Written evidence submitted by Weightmans LLP (NLR0064)

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

NHS Resolution has reported a reduction in its provision in respect of clinical negligence claims from £84.1 billion to £82.8 billion and observes a lower than expected number of incoming claims and reduced claims inflation. Nonetheless the NHS is continuing to incur around £8 billion annually for the cost of clinical negligence, of which maternity claims make up 65% of the NHS Resolution provisions for claims.

Our analysis of Trusts' contributions to CNST relative to their annual income is summarised in the table below and shows on average trusts are contributing 1.78% of income to fund clinical negligence claims. The percentages are higher for acute (2.51%) and foundation trusts (1.83%) which we anticipate is due to the number of maternity claims.

2019/20 Data	Overall	Acute	Ambulance	Community	Foundation	Mental Health
Top Contribution	11.21%	4.38%	0.85%	0.30%	11.21%	0.37%
Least Contribution	0.01%	0.19%	0.26%	0.09%	0.01%	0.20%
Average Contribution	1.78%	2.51%	0.55%	0.18%	1.83%	0.28%

It has been reported that spending on clinical negligence has been increasing much faster than NHS funding and if this continues it must become unsustainable. (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/248285/0576.pdf; https://www.nao.org.uk/wp-content/uploads/2017/09/Managing-the-costs-of-clinical-negligence-in-trusts.pdf)

The above costs are the direct costs of clinical negligence litigation and in addition to this must be considered the indirect costs, the impact and consequences of litigation on both patients and workforce. This includes the time needed from clinicians, legal teams and others within the NHS in investigating, providing evidence and managing claims, staff absences due to stress and increased care costs to treat patients harmed.

2. **What are the key changes the Government should consider as part of its review of clinical negligence litigation? In particular:**

    a. **What changes should be made to the way that compensation is awarded in clinical negligence claims in order to promote learning and avoid the same problem being repeated elsewhere in the system?**

We have considered alternative tests/standards of care used by some other jurisdictions to establish liability, but many involve similar issues to the current tort-based assessment carried out in the UK, involving expert assessment, lawyers and interpretation of how any new standard of care is applied. We are not aware of any evidence that a different standard of care would promote safety and learning and it is inevitable that any change of such a fundamental nature would give rise to increased costs and time to implement.

Often learning from clinical negligence claims comes too late after the events when some clinicians will have moved on and processes and procedures have changed. It is therefore important that investigation of incidents that might lead to claims are carried out as soon as possible after the events. The Early Notification Scheme provides for this in maternity claims which make up over half of the value/cost of claims to the NHS. We have been involved in several cases where investigation of these cases has led to changes in practices/procedures in a timely fashion:

- analysis identified a safety concern which led to a change in Trust documentation which increased their ability to detect growth abnormalities which otherwise may have been missed.
- investigations/advice led to the Trust changing their induction policy to factor in staffing acuity levels and the need to transfer patients to another hospital earlier (if the trust could not induce in a timely way) to ensure appropriate care.

Many claims are preceded by complaints which provide an early opportunity for investigation and resolution. However, many complainants/claimants are not satisfied by the NHS complaints' handling process and gave this as a reason why they brought a claim. (https://resolution.nhs.uk/resources/behavioural-insights-into-patient-motivation-to-make-a-claim-for-clinical-negligence/)
The complaints and investigation process within NHS trusts often includes witness comments/ statements but less often an early independent expert report which can be valuable in addressing both patients' and clinicians' concerns independently. An improved complaints process will promote local and more timely learning.

In the past, it was a requirement of LSC funded claims that a complaint had been made to a trust before the LSC would provide funding for a claim. This would allow a trust to consider the issues locally before solicitors are instructed and legal costs escalated. It could be a requirement that a CFA and ATE insurance could only be engaged once a formal complaint had been made and response received (or the appropriate period for a complaint response has lapsed).

Early investigations and timely resolution are key to ensuring that lessons are learned from claims (and the incidents that give rise to claims). Some equivalent duty, or onus, by/on claimant advisors to provide early information in the spirit of the duty of candour would facilitate earlier and more effective investigation allowing the NHS to investigate earlier ensuring that patients and their families get early answers, candour and, where appropriate, compensation.

We have suggested in response to the questions below a variety of ways in which pre-action investigations and claims handling have and can be speeded up.

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

We suggest a less adversarial approach to claims with a focus on early pre-action resolution. Much work has already been done on this both by NHS Resolution and its panel lawyers as well as claimant lawyers and organisations such as AVMA and SCIL. Litigation should truly be the last resort and claimant/claimant firms who litigate prematurely should be effectively sanctioned.

We have been involved in a variety of dispute resolution models including:

- Negotiation

- Settlement meetings (including "bulk settlement" meetings involving discussion of a number of claims at the same meeting)
- Mediation
- Group settlement agreements (where we have agreed a protocol/process for claims handling with advisers for the claimants)
- On-line and virtual ADR
- Early exchange of expert evidence and experts' meetings ("hot tubbing").

Using a variety of dispute resolution methods NHS Resolution now settle the majority of claims without formal legal proceedings being required.

We suggest that this could be increased further by amendments to the pre-action protocol to promote earlier resolution of claims including:

- Speed up the provision of medical records. These are usually disclosed by Trusts to claimant's solicitors at an early pre-action stage and sorted and paginated by them. Claimant's solicitors should be required to provide a copy of the paginated medical records with the letter of claim. This could be done via sharefile/Mimecast at little/no cost. At present defendant's solicitors often face delays in receiving records, either from the Trust due to resources or the claimant's solicitors who can be unwilling to share them without receiving payment first despite.
- In cases in which liability is admitted in the letter of response, a requirement on the claimant to provide a schedule of loss and quantum evidence in support (both expert and non-expert) pre-action, within a further agreed period of time, e.g. 4 months. We recognise that this may not be possible in all cases, particularly those of high value.
- Compulsory dispute resolution (mediation, settlement meeting, early neutral evaluation) pre-action. Claimants who issue proceedings without agreeing to this step could forfeit the right to recover court issue fees and associated legal costs of issue. Defendants who refuse to engage in this process should also be penalised in costs.
- A requirement to agree an extension of the limitation period particularly in cases where liability has been admitted, again with costs penalties for parties who refuse and/or issue proceedings without extending limitation.
- Consideration of joint expert evidence on quantum particularly where liability is admitted and for cases with a value of up to £25,000 (in line with fixed recoverable costs).

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

NHS Resolution, its panel lawyers, claimant lawyers and organisations such as AVMA and SCIL have already taken large steps towards greater collaboration.

Examples include:

- Covid 19 Clinical Negligence Protocol – we see no reason why much of this should not be continued indefinitely.
- An ADR initiative scheme with a leading claimant firm where we meet regularly to break down barriers to resolution and explore alternative processes. This has included meetings between teams from both claimant and defendant firms, joint training and an opportunity to explain our respective positions. A relationship of understanding develops which increases the prospects of early resolution.
- Increased use of mediation.
- Increase in pre-action settlements.

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

An expanded Early Notification Scheme may have a role to play in improving transparency and efficiency. It is appropriate that it is focussed on maternity claims given that such claims represent 59% of the total estimated value and 11% of the number new claims. Any expansion of the scheme needs to take into account the following factors:

- Many incidents that may give rise to claims are already investigated either as a SI or complaint and duplication of investigations should be avoided wherever possible. The ENS scheme has already recognised this and investigation by NHS Resolution is now undertaken after and taking account of any HSIB investigation.
- Resources to carry out further investigations are limited and any expansion should be limited to high risk and high value or frequently occurring incidents.
- The impact of the Early Notification Scheme and accelerated liability investigations has had a direct impact on the value of clinical negligence claims reported. Any expansion of the scheme beyond maternity is likely to result in a similar increase.
- The current EN scheme does not prevent patients seeking legal advice or claimants' solicitors carrying out their own liability investigations either at the same time as the ENS investigations or after they have been concluded. Any expansion of the scheme should follow discussions with claimant representative groups and in collaboration, involving potential claimants in the investigations while at the same time putting independent claimant investigations on hold pending the outcome of any EN investigation.

e. 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?

While the value of the claim is not the sole determinant of importance or complexity, in line with the CPR overriding objective that costs should be proportionate to the value of a claim we consider that there are very few cases of low value where fixed recoverable costs should not apply. However, we consider that there is a case for alternative and higher fees in cases involving stillbirth or early early neonatal death. Such cases are often similar in complexity to cerebral palsy claims. In order to fully investigate whether a child should/would have survived, one needs multiple liability experts (obstetrics, midwifery, neonatology and/or paediatric neurology, possibly neuroradiology). Given the complexity experts are unwilling to agree fixed fees. Most of these cases do not give rise to high value settlements, but in addition to their complexity are also very sensitive and the parents have a huge investment in them and deserve answers.

We also suggest that additional fees may be needed for mental health claims such as suicides and failed suicides where there are extensive records and expensive psychiatric expert evidence is needed.

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

In our experience "blame cultures" are not created by litigation per se. Where blame cultures exist, they are usually present within Trusts first and create or contribute to issues leading to

incidents/claims and ultimately litigation. By the time many claims are intimated, claimant and defendant positions are entrenched.

Professionals are regulated and are always subject to their professional body, the GMC for example. They are more fearful of a professional body investigation than adversarial clinical negligence litigation. Giving evidence at inquests can also give rise to blame cultures and can cause great fear. Then it is the fear of saying something wrong and their colleague saying something differently and there being a contradiction between them. Promotion of a just culture is required; challenges to NHS employees are numerous enough; a truly open and learning culture rather than one which pay lip-service protects patients and staff.

No-one likes a complaint/claim but if this was in their student training from the outset ie. how to handle it and be ready for it and which type of issues lead to professional regulation involvement then they would be better equipped to deal with this when inevitably they become involved later in such issues in their career.

The claim process rarely requires court attendance and most cases are resolved without a hearing, or the need for the clinician to explain themselves to the patient and their family.

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

NHS Resolution and its panel firms are committed to safety and learning from claims and have developed many products and services for trusts to assist with this including:

- GIRFT Litigation packs and learning from litigation claims
- Thematic reviews
- Patient safety case stories
- Training

We provide data analysis and reports analysing clinical claims data and provide insights to NHS Resolution and trusts. We identify hotspots/common themes; volume high risk areas, trends, repercussive patterns; provide focussed training based on data and claims experience; and assist to implement changes.

Trusts use a range of these services to:

- report to Boards on claims spikes and spend;
- benchmark specialties experiencing high numbers of claims;
- understand where weaknesses are;
- share learning with relevant staff groups/encourage divisions to engage with claims/inquests process.

While therefore we do see changes in clinical practice as a result of issues raised in a claim, these are not tracked and there is no system to follow up.

Learning from claims is only one part of patient safety and learning and the primary focus of the clinical negligence claims system is not to deliver learning. Evidence-based analysis and insights from claims should not be viewed in isolation and collaboration with multiple organisations involved in patient safety and assurance is required to take the maximum benefit from that information leading to demonstrable outcomes e.g. reductions in cases, values and resolution time.

5. **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?**

There is a need to teach clinicians during their professional training more about clinical negligence, inquests, the role of NHS Resolution and what will be needed from them as clinicians both to avoid litigation and when they are required to participate in it. Anecdotally, we are aware that during a 4 year medical course, one medical school gave a one hour lecture about inquests and litigation. Only one person knew who NHS Resolution were. If medics received training about good notes, never events, common claims (and thus what to try to avoid), their role in litigation and inquests, engagement would likely be better which would minimise delays and speed up investigations. Often they are fearful of solicitors but if they knew more about the process, they might engage more swiftly.

Training in communication and patient stories would also be of benefit. Complaints are often generated by a poor initial response and communication and poor handling of complaints leads to claims as the only effective recourse.

6. **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?**

No response

7. **What legislative changes would be required to support these changes?**

Repeal of Section 2(4) of the Law Reform (Personal Injuries) Act 1948 which requires allows that all compensation awards are calculated on the basis that future care will be provided in the independent sector, and not the NHS, even when there is evidence that it is likely that the NHS will provide that care. Funds are being awarded on the basis that the money will be spent on setting up individual private care arrangements even in cases where appropriate care is being provided by the NHS and there is no need to replace this with privately paid for care. The NHS is in those cases effectively paying for the patients' care twice.

However, the largest element of many high value clinical negligence claims and in particular maternity claims is not NHS/medical care but rather social care. Legislation is therefore also needed to so that in cases where appropriate care is being provided by the Local Authority and on the evidence it is likely that this will continue, appropriate account is taken of this in the value of any settlement to avoid potential double recovery by the claimant and double payment by the public sector.

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