Written evidence submitted by Evidence from the Association of Optometrists ('AOP') (NLR0057)

Introduction

The AOP is the membership body for optometrists and dispensing opticians, including those owning and running independent optometric businesses and represents over 82% of optometrists practicing in the UK. As part of their membership fee, AOP members are provided with indemnification against clinical negligence claims, with AOP's team of in-house lawyers providing legal support and representation on behalf of the insurer. The claims costs arising from the provision of member indemnification are met via an insurance policy underwritten by a commercial provider. Due to our claims handling role and close working with the insurer, we have considerable experience both in the impact that clinical negligence claims have on members and the financial arrangements around such claims.

Impact of litigation on learning

Supporting learning and improvement in clinical practice is central to the mission of the AOP. Much of our work involves producing policy and clinical guidance for our members and we run the largest programme of post qualification CPD education in the optometric sector. We are therefore deeply committed to the idea that all adverse clinical incidents should be used as opportunities to learn and improve practice. While the current system allows space for personal development and reflection, something that we advocate to our members at the onset of a clinical complaint, it still promotes an inward-looking, and occasionally defensive, culture. A system without such high jeopardy would help to promote a culture of information sharing and improvement that would allow clinicians to learn from the mistakes of others.

Regulation in the sector currently focusses almost exclusively on the individual practitioners rather than the entity that employ them, and we believe this doesn't allow for proper consideration of practice or system failures when it comes to improving the practice of optometry as in turn the protection of the patient. Those same issues apply in litigation and this, together with the fact that the sector includes a high percentage of practitioners who are employed on a locum basis rather than as employees, can result in a conflict between the priorities of the business owner - be it protecting their customer base, their customer service or their brand - and that of the individual who will ultimately face any regulatory or civil action. It is therefore not infrequent for a business being approached for information relating to a clinical negligence claim in relation to clinical work undertaken by one of our members to make an immediate admission in such a way as to protect their own reputation and to deflect responsibility onto the individual concerned. There is no doubt in our experience that the threat of litigation produces a blame culture and is an obstacle to learning.

The interaction that sometimes exists between litigation and regulation also provides an obstacle to learning. It is not uncommon for action by the regulator to be used as a precursor to civil litigation. We always have to bear in mind the possibility that evidence submitted to demonstrate insight to the regulator, may also be used in any subsequent civil action against the practitioner. That may in some cases militate against early admission of failings and clinical learning. There is also a clear tension between the need to avoid making legally damaging early admissions and the expectation placed on the individual practitioner to observe a duty of candour and to engage in reflective practice at the earliest possible juncture.

Financial burden

The potential for being subject to a clinical negligence claim creates a significant financial burden on professionals delivering optical care. Unlike healthcare practitioners working in the NHS, our members do not benefit from the deep pockets of a state backed insurance scheme. Instead, the burden falls to those practising in the sector via private insurance costs. Retrospective analysis of settled claims we have handled in respect of our members shows that of the total amount paid out on civil negligence claims, nearly 40% of the total incurred amount was paid in respect of claimant legal costs. In some cases, the claimant legal costs are 500-600% the value of damages that the claimant received. In other words, the legal costs paid have been 7-9 times greater than the sum due to the claimant for the damages suffered. This suggests a system that is not providing for those that have suffered harm, but instead is providing a lucrative income stream for claimant legal firms. Because of the potential for businesses to pass on the responsibility for any claims made to individual practitioners, even where members are not business owners or locums, most consider it is prudent to continue to hold their own individual indemnity insurance.

Research suggests that between 2005/06 and 2017/18 the cost of litigation in regard to NHS delivered ophthalmology rose from circa £5m/year to circa £20m/year. While these costs are not directly analogous to those experienced by our members, this trend is reflected within the optometry sector where additional cost has been introduced into the system over time.

There has been a hardening of the insurance market in recent years and this combined with a limited number of insurers willing to provide professional indemnity and negligence cover results in increased costs. This is not particular to the optics market: similar features have been observed in other areas of healthcare and other professional insurance markets (law firms are finding it increasingly difficult to gain insurance against negligence claims against lawyers). There is therefore a risk that any changes to increase the likelihood of such claims arising and proving successful might have a devastating financial effect on our members and, indeed, risk them being unable to secure the insurance cover necessary to be able to practice. So, for example, should there be any attempt to reduce the threshold by which claims can be judged, the impact on the profession could be very profound, unless that reduction in threshold were to be accompanied by moves to limit the value of such claims.

Impact on innovation

Because of the way in which indemnity is provided within the profession, the risk of a claim for clinical negligence arising also acts as a brake on innovation in the sector and threatens the wider strategic objectives of Government health policy. Given the post-Covid hospital waiting lists for eyecare services, there is an explicit move within the NHS to contract more eyecare services out from hospitals into the community. Optometrists are trained health professionals entirely capable of managing pre- and post- cataract patients, for example, or dealing with cases involving glaucoma.

This evolution of the optometry clinical care model changes the risk profile of the patients seen by our members. The increased risk posed by some of the patients who are currently dealt with in a hospital setting but now will be dealt with in the community is likely to be accompanied with a further rise in insurance costs, a burden which will once again fall upon optometrists who do not benefit from a state backed insurance system. If the cost of insurance continues to rise, it risks stifling the ability of practices to evolve in their scope of practise, explore new ways of working and to invest in technology which enables this, ultimately inhibiting progression and improvements in productivity.

Reform to litigation model to reduce cost/increase speed

The invitation to submit evidence asks for suggestions as to how the current system can be reformed to reduce cost and increase speed. As an organisation which represents defendants of such actions, while we are open to examining potential reforms, we do not believe that any such changes should be at the expense of ensuring that defendants have the right to have full disclosure of what is alleged against them and the appropriate time and support in responding to those allegations.

On specific changes, the current litigation system is heavily weighted in favour of the claimant and, as noted above, the settlement of clinical negligence claims includes a payment of claimant solicitor costs which are in some cases wholly disproportionate to the settlement itself and as such we are very much in support of moves to limit costs via mechanisms such as the introduction of fixed recoverable costs for both parties and the removal of Qualified One-way Costs Shifting (QOCS).

We also consider that it would be proper to revisit mechanisms for limiting the level of compensation awarded to recognise the availability of free healthcare for those who have been damaged. While we are acutely aware of the level of suffering which many victims of clinical negligence have to endure and are not questioning the levels of compensation awarded for pain and suffering, loss of earnings etc, there is a question of the appropriateness, 75 years after the creation of the NHS, of continuing to require those quantifying compensation levels to disregard the availability of free healthcare. This is particularly the case in the face of evidence from bodies such the Law Commission, who concluded that "our own empirical research shows that only a very small percentage of claimants use private medical treatment exclusively, although a significant proportion receive some private care" (Law Com No 262). We therefore believe that it may be time to review the provisions of S2(4) of the Law Reform (Personal Injuries) Act 1948.

Specific consultation questions

Turning to the specific questions asked, the AOP's position is as follows:

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

The AOP supports any changes which serve to reduce cost for providers of healthcare services, either by creating mechanisms for limiting claimant legal costs or by reducing the value of compensation awards to recognise the availability of free healthcare via the NHS.

- **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?**

Measures to encourage and support personal reflective practice and systemic learning would be welcome. Shifting the balance of regulation and clinical claims away from the individual and more towards the entity would also be vital.

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

The AOP supports any proposals to speed the redress process. However, such changes should not be at the expense of allowing defendants adequate time and support to prepare their cases.

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

Optometry practice is not part of such a scheme. Extending such schemes to optometry would require the introduction of a system of electronic information sharing with the mainstream NHS, a move which we would thoroughly support.

- **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 clinical negligence cases?**

We support the current proposals.

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

As a membership organisation dealing with clinical negligence cases (among other matters) we are acutely aware of the pressure on members accused of clinical negligence. It is certainly the case that in many instances our members report feeling part of a blame culture.

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

We routinely advise our members to engage in active reflection about their part in any incident, both to improve their own professional practice and because it is a discipline which is required of them by the regulator. However, the current system makes systemic learning more difficult, with little or no mechanism for institutional learning beyond the individual involved.

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

The learning mechanisms currently in place are focussed largely on the secondary care system and impinge only slightly on private healthcare providers such as most optometrists. If learning is to be achieved, the place of such primary care and predominantly private providers such as optometry needs to be considered seriously by the NHS.

- **How can the Healthcare Safety Investigation Branch work to improve short-term responses to patient safety incidents and therefore reduce the number of those who are forced to pursue litigation as a means of obtaining non-financial remedies?**

N/A

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

Consideration should be given to revisiting S2(4) of the Law Reform (Personal Injuries) Act 1948.

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