Action against Medical Accidents (AvMA)

Response to Health and Social Care Committee: Call for evidence NHS litigation reform

Introduction: About Us

Action against Medical Accidents (AvMA) is an independent charity specialising in advising supporting people who have been affected by avoidable harm in healthcare and working for better patient safety and fairer systems for responding to avoidable harm. We advise and support around 3,000 people a year, helping them understand their rights; get the answers they need; and make informed choices about which procedures to use to achieve their desired outcomes. This gives us a rich insight into the experience of people affected by lapses in patient safety. Some of these people require more specialist legal advice than we can provide ourselves in order to obtain compensation for the life changing injuries sustained. For this reason we have also always taken a keen interest in clinical negligence litigation and accredit specialist clinical negligence solicitors for our 'panel'. These solicitors are ones we would be happy to refer our best friend or family member to. Our association with specialist clinical negligence solicitors and also with medical experts who give evidence in such cases, coupled with the experience of our beneficiaries means we have an in depth knowledge of how clinical negligence litigation works. The main authors of this response are Lisa O'Dwyer, AvMA's Medico-Legal Director who has also worked as a specialist clinical negligence solicitor in private practice, and Peter Walsh, AvMA's Chief Executive.

Summary of Key Points:

- Whilst the cost of clinical negligence to the NHS is large, it needs to be kept in context. It compares favourably with the cost of indemnity cover in other industries, organisations/professions
- Patients/families deserve full and fair access to justice and should not have to pay twice by sacrificing access to justice or be treated less fairly than people injured in other settings in society
- As well as providing compensation and vindication for injured patients and families clinical negligence litigation provides an added incentive to improve patient safety and opportunities to learn from cases where fault is not recognised initially. Making it even more difficult to bring a claim would lead to errors going unrecognised.
- Improving the quality of investigations; empowering patients /families in investigations and implementing the Duty of Candour fully would reduce the need for litigation; reduce costs; and improve learning for patient safety
- Fixed recoverable costs in clinical negligence are a flawed concept. Exemptions and safeguards will be needed if they are brought in
- Much more could be done to learn from incidents which are the subject of claims, including use of the patient safety letter/review process following claims
- The Early Notification Scheme has potential but needs significant improvements and independent evaluation before consideration is given to extending it
- Clinical negligence litigation, whilst uncomfortable and adversarial, does not itself create or contribute to a 'blame culture'. More could be done to reduce the stigma attached to 'negligence' through education, but blame culture is more about how management / employers treat their staff – particularly when things go wrong

Below we answer each question posed by the Committee in more detail:

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

The current costs of NHS clinical negligence litigation are high but this needs to be considered within the context of indemnity costs incurred by other professions, and the sheer size, complexity and risk involved in running the NHS. Over the past four years total payments and administrative costs under the NHSR clinical schemes amount to circa 1.5% - 1.6% of the total NHS budget. This compares very favourably with indemnity costs in the form of professional indemnity insurance premiums paid by most other professions and commercial organisations. For example, typically, surveyors pay between 2% - 15% of their budget; solicitors 1% – 10 %; accountants 2% - 8%; insurance brokers 2% - 7%; architects and engineers 2% - 6%; construction 5% plus.

NHS Litigation and compensation costs for clinical negligence must also be considered within the context of the human cost of avoidable injury. Our charity sees on a daily basis the enormous human cost of errors or failings which cause harm to patients. By definition, these incidents and the resultant costs are avoidable. Even when negligent incidents do occur and cause harm, most of the legal costs at least could be avoided whilst still compensating the injured patient or their family fairly if the incidents are investigated properly; fault is recognised and admitted; and offers of compensation are made early. We are increasingly hearing phrases like "*we need to strike a balance between access to justice for injured patients and the cost of clinical negligence to the NHS".* This is quite simply the wrong way to look at this problem. It wrongly implies that there is no alternative but to reduce access to justice for the very people who the NHS has harmed.

Patients injured through NHS negligence and their families have already suffered greatly through no fault of their own. To make them pay again for NHS failings by denying or watering down their access to justice should have no place in a system which aspires to a 'just culture'. Investment in learning from mistakes, improving patient safety and avoiding these incidents is the right way to address the cost of clinical negligence, together with finding more efficient but fair ways of compensating people.

The contingent liability provision published by NHS Resolution (currently £82 billion) is an estimate of the cost of all anticipated future claims if all of them were settled at full cost. This bears no relation to real trends and so should be kept in context. The important figures to look at are the trends regarding actual claims.

It should be remembered that the legal test for clinical negligence is rightly, both exacting and demanding. For a patient to bring a successful claim against a healthcare provider they must show that the care they received was so low that no doctor of ordinary skill and care would have offered that level of care. The patient must also show that they have sustained injury as a direct consequence of the poor care received. It is difficult for patients to show this.

As well as compensating people fairly, a positive impact of litigation is to ensure that healthcare providers have an additional incentive to ensure that their employees are maintaining the professional standards expected of them and treating their patients safely. If it is made harder for patients or their families to make a claim, this will dilute that incentive. It would also mean that many incidents which become a claim and are ultimately found to be meritorious after initial investigations have not identified failings would be swept under the carpet. These unintended consequences of diluting access to justice would end up costing more both in financial and human costs through the lack of learning for patient safety.

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

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

   This question conflates two issues, first the way in which compensation is awarded, the second what changes need to be made to the litigation process to promote learning and avoid the same problem being repeated elsewhere in the system.

   Although we welcome fair and appropriate use of alternatives to litigation, generally speaking there are no difficulties with the way compensation is currently calculated or awarded in clinical negligence litigation. An award of damages is calculated with reference to the evolved and well-established legal principles of tort law, like any area of law, tort law is constantly developing and reviewed by an independent judiciary. The law of tort governs all civil wrongs - it does not just apply to clinical negligence claims. It would be abhorrent if people injured by the NHS had lesser access to justice than those caused personal injury in other parts of society.

   However, changes do need to be made to ensure learning comes out of the litigation process. We welcome the start that NHS Resolution have made on seeking to reap the learning opportunities provided by clinical negligence claims, but to date we have not seen a great deal of evidence of this resulting in improvements in patient safety and reduction of incidents.

   As members of the Civil Justice Council working party on fixed recoverable costs, AvMA submitted suggestions for discussion and development on how greater learning and improved patient safety might be harnessed through the litigation process. Our suggestions included a requirement following a claim for the healthcare provider to reflect on the patient safety issues identified and what is being done about them and put this in a 'patient safety letter'. This would be a good discipline; provide useful intelligence for regulators; and reassurance to the injured patient/family and wider public. These proposals have never received a substantive reply from either the DHSC, NHS Resolution, or any defendant group. The response from these organisations has been to say that ***"all indemnifiers agree that patient safety and learning is important, however the difficulty is that indemnifiers cannot commit to imposing anything on the healthcare professional/Trust, who are outside their control."***

   We encourage discussion on this issue and refer to our suggestions which can be found here:

   Our other suggestions elsewhere in this paper also speak to the question of what key changes the Government should consider as part of its review of clinical negligence litigation.

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

Most patients want to understand what happened to them or their loved ones and to make sure that avoidable harm is avoided in the future, so others do not need to suffer in the same way. They do not want litigation which is viewed in most cases as a last resort.

The key factors which would help avoid clinical negligence litigation and reduce the cost of such litigation when it does occur are:

- High quality investigation of incidents by trained and experiences specialists to establish the facts and identify where there have been lapses in patient safety
- Involvement and empowerment of patients/families in investigation including access to independent specialist advice/advocacy
- Full openness, honesty and compliance with the Duty of Candour
- Proactive acknowledgement of failings or admissions of liability and offers of appropriate redress / compensation
- Better co-operation between defendant and claimant solicitors and rigorous application of the clinical negligence 'Pre-Action Porotocol' (See https://www.justice.gov.uk/courts/procedure-rules/civil/protocol/prot_rcd)

"Risk management: Extreme honesty may be the best policy" is an American paper authored by Kraman and Hamm, published in December 1999: https://pubmed.ncbi.nlm.nih.gov/10610649/ The paper concludes "***that an honest and forthright risk management policy that puts the patient's interests first may be relatively inexpensive because it allows avoidance of lawsuit preparation, litigation, court judgments, and settlements at trial…"***

With the above in mind, the focus should be on investing time and money to properly investigate complaints at the outset and by being open and honest and accountable.

In March 2014, this committee received evidence on "Complaints and Raising Concerns", this enquiry was launched shortly after the Clwyd/Hart report was published in 2013: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/255615/NHS_complaints_accessible.pdf The Clywd/Hart report made several recommendations including the need for greater perceived and actual independence in the complaints process. It also noted that there should be improvements in the way complaints are handled: a need to develop appropriate professional behaviour in the handling of complaints, engaging in genuine openness, honesty, and a willingness to listen. Insufficient progress has been made in this regard.

Patients/families need a level playing field / to be empowered when things go wrong and cause harm - independent advice, information and support can contribute to creating that equality of arms. Currently, although there is funding for independent complaints advocacy to help people 'navigate the complaints procedure' in England, there is no funding for specialist independent advice and advocacy for people going through patient safety investigations; facing an inquest about an NHS related death; or considering whether to make a claim. NHS England/Improvement and NHS Resolution acknowledge there is a gap in such provision. It has been highlighted in many of the inquiries into NHS scandals and was a major need identified through *Learning from Deaths* which has never been addressed.

Robust, independent, open, and honest investigations create an opportunity for early admissions of breach of duty and with that is an opportunity to identify fair and appropriate compensation and early resolution. That principle applies regardless of the value of the claim. NHS Resolution itself recognises the importance and economic effectiveness of early investigation and admissions through its own Early Notification Scheme.

Patients/claimants need to be supported to help them play a meaningful role in investigations, Patients feel secure receiving independent, impartial advice on all their options for redress, that requires funding for support and advocacy at an early stage. A proper, early investigation will enable patients and or their families to make informed choices early on. There will always be some cases that require specialist legal representation, but many cases could and should be resolved early on to the satisfaction of both the patient and the healthcare professionals without the need for litigation. Access to specialist independent advice would help that.

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

We have no doubt that this is both needed and achievable.

As an example we point to the Clinical Negligence Protocol, which was devised in collaboration with AvMA, NHS Resolution and the Society Clinical Injury Lawyers (SCIL). https://www.avma.org.uk/wp-content/uploads/SCIL-AvMA-NHSR-CN-Protocol-finalamended-08.06.2021.pdf

The protocol was introduced and designed to assist specialist clinical negligence lawyers (claimant and defendant) during the difficulties created by the Coronavirus pandemic, the protocol has been in place since August 2020 and states: "***This protocol should be seen as a reflection of the cooperation between the parties in clinical negligence claims It is intended that this protocol will encourage positive behaviours from both claimant and defendant lawyers and organisations as well as consistency of approach in practices around England…"***. Parties have met regularly every eight weeks to discuss what is working well and to address problems that have emerged because of the ongoing pandemic. Those regular meetings have contributed to the protocol's ability to evolve and meet changing needs, it is widely considered to have been very successful and NHS Resolution recognises that this collaborative approach has not only been successful but has led to substantial cost savings.

There are already strong incentives for claimant solicitors to assess and manage claims effectively and to resolve case as early as possible. Claimant solicitors only get paid their costs if their case is successful. The vast majority of potential claims are screened out the assessment stage – estimated at over 90%. However, defendant solicitors are paid whether they win or lose their case. Consideration should be given to introducing strong incentives to recognise and settle meritorious cases quickly rather than build up unnecessary legal costs by defending these cases for longer than they should be.

For example, according to NHS Resolution, **in 2019/20 out of 3,303 clinical negligence claims where proceedings were issued over 80% (2,699) settled in favour of the claimant**[i]. This represents a huge missed opportunity to settle cases before proceedings which would save an enormous amount of legal costs. Some cases are also defended for a very long time before settlement is reached causing additional harm to those patients/families. We believe that these cases should be reviewed to identify why it wasn't possible to recognise the failings and reach a settlement earlier.

As well as a strong incentive for defendant solicitors to recognise failings and settle cases earlier, we believe there are two other things that would help them do this. Firstly, the quality of patient safety investigations needs to be improved greatly, as discussed. This would give claimant solicitors much better quality information to go on when assessing a claim. Secondly. Whilst there is accreditation for solicitors specialising in clinical negligence[ii], no such scheme exists for defendant solicitors. Sometimes claims are handled by relatively junior and inexperienced claimant solicitors. Quaity assurance of defendant solicitors would be helpful for all concerned.

Alternative Dispute Resolution of various kinds offers a good way of resolving some claims in a more constructive and economical way. The Mediation scheme administered by NHS Resolution currently is growing and shows promising signs of success. It should continue to be promoted and supported. As well as dealing with settlement of claims it has other potential benefits such as giving the opportunity for the claimant and healthcare provider to come to accepted understanding of what went wrong and why and to achieve closure which is not possible through an award of damages alone. It can contribute to learning for patient safety. However, alternative dispute resolution only works if there is a level playing field and claimants are able to litigate if they have to. Limiting access to justice in the ways that are being considered would take away the incentive for defendants to 'get around the table' and settle claims in this way.

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

We support the principle of the Early Notification Scheme (ENS) as an alternative to litigation and certainly support the need for early investigation, early admissions, and early resolution of claims. However, ENS is currently operating as part of the litigation process not an alternative to it (see below). We have always argued that if the NHS was much better at investigating incidents and thereby recognising where there seems to have been negligence, it should be possible to resolve many cases without the need for litigation, as well as building in learning for patient safety as a priority. We do have some concerns about how the ENS is currently administered and have not seen enough evidence to suggest it is yet achieving the desired results. IF these problems were to be addressed and the scheme is independently and thoroughly evaluated as working appropriately, we think there is potential for expanding this approach to other types of incidents/potential claims beyond the current ENS criteria. Any expansion to other areas of the system should also be piloted and evaluated before being rolled out.

Our main concerns about the ENS at present are:

- **Confusion over whether this is an alternative to litigation or a formal legal process.** On the face of it, the ENS is an alternative to litigation. However, NHS Resolution have decided to treat it as a formal legal process covered by 'legal privilege'. This means that any evidence from the ENS investigation which follows the HSIB investigation and details about the decision over whether the criteria for awarding compensation are met is kept secret In other words, families are encouraged to take part in a process as an alternative to litigation but they are treated as if they were making a formal legal claim anyway.

- **Lack of transparency.** In spite of our representations, families are still not being informed that 'legal privilege' is being applied, as above. Furthermore, very little information is publicly available about how decisions within the scheme are made and by whom. We have had

families come to us who did not even know that there were concerns about their baby's case or that the case had been referred to ENS for investigation.

- **Lack of independent advice and support for families**. Families do not routinely have access to independent advice, information and support. Although NHS Resolution does offer some signposting (for example to AvMA), that signposting is weak and no resource is put in to ensure that independent advice and support is available to families who are in touch with the scheme. Going through this scheme in the knowledge that your baby may have been caused serious avoidable harm is a big thing for families. They should have access to such advice and support. Also, families do not necessarily understand that they have options and that there may be other avenues of redress open to them. If you do not know what your rights and options are, you cannot be expected to make informed decisions and explore alternative routes should you wish to do so.

- **Lack of independence.** The ENS is administered by NHS Resolution, part of whose role is to defend claims against the NHS. Whilst we do not question NHS Resolution's intentions, there is a potential conflict of interest here. The medical experts who decide on cases are chosen by NHS Resolution. The lawyers who advise on these cases are defendant lawyers who get their work from NHS Resolution. It is easy to see how families might lack confidence in such an arrangement. Consideration should be given as to whether the ENS should be administered by an independent organisation. If that is not possible, it is possible to at least introduce elements of independence. For example, the scheme could be overseen by an arms-length advisory board including external stakeholders. Medical experts could be drawn from a list approved by both NHS Resolution and claimant organisations. Independent lawyers could be paid to take part in the assessment of cases. It is a reasonable assumption to make that an experienced claimant lawyer may spot things in cases that a defendant lawyer wouldn't.

6. **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?**

The Government has stated its intention to extend fixed recoverable costs in clinical negligence claims, AvMA believes that this approach is fundamentally wrong for several reasons. Reducing costs in this way will simply

- Drive down the public's ability to access justice.
- It will not reduce the number of incidences giving rise to clinical negligence claims
- It will not go the heart of why costs are so high in the first place.
- Not offer any incentives or improvements to patient safety
- Reduce the public's right to redress when things go wrong.

There has yet to be any evidence that a fixed recoverable costs scheme can truly reduce the costs of litigation. It will however reduce the individual's ability to access justice. If you prevent the public from being able to enforce their rights because the cost of doing so is too high or disproportionate to the amount they are seeking to recover, you are saving money by reducing access to justice. The costs saving does not come about because of any benefits or incentives offered by fixed costs themselves.

There has been no analysis of to what extent, if any, the proposed fixed costs process represents any sort of improvement on the current process. The government has promised a public consultation on the fixed costs proposals in low value clinical negligence claims, that consultation has not occurred yet despite repeated promises and assurances this would happen.

It is a matter of considerable concern that the government appears to be stating a commitment to fixed costs in clinical negligence claims before it has even considered the evidence. It suggests that the government is wedded to introducing fixed costs at any cost and that the outcome of any consultation is a forgone conclusion.

However if fixed costs is brought in there are a number of safeguards that are needed in addition to the exemption of certain types of cases from the scheme, so that it:

- **Protects client damages:** The proposed fixed costs scheme is intended to work with Conditional Fee Agreements (CFA). Unlike success fees which are ringfenced at a maximum of 25% of a client's general damages and past losses. Shortfalls in costs that occur under a CFA are not similarly ringfenced. The scheme does not offer any protection for client damages.

  If claimant lawyers are forced to look to their client's damages to recover their costs this risks client damages being severely reduced or even wiped out altogether by their solicitor own client costs. This is an untenable position for both lawyer and the client and must not be allowed to happen.

- **Avoid cases being under settled:** Lawyers may be forced to recommend their client accept low offers and under settle the claim if the cost of pursuing the litigation is likely to increase the costs and the deduction from client damages. In real terms, the client will have achieved an increased settlement on one hand but will have paid for the privilege of securing what was rightly theirs with the other.

- **Include effective sanctions:** The FRC system needs to build in effective sanctions for penalising poor behaviours. As it stands, the level of costs proposed appear to us to be so low that they will not act as an incentive for defendants to extricate themselves from the litigation process and to resolve claims more swiftly. The status of the part 36 CPR offer and the entitlement to indemnity costs within the bounds of FRC regime needs to be made clear.

7. At what level should costs be fixed?

It is not within AvMA's remit to advise on what the correct level of remuneration to solicitors in a fixed costs process should be, other than to say that remuneration must be sufficient to make it commercially viable for specialist solicitors to represent these clients. Otherwise, many would-be claimants will be unable to get legal representation or make a claim. As well as denying people access to justice, this would also mean that many patient safety failings would never come to light, as it is often the claims process that brings this about. The rates need to be fair and reflect regional variations. Failure to do so may mean that patients in some parts of the country will not have easy and local access to legal representation. Incentives need to be built into any scheme to ensure that low value, but complex and therefore typically expensive claims can secure access to justice. It is important that the remuneration is sufficient to allow the continued involvement of accredited specialist solicitors in clinical negligence, as it would be in no-ones interests for non-specialists or 'claims farmers' to be involved. NHS Resolution confirm that claims are handled more efficiently when specialist solicitors are involved.

In case this question relates to the size of claim that fixed recoverable costs would apply to rather than the rate that remuneration is set at, we will also address that. We and many others have serious concerns about the rationale for fixed recoverable costs and the ramifications if they are brought in. Lord Justice Jackson recommended only claims where settlement would be less than £25,000 because of the perceived disproportionate legal costs compared to damages in those cases. We see no good reason to apply fixed costs to larger claims, especially as this is such a controversial and untested approach.

8. Are there any circumstances in which they should not apply to low value clinical negligence cases?

There are cases which are not suited to a fixed costs regime. These are:

Fatal Accident Claims: Death is the worse outcome possible especially when the injury was avoidable. The sensitivities and time required for lawyers to deal with bereavement cases, makes them unsuited to a FRC scheme. The NHS Resolution commissioned a report entitled "**Behavioural insight into patient motivation to make a claim for clinical negligence"** published in August 2018. That report illustrates how important compassion is to claimants. (Para 4.2.1). There is a real and pressing need for healthcare providers to be accountable and to learn from their mistakes when the outcome is as severe as death.

It is in the public interest that proper care and attention is given to the reasons why death has occurred particularly in the case of elderly people whose services are underfunded. Deaths associated with mental health and suicide require proper and thorough investigation, these cases are often complicated by the need to consider law from European Convention Human Rights (ECHR).

Introducing FRC for fatal accident claims will impact on a firm's ability to recover inquest costs. As the Justice Committee report on Coroner's court recently noted families require proper access and funding to participate in the inquest properly. If fatal accidents are included as part of a FRC scheme then it is far from clear who will bear the inquest costs and how they will continue to be recoverable.

Protected Parties: Cases that involve issues of mental incapacity should not be included in a FRC scheme and should be excluded owing to the complex nature of taking instructions through a third party. It takes time to take instructions in this sort of case and to ensure the client understands the process well enough to enable them to make informed choices.

Secondary victim claims: If the primary victim claim is dealt with under FRC regime then it would be expected that the secondary victim claim would also fall under this scheme. If there is no primary victim claim brought under FRC then the secondary victim claim should be excluded. Although often low value, these tend to be complex.

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

Nobody wants to be involved in clinical negligence litigation if it can be avoided. It is often adversarial but is an important safety net for vulnerable people who have been harmed through no fault of their own. It also unveils patient safety failings which would not otherwise be recognised and provides an incentive for NHS bodies to improve safety. Alternatives to litigation are to be welcomed where they are fair and litigation remains as a viable option / as a last resort.

We do not believe that clinical negligence itself ‘creates’ a ‘blame culture’. Rather, the way that organisations and employers react to litigation and indeed patient safety investigations or complaints is influenced by an existing ‘blame culture’. It is all too easy for a healthcare provider to point the finger of blame at an individual clinician who is cited in a clinical negligence claim rather than accepting organisational responsibility for lapses in patient safety. This is why it is so important that work continues on developing a “just culture” as part of a “patient safety culture” in healthcare as per the Patient Safety Strategy for England. There is growing acceptance that such a culture should embrace accountability whilst avoiding individual ‘blame’ and also that it should embrace being fair to patients/families who experience harm. It is hard to reconcile a ‘just culture’ approach with some of the proposals emerging which would dilute or deny access to justice for the very people the NHS has harmed through negligence.

Naturally, health professions have a fear of being involved in a clinical negligence cases. Fortunately however, the NHS indemnifies all the staff involved. It is the NHS that is sued – not individual clinicians. This means that ‘defensive medicine’ is much less likely than for example in the USA where individual clinicians have to indemnify themselves. We are not aware of significant evidence of defensive medicine in the NHS. At its worst ‘defensive medicine’ could see clinicians refusing to take on patients with complex needs because of the risks of getting things wrong. More commonly, it might mean unnecessary tests or treatment. However, clinical governance in the NHS should mean that this does not happen.

More could be done to remove the stigma felt by clinicians whose treatment is found to be negligent. Clinical negligence looks at individual incidents rather than patterns or professionalism. Some of the best clinicians can be capable of an individual mistake which is deemed to be negligent and here is no evidence to suggest that a clinician who has been negligent cannot learn from that incident and become an even better clinician. There is also a lot of misunderstanding and a degree of mythology about clinical negligence. For example, the threshold of negligence is very high; it is very hard to prove; and patients are not as a rule litigious. There needs to be better training and awareness about these issues.

One suggestion that AvMA has made over the years is that instead of the test of individual ‘negligence’ for awarding compensation, an ‘avoidability test’. This would be less stigmatising and would be more aligned with corporate responsibility and patient safety.

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

It is not only important, but also crucial and central to the reason why many people end up bringing litigation. Please see our suggestions on how this can be improved elsewhere in this response. The focus should be on how learning can be derived from the clinical negligence system, whilst maintaining at least the current levels of access to justice for injured patients. Alternatives to litigation should be tested against both these criteria as well as against savings which they may deliver.

11. What changes should be made to clinical negligence claims to enable a move away from a blame culture and towards a learning culture in the NHS?

The culture in the NHS itself needs to change, to be more accepting of the need for early injury review, full disclosure and of the fact that human beings are fallible, and mistakes will be made. Covering up

and or focusing on trying to minimise the mistake and/or injury is injurious to both the patient and the healthcare professionals involved. NHS staff often fear blame from management as much as the sense of blame associated with clinical negligence litigation. Most staff would like to see injured patients/families fairly compensated.

Support needs to be given to healthcare providers to help them become more invested in the progress of the claim and to understand how their care caused and/or contributed to the breach of duty and injury so they can focus on learning from their mistake/s and preventing them from happening again in the future. Healthcare professionals should be encouraged to look at their mistakes differently so instead of seeing them as being associated with a loss of reputation or being professionally ostracised they are seen as positive opportunities where all members of staff and the team can learn from the mistake.

The NHS also needs to accept findings of systems failures that may have contributed to the individual healthcare providers breach of duty and address those systems failures as a matter of urgency.

12. 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?

The HSIB plays an important role in maternity cases which are then reviewed by the NHS Resolution Early Notification Scheme. This not only offers the opportunity to award compensation without the need for litigation but is focused on learning for patient safety. In theory the HSIB could be expanded to cover other types of incidents but it is hard to see how it could ever oversee every patient safety investigation. What it could do is serve as an exemplar and spread good practice and training in good incident investigations, which is sorely needed.

The HSIB agrees with us that the notion of 'safe space' (a legal prohibition on sharing information from investigations), which is part of proposals for how it handles its small number of thematic national investigations, is not appropriate for maternity investigations or any investigations into individual incidents. The Public Administration and Constitutional Affairs Committee also found that applying 'safe space' to local investigations would be counter to the Duty of Candour, and this should be avoided.

It is still relatively early days in terms of assessing the impact of HSIB investigations, but the fact that HSIB can only make recommendations potentially dilutes the impact of their investigation and reporting process. There should be a statutory requirement to consider and either implement or gain agreement from an appropriate authority not to implement HSIB recommendations

There is a need for an overarching body that can collate all the evidence from the different inquiries into large scale patient safety scandals and lead on sharing learning and coordinating the implementation of solutions but also ensure recommendations are implemented. This could be a role for HSIB or another body / committee set up for that purpose.

13. What legislative changes would be required to support these changes?

Amendments should be made to the Health and Care Bill currently before Parliament ensuring that:
- maternity investigations and other investigations into individual incidents are required to ensure 'safe space' is not applicable in HSIB maternity investigations or other investigations into individual safety incidents
- there is a statutory responsibility to respond appropriately to HSIB recommendations
- funding is made available to ensure that patients/families who experience significant patient safety incidents can access independent advice/advocacy

Lisa O'Dwyer and Peter Walsh: 19th October 2021

References:

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[i] House of Lords written answer, 6th August 2020, Lord Bethell to Lord Hunt of Kings Heath

[ii] Two well established accreditation schemes exist for claimant clinical negligence solicitors – one administered by AvMA and the other by the Law Society