[Simon:
Thank you and good afternoon everyone. I'm acutely aware I'm keeping you from lunch so I will try and make this quick, obviously subject to how many questions that everyone wants to ask afterwards.

So, I'm going to cover off this from a bit of a unique perspective and that's really just looking at it from the claims aspect whilst touching, obviously on some of the legal issues that have already been discussed. And that doesn't take away from, I think the really important conversations that have been had this morning which is it's about that two-way process, and the patient and the clinician are at the heart of that. And I'll touch on that in a little while.

So the numbers. 'Why is consent so important?' Well, I think these will probably speak for themselves. In the last five years, we received circa 4,700 claims related to consent type actions. Now, I will place a caveat on this because consent can transcend all aspects of clinical specialty. So these might necessarily not be complete consent cases. These will be cases where there is some aspect of failure to warn, failure to consent could be embroiled with other aspects of negligence or alleged negligence that could have occurred. And the ratio of these, and when I say ratio, what I mean by that is how many were settled, is about 50-50. So that's going to change year upon year, but over the last five year period, on their closed claims, we settled circa about 50% with a damages payment. So that is 50% whereby, there was an allegation raised in respect of some aspect of potential consent and a damages payment made because we either didn't have the evidence to defend it to counter those allegations, or it was accepted. And I think what Bryony said was absolutely critically key. Mistakes are going to happen and that is the purpose of, obviously indemnity, that is why we are here. But it just goes to show the volume of those cases that are settled.

Now, I'm going to play a bit of audience participation here. It doesn't require a lot of energy. It requires a hand up or down at a given moment. But in essence, what we're gonna do is guess the total of compensation paid. So this includes legal fees over the last five years. And these, again, is in terms of cases where we have made damages payment. So you've got three options of the volume. Sorry, the value, I should say.

So who thinks it's 528, sorry, 522 million? Show of hands? Not that many.

Okay, 658? Okay.

And 320. Clearly a pessimistic bunch in the room.

(Audience chuckles)

It's actually A. It's 522. So you overestimated the costs there, which I don't know what to read into that really. (Chuckles) But it's a big number. Now, I think that speaks for itself in financial terms, and we obviously have to look at things from financial terms, that's our role in relation to managing the indemnities that occur. But essentially, that doesn't take away from the harm that has occurred. So looking at it just in that context isn't the right context to look in, but clearly it does give you an identification of the type of value that is placed in relation to consent type actions.

I often speak as well on not just the value and the harm caused, but actually the damage to the relationship. Because one thing that we will all appreciate and you will all appreciate more than us is you often have a repeat relationship with these individuals. So if you have a situation where somebody is alleging that you didn't consent them to any form of treatment, harm will have occurred, usually. But essentially your organisations are going to continue to treat those individuals, because they will need healthcare. It's not a transactional system. We're a unique place in health, whereas in corporate law, personal injury law, it's often a one-off transaction. If you are harmed by that transaction, you walk away from that relationship, you can't walk away from that relationship with the patient. So again, that comes back to the trust issue between clinician, healthcare advisor, healthcare practitioner and the patient. And for me, that's also a critical point of this whole process and the discussion.

I'm going to just touch on the requirements to make a claim and I'm not going to really go over this in any great detail because others have spoken about it. I think the key one is that last point. And again, just to put this into context for you all. The average claim we receive, the first notification, we as an organisation or you as an organisation

receive of a claim, is an average about three years post-incident. So if you put that into the context of record keeping, can any of you tell me what a conversation individually you had with a specific patient was, potentially three and a half to four years ago when we are asking you, to say what happened on the day?

And we've heard, my colleagues went through the law very, very adequately earlier, very, very good explanation of actually some of the key issues around this. But that for me is one of the principal takeaways of the whole process. We've discussed a lot today about record keeping, about consent about that conversation. Hugely important. But actually, if the conversation isn't documented and the conversation isn't recorded somewhere, however good it will be, that is the issue that we have and that's the issue that we can find. And I'm going to come onto a case study of a live case that we recently settled. And again, there's a bit of an audience participation on that for you to guess the result later. But that's the closure.

So that's really the key thing here is these cases do come down to witness testimony and records. But witness testimony is obviously three, four, five years post the event quite often. So it's quite difficult to remember unless something stands out so well in your mind, that it's such a unique occurrence, that actually you have either learnt something from it or it stands out because it was so rare. Obviously a reminder of what's expected. I'm not going to go through this. That's really the key findings from here, which other people have flashed up and discussed in much more detail than I'm going to cover today. But I think what it does, in the way that I see it, is it recognises those societal changes, that people are becoming more informed. I know full well if the doctor tells my mum that something's good for her, she's gonna say, 'go ahead and do it.' She's not gonna ask him a question, that's the way that things were when she was growing up. Things have changed.

When I go to consultations now with that, I will ask the appropriate questions because I want to be able to talk to my parents in relation to what it is that the doctor is proposing, as far as treatment is concerned in that space. That's not a bad thing. I think that's actually a good thing because it allows people to make those informed decisions but it also means that you can explain the risk when you have someone, I think

other people have explained that and I think Bryony just touched on it, that it often becomes a two-way sharing process when you know your patient. I found it quite interesting that she said she wants to know what job they do, just for an openness, I never tell anyone what job I do when I go for healthcare, for obvious reasons.

(Simon and audience laughs)

The future of the law, this is fascinating. 'Is it settled?' Or, 'do I think it's settled?' And this isn't an NHS resolution opinion, this is probably more of a personal opinion. I think the answer, it's no, probably not. Because I think as you have already seen, even though we've had those seminal cases which have occurred and reference that one there in McCulloch, things are still going to get tested. Because actually, as these cases come down to factual disputes, on what people have said, what people heard, what people's interpretation of those were, then they will become challenged. Now, the question for me is, does this mean that people will become more defensive in the way that they approach consent, with regards to material risk and options for treatment. And that's a really fine line for a lot of people, and it's a really fine line for you all to work with, who are in the clinical space today. Because you want to make sure you have covered off all of the appropriate dialogue and risks, material risks certainly, that the patient may be suffering or may potentially suffer or become aware of, and also what those options are and why you have chosen to deliver those risks from those options.

But on the flip side you don't want to be defensive and overload the patients. We've heard from people in the room already about overloading the patient with information. An overload of information isn't going to be informed consent because the patient's not going to be able to understand exactly what you're telling them in the huge amount of information. So I think there's a real fine line there between actually the process of understanding what the legal requirements are, and I don't think we should be talking about this in the legal requirement sense, but we are. But more importantly, what is right for you to discuss with the patient and what those options you should be giving the patient are. And I think that's really where we need to understand the best way of doing that, be that digital, be that through traditional paper methods, be that

be in any way that can be informed. And I think that's the keyword for me, is informed.

I'm not going to read that one, because that's a practical example. That was flashed up on earlier. That is actually the practical example that really sets out the test, and that's from McCulloch, and I think it just completely spells out the difference between the material risk and essentially the options, and where Bolam comes into this, which I think was explained in sort of greater detail earlier. But what I want to move on is a case study. This is a real case study. I've anonymised it for obvious reasons and I've taken out some of the actual specialty details, so essentially no one will be able to identify who this is, but this was a real case which has very, very recently come to trial. In the last couple of months, this has been settled. So person A collapsed whilst out socially during the day. There was a diagnosis of a condition that affects the large intestine and colon and it's caused by the development of bulges. I am not going to try and describe the condition and please don't ask me the condition there is more educated people in the room that will be able to do that. That's the number that was alleged. So we're talking a claim of circa 1.5 million pounds. So that's essentially what was in dispute between the doctors who performed the surgery and the patient and the patient's representative, obviously legally represented.

Now, the consultant originally tried to treat this conservatively. Subsequently the scans showed a deterioration in the condition, perfectly normal set of circumstances and events that had occurred there. They had one surgical intervention, which unfortunately failed and the patient became very ill. A second different surgical procedure was then carried out under emergency conditions. So again, probably something that you see day to day in the types of patients that some of you will be dealing with. The patient remained in ICU, recovered, but had ongoing, lifetime, daily impairments to activities and also post-traumatic stress disorder. So you can see how this probably occurs day-by-day in all of the trusts that are our members and that you work at. This type of event will occur. It is a risk. The first surgery failed. The second surgery corrected it, but left with ongoing impairment.

So there was two key allegations here. The first was that the clinician gave the wrong diagnosis and treatment. So in essence they didn't give

the correct treatment. Standard clinical negligence allegation. It was wrongly diagnosed and the wrong treatment was given. The second allegation, which was linked, and again, you can see where this all becomes linked into one, was a failure to consent to the first surgical intervention or advise of alternative treatment. You can see the relevance straightway to both of those tests in that second allegation. Now, the allegations were that the surgeon should have sought a specialist opinion in the first place, so referred to a colleague, which would have recommended the second surgical procedure and potentially avoided the adverse outcomes. So avoided the need for the first surgery and avoided the long-term complications. The allegation was also that the surgeon had failed to consent to the first surgical intervention as an alternative treatment, i.e, the alternative treatment being the second surgical intervention wasn't discussed, and that's the material risk point.

So the evidence was contested, and the clinician alleged that he'd explained both procedures to the patient prior to proceeding with surgical intervention number one and the patient had understood those risks. This is quite an important point. The patient had posted a review. This was an online review of the surgical staff and team following the procedure, and that was extremely positive. So this was post the second surgical procedure. This was post-discharge, had actually posted a review or provided a review saying that the staff were excellent and everyone had cared for them in a very satisfactory way. Now, the court referred specifically in this case to the three legal tests. So this is where it does become real, because this is a real life case and this is what the court was having to determine. Bearing in mind, this case probably occurred about seven years prior to both parties standing up in the witness box and giving evidence. So the claimant themselves was standing in the heat of the moment in the witness box answering questions, so was the surgeon. But that was probably six or seven years post the actual incident occurring. So the court referred to the Bolam test for the first type of allegation and clearly, Montgomery and McCulloch for the second.

So what were the findings? The findings were the recorded notes by the clinician, were by their own admissions, poor. Now, what the judge actually reflected on here was there were some notes made, and there were some notes of conversations that had occurred, but by the clinician's own

admissions they weren't exactly comprehensive. There were a couple of words or a couple of lines in various places to document a conversation that had taken place in relation to surgical intervention. But where they were made, they did in the round, support the clinician's evidence.

So, audience participation number two, your last one before lunch.

Who believes that the case was successful in the fact that the claimant was awarded some damages? So who believes that the claimant was successful in actually getting awarded damages here?

Okay, and who obviously doesn't? so about the rest should be about half. It's about half and half.

I think that's quite an interesting thing because you can see there, that's what the judge was facing. I know he would have had a lot more detail, but half of the room here felt the consent wasn't appropriate, half felt that it was. It just goes to show the challenges that we have in this area. Case was dismissed. On Bolam, the expert witnesses supported the decision made, so there was a body of medical opinion that said yes, in relation to the first and second surgical procedures, it was absolutely appropriate that those options were considered and they were considered in the right way.

On consent, it says the clinician did explain the risks of both surgical options so, satisfied Montgomery. In relation to the McCulloch test, which is slightly backwards here as I've put it, the clinician did offer the second procedure before the first. So he did have that conversation with the patient to explain you can either have the first surgery, which has the risks, or you can move straight to the second surgery, which actually has a greater degree of ongoing disability or ongoing impact. And the patient chose to go through the first surgery, to try and avoid that impact. So therefore, McCulloch was satisfied. Now at the end, the judge commented on this case. One of the benefits of contemporaneous records, is that they preside insights into events that is not susceptible to degrading of memory, or the fact agendas on either side.

Now, what the judge meant by that was, they often see cases where people have six years to reflect on a conversation that occurred at a very, very

traumatic moment in their life. And people's memory will often build facts to support a narrative in relation to that, not on purpose, there was no allegation anywhere here that anybody was lying about the circumstances of any discussions, was being disingenuous in any way. But there was a clear, factual dispute about what the conversation was between the surgeon and the patient at that specific time, and what both of their recollections were in that regard. So it is clear again, the judge was being very, very specific and if it's one thing to take from what I'm saying today, and probably what others are saying today, was very much on the case that a judge is going to look at those contemporaneous records and then hear what the parties have to say. If it does become into a dispute about what those contemporary records mean and what the nature of those conversations were.

So documenting your conversations in whichever way you choose to document them, in the most appropriate way to document them. Be it digital, be it non-digital about the risks, about the nature of the conversation, about the options that you provided, will mean that actually when somebody looks at that for the patient, and we have to remember on this specific case, the patient probably suffered to a degree compounded harm. They had to relive that traumatic surgical experience that gave them that long-term, ongoing disability all over again. Through a litigation process that went all the way to a trial, for them to stand up and give evidence and be cross examined. Which, if any of you have been in the witness box, it's certainly no easy feat when you are having to answer questions in front of a court of law which is a completely alien environment for you.

So recording consent appropriately, cannot just help you in relation to justifying your actions, but it can also help the patient in understanding what the nature of the conversations were that they had at that specific moment in time. And what it meant to them at that specific moment in time rather than having to potentially re-live it through a court environment.

And that's it. Thank you very much.

(Round of applause)

[Matthew:

Thank you very much, Simon.

Now, don't let peer pressure get the better of you. We do have time for a couple of quick questions, but there will be eyes on you. So make it a short, concise question.

Joe.

[Joe Clift:
Hi. I was just interested to know, on your case study that went to court, What played into the decision to take it to court? Was it the value of the claim? Or was it that you were very confident about the defence? Or?

[Simon:
To be honest, it was probably a mix of all aspects. I think specifically in relation to that case, the consultant was definitive and the review really did help, because it was something you could point to that actually the patient had stated they had a good experience. So in the round, it supported the clinician's view that they had discussed everything with the patient beforehand.

[Joe Clift:
Yeah. Interesting. And, because presumably you don't take much, there's not a large proportion of stuff you take to court?

[Simon:
No. I mean, I think our statistics are something like we settled, you gonna test my knowledge from our annual report now, I think we settled around 14-15,000 claims last year and 40 something of them went to court. So nought point nought something percent probably.

[Joe Clift:
Yeah, still quite a few going to court though. It's interesting, yeah, thank you.

[Simon:
Yeah, I mean just again on the court statistics, we have to be fairly confident that you're never going to be 100% confident in, again it comes back to I think the point about surgery. And if you're not doing enough

of it, then if you don't have something to go wrong, et cetera. It's very similar in the court environment. There is an aspect that some things you do have to test and we will certainly take things to appeal. So some of the cases that you will read about are ours, we will take them to sort of the higher courts to make sure the laws interpreted in appropriate way, but we are very selective because taking something to court is, it's not just the financial cost. It is the stress. It's the stress of putting clinicians and healthcare practitioners in the witness box, justifying what they did and the stress for the harm patient, who's got to re-live all of that. But that, I think the percentage of success is about two-thirds, one third on defended cases versus settled cases at trial.

[Rob Hughes:
Simon, just before you do the next one, what was the time lapse between the treatment and the case going to you guys? Was it like five years? six years? seven years?

[Simon:
On that particular one?

[Rob Hughes:
Yep.

[Simon:
To be honest, I don't know. I mean, the average is three years. If you're talking in some of the other specialties, some things like maternity it's even longer, that can be up to six years.

[Unnamed attendee:
Yep Thank you. You've distilled clearly a complex case. Is that a published judgment, and if so, could you give us the citation? Thankyou.

[Simon:
It's not a published judgment, that’s why I anonymised it.

[Male attendee:
Right, and you don’t think it’s going to be published?

[Simon:

Nope. Nope, won’t be. In essence it follows the law. In truth, so whilst it, I think it articulates it quite well, but actually all it does is follow the Bolam, McCulloch, Montgomery principle. And again, when we're looking at cases, that's exactly how we have to look at it. So does it follow all three of those and can we tick all of the boxes to say, yes, those three tests are satisfied? And if they are, then clearly we have a defensible action.

[End of transcript]