Written evidence submitted by Tees (NLR0062)

ABOUT TEES

Tees was established in 1913 by Herbert Stanley Tee in Bishop's Stortford (where it is still one of the town's major employers). The firm is a major regional legal and wealth management firm, with offices in Bishop's Stortford, Brentwood, Cambridge, Chelmsford, Royston and Saffron Walden. The Tees Clinical Negligence team is a Legal 500 top tier team with three leading individuals. Visit: www.teeslaw.com

WHY WE ARE SUBMITTING EVIDENCE

Tees represents patients who have suffered avoidable harm as a result of medical accidents. We have extensive lived experience of NHS Litigation and are passionate about improving patient safety and giving our clients a voice.

We have significant concerns about the Inquiry and the questions raised and want to make sure that patients who have suffered avoidable harm at the hands of the NHS are appropriately represented, their voices heard and that access to justice is not compromised.

Although we have considered the Inquiry in full, we have only answered the questions we believe we are able to contribute lived experience and expert knowledge.

SHORT SUMMARY

The NHS is the largest employer in the UK and one of the largest employers in the world and the cost of NHS litigation must be seen in that context.

Over the past 4 years total payments and administration costs under the NHS Resolution clinical schemes have remained steady at between roughly 1.5% and 1.6% of the total NHS budget. This is a very low percentage as compared to other organisations, where indemnity costs range from 1% to 15%, with almost all over 2%.

The main way to reduce cost (human and financial) is to reduce avoidable harm.

There is evidence of a "defensive culture", "dysfunctional teams" and "safety lessons not learned" across the NHS and until this is addressed, lessons will not be learned, change will not be implemented, errors will continue to be not just made, but repeated.

It is morally reprehensible to look to introduce any kind of legal reform which impedes access to justice or appropriate compensation for those who have been injured at the hands of the NHS through no fault of their own.

We note the issues that the Inquiry is attempting to address, but consider that the approach is fundamentally flawed.

ANSWERS 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?***

  The way this question has been framed does not look at the problem in the correct way.

  The cost of litigation, which has actually been decreasing[1], would inevitably reduce significantly if the NHS were to learn from their previous mistakes. Improvements to patient services and safety will have the greatest impact on the NHS' finances and will lead to a significant reduction in legal fees and compensation paid out.

  Unfortunately, however, there is widespread evidence that lessons are not learnt, and patients continue to suffer avoidable harm – see more beneath.

  There does, also, need to be some pragmatism. The NHS is the single biggest employer in the UK and with one of the largest workforces in the world. Errors will happen as they do in any organisation. The correct question should, therefore, be whether the cost of administering the NHS R clinical scheme is unsustainable or unreasonable as a percentage of the total budget.

  Over the past 4 years total payments and administration costs under the NHS R clinical schemes have remained steady at between roughly 1.5% and 1.6% of the total NHS budget. This indemnity cost as a percentage of turnover compares very favourably with indemnity costs paid by other professions, e.g. Surveyors, Solicitors, Accountants, Insurance Brokers, Architects, Engineers and Construction where premiums range from 1% to 15%, with almost all over 2%.

  This shows that the amount spent on indemnity by the NHS is well within the realms of what is to be expected of such a large organisation.

  Overall, we consider that the aim should be to:

  - improve patient safety, with a view to reducing not only the financial impact, but also the human cost;
  - ensure appropriate redress is available to those who suffer avoidable harm, including full and fair compensation.

  We do not see that either of these aims jeopardise the financial sustainability of the NHS and/or the provision of patient care in the context that the spending is 1.5%-1.6% of the total NHS budget.

- ***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?***

[1] The costs of the current litigation by way of compensation and Claimant's legal costs have, been reducing as evidenced by the NHS Resolution Annual Reports in 2020 and 2021.

We do not consider that any changes are needed to the way that clinical negligence compensation is awarded, nor do we consider that changing the way that compensation is calculated will promote learning or avoid the problem being repeated elsewhere in the system.

Compensation is calculated in accordance with the law of tort. This applies not just to healthcare, but to all areas of civil life, for example, road traffic accidents, accidents at work etc..

Compensation is not a windfall – the aim is to put the injured person (howsoever injured) in the position that they would have been in had that carelessness not occurred.

Injured patients and their families have often faced financial hardship (for example, loss of earnings, travel expenses, care costs) as a result of the avoidable harm suffered at the hands of the NHS and they may face life-long, life changing injuries and an uncertain future through no fault of their own. Compensation is intended to meet the care, support and rehabilitation they need as they move back into society.

It is morally unacceptable to think that the right way to reduce the sums paid out by the NHS in respect of harm it has caused through its own carelessness, is to stop patients and their families claiming the compensation needed to try to get their lives back on track.

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

It is important to look at the Harmed Patient Pathway from the beginning – for the patient (and the clinician) a patient safety incident does not start with the claims process.

Patient complaints should be independently investigated, and families should be compassionately engaged and meaningfully involved throughout.

Hospital Trusts and Clinicians should be complying with the statutory Duty of Candour.

Many patients will choose not to bring a legal claim if they feel that their case has been carefully, honestly, openly and independently considered and they have been involved in the process throughout.

Where, however, a patient does then look to seek legal redress, the Pre-Action Protocol for the Resolution of Clinical Disputes is already utilised as a clear framework for the management and progression of Clinical Negligence claims. However, in our experience, whilst there has been some improvement, in some cases, a culture of deny, defend and delay continues. This increases both the costs and the time spent to conclude claims.

The NHS needs to consider making earlier and binding admissions, particularly where learnings and failings have been identified as part of the RCA or SI investigation process. It is accepted that RCAs / SIs / HSIB reports have a different remit, but in many cases it is clear to an experienced and specialist clinical negligence lawyer, at an early stage, whether, based on those investigations, there is evidence of substandard care causing harm. In practice, this does not happen.

Despite being invited to admit liability early (to avoid the associated costs of obtaining expert liability evidence), Trusts rarely do so, only to admit liability later when costs have escalated.

Even worse, in some cases, Trusts' resile from the findings of heavily critical RCAs / SIs, asserting that the findings of their own RCA or SI were incorrect. This reduces public faith in the NHS, any

apologies given, or concessions offered as part of the RCA or SI appear meaningless, it exacerbates the mental distress of the patient and their family and it sends mixed messages (to both clinicians and patients alike). It undermines confidence in the RCA and SI processes and escalates litigation costs. For the families concerned, redress includes the admission that mistakes have been made and that lessons will be learned. Denials perpetuate the victim's distrust of the NHS and 'the system'.

On many occasions, court proceedings have to be issued because liability has been denied during the Pre-Action Protocol Period, only for liability to be admitted thereafter and/or settlement achieved without any admissions of liability.

We would suggest that consideration be given to the following: in the same way that a Party that refuses to engage in ADR has to serve a witness statement[2] giving their reasons, following service of the Letter of Response, Trusts could be required to prepare such a statement to the court stating why admissions have not been made, with costs consequences should the reasons be deemed illogical or insufficient at the end of the case.

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

In our experience there is already a very large degree of collaboration between legal advisors in practice and where this does not happen, it is the exception rather than the rule. The Covid-19 Protocol has fostered much greater co-operation and collaboration between the Parties, particularly with regards to limitation moratoria. Mediation is now much more commonplace.

However, it may not always be possible for the parties to engage in collaborative discussions with a view to resolution early in the case. Unless there is a comprehensive Independent Investigation, complex issues of breach of duty and causation arise in clinical negligence claims which require careful examination by medical experts before the parties can engage in constructive discussions.

One potential area for exploration is the amount of evidence required for the Parties to form a sensible view on the valuation of a case. Our experience has been, historically, that the NHS will not consider resolving cases without every single piece of evidence justifying every single penny. This is disproportionate and costly. Experienced specialist practitioners can and should be able to take a sensible view to work towards earlier 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 do not agree that Fixed Recoverable Costs (FRC) are appropriate in any medical negligence case. Nor do we believe that the introduction of FRC would have the intended impact on reducing the overall legal costs associated with administering clinical negligence case.

Even if FRC were extended to clinical negligence claims we do not agree the settlement value of a case is the right metric by which to determine whether Fixed Recoverable Costs do apply or do not apply.

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[2] The statement is not shown to the trial judge until the question of costs arises.

The Civil Procedure Rules (Rule 44.3) clearly state that the sums in issue are just one of 5 factors to be taken into account when considering whether the costs incurred are proportionate. Other factors include the value of any non-monetary relief in issue in the proceedings, the complexity of the litigation, any additional work generated by the conduct of the paying party and any wider factors involved in the proceedings such as reputation or public importance. In almost every medical negligence case, every factor is at play. For patients, the sum in issue is often the least important.

There are already mechanisms by which patient's costs are controlled in the form of costs budgeting and the ability for the NHS to ask the court to assess the patient's legal costs at the end of the case. Proportionality is considered at both stages.

A case sometimes settles for less than its full valuation, to take account of a patient's attitude to risk, or other circumstances.

Further, settlement value does not reflect a claim's complexity. For example, a baby born with a brain injury as a result of substandard care during the delivery may survive with cerebral palsy, or they may die shortly after birth. In both of these cases, the liability investigations and the number of experts required (e.g. Midwife, Obstetrician, Neonatologist, Neuroradiologist, Neurologist) would be the same. However, the family who have lost their baby may find that the settlement value of their case is less than £25,000 and that they are unable therefore to access justice – see beneath.

Importantly, claims in which damages do not exceed £25,000 most often arise in matters relating to the elderly, children, and those with mental ill health. These groups need and deserve access to justice just as much as the rest of society, and they are the most likely to require the services of skilled legal professionals to assist them. There are real concerns that the introduction of Fixed Recoverable Costs would have a disproportionate effect on the most vulnerable in our society, contrary to the principles of equality, diversity and inclusion.

We note that the Government's proposals for Fixed Recoverable Costs focus solely on Claimant costs, which, are already reducing year on year as the NHS Annual Reports show. This will create an inequality between the individual harmed and the Hospital Trusts and clinicians who all have access to either NHS Resolution or their own Medical Defence Organisation lawyers[3].

If FRC were introduced, it is not possible to assess at what level Fixed Recoverable Costs could fairly be set as each case turns on the facts of the case (e.g. how many witnesses are needed, how many experts are needed, the patient's medical history and personal circumstances) and the behaviour of the Parties. The Defendant's behaviour, in particular, can significantly increase legal costs if they delay, deny and defend a case. The Government's proposals provide no sanctions in the event that the Defendant denies, defends and delays. FRC would incentivise poor Defendant behaviour to make cases under £25,000 untenable for patients to pursue through appropriately specialist qualified legal advisers.

We believe that the FRC would not achieve the intended impact of reducing the costs of administering NHS litigation, but would increase it.

FRC will make it economically unviable for specialist medical negligence firms to pursue these cases caught by the scheme. Specialist firms have an important role as a "gatekeeper", fielding hundreds

[3] Such an inequality of arms is already acutely apparent in inquests where the removal of Legal Aid means that families often turn up alone, without representation and are faced with a panel of lawyers representing the interests of the clinicians involved.

of patient enquiries annually pro bono with the vast majority not being pursued following careful investigation. Without them so doing, the NHS will be flooded with Litigants in Person, pursuing cases for which there is no reasonable prospects of success. Additionally and/or alternatively, there will be a gap in the market that no doubt will be filled by claims management companies willing to send speculative Letters of Claim that the NHS will have no choice but to investigate and respond to.

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

The Clinical Negligence system itself is not adversarial. It is the approach taken.

Most commonly patients want to try to bring about learning with the NHS, an open, honest, transparent and independent explanation, an apology and accountability. Few want an adversarial process – most dread the possibility of having to go to Court.

The main driver for patients bringing a claim is to try to avoid what happened to them happening to anyone else. Patients understand that clinicians are under pressure, work hard and do their best in often trying circumstances. Cases are often complex and multi-factorial and are rarely the result of isolated individual clinical failings. Very rarely, does the patient attach "blame" to a particular healthcare professional within the NHS. Most see it as the system that has let them down. The correct legal Defendant is the trust, not the clinician.

It is not the current clinical negligence system per say that creates a blame culture, but leadership and culture within the NHS. In a healthy workplace with a learning culture where psychological safety is embedded, complaints, litigation, or any other form of investigation should be welcomed as an opportunity to reflect, analyse, learn and improve. Alarmingly, there is evidence that this is not the case – rather the Safety of the Maternity Review report noted that there was a tendency for employers to say "who is to blame here?".

A change in culture will do more to reduce the costs of NHS Litigation than any proposed changes to Claimant's legal costs and compensation.

Our experience is that the culture at some Trusts is much better than others.

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

We continue to see the same mistakes, often by the same trusts being repeated. This demonstrates a failure to learn from past mistakes and causes avoidable harm to more patients, with the associate human and financial cost.

It is vital that lessons are learned from clinical negligence claims (and from complaints which do not lead to claims), in order to improve services within the NHS and to prevent errors being repeated. This is, most commonly, the primary driver for the patient and their family in any case.

The NHS should be complying with the statutory Duty of Candour. It is, however, important that this is not a "tick box" on a checklist and that it is viewed as an opportunity to learn, improve and avoid patient safety incidents in the future.

It is imperative that clinicians are supported and applauded when raising patient safety issues (both near misses and events causing harm). They should be given appropriate time away from (not in

addition to) clinical duties to analyse what happened, they should have an integral role in identifying the solution and making recommendations and given the training they need. Too often, we have heard that clinicians are not aware of the outcome of an investigation or claim. This is a lost opportunity to learn and is disengaging.

Lesson learning and a commitment to change is, however, not enough. There has to be resource and a commitment to *implement* change. This includes time which is separate to, not in addition to clinical responsibilities.

It is the implementation of lessons learned and commitments made that has so often been lacking. For example, the NHS is acutely aware that maternity claims make up half of all of the costs and compensation awarded and, despite numerous reports, inquiries and commitments over the years, the most recent report from the Health and Social Care Select Committee found that improvements in maternity services have been too slow, with the CQC's Chief Inspector of Hospitals reporting evidence of a "defensive culture", "dysfunctional teams" and "safety lessons not learned".

There are examples of good practice, and these should be replicated. One example of how improving patient safety reduces claimant costs is Bristol Southmead Hospital. They implemented a training programme in 2000 to reduce avoidable harm. This resulted in a 50% reduction in babies born starved of oxygen and a 70% reduction in babies born with a paralysed arm[4]. If the training was implemented nationally, over 100 severe birth injuries would be prevented each year, not only would this improve patient safety, but it would reduce £64 million pounds per year in NHS claims alone. If similar reductions in harm at birth were made across England there would be NHS savings in maternity claims alone of £2.8billion in a decade. These figures also do not include the lifelong costs to the NHS of caring for these severely harmed children.

The fragmentation of the NHS does not assist organisational learning and that this represents a lost opportunity for learning and change to be made, implemented and replicated across the NHS with much greater impact.

[4] https://www.health.org.uk/fellow/tim-draycott