satisfied with their response but still seeks compensation will engender a more collaborative approach than a patient who enters litigation as a result of their dissatisfaction with the Trust complaints process.

We also consider an expanded pre-action protocol which promotes early engagement between parties solicitors, collaboration and not an adversarial process. It should include exchange of the parties evidence, stock-take discussions between the parties at different stages with the aim of working together to achieve resolution. The claim would progress through a pre-action process that effectively keeps the claim outside formal litigation. We support the process which was explored by the Civil Justice Council's Working Party for Fixed Recoverable Costs (see Chapter 3 and Appendix I of the Report – 'Fixed recoverable costs in lower value clinical negligence claims' - dated October 2019).

Within the current litigation system we consider joint quantum experts (rather than each party instructing their own quantum expert) would simplify the quantification of damages.

We consider NHS Resolution's Early Notification Scheme is a good example of how early engagement facilitates greater collaboration and resolution of liability.

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

We agree greater collaboration between patient and defendant legal advisors would lead to early and constructive engagement between parties.

We have been working with NHS Resolution and a patient law firm on a confidential pilot project that has involved joint training between both parties legal advisors on working collaboratively and what that means in practice. The project has encouraged early communication by telephone between legal advisors to agree a 'road map' for the management of the claim. There has been a focus on legal advisors speaking to each other to break down barriers and engender trust in the relationship. We have focussed, at the pre-action stage, on early without prejudice exchange of evidence, early meeting of experts to determine liability and Early Neutral Evaluation with the aim of achieving resolution at the pre-action protocol stage. This project has shown that the building of trust between the parties generates greater collaboration.

The Clinical Negligence COVID-19 Protocol between NHS Resolution, Society of Clinical Injury Lawyers and Action against Medical Accidents is an example of how the three organisations have worked together to change working practices in the middle of a pandemic. The group involved in this Protocol have built up trust and are continuing to work collaboratively with the aim of collaborating beyond the pandemic.

As we state above, if the pre-action protocol was amended as proposed by the Civil Justice Council's Working Party we consider this would strengthen collaboration between legal advisors and facilitate engagement between the parties as it is built into the process.

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

We endorse the expansion of NHS Resolution's Early Notification scheme (ENS) to other injury types. We do however recognise resources are not available to adopt such a scheme for all medical incidents, but consider an expanded scheme could cover those concerning catastrophic injuries and certain fatalities - whereby a medical examiner and/or a Coroner has identified failings and/or lessons to be learned, which are reported into an ENS portal.

The ENS approach promotes excellent collaboration with all interested people and as the cases touched on concern incidents which have recently occurred, the patients, their relatives and the healthcare professionals concerned are able to better recount what happened, why and how it occurred. This produces rich evidence for improvements and learning and encourages collaboration, leading to better outcomes for patients, with swifter and more effective resolution outside the traditional litigation process.

Of course, ENS is not an enforceable scheme and remains voluntary only, leaving conventional litigation available to Claimants. For those cases which fall under the (expanded) ENS, we would endorse statutory provision that ensures each investigation undertaken within ENS is allowed to be completed before any party is permitted to go down the more conventional litigation route, placing an effective stay on proceedings. We would endorse cost penalties for those who choose to bypass the ENS process and instead unreasonably incur costs under the conventional litigation route.

- **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 strongly favour the introduction of fixed recoverable costs. Defendant legal advisors acting for NHS Resolution and currently working on claims up to £250,000 in damages have fixed/capped fees. We consider a model could be implemented to introduce fixed recoverable costs at different levels for damages up to £250,000.

  Without the introduction of fixed recoverable costs there is no scope to regulate this part of the legal market which represented £448.1m in NHS spend (see Table 1, page 15 of NHS Resolution published accounts dated 15 July 2021).

  Fixed recoverable costs should also look to regulate expert fees.

- **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 experience, it is both the adversarial nature of the current clinical negligence system as well as the underlying human element of all clinical negligence claims that contribute to a "blame culture" which in turn can affect medical advice and decision making. Trust is understandably placed by individuals and/or their family in medical professionals. Through one means or another, whether by mistake, an accident or communication errors, if an individual has been harmed, perhaps irrevocably and potentially in a life changing way, this in itself creates a very emotive atmosphere with that individual or their family often seeking to attribute blame for what happened.

  In our experience, this can lead to medical professionals taking a more guarded approach to treatment, potentially hindering more progressive medicine.

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

It is clearly important that any clinical negligence system encourages lesson learning and commitment to change as the result of any action.

Early reporting is the key to improving a clinical negligence system, which is tried, tested and already contributes to better patient care, via learning and the desire to improve.

Investigation pre-action and engagement with staff already encourages lesson learning and change. There is however scope for improvement.

In our experience, learning lessons is about healthcare professionals being open to reflecting on "good practice". Clinical negligence provides structure for determining failures, asking difficult questions, without blame, listening and, at its best, developing a strategy to avoid future adverse events.

Fair and open investigation avoids legal proceedings. However, clinical negligence still allows opportunity for redress if this fails with an opportunity for rebuttal from healthcare professionals where valid.

Clinical negligence data evidences local, regional and national trends. The Getting it Right First Time initiative, built on such data, is being listened to and bringing positive change.

We work with governance within healthcare organisations, who we represent, to provide data from claims and assist in setting the focus for Boards to bring about change.

We have found clearly defining what is required, evidencing past financial impact, communicating with the Board, developing training and providing support for bringing about change has been well received by the NHS Trusts that we represent. It is the clinical negligence system that is the basis upon which the above is built.

- **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?**

With reference to our responses to the questions above we highlight the benefits of greater collaboration between patients, their legal advisors, compensators and the organisations or individuals providing the care. This we consider is essential to help move away from a blame culture and is vital to promote learning and avoiding the same problems being repeated.

We also reiterate the important role that schemes such as the Early Notification Scheme can have in shifting away from a culture of blame to one of learning and improvement.

Again, with reference to our responses above we support a move away from the adversarial litigation process in clinical negligence claims - where blame is often an inextricable element - to one that encourages more mediation and dispute resolution which include, crucially, the patients, their relatives and the clinical leads from the treating organisations. We consider that this approach will help all concerned to establish what went wrong and importantly provide patients and relatives with reassurance that steps will be taken (and what those steps are) to learn from any failures and to implement improvements.

Medical professionals and NHS Trusts are encouraged to say sorry to individuals and families when an incident occurs. This can be a big step towards alleviating any sentiment of blame. NHS Resolution has published its 'Saying sorry' guidance, which highlights the importance of a sincere and meaningful apology.

- **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?**

The Healthcare Safety Investigation Branch (HSIB) has demonstrated its skills and expertise in the investigation of maternity incidents since 2018. The Health & Social Care Bill currently before Parliament provides HSIB with powers of entry, seizure and inspection for the purpose of investigating any – not restricted to maternity - qualifying incident that may have implications for the safety of patients. It will be up to HSSIB itself and the Secretary of State to determine those qualifying incidents but access to the latest patient safety and claims data may assist in identifying those incidents, or types of incidents, that would benefit most from HSSIB's investigatory scrutiny.

The Bill contains a prohibition on disclosure of material collected during the course of investigations and reports will not be admissible during civil proceedings except by Court Order. However, under current drafting, HSSIB final reports will be required to contain a statement of findings of fact and an analysis of those findings as well as recommendations. This in itself could provide answers for patients and their families at an early stage and without recourse to litigation. Further this statement of facts could form a factual platform for discussions between the patient, their family and the healthcare provider to discuss any safety and learning recommendations and any other non-financial remedies.

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

Claims inflation has become unsustainable over the past few years. The number of medical malpractice claims have generally levelled off but the value of damages have continued to increase. This is due to a number of factors influencing claims inflation outside the governance of claims. These include life expectancy increasing, more expensive medical treatments and reductions in the discount rate. Other jurisdictions have introduced laws and amended legislation to manage clinical negligence claim values. These include tort reforms in Australia in 2002 and 2003, which introduced ceilings on recoverable damages such as loss of earnings. These reforms have been effective in reducing the threshold of damages in medical malpractice claims but still allowing patients to be adequately compensated.

Legislation would therefore need to be introduced to replace common law in respect of damages and in particular how quantum is determined. Such legislation would limit certain heads of claim such as care and loss of earnings.

We propose changes to current legislation with the repeal of Section 2(4) of the Law Reform (Personal Injuries) Act 1948, which provides that: "In an action for damages for personal injury (including any such action arising out of a contract), there shall be disregarded, in determining the reasonableness of any expenses, the possibility of avoiding those expenses or part of them by taking advantage of facilities available under the National Health Service Act 2006 or the National Health Service (Wales) Act 2006 or the National Health Service (Scotland) Act 1978, or of any corresponding facilities in Northern Ireland". We consider this substantially inflates damages paid in clinical negligence claims. Available NHS treatment is ignored for the purpose of quantifying damages.

It would also be necessary to introduce changes to the Civil Procedure Rules and Clinical Negligence Pre-Action Protocol for the Resolution of Clinical Disputes to allow claims to be managed in a more efficient way to ensure exploring of early redress and to reduce costs.

Oct 2021