Written evidence submitted by Capsticks Solicitors LLP (NLR0060)

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

The figures in context

In 2020-21 the NHS paid £2.209bn in damages and costs of claims. This cost of litigation represented a c.5% reduction on total spend as compared with the previous year[1]. The figures included costs due to the additional damages payable as a result of the 2017 reduction in the personal injury discount rate from 2.5% to minus 0.75%.

The total NHS budget for 2020-21 was £148.7bn (excl. of Covid-19 funding)[2]. At £2.209bn the cost of litigation (including damages paid and legal costs) represented 1.48% of the budget.

NHS Resolution's reduction in total claims spend is mirrored by reductions in[3]:

- Provision for liabilities arising from claims - £1.3bn reduction.
- Cost of clinical negligence claims incurred as a result of incidents in 2020-21 - £0.4bn reduction.
- Payments made to settle claims - £120m reduction.
- Department Expenditure Limit - £445m under budget
- Annually Managed Expenditure - £9.7bn under budget

Whilst the headline rate for the current cost of litigation might appear high, it represents a very small proportion of the total NHS budget. NHS Resolution's management of clinical negligence claims reveals a sustained reduction in the cost of claims (1.5% reduction on total spend 2019-20 as compared with previous year[4]).

Alternatives to litigation

Some countries have adopted 'no fault' compensation schemes, for example New Zealand and Sweden. However, in our view they are likely to be more costly than the liability/tort based approach in this country. If eligibility criteria are widely drawn, they will attract a larger pool of claimants than the current liability/tort based system. If narrowly drawn, some of those who might otherwise have proven liability on a balance of probabilities would be reliant on the State, representing an increased financial burden for the NHS / social care, with the added potential for unmet need. Both those other countries have significantly smaller populations than the UK and arguably a more comprehensive systems of social care. If a reformed system were structured on the

[1] NHS Resolution Report and Accounts 2020-21 p.15
[2] Kings' Fund 'The NHS budget and how it has changed'
[3] NHS Resolution Report and Accounts 2020-21 p.73
[4] NHS Resolution Report and Accounts 2019-20 p.18

basis of a potentially avoidable accident being compensable but natural progression of disease non-compensable, there is significant scope for argument / appeals (or even satellite litigation) on whether a claimant is eligible for the scheme. In addition, the cost of administration of a no-fault scheme should not be assumed to be less than the costs associated with the current Tort based system.

Perhaps most significantly a no-fault scheme, by its very nature, has no means to identify what went wrong and address safety and learning to prevent recurrence / future harm. This is an essential element of maintaining patient confidence in any healthcare system and of managing the cost of claims.

In short, we consider that the alternatives to the current tort based system are likely to be more expensive and have disadvantages including the potential to negate the significant and sustained progress made by NHS Resolution on learning from claims to improve patient safety.[5]

Reducing the cost of litigation

There are a number of other ways in which the cost of clinical negligence claims could be further reduced, whilst preserving the gains already achieved in relation to patient safety.

- Use of Fixed Recoverable Costs.
- Continuing to promote the use of ADR to resolve clinical negligence disputes as early as possible[6].
- Repealing s.2 (4) Law Reform (Personal Injuries) Act 1948 which permits NHS patients seeking damages to recover the cost of treatment and care on a private basis.
- Capping damages.
- Revision of the Personal Injury Discount Rate from a negative to a positive rate.

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?

We do not agree with the premise that changing the way compensation is awarded in clinical negligence claims will promote learning and avoid repetition within the system. There are 2 different questions here – what changes could be made to the way compensation is awarded and what changes could be made to the current process in order to promote learning in the system.

Key changes do not need to be made. A continued focus on culture, behaviour and collaborative working is key to promoting learning. It is about the balance of taking responsibility for one's actions

[5] See 'Our refreshed 2019-2022 strategic plan: delivering fair resolution and learning from harm' (NHS Resolution and pp. 26-27 & 32 NHS Resolution Report and Accounts 2020-21

[6] See p.21 NHS Resolution Report and Accounts 2020-21

within a fair and just environment and not seeking to blame individuals when care in the NHS goes wrong. The recent and continuing high level of collaboration between the Claimant and Defendant community (enhanced as a result of working through the Covid pandemic) is critical to success. Both sides promoting fair and fast resolution (where claims are justified) has shifted the claims operating space from adversarial to neutral. Dispute resolution has continued to be championed and provided new virtual platforms for honest conversations, apologies and resolution-focussed exchanges.

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

We think that in the vast majority of cases patients do receive redress within a reasonable period of time.

The average shelf life for claims managed by NHS Resolution is currently 1.65 years, and 75% of claims are resolved without formal proceedings being required.
It is wrong to assume that the length of time between injury and resolution is a reflection of the complexity of clinical negligence processes. The clinical negligence system, which involves evidence gathering (factual and expert) and complying with the pre-action protocol and/or the court ordered directions timetable, is simple and straightforward. Most clinical negligence lawyers are specialists who are capable of navigating the current system.

Changing the clinical negligence system is unlikely to result in claims being resolved more quickly. Any perceived delay in resolving claims can be best understood as a function of (a) there being a limited pool of good expert witnesses (many of whom undertake this work on top of their busy NHS practice and have long waiting lists for preparing medico-legal reports), (b) limited court resources and (c) the frequent need to delay resolution until the Claimant's prognosis is fully understood, so that the Claimant's losses can be accurately assessed. Furthermore, the civil justice system must be internally consistent and fair: a person injured at work, for instance, is no less deserving of swift redress than a patient injured as a result of medical care.

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

We do not accept that in the majority of cases the parties fail to engage in an early and constructive dialogue. Collaboration between legal advisors in this area of practice is at its height.

There are a number of initiatives in place to promote collaboration between parties. These include the NHS Resolution mediation service which is intended to encourage parties to work together to resolve claims that are sensitive or where there is a barrier to settlement earlier and avoid the emotional distress and cost of going to court. Also, the "Resolution Rooms" scheme whereby Defendant and Claimant firms agree to meet to review a number of claims in one meeting, to consider whether they can be resolved at an early stage. This scheme has shown that through a collaborative approach it is possible to bring about appropriate, fast, fair resolution of claims outside proceedings whilst continuing to defend claims without merit.

The Pre Action Protocol for the Resolution of Clinical Disputes sets out what the parties could and should be doing before proceedings are issued. Greater adherence to this as well as greater exchange of information at an early stage would encourage early and constructive engagement between parties, including but not limited to:

- Confirming the disciplines of experts instructed;
- Consideration of early without prejudice disclosure/exchange of liability reports;
- Disclosure of all documents that are not privileged within a prescribed timescale;
- Greater clarity in Letters of Notification/Letters of Claim;
- Greater adherence to the requirement for a pre-action stocktake prior to issue to be required and incentives to make offers/engage in ADR at that stage. As the Resolution Rooms initiative has shown, in the right cases if the dialogue between the parties continues following the Letter of Response and the parties work together and explore the issues between them early resolution is possible without the need to issue proceedings.

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

Any expanded Early Notification scheme would need to be carefully planned and considered and detailed forethought given to the resourcing of the scheme.

The current EN scheme was developed due to the cost to the NHS of maternity incidents and claims. It would be relatively easy to identify the next most costly area of claims after maternity. Data from GIRFT could inform which medical practice areas to focus on. A similar structure of open communications between clinicians within those medical practice areas and Trust legal departments[7] could be adopted whereby qualifying incidents with a proven outcome causing patient harm (EN scheme now adopt the 'outcome first approach' where only incidents where the child has suffered a suspected brain injury are investigated) are reported to Trust legal and then to NHS Resolution. An investigation would then be carried out in a similar way with firstly (a) a clinical investigation and secondly (b) where likely substandard care found by those experts, and harm suffered, a legal investigation carried out leading to early admissions (if appropriate) and open communications with the family about the outcome.

As in EN, there would be a separate safety and learning 'arm' to process recording the data relating to the incident which is then fed back to the Trust at a local level by way of learning. The current EN team do also feedback their learning on a national level (not just Trust local level) by way of 'themes' extracted from the data; the most recent being impacted fetal head during caesarean section to encourage wider practice changes across all of NHS. This national dissemination of learning in any expanded EN scheme would be key to drive efficiencies system-wide.

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?

Lower value clinical negligence claims are not necessarily less complex. Accordingly, it would be important for complex claims to be excluded from this scheme, for example, fatal claims or claims

[7] GIRFT has established that clinicians and managers are often unaware of the claims against their own departments. This problem is reduced within maternity because of the reporting criteria required by the ENS and the need for clinicians and legal to work together to communicate with families directly – rather than wait for solicitors to be instructed.

involving stillbirth. As to the level at which recoverable costs are to be set we recommend consulting further with the Claimant community. The evidence we have demonstrates that on average, Claimant costs for claims under £25,000 are in the region of £10,000 including those cases where no damages are paid. We do not think it would be appropriate to set recoverable costs at a percentage of the damages recovered.

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

We do not consider that the current clinical negligence system is inherently adversarial. The focus of the Pre-Action Protocol for the Resolution of Clinical Disputes is on collaboration between the parties and narrowing the issues in dispute pre-action.

More recently this approach has been bolstered by the Covid-19 Clinical Negligence Protocol agreed between NHS Resolution, the Society of Clinical Injury Lawyers and Action against Medical Accidents. The Protocol encourages positive behaviours from claimant and defendant organisations with the aim of reducing costs being spent unnecessarily on issuing proceedings, applications to extend time or stay proceedings. The Protocol has further embedded the importance of a collaborative, rather than adversarial, approach to clinical negligence cases in both pre-action and litigated cases.

In addition, the duty of candour means that defendants in clinical negligence cases are required to adopt an open approach when clinical mistakes result in harm to patients, including making early admissions of liability when appropriate and saying sorry. This process facilitates a move from a blame culture and towards continued learning from clinical negligence claims and improvements in patient safety. NHS Resolution's Early Notification scheme further supports this objective.

We believe that the current system, when properly understood by clinicians, serves to improve medical advice and decision making.

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

Clinical negligence litigation was in the past seen as an issue concerning only financial and legal challenges as between patients and those who provided the treatment in question. Over time it has come to be seen as something much more important. Litigation is a reflection of the more serious underlying problem of harm to patients and presents a valuable opportunity for learning and change to prevent the same mistakes being repeated.

In May 2021 a joint report by "Getting It Right First Time" (GIRFT) and NHS Resolution entitled "Learning from Litigation Claims" highlighted work by those organisations along with other stakeholders to "ensure that claims learning and management have parity to incident learning and complaints." The report highlighted two examples where learning initiatives emanating from clinical negligence claims had resulted in real change. First obstetrics which accounted for 9% of clinical negligence claims but represented 50% of the total incoming claims value in 2019/20 had seen two initiatives by NHS Resolution in recent years – the Maternity Incentive Scheme and the Early Notification scheme. These initiatives the report stated, "helped to ensure that learning is shared across departments to improve safety and drive better patient outcomes". The other example of the GIRFT approach to analysing claims data and implementing change was in orthopaedic surgery. Visits by the GIRFT team to all orthopaedic departments at Trusts in England meant orthopaedic surgery moved from 15% of claims in 2013/14 to 12% in 2019/20, second to Emergency Medicine, having previously been the highest volume specialty.

Litigation is of course the “tip of the iceberg” in terms of numbers of incidents that result in claims. Complaints that do not lead to litigation and “near misses” which have either not resulted in harm or have not been reported constitute a greater number of events and valuable learning opportunities. What differentiates litigation to the complaints process or incident reporting however, is the detailed forensic analysis that is undertaken during the litigation process. It is this process that provides key information to healthcare providers as to the root causes of the incident in question. The anatomy of error can be clearly identified and appropriate measures and systems can then be developed to prevent similar errors. Furthermore when one looks at a large cohort of similar cases in the way that NHS Resolution have done with their thematic reviews, such as that on Cerebral palsy claims, one can see patterns emerge. By identifying these patterns, analysing the errors, recommending control measures and allocating resources to implementation, change can be effectively introduced to prevent mistakes being repeated.

It is fundamentally important that litigation is used to encourage learning and promote change because:

There is a human cost of clinical negligence which needs to be curbed. It is not only the patients themselves who suffer from the impact of harm but often their families. The wider impact for those individuals could include having to come out of the labour market or placing an increased reliance on the NHS for future treatment all of which also has an indirect financial consequence on society as a whole. One must also consider the impact on NHS staff involved in litigation. Many will have feelings of guilt over mistakes that happened and for a few the whole process can lead to them leaving the NHS thereby depleting an already challenged workforce.

It is well documented that claims inflation is the fastest form inflation with the annual cost of harm amounting to £8.3 billion in 2019/20(1). The only way to ultimately reduce the cost to the public purse is to prevent the same errors occurring time and again. This is most evident in maternity care claims which account for the largest proportion of claims by value. Almost all the independent reports into failings in maternity care over the last twenty years have identified the need to learn from previous incidents and prevent the recurrence of similar cases each of which can run into tens of millions of pounds.

The NHS is the largest health employer in Europe. It has the opportunity to be the largest learning organisation in the world through using data from litigation to help implement change within healthcare organisations. This may be through improved systems as well as education and learning initiatives based on information from claims. Research indicates that learning from clinical negligence claims influences and improves clinical practice especially in the consent process, pre-procedure patient education and clinical documentation.

Incentive schemes for Trusts are vital to encouraging commitment to change because financial and reputational incentives are aligned. For example, the Maternity Incentive Scheme currently operated by NHS Resolution rewards Trusts financially but only upon certain maternity safety and learning measures having been implemented and targets achieved. Incentivising Trusts with an outcome based approach (and one that actually bites) is important because it effectively rewards better and safer practice.

Learning lessons from litigation to help prevent future claims must be at the core of any system dealing with clinical negligence claims. As the recent report Learning form Litigation Claims states:

"the GIRFT litigation work stream has collaborated with NHS Resolution to engage with Trusts and share data regarding their own claims on a speciality specific basis in bespoke data packs. GIRFT has also conducted litigation deep dives in high priority specialties: maternity and gynaecology, trauma and orthopaedic surgery and spinal surgery, involving trust legal, complaints and clinical staff as well as senior management. These meetings have enabled us to better understand the processes that facilitate effective claims prevention, management and learning."

Only through continued investment in this type work and encouraging healthcare organisations to extract and share learning from each and every claim will the human and financial cost of claims be reduced.

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?

The focus of clinical negligence claims should be on fast and fair resolution and learning from claims in order to improve patient safety. This can be achieved by building amicable relationships with Claimant lawyers, avoiding unnecessary proceedings and focusing on early exchange of evidence to narrow the issues in dispute.

Dispute resolution remains an important tool to achieve this. Joint settlement meetings are used in appropriate cases, as is mediation. NHS Resolution's mediation service should continue to be used to resolve clinical negligence claims and to explore alternative means of redress to injured patients or their families. The involvement of treating clinicians and NHS Resolution's safety and learning team at mediations can help to facilitate a learning culture.

The civil litigation process remains a means for the small percentage of cases in which liability and/or quantum issues cannot be resolved between the parties to be determined by the Court. The Court process has a role in resolving unmeritorious cases which are brought against NHS organisations, or have been exaggerated.

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?

Currently, in qualifying maternity incidents; HSIB replaces the local Trust internal investigation and HSIB's report makes safety recommendations. HSIB also carry out national investigations into non-maternity issues as a result of referrals made by any group, organisation or person in relation to a patient safety concern. HSIB then considers whether to conduct a national investigation and then a report is published including generic (not usually Trust specific) safety recommendations.

HSIB reports are lengthy, investigators interview numerous staff, and the process can take months. Further, they are not always 'outcome first' focussed (i.e. they will investigate qualifying incidents even if no harm has occurred).

We think that to improve responses, as is currently done in EN, there could be a role for HSIB to take over the local investigation, rather than the Trust in certain claims (for example, in A&E or general surgery), guided by an outcome first approach i.e. only where proven harm to the patient.

What legislative changes would be required to support these changes?

The following legislative changes could help reduce the cost of clinical negligence:

- Repealing s.2 (4) Law Reform (Personal Injuries) Act 1948 which permits NHS patients seeking damages to recover the cost of treatment and care on a private basis. (However, ironically this might increase the burden on NHS waiting lists.)
- Capping damages.
- Revision of the Personal Injury Discount Rate from a negative to a positive rate.

Oct 2021