Written evidence submitted by Bevan Brittan LLP (NLR0058)

This is a response to the Committee Call for Evidence in respect of NHS Litigation Reform.

Bevan Brittan LLP is a law firm with extensive experience in providing legal advice to the NHS and the health sector. We operate a specialist clinical negligence team and are current members of NHS Resolution Clinical Negligence legal panel.

Summary

- The current financial cost of NHS Litigation is high in both financial and personal terms for the patients, families and NHS Staff who are affected.
- Support for NHS Trusts to deliver early and co-ordinated management of concerns arising from adverse outcomes to patients with fair and empathetic engagement with patients and staff is likely to reduce litigation and "blame" and improve opportunities for learning and avoiding the same problems arising again.
- Improved access to alternative dispute resolution processes closer to the point of incident and before litigation is commenced is likely to result in earlier and quicker resolution.
- The development of the Pre-Action Protocol for Clinical Negligence to provide opportunities for resolution without litigation should be encouraged and can be achieved through further collaboration between claimant and defendant representatives.
- We support the development of Fixed Recoverable Costs to manage the cost of litigation.
- Developing better collaboration between Trusts, HSIB, NHS Resolution and Claimant lawyers and patient organisations can lead to more effective and empathetic engagement with patients and their families, process improvements and thereby reduce delays and cost and provide greater opportunities for learning.

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

The Committee has noted that the cost of settling claims and paying legal costs in 2020/21 was £2.26 billion.

According to the Kings Fund planned spending for the Department of Health and Social Care in England was £212.1 billion in 2020/21 including more than £60 billion of extra funding in response to the Covid-19 pandemic. On any analysis the proportion of spend on NHS litigation is significant. It has a direct impact on the funding available for patient care and whilst others are better placed to assess questions of financial sustainability, any reduction in cost of litigation will benefit patient care. However, in managing clinical negligence claims for the NHS we can attest to not only the high personal cost to patients and their families who have been harmed but also the impact on staff delivering care where poor care results in an adverse outcome and litigation results. Whilst only 0.3% of cases are resolved at a trial, the engagement of healthcare staff in the litigation process takes healthcare staff away from frontline duties and is a source of significant personal distress. At worst it results in healthcare professionals leaving the profession. This is a hidden but real cost of litigation.

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

In the context of maintaining a balance between fair resolution and access to justice for patients and protecting resources for patient, we consider that there are changes that could be made to improve the process of dispute resolution where patient harm has arisen.

Litigation is increasingly regarded as a remedy of last resort but a more collaborative and empathetic process of engagement with patients, their families and their lawyers at an early stage and better access to alternative methods of dispute resolution could do more to resolve cases quickly.

Our experience is that many legal services, complaints and PALs services are under-resourced and struggle to keep up with the demands of a multiplicity of investigative processes, inquests and litigation leaving them unable to take a pro-active approach to identifying issues, engaging with patients and their families and developing actions to prevent incidents occurring again. The interface between trust and patient is the starting point in a chain of events where every effort should be made to focus on resolution rather than litigation. We would support changes which :

(a) increase investment in the development of skills and resource at NHS Provider level
(b) facilitate the appointment of a patient liaison officer for all cases where serious harm has occurred to maintain communication and answer questions
(c) provide greater access to mediation/ADR services at a pre-action stage which is closer to the point of incident.

In particular:

(a) 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?

As acknowledged by the National Audit Office 2017 report[1], it takes on average two to three years for a patient or their representative to notify NHS Resolution of a claim following a clinically negligent event. The opportunity for learning is significantly compromised by this delay. However, building on the duty of candour requirements and undertaking appropriate investigations where things go wrong at NHS Provider level enables early learning and feedback on the causes of harm to take place. It also improves the opportunity for engagement with patients and their families so that earlier decisions can be taken about whether compensation may be payable.

Compensation can be awarded without litigation and more early collaboration with pre-action access to alternatives to litigation (whilst preserving the right of the patient to seek legal redress) also increase the opportunity to focus on redress beyond financial compensation. We know that claims can be motivated by the patient wanting to avoid the same thing happening to someone else and therefore a dialogue about avoiding future harm can be a valuable part of the process.

If litigation cannot be avoided, the legal process itself cannot do more than decide whether there has been negligence and to make an appropriate assessment of damages. However, there are opportunities to build on the expertise of the NHS Resolution and its Safety and Learning team and to take the learning from clinical negligence cases as part of the NHS claims handling process and avoid the same problems being repeated elsewhere in the system. Their work already includes close working with NHS Providers to provide feedback on claims and the publication of thematic reviews and case stories and joint working with GIRFT. This could be expanded and a key improvement would be to ensure that this work and the learning from claims is effectively incorporated into the wider NHS Patient Safety Agenda. This might include the development of additional incentive schemes, building on the Maternity Incentive Scheme, to link pricing for NHS Provider indemnity to patient safety initiatives.

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1 Managing-the-costs-of-clinical-negligence-in-trusts.pdf (nao.org.uk)

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

We consider that greater focus on simple pre-action processes (see below) and alternative dispute resolution can help ensure that patients receive redress more quickly. The following process improvements could be included:

1 **Improved access to medical records** - considerable delays occur in the investigation of claims where the parties are reliant on obtaining paper medical records and imaging or where digital data cannot be accessed. Support and investment in centralised digital records which can be securely held and easily accessed will reduce delay.

2 **Appointment of Patient Liaison Officers** – where initial investigations suggest that patient harm has occurred, the nomination of a liaison officer, as noted above could help maintain communication and provide support. Where this has been provided we know it has been valued by the patient.

3 **Process co-ordination** - Clinical negligence investigations form part of a multiplicity of processes (including inquests, complaints and investigations by the PHSO). Improved resourcing of complaints and legal services departments and better systems for data capture and triangulation between processes could minimise duplication in inquiries and improve information sharing as well as flagging up cases where a patient may be entitled to compensation. The NHS Resolution inquest scheme already assists in co-ordinating the management of claims and inquests and is a helpful model.

4 **Access to pre action dispute resolution processes** - Recognising that redress can encompass more than financial compensation and that an apology and an explanation are an important part of redress for an injured patient, we endorse the provision of access to processes which may avoid a claim being litigated. Pre action mediation services and point of incident mediation, as well as access to early neutral evaluation can offer simpler and therefore fast methods of resolution. Direct access to an approved service by NHS Trusts may be beneficial. We note that NHS Resolution already manages a mediation service and we support the development of this to incorporate suitable cases at a pre-action stage.

5 **State Funded Provision -** a simplification of the quantum assessment process that would facilitate earlier care and support could be achieved by potential claimants being supported to access benefits and state funding to assist with equipment, therapies, accommodation and health and social care. Support should also be readily available to ensure that families caring for patients have a carer's assessment. The current system provides for a once and for all award of compensation where to protect the Claimant's interest it is necessary for their advisors to typically seek to "maximise" the award of damages. Where the compensation is publically funded we support the view that it is reasonable to expect the Claimant to mitigate their loss by accessing state funded provision. The current system does not provide protection against double recovery with Claimants receiving an award of compensation on the assumption that all care and support is privately funded when in reality, and because need is never entirely foreseeable, recourse to NHS and social care may be required in any event. With the availability of direct payments and an existing assessment infrastructure for care funding through NHS Continuing Healthcare, a package of care and support can be provided to meet the needs of the patient without waiting for litigation to resolve or an interim payment. A personal health budget can provide choice over the services and care that are received.

Reform could include provision to extend continuing healthcare provision to cover social care requirements where appropriate. Provision to meet the patients' needs would not therefore need to wait for resolution of the litigation or for an interim payment award to be made to ensure that needs are met. Such a process would significantly reduce the heads of loss where care and case management costs make up the majority of the value of cases with significant future needs. Such a process would also offer Claimants the opportunity to have regular assessments of need. The current system is predicated on a once and for all settlement with experts being required to make predictions of life long need which must inevitably prove to be inaccurate. Whilst periodical payments provide the security of life long payments for care the assessment of the cost of care will inevitably be unsatisfactory either over compensating or under compensating the Claimant. Where a Claimant needs to secure accommodation which is suitable for long term disabled living with accommodation for carers and equipment the assessment of future need bears little relationship to the actual expenditure due to the need to divert funds for the purchase of accommodation.

State provision could be brought into account by extending scope of the Compensation Recovery Unit reporting of state benefit provision. Deduction of state funded provision could occur as a matter of course and avoid double recovery.

6 **Quantum Assessment -** Where redress requires financial compensation, the assessment process is often protracted due to the need for multiple assessments by a range of experts including medical experts advising on causation condition and prognosis and non- medical experts advising on care costs, therapy needs, accommodation, deputyship costs, assistive technology etc. Greater use of single joint experts could resolve cases more quickly and reduce the adversarial nature of quantum assessment.

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

NHS Resolution has already successfully developed a protocol for the management of clinical negligence claims during the Covid-19 pandemic. There is scope to build a more effective culture of collaboration and to develop further protocols to manage both pre action and litigation processes.

Reform/overhaul of the current pre action protocol for clinical negligence could strengthen collaboration between legal advisors by setting expectations. The introduction of letters of notification to give early warning of a claim has been helpful but could be extended.

The clinical negligence pre action protocol was developed through a collaboration between claimant and defendant lawyers and has been successful in establishing a process for early investigation and have contributed to a high rate of pre action resolution (74.7% of claims were settled without formal Court proceedings in 2020/21 compared with 71.5% in 2019/20). An extension of the pre action protocol to permit or facilitate pre action ADR where (if both parties agree) and/or pre action quantum assessment could offer a simplified process.

Such a process might include provision for:

Defendant pre-action offers: Defendants to make an assessment of damages and an offer to the Claimant where liability is admitted before the Claimant is permitted to issue proceedings. This would be an extension of the current pre action protocol which provides the Defendant with an opportunity to respond to the claim before issue of proceedings with adverse cost consequences for non-compliance.

Use of single joint liability experts – one significant reason for litigation taking time to resolve is the use of experts by each side followed by a process of joint meetings and ultimately Court adjudication between the

experts. Balancing the challenge of an adversarial process in ensuring that public funds are appropriately deployed and against the benefits for patients and healthcare staff in early resolution, a greater number of cases could be resolved by the appointment of a single adjudicating expert (with the opportunity for each party to put questions to the expert). Use of a single expert at a pre-action stage and as part of a pre-action protocol process could be effective in lower value cases within a protocol framework which ensured a fair process for all parties.

Pre-Action Mediation/ADR - Provision for Pre-Action mediation/ADR in suitable cases with cost consequences for issuing proceedings without engaging in a dispute resolution process.

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

The key feature of the Early Notification Scheme is that investigations are commenced where defined criteria are met which indicate that the claimant may be entitled to compensation for their injury. An early decision can be made by NHS Resolution as the compensating authority as to whether they wish to make an admission of liability and an offer of compensation.

An expanded Early Notification Scheme would require careful consideration of suitability with defined criteria in order to achieve a balance between fairness and cost. At this stage in the development of the Early Notification Scheme, it may be premature to extend it. Any new scheme is likely to be suitable for high value complex claims, potentially spinal/neurological claims, neonatal or paediatric claims or frequently seen claims such as pressure ulcers, laparoscopic cholecystectomy cases.

Cases where there is a serious untoward incident or the duty of candour has indicated that there is a concern over service delivery could be suitable triggers for an expanded scheme. It is unlikely that such a scheme would be proportionate in lower value matters where there “may” be a claim. This could lead to an increase in claims and it is likely that existing triage processes by experienced claimant’s solicitors firms who produce detailed letters of claim supported by expert evidence are a more effective way of achieving efficient and transparent resolution.

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 support the introduction of fixed recoverable costs (FRC) in clinical negligence cases with a damages value of up to £25,000. We are aware of the data that indicated that in claims under £25,000 claimant recoverable costs are on average 220% of damages awarded. In our view this is unsustainable and diverts finite funding away from frontline services and patients. We were involved in the initial stages of the original Law Society core working group on FRC, whose work ultimately went on to inform the Civil Justice Council’s 2019 report on fixed recoverable costs in lower value clinical negligence claims.

We are aware that the question of the level of FRC in cases with a value less than £25,000 is complex and contentious, with much depending on the process that is agreed to deal with these cases. Much work has previously been done by the Law Society and the CJC. If the pre-action process set out in chapter 3 of the CJC’s report is adopted, including the proposal for a twin track approach (standard track and light track) leading to stock take and mutual evaluation, then we would endorse the defendant group’s proposed FRC figures set out at paragraph 5.16 of the CJC report, namely:

Standard track

Stage	Description	FRC
1	All steps up to and including stock take	£5,500 plus 20% of agreed damages
2	From stock take up to and including mandatory mutual evaluation	£500 in addition to stage 1.

Light track

Stage	Description	FRC
1	All steps up to 21 days after letter of response is due	£1,000 plus 10% of agreed damages
2a	From 21 days after letter of response up to and including stock take	£500 in addition to stage 1.
2b	From stock take up to and including mutual evaluation	£500 in addition to stages 1 and 2a.

Exemptions

We consider that the following clinical negligence cases should be excluded from any FRC regime:

- Damages above £25,000
- Limitation is raised by the defendant as an issue
- There are multiple defendants
- There are more than two experts required
- Stillbirth and neonatal death cases
- Cases involving protected parties, save that cases involving children under 18 who would not otherwise be a protected party should be included subject to a bolt-on fee to cover the need for additional work, e.g. an infant approval hearing.
- Inquest representation

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

To succeed in a claim for clinical negligence, the current system requires a claimant to establish fault. Although, there may be a minority of claims in which the fault is a system related failure, in most claims the fault is personalised to either an individual practitioner (or a group of individual practitioners) who are accused of making an unacceptable mistake and are to blame. Blame is a necessary component part of success for a claimant.

As a result, it would be difficult to argue that the need to establish fault, does not play *some part in the perpetuation of a blame culture in clinical practice*. However, there is some evidence that the current clinical negligence system is already becoming less adversarial. With targeted early intervention and assessment of cases, entrenched positions can be avoided by the parties to a dispute by identifying common ground and addressing points of issue in a non-adversarial way. Particularly since the start of the pandemic, parties have been taking a collaborative approach and engaging in the full range of ADR options, with positive feedback and a reduction in the number of cases progressing into litigation.

However, the extent to which the current system affects medical advice and decision making is more arguable. The clinical negligence system is only one part of a range of processes bearing down on clinicians involved in everyday practice and there is often a significant time lag between the episode of care in question and a claim. By contrast, the threat of regulatory oversight by the GMC, NMC etc. as well as the

range of investigatory and disciplinary processes which are triggered by an adverse incident much closer to the point of care, will also have a significant and arguably greater impact on advice and decision making. The number of those incidents which progress into formal claims would be a very small percentage indeed.

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

Whilst clinical negligence *litigation* is limited in its ability to encourage lesson learning and commitment to change, the overall clinical negligence system involving NHS bodies, NHS Resolution, Medical Defence organisations and NHS staff does have an important role to play in encouraging lesson learning and commitment to change as a result of litigation. NHS Resolution has already made a clear commitment through the establishment of its Safety and Learning team, its work with GIRFT and its Members. Where it can, the system should encourage learning but it must be remembered that there is always a time lag between incident and claim and there is therefore more value in learning on a cohort basis, through thematic reviews and using data between defined dates.

Learning is very important to patients and their families when their care goes wrong. Feeling that nothing has changed can motivate a claim. Learning lessons is also important for the well-being and morale of the staff involved. Health workers who see the same things happen time and again without any changes can become demoralised, disengaged or even leave the profession which results in a depleted workforce which in itself can give rise to more failings in care.

Learning lessons to avoid repeat occurrences and to reduce the overall patient harm also has the obvious clear financial benefit of reducing the cost of clinical negligence claims and providing more funds for patient care.

As noted above, it is important that lessons learnt from litigation forms part of a coherent patient safety strategy for the NHS with clear incentives and resourcing to implement change. NHS providers and clinical leads struggle with a multiplicity of recommendations, making it difficult to prioritise and implement recommended changes in a systematic and effective way.

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?

Few cases come to trial and so reform of the clinical negligence process to avoid entrenching the feeling of being blamed must include changes early on in the process. The downside of getting it wrong is (i) defensive medicine characterised by over-testing ("I must not miss anything") and by choosing not to treat the most complex, and therefore riskiest, patients (too dangerous something might go wrong). (ii) Individuals become resistant to reporting errors, meaning that incidents are not investigated, underlying causes are not exposed and no learning can occur for others. We know that this is not just a UK problem, Lucien Leape said in testimony to a congress in the US "*the single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes*".

We consider that we need to focus on system based investigation which can potentially then feed into early resolution through methods such as an extended Early Notification Scheme, or pre-action processes through protocols or Trust based resolution dispute procedures following duty of candour. We know that the multiplicity of processes and getting asked the same question for the complaint, the inquest, the HSIB interview and finally, the claim reinforces feelings of being blamed by staff. We advocate going back to "to err is human".

In encouraging system based investigations, inquests can, for example, offer good opportunities to understand what went wrong and learn from the incident and to give the families a chance to understand what happened and be reassured that things have improved. We favour a review of inquest funding to avoid the current system whereby claimant's solicitors have no alternative but to threaten a clinical negligence claim in order to recover the costs of representation at the inquest thus shifting the inquest system into an adversarial space.

We also highlight the difference in approach between hospital staff and primary care practitioners. The extension of Crown Immunity for NHS hospital staff was a positive step in the right direction as the individual hospital clinician is not named in the proceedings and accountability is not linked to concerns about indemnity. The introduction of the Clinical Negligence Scheme for General Practice (CNSGP) provides an opportunity to develop a similar approach for primary care practitioners who in addition to facing litigation or other processes experience the trauma of seeing their names on public court proceedings. We recommend developing an approach which discourages parties from naming individual primary care practitioners as Defendants. This is likely to generate more honest reflection to identify the mistakes made (by them and by others) so that the process and culture of treating all incidents as an opportunity to learn can work in practice.

How can the Healthcare Safety Investigation Branch (HSIB) 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?

HSIB already works closely with families and involve them in their investigations. Support for them to expand their work to investigate patient safety incidences would support the provision of explanations to families who have been affected. Those who have suffered a significant financial impact as a result of their injuries may have no choice but to make a claim. However, where there has been a patient safety incident, HSIB can help avoid the relationship between the patient and their family and the trust becoming polarised at an early stage. Timely investigations, clarity around the scope of the investigation and its terms of reference (which do not include addressing questions of negligence) with progress updates can help both the family and the trust and may avoid early recourse to litigation due to frustration. Signposting families to services and resources that can provide support would also be valuable.

NHS Resolution already works collaboratively with HSIB and is able to review their reports in respect of birth injury cases. This provides an opportunity for early investigation and potentially an early admission of liability or indication that compensation will be paid without the need for the patient or their family to pursue litigation.

Closer collaboration across a greater range of patient safety incidents would provide more opportunities for NHS Resolution to take a pro-active approach to ensuring that a claimant with a valid claim in negligence receives appropriate compensation as close to the point of incident as possible and that the compensation is fair.

What legislative changes will be required to support these changes?

Repeal of Section 2(4) of the Law Reform (Miscellaneous Provisions) Act 1948 would be required in order to address our recommendation that claimants should mitigate their loss by accessing state funded provision.

This provision provides that in an action for damages for personal injuries (including any such action arising out of the 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 1946 or the National Health Service (Scotland) Act 1947, or of any corresponding facilities in Northern Ireland.

The rationale for this provision was to protect the claimant from being required to receive care from the body that had caused them harm. The NHS does not function as a single body. A claimant who has been harmed by one NHS Trust is free to receive care from any other NHS Trust and may in fact as a matter of course receive treatment in a private hospital. To litigate on the sums that should be paid for care which a claimant would be entitled to receive free from the NHS is illogical. The provision is limited to NHS care and we would recommend appropriate reform to extend the duty to mitigate to cover both NHS Care and Social care.

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