Written evidence submitted by The Centre for Socio-Legal Studies (NLR0063)

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1. Clinical Negligence litigation

Overview

Clinical negligence litigation enables individuals to obtain legal redress in the form of financial compensation when they are able to prove negligent harm. Government policy in this area has three key aims:

- to reduce the number of incidents of patients being harmed via providing an information base for future learning;
- to provide access to redress for those harmed by the system;
- and to manage the cost of such incidents to the public purse.

This paper argues that the clinical negligence system is expensive, inefficient and slow, effectively excluding access to redress for most of those harmed by the system and acts as a real barrier to creating a learning environment. In the view of the authors, the evidence suggests that attempts to reform the system to remove these obstacles are unlikely to be successful and would create unacceptable levels of cost and that an administrative redress scheme would be more effective in reducing harm and providing individual redress.

Where figures are quoted from NHS Resolution they are generally taken from the 2018/19 report to avoid the impacts of the covid pandemic.

Introduction

In the UK clinical negligence litigation is the predominant mechanism of obtaining justice for those who have been injured by substandard care. Compensation or damages can only be obtained if it is found, on the balance of probability, that the care provided fell below medically acceptable standards and directly caused the injury. Compensation for clinical negligence hinges on the circumstances in which the harm occurred, not the needs of the injured person. Whether this system is truly just is open to question.

Clinical negligence cases have mushroomed, both in terms of claim numbers and award values, since NHS Resolution (then known as the NHS Litigation Authority) was founded in 1995. Given these substantial shifts it is not surprising that further changes are being sought, but before undertaking more reforms it is worth a very brief consideration of the major reforms which have already been implemented.

Legal aid and LAPSO

The availability of legal aid for clinical negligence had been narrowing for years, with a ‘fixed fee’ system operational between 2006-2009, followed by a 10% fee reduction in 2010. The most dramatic reduction came in April 2013, when the Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LAPSO) was introduced. LAPSO effectively removed legal aid for almost all clinical negligence cases, the only exception being brain injured babies. These changes have shifted the way cases were funded towards Conditional Fee Agreements (CFAs or “no win no fee”).

LAPSO also dramatically impacted litigation funding from CFAs. Prior to LAPSO coming into effect in April 2013, a claimant could enter into a CFA and purchase an ATE policy. This meant that if they lost their case they did not have to pay their solicitor due to the CFA; the ATE policy covered the defendant’s legal costs; and often, the payment of the premium to purchase the ATE policy had been deferred and self-insured, meaning that the claimant did not actually have to pay it. This was a risk-free position for the claimant (though not for their solicitor who would remain unpaid for any work on the case). If a claimant won their case they could recover damages, their own legal costs, a success fee and the cost of the ATE premium from

the losing party. In clinical negligence litigation only claimants use CFAs and this was felt to place excessive cost burdens on defendants, so was reformed under LAPSO.

Key points for CFA agreements entered into after 1 April 2013[1] are summarised below.

- Success fees are no longer recovered from the losing side, but are taken out of the claimant's compensation. Success fees cannot exceed 100% of legal base costs, and additionally cannot exceed 25% of the compensation awarded (except for appeals where the cap is 100% of the compensation).
- Pre-LASPO the whole value of the insurance premium for legal costs insurance (either before the event, BTE, or after the event, ATE) could be recovered from the losing side. LASPO changed this and in clinical negligence litigation the premium is now partially recoverable - the portion of costs insurance premium relating to expert report fees is recoverable.
- Qualified One-way Cost Shifting (QOCS) applies to clinical negligence cases. QOCS protects a losing claimant because, in the majority of circumstances, the unsuccessful claimant is not liable to pay the defendant's costs. QOCS were introduced so that claimants would not need to purchase ATE legal costs insurance, and therefore would not be disadvantaged by not being able to fully recover the premium.
- In clinical negligence cases successful claimants will have a 10% uplift applied to their general damages for non-pecuniary loss (i.e. pain and suffering, loss of amenity, etc) to make up for the loss of recoverability and the fact that the success fee (of up to 25%) is taken from their damages.

While these might seem quite dry technical issues it is useful to consider the intentions behind them. These changes were brought in in an attempt to rebalance what was seen as disproportionate risk and costs between defendants and claimants, while still providing access to justice. These reforms are particularly important when considering fixed recoverable costs for low value claims, which raise similar arguments about disproportionate claimant costs and issues of recoverability.

It is also worth looking at the impact these funding changes have had on claims numbers. A bulge of claims was seen just prior to the implementation of LAPSO which was thought to be due to solicitors trying to get claims in under the old more profitable regime. Since then the number of claims notified to NHS Resolution has stabilised and remained marginally above 2012/13 levels until 2018/19. The legal market has adapted and found a way to work, and remain profitable, within the post-2013 funding regime.

Driving harm reduction – the impact of clinical negligence

There are a plethora of interventions, strategies and programmes aimed at reducing harm in the NHS. A key objective for Government is to drive harm reduction by encouraging a culture of learning from medical mistakes. However, in our view, clinical negligence cannot effectively deliver this objective. This is for a number of reasons.

First, the NHS utilises cases which are litigated to provide a data set for learning. Litigation provides the only route by which those who have been harmed can access compensation, and it appears that a substantial proportion of those who litigate do not engage with other ways that the NHS could obtain information on their grievances, such as the complaints system.[2] The barriers to litigation very significantly limit the number of claims. Clinical negligence law firms tend to operate initial stringent screening processes which on average

[1] Full requirements are detailed in s.44, s46 and s.48 of LASPO 2012; Arts 1-6 of Conditional Fee Arrangements Order 2013; s. 58 of Courts and Legal Services Act 1990; The Recovery of Costs Insurance Premiums in Clinical Negligence Proceedings Regulations 2013 and part 48.2 of the Civil Procedure Rules

[22] The 2018 Behavioural Insights Team report prepared for NHS Resolution *Behavioural insights into patient motivation to make a claim for clinical negligence* found that 52% of claims are made without a claim attached, 10% of claims have no complaints information recorded and 7% are unclear. Only 31% of claims clearly have an accompanying complaint.

reject over 90% of potential cases raised with them, either because they show little likelihood of being able to pass the (very high) threshold for proving legal negligence or because they do not meet basic tests for tenable claims (e.g. they are out of time or not about a matter which is actionable). Even where potential cases pass these tests, some of them will be rejected as uneconomic if the law firm assess the financial return as insufficient compared to the outlay required; others will be written off after initial enquiries rule case doubt on the viability of the claim. Overall, it is reasonable to assume that only around 3%-5% of potential cases raised with clinical negligence solicitors result in litigation action even being initiated,[3] and this percentage significantly biased towards matters where the value of the claim is likely to be high. Litigation simply cannot offer a broad evidence base for the NHS to learn from when the vast, vast majority of the information is received by, and discarded by, claimant lawyers without any NHS involvement or awareness.

Second, the litigation process is very slow. Learning requires prompt actions, not lessons coming to light many years down the line when the processes and people involved in the incident have changed. If we take birth injuries as an example, in 2017 the average time period from a birth related brain injury in a baby occurring to full quantification of a settlement was 11.5 years.5 years. As this is an average some claimants were clearly waiting longer. In comparison international non-adversarial schemes could determine eligibility and quantification for all claimants within a year.[4] Since 2017 efforts have been made to improve the speed of birth injury litigation, but we are still nowhere near these international schemes.

Third, the process of litigation is inimical to achieving learning outcomes. A learning environment requires a good flow of accurate, timely data about adverse incidents. That means all those involved in the system – medical professionals and patients – must be incentivised rather than disincentivised to facilitate this data flow. In their 2013 paper[5] Robertson & Thomson describe midwives' experiences of clinical negligence in England, quotes from midwives make clear how difficult some individuals find the litigation process. Case conferences with their own barristers were described as *'Absolutely awful. I can't describe to you how intimidating those meeting are…'* and *'Even though everybody, I have to say, were trying to make us feel at ease, you just thought 'I can't speak here', it was terrifying is the only word. To the point that even when the barrister asked me a really simple question, I'm just staring at him like the village idiot…'.* After an adverse event there are some concerns such as damage to professional reputation and employability (including possible fitness to practice hearings), a disconnect between the professional's perception of themselves as a caring professional and the adverse event outcome, and a heartfelt concern for the injured patient, which can impact on open disclosure in any investigatory context. However, these quotes clearly illustrate how the adversarial litigation process itself can inhibit the open sharing of information about what had happened.

Faced with the possibility that their words may be used as part of the evidence base for litigation practitioners can retreat into defensive positions, understandably cautious about sharing information while legal action is pending. Moreover, where there are different parties or disciplines involved in a single incident, there may be a temptation for practitioners to close ranks and report events in such a way as to minimise their own profession's part and emphasise the role of others. The move towards an integrated care systems model may exacerbate this issue as it raises the possibility of incidents involving different health care disciplines across both primary and secondary health care settings and from the public and private sectors, with their differing liability arrangements. That can set up competing narratives which cause further

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[3] See the Society of Clinical Injury Lawyers Campaign, the Access to Justice section states 'cases are filtered by professional, experienced lawyers to ascertain if there is a case. Only circa 3% are deemed to be actionable'

[4] There are two birth injury schemes in the US in Florida and Virginia. Both have statute-defined timeframes. Claims are determined claims in less than eight months in Florida and less than four months in Virginia.

[5] Robertson JH and Thomson AM, *A phenomenological study of the effects of clinical negligence litigation on midwives in England: The personal perspective.* Midwifery 30 (2014) e121-e130

confusion. The lack of a clear, uncontested and early factual basis from which to work makes learning very difficult.

Delivering Redress - does clinical negligence deliver what is wanted?

There is a substantial body of research[6] that indicates that what people actually want after they have been harmed in a healthcare setting includes:

- Preventing the same thing from happening to someone else;
- Obtaining an explanation;
- A desire for the staff/organisation to be held accountable; and
- To obtain compensation/redress.

Tort litigation is strictly limited in the outcomes it can achieve. This Inquiry's Terms of Reference ask 'How important is it that any clinical negligence system encourages lesson learning and commitment to change as the result of any action.' For clinical negligence litigation this is the equivalent of asking a fish to ride a bicycle. Litigation is not set up to deliver learning outcomes, and courts do not have the power to force individuals or organisations to reflect on their practice, apologise or change the way they work. All the courts can do in clinical negligence cases is order financial remedies in individual cases where legal liability is found. Lesson learning and change cannot be driven by the Courts.

Financial compensation is vital in cases which involve direct financial loss. However, while still useful, it is less appropriate a remedy for cases involving physical or emotional harm. In theory, the aim of a damages payment is to put the person in the position they would have been had the harm caused by the negligence not occurred. This is an impossibility. Money can make life easier for survivors of clinical harm and can pay for treatment and care. However, no amount of money can put an injured patient back to what they were or would have been, no more than it can it restore a dead patient to life.

Containing Cost

Litigation is expensive and the transactional costs are high. Between a quarter and a third of the cost involved in clinical negligence goes to fund lawyers rather than to harmed claimants. In 2018/19 the total income to the legal community of the clinical negligence market was over £650m, with the total paid in compensation in the region of £2bn. The 2017 National Audit Office report is clear that the rising costs of clinical negligence litigation is unsustainable, and that the current strategies will not curtail the costs. The affordability problem is compounded by a negative discount rate, which further increases the cost of damages. A more cost-effective approach is badly needed.

However, we do not consider that there are easy mechanisms by which this can be achieved. At various times and in various guises, the authors have had occasion closely to study the manner in which the legal clinical negligence market operates. That work has led us to the following conclusions:

- The proportion of people who make a claim after an adverse incident is very low. Many clinical negligence firms therefore, understandably, consider that the clinical negligence market provides an opportunity with significant untapped potential. It cannot be assumed that the status quo will

[6] For example see Vincent, C., M. Young, and A. Phillips, *Why do people sue doctors? A study of patients and relatives taking legal action.* Lancet, 1994. **343**(8913): p. 1609-13.; Bismark, M., et al., *Accountability sought by patients following adverse events from medical care: the New Zealand experience.* Cmaj, 2006. **175**(8): p. 889-94.; Friele, R.D. and E.M. Sluijs, *Patient expectations of fair complaint handling in hospitals: empirical data.* BMC Health Serv Res, 2006. **6**: p. 106

remain; should claimant lawyers develop mechanisms to convert this potential, this could lead to substantial increases in claimant numbers.

- The recent expansion in the clinical negligence market shows little sign of slowing. Individual firms are continuing to plan for increased activity and independent market reports predict further increases in turnover and profitability;
- The clinical negligence market is adept at adapting to gradual, predictable reforms of the sort which have been introduced over recent years and many firms remain confident of surviving any such shifts which are currently under discussion (such as fixed recoverable costs);
- There remains capacity in the clinical negligence model for some reductions in cost to help offset the reduction in profitability which results from any immediate shifts in Government policy. AI systems, reductions in expert fees, and improved efficiencies still have potential to make case management less expensive for providers;
- There is a slow growth in the sophistication of clinical negligence firms' mechanisms for sourcing potential claims, via advertising (both general and targeted), partnership arrangements and relationships with third party referrers (eg claims management companies). These arrangements look set to continue to drive potential claims numbers.
- Any significant reform in clinical negligence is likely to impact largely on the profitability of medium and lower value cases and will therefore have the effect of reducing the number of such cases litigated, further limiting the already tiny data pool for learning. There is little to indicate that any of the reforms currently being considered will affect the small number of high value cases which make up the bulk of NHS costs in this area.

Moving forward

Our current redress and related patient safety systems are suboptimal and do not reflect best practice. There are plenty of models to learn from. These include international models on delivering compensation for medical harms, and redress delivery mechanics in other specialist sectors both in UK and abroad.

Any reforms must:

- **Improve patient safety**
- **Improve the efficiency (in financial and time terms) of the process for providing redress**
- **Improve the appropriacy and fairness of the redress provided**

There are a number of initiatives which are being undertaken which aim at this result. The likely impact of these will be discussed. After that, a set of wider reforms will be suggested based on evidence from various international models that have actually delivered these objectives.

2. Current initiatives to reduce the clinical negligence spend

Some of the harms that occur during NHS care cannot be helped; they are unavoidable. However, the majority of harms[7] could be avoided if different care was provided. There is increasing attention and a plethora of proposed solutions, described in the Patient Safety Strategy and elsewhere, on how we reduce future harms and create a learning culture.

This inquiry is focussing on clinical negligence rather than patient safety more broadly. Therefore, this paper will consider the current initiatives to reduce incidents and spend in clinical negligence:

- birth injuries which have the highest compensation costs, and
- fixed recoverable costs on lower value claims, where the value of legal fees often outstrips the value of the compensation paid.

Birth Injuries

Birth injuries can result in life-long consequences for the baby and have an enormous impact on families and also on NHS staff. In 2019/20 clinical negligence payments were just over £2bn. Over the last few years obstetric claims have made up c.10% of the claims, but have accounted for half the money paid, which is why they have been a particular focus. Obstetric claims include injuries to both the mother and her baby. The courts do not value these injuries equally. Baby deaths, either early neonatal deaths or intrapartum stillbirths, are usually valued in the hundreds. By contrast serious brain injuries to babies, with the associated life-long care costs, can result awards into the tens of millions. Any reduction in the number of these multi-million pound awards would have a significant impact on the overall clinical negligence spend.

Harm reduction initiatives

Each Baby Counts was a quality improvement programme aimed at reducing birth related deaths and brain injuries. It collected data from 2015-2018 and investigated births resulting in an intrapartum stillbirth, an early neonatal death, or a baby who meets the criteria that indicate a risk of a brain injury. EBC investigators report that three quarters of these incidents were avoidable, though when the same cases are reviewed by an EBC neonatologist they find 40% were avoidable. Even if it were only 40% of cases were avoided, this is a number of lives not blighted and has the potential to generate a substantial reduction in the clinical negligence spend.

In 2015 the Government launched a strategy to halve stillbirth rates, maternal morbidity, neonatal mortality and serious brain injury by 2025. The NHS is better than on track for the interim aim of 20% reduction by 2020 for stillbirths and maternal death. This is a hugely positive development for patients and the NHS, but its impact on the clinical negligence spend is not huge. There is no clear decline in brain injuries, which have the largest impact on the compensation awarded. In 2017 the 2015 Government . This strategy included improved investigations into babies whose outcomes met the EBC criteria, additional quality improvement and learning support, and a maternity incentives scheme run by NHS Resolution. Safer Maternity Care. This strategy included improved investigations into babies whose outcomes met the EBC criteria, additional quality improvement and learning support, and a maternity incentives scheme run by NHS Resolution.

[7] The classic paper on this was the Harvard Medical Practice Study. This reviewed 30,000 randomly selected discharge records from 1984 from 51 New York hospitals. They concluded that serious adverse events occurred in 3.7% of the hospitalizations. **Of these patient adverse events, 58% were attributable to error (i.e., they were avoidable),** see Brennan TA, Leape LL, Laird NM, et al. Incidence of adverse events and negligence in hospital patients: results of the Harvard Medical Practice Study. N Engl J Med. 1991;324:370Y376.
More recent studies indicate that patient adverse events may be several fold higher than the Harvard study findings.

NHS Resolution's Maternity Incentives Scheme & Early Notification Scheme (ENS)

The Maternity Incentives Scheme consists of ten 'safety actions'; a Trust that completes these ten actions will get a rebate from the money they have paid to NHS Resolution to cover their clinical negligence costs. There are questions over how these 'safety actions' correlate to safety - almost £1m was paid to Shrewsbury & Telford Trust for completing them, despite the maternity care they provided being the subject of an external review and having been judged 'inadequate' by CQC. Similarly East Kent are paying back money and are the subject of an inquiry into maternity safety, which follows a successful criminal prosecution by the CQC over the death of baby Harry Richford in 2017. In fact, several NHS Trusts have had to pay back millions to the scheme after their assessments of their maternity safety were found to be incorrect.[8] In response to this, the processes for self-certifying the safety actions have been tightened up.

Since 2017, the ENS has required all members to report births that met the EBC criteria for brain injury to NHS Resolution within 30 days. The ENS aims to establish liability early and to shorten the legal process. ENS has substantially reduced the time taken for NHS Resolution to become aware of an incident. NHS Resolution's reports on ENS talk the talk about 'avoidable' harms, but in reality NHS Resolution cannot walk that walk – their statutory framework means they cannot make a payment unless there has been negligence and their investigations have to determine liability not avoidability.

Healthcare Safety Investigation Branch (HSIB).

HSIB were asked to carry out independent investigations into births that meet the EBC criteria on a no-blame basis. These started in April 2018 and achieved full national coverage by April 2019. Providing that a family consents to the HSIB investigation, it will replace a local investigation.

Draft and final investigation reports are shared with the family, the Trust, staff involved and other relevant bodies. An anonymised report including safety recommendations is published. There is no linkage between the HSIB report and litigation.

Lower Value claims

Proportionality

Proportionality is an important issue: lawyers have no desire to do the work then find that they go unpaid as their costs are deemed disproportional. The requirement to be proportionate applies across all values of clinical negligence claims, but pertains particularly to the lower value cases. Proportionality is set out in the Civil Procedure Rules (CPR) at part 44. Proportionality of costs, including ATE costs, was addressed by the Court of Appeal in the recent *West & Demouilpied* case.[9] These were both clinical negligence claims against Stockport NHS Foundation Trust which had been settled before proceedings were issued.

The Demouilpied claim settled at £4,500 with a bill of costs of £8,376. West settled at £10,000 with a bill of costs at £31,714. At first instance NHS Resolution successfully challenged the premiums for ATE insurance as disproportionate (the policies both cost £5,088 and were reduced to £2,500 in West and £650 in Demouilpied). These were block rated ATE policies, which are usually purchased in bulk and cover a number of cases: block rated policies are not adjusted to the specific risk of the particular case being insured. West and Demouilpied both appealed and the Court of Appeal considered their case together and found in their favour. The justices determined that 'unavoidable' costs (court fees, VAT, cost of preparing the bill, block ATE policies,[10] etc) should not be included when applying a proportionality test to costs. This has cemented

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[8] Shaun Litern 'Hospitals forced to repay millions after falsely claiming their maternity units were safe' The Independent 8 March 2021 available at https://www.independent.co.uk/news/health/maternity-safety-nhs-hospitals-shrewsbury-b1804683.html?fbclid=IwAR2vSrgUCbbzOnX3lkIgtxrA_575RpBzDIjrqGWB2TZEGBoV_WcRq6EtPZ4

[9] West and Demouilpied v. Stockport NHS Foundation Trust [2019] EWCA Civ 1220

[10] Bespoke ATE policies can still be challenged more easily on the basis of error in attributing risk.

the recoverability of ATE premiums in clinical negligence claims and leaves the sector in the position whereby claimant costs can easily outstrip the settlement value and still be considered proportionate.

On lower value claims, legal costs are high relative to the value of compensation paid. Figure 1 (taken from NHS Resolution's 2018/19 Annual Report) shows that on awards of £25,000 or less, claimant legal fees average £20,785. This does not include NHS legal costs; on average these are approximately one third of the claimant legal costs. Assuming that this pattern pertains then for awards of £25,000 or less then more money will be more being paid to lawyers than is paid in compensation. This disparity has increased substantially in the last decade and it has been recognised that the balance between costs and compensation needs to be addressed.

Figure 1. Average claimant legal costs for awards ≤£100,000 from NHS Resolution's 2018/19 Annual Report.

An additional cost on top of the claimant and defendant legal costs listed above are the administration costs both for NHS Resolution and the cost incurred by each Trust of running their legal department, some of which will be attributable to clinical negligence.

Fixed Recoverable Costs

It was against this backdrop that a fixed recoverable costs scheme for claims valued up to £25,000 was considered by the Civil Justice Council, who could not reach an agreement on how this should proceed. The aim is to curtail the costs associated with lower value claims. The Government's recent announcement that they intend to proceed with an FRC scheme. We are certain that you will receive a substantial response on this from those better placed than us to respond.

Conclusions on current strategies to address clinical negligence litigation

The 2017 NAO report was clear that the two major proposals to address the rising cost of clinical negligence litigation, a focus on birth injuries and the introduction of FRCs will not be sufficient to curtain costs. The most effective way to curtail costs is to prevent harm in the first place. In the next section we will set out alternative proposals that the evidence we have analysed suggests will drive learning and reduce costs.

3. Alternative redress processes for clinical injuries

Overarching approach

The foregoing analysis indicates that the current system of litigation to deal with clinical harm is harmful to the creation of a learning environment, does not deliver the outcomes that those who have been harmed or their families are seeking, and is immune to easy reform to control cost. However, evidence from other nations and other sectors within the UK indicates that these outcomes – learning, better redress and cost control - can be achieved by replacing clinical negligence litigation with redress delivered via an administrative scheme. Schemes are now used across many UK professional disciplines, particularly in the guise of Ombudsmen, and have been successful both in providing individual redress and providing high quality information which have enabled those professions to understand the causes of adverse events and improve their practice. The costs associated with a well-designed administrative redress scheme should be no more – and could be far less – than the current system of litigation.

Learning

Critical success factors in creating a learning environment include a system which provides as much data as possible about adverse events and where professionals are not disincentivised to share openly about their part in those events. Administrative redress systems in other jurisdictions or other professions have been more successful in creating those conditions. Systems which work to an inquisitorial rather than adversarial model are shown to reduce the likelihood of professionals retreating into defensive positions and increase the likelihood of early and open co-operation with investigations. The threshold used by an inquisitorial system is also important. When the ACC shifted from 'medical malpractice' (individual fault-based) to 'treatment injury' (an avoidable harm threshold that looks at systemic issues as well as individual errors), the average decision time for a claim fell from over 5 months to 13 days.[13] This was thought to be because doctors were not so fearful of being found at fault so supported patient claims. This is not surprising: no one wants to be blamed. This demonstrates that even in a non-adversarial system it is essential to apply a system-wide eligibility test to maximise efficiency. Such systems are also more successful in resolving cases quickly. Critically too, by providing access to potential redress without the barriers to success of a litigation-based model, administrative schemes centralise the reporting of potential cases, providing a far richer source of data and therefore learning. In the UK context, replacing the current litigation model with an administrative redress scheme would enable the NHS to learn from some of the 97% of cases which are currently raised with clinical negligence firms but screened out by their case selection processes.

Getting it Right First Time, GIRFT, has shown learning is possible (the original GIRFT programme had information form the national joint registry as well as from litigation) but it is far easier when you have a more data to work from. The fact that the NHS would therefore possess a richer source of data would then enable the proper analysis of trends and improve the drive towards reducing the incidence of adverse clinical events. This has worked in other jurisdictions. In the Committee's previous inquiry into Maternity Safety Pelle Gustafson presented the outcome of the Safe Delivery Programme education programme which was derived using evidence from Lof claims: the drop in birth injury rates that resulted from this programme was clear.

Redress and Financial Control

One of the authors has set up two redress schemes in the UK and advised on the creation of a third; the other has researched schemes worldwide. From our experience, three factors have to be considered in

[13] Manning J. Access to justice for New Zealand health consumers. J Law Med. 2010;18(1):178–94 at FN 65

modelling the financial costs associated with systems of redress (whether, as now litigation-based, or administrative): administration costs, claimant numbers, and redress levels.

Administratively, litigation is less efficient in delivering redress than an administrative scheme. In 2018/19 NHS Resolution's Clinical Negligence Scheme for Trusts (CNST) figures show that the combined claimant and NHS legal costs made up around a quarter of the total money paid out of CNST. That does not include the £13.3 million cost of administering CNST. Administrative schemes such as New Zealand or Sweden have a very different profile: the administrative costs average between 12-18% of the spend with the rest being compensation payments. This is a stark difference; far more of the money paid is going to compensate victims.

Limiting claimant numbers is more difficult and requires a close balancing of the desire to increase the data pool to drive learning and provide access to redress on the one hand and to manage costs on the other; more claimants results in greater cost. Three factors are likely to impact on claimant numbers: the mechanisms for alerting claimants to the existence of the scheme (the activity of the claims management industry in publicising PPI compensation massively increased claimant numbers at the Financial Ombudsman); the rules by which eligibility to claim are decided; and perceptions of the scheme's fairness. However, experience shows that good modelling and good scheme design (eg to reduce or eliminate the incentive for claims management companies to use a scheme as an opportunity for profit) mean that costs can be properly predicted and controlled.

The third element of financial control relates to the value of the redress given. One of the advantages of administrative schemes over litigation-based schemes is that they offer a wider range of redress mechanisms, many of which are non-financial: apologies, explanations, action to directly repair any harm (where possible). Many instances of redress therefore carry little cost. However, there is no doubt but that widening the pool of eligible claimants widens the possible compensation bill, particularly if the test for a successful claim is reduced from clinical negligence to, say, reasonable harm. For comparison when New Zealand shifted from 'Medical Malpractice' to 'Treatment Injury' claim numbers went up by 42% and the proportion that were paid went from 38% to 64%. In contrast in Sweden an avoidable harm threshold is used and around 40% of cases are paid.

This is a risk which has been faced by other jurisdictions with similar legal systems to the UK and successfully overcome. Of particular relevance is the fact that other countries with established systems of social medicine and care have moved to take the value of that care into account in setting the value of compensation. Among other things this could include consideration of reforms to section 2(4) of the Law Reforms personal injuries act, and/or reviewing the way the Compensation Recovery Unit functions.

Implementing an Administrative Redress system

The above savings are, of course, only achievable if it is possible to limit or eliminate litigation. Some of the schemes mentioned earlier, for example ACC in New Zealand, are exclusive remedies; they are the only option for individuals seeking compensation as have entirely replaced litigation. Replacing litigation extinguishes the possibility of costs being accrued there. However, in a UK context, this would require a change to primary legislation and would be likely to prove highly contentious, with the legal profession opposing it vigorously. Any replacement for litigation would almost certainly be challenged under Article 6 of the European Convention of Human Rights. There are precedents for UK Ombudsman decisions being challenged in this way, for example the compatibility of the Financial Ombudsman's processes with Article 6 was challenged in the European Court in 2011;[14] The judgement described the challenge as "manifestly ill-

[14] Heather Moor & Edgecomb Ltd v the United Kingdom - 1550/09 [2011] ECHR 1019 (14 June 2011)

founded"; however, that challenge was with regard to Ombudsman process and it is possible that a challenge to the principle of eliminating access to the courts entirely may be treated differently.

The less contentious option would be a system that co-exists with litigation. There are two variants of this model: a free choice option where claimants choose, or a model in which litigation is only open to those who have already been through the administrative redress scheme.

In Sweden patients chose whether to use the Lof's administrative scheme or to litigate. The vast majority go to Lof. A redress scheme that runs in parallel to the courts based on patient choice would have be structured so it is more attractive than litigation. In Sweden this is because Lof is non-adversarial, faster and offers parity of compensation. Parity does not necessarily mean exactly the same. Almost all clinical negligence claims are bought using a conditional fee agreement aka 'no win, no fee'. These allow a solicitor to charge a success fee (additional to their basic costs, which are also recovered in the event of a claim succeeding) of up to 100% of their fees capped at 25% of the damages awarded. For lower value claims the claimant usually gets 75% of the value of the court award. A detailed economic breakdown of what claimants actually receive is needed so that claimants can compare what an administrative scheme is offering with what they would get from a court.

The requirement model has been adopted in other contexts; for example, alternative dispute resolution (ADR) is a required step before access to the courts in divorce and employment. This is entirely acceptable to the courts as long as the scheme is set up as an ADR mechanism and adheres to basic principles of justice.

The major UK Ombudsman schemes are something of a hybrid. They do not choke off the possibility of court access entirely but litigants are usually required to have gone to the Ombudsman before being granted access to the courts. Moreover, because Ombudsman schemes are treated by the courts as acceptable models of justice, Ombudsman decisions are usually endorsed by courts. Ordinarily their powers are set out in primary legislation if only to ensure that their decisions are binding on the service provider and to provide them with the powers e.g. to compel access to evidence. Some schemes such as the Financial Ombudsman, began as voluntary before becoming statutory. It would be possible to set up an acceptable administrative scheme for clinical harm along Ombudsman lines without primary legislation. A scheme that was required before litigation would only need a change to the civil procedure rules which govern litigation processes.

We have outlined in our written evidence submission to the Committee's previous inquiry into Maternity Safety the scheme design requirements that would need to be considered in any alternative to litigation. These include considering the remedies available, the eligibility criteria, the threshold for redress and the scope of the scheme.

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4. Answers to the questions posed in the Terms of Reference

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

It should consider replacing adversarial litigation with an administrative system based on system-wide judgments of culpability rather than individual blame.

❖ 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?

Litigation as a mechanism to deliver compensation has a double impact, it is adversarial and it uses an individual-focused threshold to attribute liability. Both of these have the potential to impact on willingness to disclose information, and therefore on learning. For example, when the ACC shifted from 'medical malpractice' (fault-based) to 'treatment injury' (an avoidable harm threshold that looks at systemic issues as well as individual errors), the average decision time for a claim fell from over 5 months to 13 days.[21] This was thought to be because doctors were not so fearful of being found at fault so supported patient claims. This is not surprising: no one wants to be blamed. This demonstrates that even in a non-adversarial system it is essential to apply a system-based eligibility test to maximise efficiency. Exactly what that test is would depend on the scheme design, but what is essential is that you have both a non-adversarial system and a system-based eligibility test.

It is impossible to know if the problem you see in a claim is a one off or part of a pattern if you have limited information on how often that problem occurs. NHS Resolution is not notified of 97% of potential clinical negligence claims. It is impossible to learn from an incident you don't know about. When you are limited to just 3% of the opportunities to learn, the ability to spot trends and patterns is drastically reduced. If contacts/potential claims were known to the NHS this would enable far greater analysis. This could be achieved by replacing litigation with an administrative system where claimants report to that rather than to a solicitor who filters out most of the information before it gets to the NHS.

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

There have been improvements, for example the faster notification seen under the ENS. In practice improving the speed of notification is out of the hands of NHS Resolution for the majority of cases. It is only possible in birth injuries because of EBC investigations and later HSIB investigations. In theory this type of approach could be expanded to other types of harms which fall into specific criteria, but as there is no centralised NHS reporting on these there is no obvious mechanism. It is, and will remain, in the hands of claimant lawyers to notify. They can only do this once they have investigated whether there is a valid claim, and it any attempt to time-limit to this process is likely to be difficult and contentious.

'Delay, Deny, Defend' was the mantra used to attack NHS Resolution. While things have improved the process could be speeded up further. We have heard a lot of anecdotal reports of delays by defence solicitors because they are under resourced and therefore always behind the curve. Funding for defence

[21] Manning J. Access to justice for New Zealand health consumers. J Law Med. 2010;18(1):178–94 at FN 65

panel lawyers should be reviewed to ensure that budget savings are not at the cost of the efficiency of the litigation process.

Regardless of how litigation processes are improved they simply cannot compete with non-litigation alternatives. The most striking example is in birth injuries. Since 2017 the ENS has led to significant improvements to the speed of birth injury litigation, but we are still nowhere near the timeframes that international administrative schemes operate - under four months in Virginia and under eight months in Florida. While birth injuries provide a vivid example there is a plethora of evidence[22] from other schemes, such as ACC in New Zealand and the Nordic countries, which indicates that administrative schemes have much faster claim processing times.

A specific change could be made to legal aid in negligence claims. Virtually the only group who can obtain legal aid for clinical negligence litigation are brain injured babies. However, many such cases are brought on CFAs despite legal aid being available. Anecdotally some, but not all, claimant solicitors report the conditions on legal aid timelines are so slow and payments to experts are so low value that they feel legal the service they provide on legal aid is substandard. Retaining access to legal aid for brain injured babies was a policy decision, if that decision has been reversed then it should be clearly stated rather than effectively shunting that option in via the back door. If the policy remains unchanged then efforts should be made to improve Legal Aid and make it workable, including looking at timeframes for payments, the level of expert fees paid and, potentially, this could include exploring mechanisms to limit the use of CFAs such as prohibiting success fees where legal aid provides a reasonable alternative.

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

This scheme makes litigation run more smoothly, it does not address the blame culture, which has implications for open disclosure and transparency. All of these qualifying maternity incidents will be investigated by HSIB in a no-blame investigation, which encourages openness. Ideally the ENS should be halted and an administrative scheme which delivers both the investigation and compensation decisions should investigate. While this could be achieved by adding a compensation function to the HSIB maternity investigations, this is not what HSIB was set up to do and may detract from their core purpose. Moreover, if the ultimate aim is to covers all clinical negligence (as we suggest) then a new bespoke organisation would be a better solution.

When Better Births, the report of the National Maternity Review, was published In February 2016 it recommended an administrative Rapid Resolution and Redress Scheme (RRR). RRR comprised a non-adversarial insurance-based scheme for obtaining redress based on avoidable harm. An independent organisation was to investigate births that met the EBC criteria to see if the harm could have been avoided, and if so compensate the families and disseminate learning. This was influenced by LOF the Swedish patient injury scheme which resolves claims using an administrative scheme based on avoidable harm. This collates all the information, like ENS. However, unlike ENS Lof uses a system-wide approach to avoid individual blame, meaning that doctors will help patients make claims because they don't fear the consequences. These factors enable better learning and the resulting drop in birth injury rates was clear from the evidence presented to the Committee's Maternity Safety Inquiry by Pelle Gustafson from LoF. RRR as it was envisaged has not been implemented, instead we have the blame focussed ENS. We do not have a clear decrease in brain injuries, and as a result we have an increasing clinical negligence bill.

[22] Macleod & Hodges Redress Schemes for Personal Injuries (Hart, 2017)

- 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?

The 2017 NAO report is clear that the current proposals, including FRCs would not be sufficient to curtail the rising clinical negligence bill. We cannot comment on the level at which costs should be set. However, we spend a lot of time with both the defence and claimant law communities, and we are acutely aware of numerous anecdotal reports that the defendant solicitors are under-resourced which causes delays to the litigation process and therefore adds cost. We would caution against using the costs incurred by NHS Resolution's panel solicitors as a basis for calculating FRCs without an extensive analysis of whether the rates paid to them are realistic and actually represent value for money. Whichever threshold is selected there will be a degree of threshold massaging, which has the potential to distort claims values.[23]

Even if FRCs are introduced, we – and many lawyers to whom we have spoken in the course of our work in this area over the recent past - would expect that the sector will weather this storm. Claimant lawyers are resourceful, and if a system is workable they will make it work. Solicitors firms are savvy commercial enterprises and there will be an analysis of the stage a claim needs to get to in the FRC processes which maximises returns s. If FRCs are not workable and the only available route to justice is denied then the judiciary will take action to correct this.

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

It is very clear from the that the midwives' testimonies in the Robertson & Thomson paper that clinical negligence can be an extremely stressful process. The impact this had on these professionals is clear, including eroding their professional identity, causing stress related illnesses and, in some cases, resulting in an unhealthy use of alcohol. No profession would want its members to undergo this level of stress, and the inevitable impact it has on staffing and the provision of care.

While the adversarial nature of litigation is important in creating a blame culture the threshold used to judge eligibility for compensation is also important, see the answer to the *'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?'* question above.

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

It is very important that lessons are learned and that there is a commitment to action. However, there are very limited mechanisms which clinical negligence can used to do this. The only outcomes the courts can demand from clinical negligence litigation are damages. We do not have a culture of exemplary or punitive damages, as there is in US for example, and given the NHS is state funded this would be entirely inappropriate (not to mention of questionable effectiveness). The courts have limited scope to encourage lesson learning.

There is some scope for NHS resolution to encourage lesson learning using financial leverage by risk pricing the CNST premium. There is also the potential to benchmark services to facilitate organisations knowing

[23] See Chapter 10 Motor Vehicle Coverage in the USA In Macleod & Hodges Redress Schemes for Personal Injuries (Hart, 2017)

where their services rank. Benchmarking needs data, and litigation is a poor source of data, as is discussed above in '*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?*'.

NHS Resolutions Maternity Safety Incentives Scheme was an attempt to encourage safer care using financial incentives. In some cases, East Kent, etc, it was an abject failure. Not only did it fail to ensure safer care, but worse still it enabled Trusts that were providing inadequate services to publicly state they were part of a Maternity Safety scheme. Lesson learning in clinical negligence has to apply to everyone, not just healthcare providers.

- 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 fact that a midwives describe conferences with their own barristers, who are on their side in the litigation, as 'intimidating' and 'terrifying' indicates how difficult this adversarial process can be. Blame, and feeling blamed, can come from a range of factors. This includes the adversarial process, the thresholds used to determine compensation, the threat of regulatory sanctions and issues of professional identity.

Changing the system by which we compensate harmed individuals can have a significant impact. We return to the example from New Zealand when the ACC shifted from 'medical malpractice' (individual fault-based) to 'treatment injury' (an avoidable harm threshold that looks at systemic issues as well as individual errors), the average decision time for a claim fell from over 5 months to 13 days.[24] If you lessen the barriers that prevent professionals from making early candid disclosure you will have a system that works better both for doctors combined with quicker earlier resolution which is much better for patients

- 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?

This comes back to the point that litigation cannot mandate non-financial remedies, so is not the most appropriate mechanism for that end. We know that individual's end up in litigation out of sheer desperation to prevent the same thing from happening to someone else, to obtain an explanation, or to hold to account the staff/organisation. HSIB carry out two types of investigations, national investigations and maternity investigations. The National Investigations involve affected families, but they are strategic projects and they cannot realistically engage with every individual who has been affected by the topic. For this reason, national investigations are unlikely to provide the specific answers relating to the treatment of an individual that claimants are looking for.

The maternity investigations are very different, they are focussed on the care that individual received. They are comprehensive in that all qualifying incidents should be investigated. For that reason, they are able to provide answers about the specific treatment a patient received.

HSIB maternity investigations replace a local investigation. This raises concerns of a lack of local ownership and accountability. Joint investigations would enable a Trust to have ownership of any learnings and the resulting strategies implemented to prevent reoccurrence. This is key in driving improvements.

One very positive UK development is that birth injuries information is being collated to enable learning. However, Trusts must notify both HSIB and NHS Resolution's ENS. There are plans that this is rationalised so

[24] Manning J. Access to justice for New Zealand health consumers. J Law Med. 2010;18(1):178–94 at FN 65

that information is entered into a single notification point. There is a concern that this will actually inhibit the open flow of information. The initial information will feed into HSIB for a 'no blame' investigation; while at the same time reporting to the Trust's legal department under ENS, which is blame-based. The rationale for 'safe space' is to enable open disclosure. This joint initial reporting risks contaminating all of the investigations with a closed blame culture, rather than in an open safe space.

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

This depends on what options are chosen. If an administrative redress scheme was to be an exclusive remedy instead of clinical negligence litigation that would require primary legislation and would be highly contested.

If a scheme were to sit alongside clinical negligence limitation as an alternative to litigation no legislation would be required.

If a scheme were a precursor to litigation, then it would be possible to set up an acceptable administrative scheme for clinical harm along Ombudsman lines without primary legislation. A scheme that was required before litigation would only need a change to the civil procedure rules which govern litigation processes.

Trusts are not required to use NHS Resolution; it is a choice. At the moment Trusts have no option other than litigation, but there is scope for change.

- **Biographies and relevant publications**

Dr Sonia Macleod is a researcher on the Access to Civil and Administrative Justice Programme at the Centre for Socio-Legal Studies, University of Oxford. Her research spans medical law, dispute resolution and redress, with a particular focus on alternatives to litigation. She is the author of Redress Schemes for Personal Injuries, a comprehensive consideration of alternative ways to deliver redress to those who have suffered injuries. She also works as a consultant for a variety of clients on related issues. Sonia was the Lead Researcher for the Independent Medicines and Medical Devices Safety Review chaired by Baroness Cumberlege which reported in July last year.

Adam Sampson has had a long career in the voluntary and public sectors, including as CEO of Shelter and St Elizabeth's, a provider of care and nursing services, and is currently CEO of the Association of Optometrists, in which capacity he oversees a scheme insuring optometrists and optical practices against clinical negligence claims (the AOP will be submitting evidence separately; this submission is in his personal capacity). He led the establishment of the Prisons Ombudsman and, as Chief Legal Ombudsman, set up the Legal Ombudsman following the 2010 Legal Services Act. He has also consulted on health, redress and legal matters, with clients from the corporate, voluntary and public sectors, as well as central Government, and is a Programme Associate on the Civil Justice Programme at the Centre for Socio-Legal Studies.

Relevant publications

Macleod Sonia & Chakraborty Sweta ***Pharmaceutical and Medical Device Safety: A Study in Public and Private Regulation*** (2019, Hart)

Macleod Sonia & Hodges Christopher ***Redress Schemes for Personal Injuries*** (Hart 2017)

Macleod S.A., Sampson A., and Hodges C. ***The Rapid Resolution and Redress Scheme for Birth Injuries: An Alternative Scheme Design*****.** Foundation for Law Justice and Society Policy Paper 13 September 2017 available at http://www.fljs.org/content/rapid-resolution-and-redress-scheme-birth-injuries-alternative-scheme-design

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