Health and Social Care Committee Inquiry
NHS Litigation reform

Evidence from the Association of Personal Injury Lawyers

About APIL

The Association of Personal Injury Lawyers (APIL) is a not-for-profit organisation which has campaigned for the rights of people injured through no fault of their own for more than 30 years. Our vision is of a society without needless injury but, when people are injured, a society which offers the justice they need to rebuild their lives.

Executive Summary

- NHS Resolution statistics demonstrate that the cost of clinical negligence is falling. It currently represents 1.5 per cent of NHS England's total budget for the year.

- The purpose of clinical negligence litigation is to help restore a patient's life when needless injury has occurred. An injured patient requires full and fair compensation: this is not a windfall, but rather a 'return to normal'.

- The current approach to patient safety has failed. The patient safety crisis requires a Patient Safety Commissioner with an overarching remit to create a meaningful link between patients, regulators, healthcare providers and policy-makers.

- There is no link between providing redress for patients who have been harmed needlessly and the sustainability of the NHS.

- There must be greater candour between clinicians and injured patients: this can help patients come to terms with what has happened and may obviate the need for litigation as a solution.

- Collaborative work between NHS Resolution and patients' lawyers is growing and could be increased with the expansion of an existing Serious Injury Guide, developed by claimant and defendant lawyers.

- Clinicians need to be confident that they will receive support from the NHS, their colleagues and regulators when things go wrong: a culture of openness can generate a willingness to accept accountability when things go wrong, and this is incredibly important to injured patients.

- The availability of private treatment for injured patients must be retained in fairness to patients who have suffered terrible hurt, and subsequent loss of trust in the NHS; to provide them with prompt rehabilitation and therapies, and avoid overwhelming additional cost to the NHS.

- A 'no-fault' system would not provide full and fair redress to injured patients, would be unaffordable and would not improve patient safety.

Costs, and the value and role of compensation

This inquiry is based on two false premises. The first is the claim of a 'significant increase in costs'. In fact, NHS Resolution's annual report for 2020/21 demonstrates clearly that £2.2 billion was spent on clinical negligence claims in the past year, including spend on claims settled in previous years. This is a drop of £114.9 million on the previous year[1]. It represents 1.5 per cent of NHS England's total budget for the year, which is a drop from 1.9 per cent in 2019/20 and 2.1 per cent in 2018/19. There is no evidence of 'a significant increase in costs'.

The second is that the clinical negligence process does not do enough to encourage lessons to be learned. The fact is that, while clinical negligence litigation can help to highlight patient safety issues and thereby encourage learning from failings, that is not its purpose. The purpose of compensation is to restore an injured patient's life, as much as that is possible, to where it would have been, but for the needless injury. For the child who suffers a severe and avoidable brain injury at birth, that will mean a lifetime of care, therapies, equipment and living in specially-adapted accommodation. In essence, clinical negligence litigation treats the symptoms of NHS failings, not the causes.

[1] *NHS Resolution Annual Report and Accounts 2020/2021* p43

It is not the purpose of compensation to punish those responsible for causing needless injury, nor can compensation be awarded when injuries could not have been foreseen, or where medical care has not been first rate. The law does not require clinicians to provide exemplary standards of care, it only requires healthcare professionals to exercise reasonable standards of care and skill.

The decision about what level of care is reasonable is made by fellow clinicians and, where the standard has fallen below that benchmark, that patient has every right to full redress to help put things right. It is important to remember that the relationship between claimant and defendant in these cases is unique: pregnant women and patients who are already ill or injured have placed their trust and welfare entirely in the NHS' hands. In that sense, injured patients are uniquely vulnerable.

In the apparent obsession with the financial cost of clinical negligence to the NHS, it must never be forgotten that any reforms which fail to provide full redress for injured patients will cause incredible hardship to them and their families and will do nothing to improve patient safety. The principle of 100 per cent compensation, has been acknowledged many times during political debate, including in the House of Lords during questions on this issue in 2018. At the time, the then-minister for health Lord O'Shaughnessy, said "The issue of reform to tort law is difficult. We have to be very careful when stepping across the idea of full compensation."[2]

Injured patients interviewed as part of a research study commissioned by APIL would agree. The study points out: 'Compensation does not provide the means for people to elevate their standard of living. It simply facilitates a 'return to normal', or an adaptation to a 'new normal', post the negligent event.' It goes on to quote an injured patient who was interviewed for the study: "I think the most important thing to understand is that, if there has been a miscarriage of justice, people have been failed in their health…they're going to need…not just their wheelchairs and things, [and] adaptions around the home but maybe the loss of earnings for the rest of their life… We're not naming and shaming or anything like that, but someone is still at fault. It is your health, your life."[3]

[2] Questions in the House of Lords, 31 January 2018 https://hansard.parliament.uk/Lords/2018-01-31/debates/0955B4A2-9ECD-454A-8B91-CBF6E168C776/NHSClinicalNegligence#contribution-7EB791AA-D007-4C48-9B9E-B15722878159
[3] *The Value of Compensation*, Opinium Research, p7-8

The patient safety solution

Reducing avoidable harm to patients is the obvious way to prevent unnecessary suffering. It is also the obvious way to reduce the amount paid in compensation, and the costs associated with that.

Yet the link between injuring patients and the cost of putting things right when things have gone wrong is rarely discussed. It was certainly never a factor in the Civil Justice Council's work on fixing legal costs, despite repeated attempts by patient representatives to put patient safety on the agenda.

The current approach to patient safety is impossibly multitudinous and fragmented. It includes, for example, the NHS Patient Safety Strategy; National Patient Safety Improvement Programme; Patient Safety Incident Response Framework; Learn from Patient Safety Events; Maternity Transformation Programme; Maternity and Neonatal Safety Improvement Programme; Maternity Safety Support Programme; Patient Safety Incident Response Framework; National Learning Report. Then there is the work of the Care Quality Commission (CQC); the Healthcare Safety Investigation Branch (HSIB); initiatives from the Royal Colleges; recommendations from numerous public inquiries into NHS failings, and recommendations from the Parliamentary and Health Service Ombudsman. This patchwork quilt of programmes, recommendations and reports is inefficient and lacks coherent leadership. Furthermore it is, demonstrably, an approach which has failed.

Since 2010, NHS organisations have been mandated to report all patient safety incidents resulting in severe harm or death. During that time no progress has been made in reducing the number of incidents. In fact, between 2010/11 and 2019/20, the number of these incidents actually increased by two per cent.[4]

[4] National patient safety incident reports, NHS England, available at https://www.england.nhs.uk/patient-safety/national-patient-safety-incident-reports/ (latest data published September 2021)

In *First Do No Harm, the report of the independent medicines and medical devices safety review,* Baroness Cumberlege delivers the following damning review of the current system:

> We have found that the healthcare system …is disjointed, siloed, unresponsive and defensive. It does not adequately recognise that patients are its raison d'etre. It has failed to listen to their concerns and when, belatedly, it has decided to act it has too often moved glacially. Indeed, over these two years we have found ourselves in the position of recommending, encouraging and urging the system to take action that should have been taken long ago. The system is not good enough at spotting trends in practice and outcomes that give rise to safety concerns. Listening to patients is pivotal to that.[5]

A new Patient Safety Commissioner (PSC) is to be appointed by the Government, following a recommendation from *First Do No Harm.* Emerging as it has from this review, the PSC's remit is currently restricted to issues relating to medicines and medical devices, but it is clear that there is now an urgent need to expand the role and create a meaningful link between patients, regulators, healthcare providers and policy-makers. Critically, the role is independent, and has the power to make organisations, including the Department for Health and Social Care, respond to it. Building on this existing policy is surely the simplest, quickest, and most coherent way of tackling the patient safety crisis and the cost, in both human misery and the need for redress, that accompanies it.

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

The concern of our members is for those who have been injured or killed while receiving NHS care. Behind every media headline on this subject are people whose lives have been turned upside down by an institution which is supposed to have helped them. When the worst happens, those patients must have the support they need to help them get their lives back on track.

Linking this need with the financial sustainability of the NHS is completely inappropriate. It is very difficult to understand how anyone could tell the parents of a child whose life has been devastated by negligence that the compensation which is designed to help that child is 'unsustainable'.

[5] *First Do No Harm: The Report of the Independent Medicines and Medical Devices Safety Review*, p i-ii

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

As stated earlier in this evidence, providing compensation to needlessly injured patients and promoting learning are two different things. There is, however, a considerable amount that Trusts themselves can do to promote learning, and also to treat patients in such a way that they do not necessarily feel the need to make a claim for compensation in the first place.

APIL members consistently report that many injured patients simply want an apology for what happened, and assurances that lessons will be learned so the same thing does not happen to anyone else.

Since 2014, healthcare professionals in the NHS have had a duty of candour to patients which involves telling the patient when something has gone wrong, offering an apology, offering a remedy or support where possible to do so, and a full explanation of the short and long term effects of what has happened.

Our members report that application of the duty of candour is rare. Feedback also suggests that, where individual clinicians may wish to engage with patients in this way, many do not know how to do so, do not have the support they need, or are discouraged from engaging with patients by the Trusts' own legal teams. At a recent event organised by the patient safety charities Harmed Patients Alliance and Baby Lifeline, this theme was explored by keynote speaker Dr Bill Kirkup, chair of the independent investigation into East Kent maternity services.

Dr Kirkup said there are often powerful incentives to avoid saying anything has gone wrong, and the prospect of litigation is just one of them. Criticisms from colleagues, from clinicians' regulators, the media and the prospect of prosecution all play their part in preventing clinicians from sitting down with families and being honest. He also said that once Trusts' legal teams get involved, they often delay and obfuscate as much as possible.

Sir Robert Francis QC who, among other work, chaired the two Mid-Staffordshire NHS Foundation Trust inquiries has also explored this theme. At a Westminster Health Forum held in January this year he said that, in his experience "so many victims wanted but were denied honest explanations, appropriate apologies and timely support for their needs."

He said many people would be satisfied to be treated with respect. He also highlighted a lack of learning from complaints. In a theme which ran right through the event, Sir Robert reiterated that patients require transparency, candour, remedial support and "true involvement, not just in establishing what happened, but in devising solutions."

NHS staff, he said, needed the support, training and time to improve their communications with patients, pointing out that it can be difficult to know how to receive criticism and how to have a difficult conversation with a patient who has been injured.

The *Value of Compensation* report highlights discrepancies between NHS Trusts in terms of transparency:

> Patients reported very different experiences with transparency in the NHS. A few said that the NHS had been very upfront about what had gone wrong and about the learnings that had emerged from the case, with consultants even recommending that the patient take legal action. However, most had a much less open experience. In the worst cases, NHS staff had tried to proactively cover up the errors that had been made and some reported that medical staff had lied about the events and even fabricated medical records. Those having to deal with a negative backlash of claiming and proving the credibility of their case felt betrayed by the NHS and found the process especially stressful.
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> "They basically said that I was lying or embellishing [it] … in the end it was the other nurse that admitted it [that mistakes had been made]. They weren't helpful at all. It seemed to be all the proving and all the proof had to come from my end ... I had to prove everything to make them believe that they're the ones that caused my pain. They never offered an apology." LB, 32[6]

In 2018 NHS Resolution published a report which examined the motivations of injured patients when making claims. When asked to select all the reasons for making a claim which applied, 76 per cent of respondents to the survey included 'frustration with the handling of the incident' in their responses. 87 per cent included 'to prevent similar incidents happening to others' and 80 per cent included 'to get an apology'. Comparatively few respondents (41 per cent) included 'to get financial compensation'.[7]

[6] *The Value of Compensation*, Opinium Research, p25
[7] *NHS Resolution: Behavioural insights into patient motivation to make a claim for clinical negligence*, p45, fig 13

Injured patients who need to claim financial redress to help restore their lives should always be able to do so and should always receive the full amount they need. The evidence is clear, however, that honesty, transparency and an apology can go a long way in helping people come to terms with what has happened to them and may obviate the need for litigation as a solution in some cases.

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

Proper support for patients and access to independent legal advice is key. Should patients wish to proceed with a legal claim, then earlier investigation into patient safety incidents and earlier admissions of liability by NHS Trusts will do much to speed up the system.

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

The growth in collaborative working between claimant lawyers and NHS Resolution, which is highlighted in the NHSR's annual report published in July, has been extremely encouraging. Greater collaboration generates greater efficiency which obviously results in lower costs, without removing the injured patient's need for, and right to, full and fair compensation.
In the NHSR report, chief executive Helen Vernon said "a welcome development… was greater cooperation between the parties. Our efforts to keep cases out of court gained more traction as there was an increased willingness to resolve matters without formal court proceedings and to try new approaches such as remote mediations."[8]

There is no doubt that more can be done to promote collaborative working and a guide to the conduct of serious injury cases, developed by APIL and the Forum of Insurance Lawyers (FOIL) presents a blueprint of how this approach could be expanded. The overarching aim of the Serious Injury Guide (SIG) is to put the injured person at the centre of the process and encourage parties to work together, allocating tasks, and narrowing issues throughout a claim. It currently excludes clinical negligence cases and so represents a real opportunity to build on a formula which has achieved some success since its formal launch in 2015.

[8] NHS Resolution Annual Report and Accounts 2020/2021, page 10, paragraph 1

The aims of the Serious Injury Guide are to:

- resolve liability as quickly as possible
- where beneficial to the claimant, to provide early access to rehabilitation to maximise recovery;
- to resolve claims in a cost appropriate and proportionate manner;
- to resolve claims within an appropriate agreed time frame;
- resolution through an environment of mutual trust, transparency and collaboration.

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

The early notification scheme (ENS) for birth injuries is, in principle, a scheme which APIL supports, but there are some fundamental concerns about how it currently operates. A key concern is that families should be informed by NHS Trusts that they have a right to independent legal advice, but there are indications that this is not happening. Certainly, NHS Resolution's guidance to trusts does not expressly mention that hospitals should tell families that they have the option to obtain legal advice.

APIL members have reported that families are either not told that an investigation is happening, or that they are not as involved as they should be. Given the importance to patients of transparency and candour as identified earlier in this evidence, this is a significant systemic failing of the ENS.

Given the disparate approaches to clinical negligence across NHS Trusts it cannot possibly be in the best interests of patients to receive advice only from the institution which has potentially caused the harm.

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?

A substantial amount of discussion and consultation with the parties has been conducted by the Civil Justice Council and recommendations presented to the Government. As the Government has indicated that it intends to consult on those recommendations, it would be inappropriate to comment on the issue further in this paper.

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 Health and Social Care Select Committee's report on the safety of maternity services included some interesting observations on this point. The report points out that the legal defendant is the Trust, not normally individual clinicians – the fear of blame is largely based on the way those individual clinicians are then treated by their respective regulators. In addition to that, there are ongoing reports about clinicians' fear of being blamed by their own colleagues, as noted by Dr Kirkup earlier in this paper.

The British Medical Association highlighted the issue of blame in the NHS in a research report published in 2018[9]:

- BMA's survey findings show clearly that a culture of fear and blame persists in the NHS. This is a risk for patient safety, prevents people from being open about errors, learning from mistakes and contributing to continual improvement. The recent case of Dr Bawa-Garba reinforced perceptions amongst doctors that they will be held accountable for wider systemic failings.
- Patient safety in our health services is of paramount importance – so it is of considerable concern that many doctors (55%) are reporting that they fear being unfairly blamed for errors due to system failures.
- Five years ago, landmark reports by Robert Francis QC and patient safety expert Don Berwick called for fundamental cultural change in the NHS . The Berwick report stated clearly that "NHS staff are not to blame in the vast majority of cases it's systems, environment and constraints they face that lead to patient safety problems". Not only has no progress been made, but things are getting worse, with 55% of doctors reporting they are more fearful of making an error now than they were five years ago.
- System pressures are a serious patient safety issue, with the vast majority of doctors (93%) saying that system pressures occasionally or often prevent the delivery of safe patient care.

[9] BMA: Caring, supporting, collaborative? Doctors' views on working in the NHS; September 2018 p13

This is the mischief which needs to be addressed. Clinicians' fear of blame from their regulators and within their own working environment cannot result in a denial of full and fair compensation for patients whose lives have been shattered by needless injury.

There is a significant difference between the language of 'blame' which essentially assigns fault and implies censure, and a genuine culture of openness which generates a willingness to accept accountability when something has gone wrong. Accountability is incredibly important to injured patients but, at the moment, many feel that accountability can only be found through the route of compensation. This is also addressed in *The Value of Compensation* report:

> The fundamental value of compensation is to help people who have suffered negligence to get their lives back on track and enable them to live as normal a life as possible. However, it also has a big role in acknowledging the negligence experienced and in recognising that it has had serious consequences on the patient's life. In some cases, the award is perceived to be a sign of respect, symbolising that the NHS accepts accountability for causing injury. This is especially important for those who have had to fight hard to win their case. A few of the people interviewed reported feeling a sense of relief after receiving their compensation as it shows that they have been believed and that they were not to blame for what had happened. "It was tremendous relief, because people had always been saying, 'No, it's not true, no, we don't want to know, you're talking rubbish' …[10]

What legislative changes would be required to support these changes?

It is almost inevitable that this inquiry, if not this question, will provoke renewed calls to remove the right to private health care for patients injured by the NHS. The repeal of section 2(4) of the Law Reform (Personal Injuries) Act 1948 could, however, have catastrophic consequences both for injured patients and the NHS.

The availability of private treatment in the provision of prompt rehabilitation is just one reason why section 2(4) of the Act is so important to injured patients.

[10] *The Value of Compensation*, Opinium Research, p24

Rehabilitation is a crucial factor if an injured person is to have any decent quality of life. The most effective rehabilitation happens soon after an injury, and the NHS can be notoriously slow to provide treatment, especially in the current Covid-19 crisis, and the consequential backlog of cases in the NHS. There is no telling how long this situation will continue. In some cases, the treatment patients need may not even be available on the NHS. Removal of the right to private care in such circumstances would be immoral as well as inhumane.

According to *The Value of Compensation* report "private treatment is often a key factor in recovery… both physically and mentally. It includes treatments such as physiotherapy and acupuncture, which contribute to better mobility and dexterity, and corrective surgery, which helps in the rehabilitation process and in improving the patient's condition. Having access to quality treatment quickly provides reassurance to those who feel like their life has been put on pause."[11]

Furthermore, any repeal of section 2(4) would be unlikely to be confined to clinical negligence cases. This would mean that everyone who is injured as a result of negligence would have to receive NHS care, including people injured in car crashes or those injured at work. Last year more than half a million compensation claims were registered with the Government's Compensation Recovery Unit. That is potentially more than half a million people who have been injured through negligence, and that is a lower than normal figure which reflects the restrictions placed on our lives because of the pandemic.

The extra pressure on the NHS of treating all these additional patients, who would usually be able to rely on treatment funded by the liable defendant, would very quickly become unsustainable.

In the unlikely event that any repeal of section 2(4) could be confined to clinical negligence cases a two-tier system would be created which would be demonstrably unfair, even opening up differences between those injured in the NHS and those injured as private patients.

Negligence does not just result in a physical injury. In many cases there can be a total loss of trust between the injured person and those who caused the injury. This loss of trust is exacerbated when the defendant is the NHS, which is responsible for patients' welfare. It could take many years for the NHS to regain the trust of an injured patient, if at all.

[11] *The Value of Compensation* (unpublished) Opinium, page 6, paragraph 4

These patients will have been through a terrible ordeal, and it cannot be right that their only hope of further treatment is from the same defendant who caused the injury in the first place. Section 2(4) ensures this does not have to happen.

There are also likely to be renewed calls for a so-called 'no fault' system to be introduced, or a system which is based on 'avoidable harm'. The feasibility of models based on such principles have been explored many times before, most recently in Scotland, and there is a raft of reasons why they do not meet the needs of injured patients in this country including:

- There will inevitably be an increase in potential claims and compensation payments will need to be much lower to avoid any increase in costs. This means that patients injured as a result of negligence will not receive full compensation, the importance of which has been stated earlier in this evidence.

- No fault systems can lead to less accountability which means that, although compensation will be paid albeit it at a reduced level, lessons are unlikely to be learned and NHS failures will continue to be repeated. The NHS will not be any safer than it is now.

- A two-tier system will be created in which injured patients will receive less than 100 per cent compensation, while people injured through other forms of negligence, such as on the roads or at work, will be able to receive full compensation.

- Comparisons with other models, such as the one in place in Sweden, fail to take into consideration the considerable difference in spending on social care, and benefits between the different jurisdictions. According to data published by the Organisation for Economic Cooperation and Development[12], spending on benefits for sick, injured and disabled people in Sweden is more than double that of the UK. To introduce such a model in England would not only deprive vulnerable patients of full and fair compensation, but then leave them in the hands of a social care and benefits system which is ill-equipped to look after them. This would surely only serve to compound the injustice of what has happened to them in the first place.

[12] https://data.oecd.org/socialexp/public-spending-on-incapacity.htm

After more than 18 months of a devastating pandemic in which people have been called upon repeatedly to do the right thing, and take care of each other, our patients deserve a much fairer proposition.

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