

Behavioural insights into patient motivation to make a claim for clinical negligence

Final report by the Behavioural Insights Team

August 2018



This report was created by the Behavioural Insights Team on the behalf of NHS Resolution.

Contents

Executive summary	5
1. Introduction	6
2. Methodology	7
Process map.....	7
Survey	7
Interviews	7
Study limitations	8
3. Overview of the study population.....	10
3.1.Mapping incidence: incidents, complaints and claims.....	10
3.2.Survey respondents	13
Demographic details	13
Table 1. Demographics of survey respondents.	13
About the claims	13
3.3.Interviewees.....	17
Table 2. Overview of claimant interviewees, their incidents and claims	17
4. Study findings: Incidents, explanations and apologies.....	18
4.1.Survey findings	18
4.2.Interview findings	19
4.2.1.Staff reactions did not meet the standards expected by patients.....	19
4.2.2.Explanations and apologies were rare or insufficient.....	20
4.2.3.Possible missed opportunities to avoid claims.....	23
5. Study findings: Complaints	25
5.1.Survey findings	25
5.2.Interview findings	27
5.2.1.Poor communication	28
5.2.2.No perceived meaningful outcomes	30
5.2.3.Meetings	30
5.2.4.Possible missed opportunities to avoid claims.....	32

6.	Study findings: Claims	34
6.1.	Claims behaviours: Capability	35
6.2.	Claims behaviours: Opportunity.....	37
6.2.1.	Prompts from NHS staff or bodies to make a claim.....	38
6.2.2.	Advertising of attractive 'no win, no fee' funding arrangements	39
6.2.3.	Word of mouth	40
6.2.4.	Identifying a solicitor	42
6.3.	Claims behaviours: Motivation	42
6.3.1.	'Hot state' and emotional responses: frustration and anger	43
	Survey findings	43
	Interview findings	49
6.3.2.	Other intrinsic motivations	49
	Survey findings.....	49
	Interview findings.....	50
6.3.3.	Summary of findings: the COM-B model	55
7.	Conclusion	56
8.	Acknowledgements.....	56
	References.....	57

Executive summary

NHS Resolution commissioned The Behavioural Insights Team (BIT) to research the **motivation** of patients making legal claims for compensation for clinical negligence (“claims”).

The NAO report published in September 2017 entitled Managing the costs of clinical negligence in trusts and the subsequent Public Accounts Committee (PAC) inquiry highlight the lack of evidence in relation to claimants’ motivation to claim. Increasing understanding around this issue is aligned to NHS Resolutions strategic commitment to increasing insight into what drives the costs of harm and developing interventions to respond to these, in partnership with others.

In order to develop insights in this area, BIT conducted several streams of work between January - August 2018:

1. To gain familiarity with the pre-claim and claims process, and to understand the scale of the problem, BIT undertook a review of the literature and created a process map summarising key findings.
2. BIT surveyed 728 past claimants. In the survey BIT asked claimants about the patient safety incident(s) which led them to make a claim, how they felt their incident and complaint (if they made one) were handled, their motivations to claim and the outcome of their claim.
3. BIT conducted one-hour telephone interviews with 20 past claimants.

BIT found that:

- Reactions of NHS staff following an incident were generally considered unsatisfactory by claimants, in terms of providing adequate and appropriate explanation and apology for events.
- The majority of the research participants were not satisfied by the NHS complaints’ handling process, in terms of communication (both verbal and written) and feeling that a meaningful outcome had been achieved.
- Both external and internal factors motivated participants to make a claim. These included:
 - **External motivations.** Some of these factors acted as prompts for the individual to seriously consider pursuing a claim.
 - Suggestions from NHS staff that making a claim would be appropriate
 - Advertising
 - Conversations with friends, family and wider social network

- **Personal or ‘intrinsic’ motivations.**
 - Wanting to prevent similar things happening to others.
 - Wanting to receive an apology or an explanation for the incident, or to trigger a detailed investigation of the incident.
 - Wanting the clinicians involved to be held to account.
 - Cognitive biases: sunk costs, loss aversion, optimism bias.
 - Emotional responses (e.g. frustration and anger) brought about by poor incident or complaint handling.
 - Financial compensation.

1. Introduction

NHS Resolution has commissioned The Behavioural Insights Team (BIT) to research the motivation of patients making claims for compensation for clinical negligence.

To understand the factors that motivate people to make a claim, we undertook several pieces of work:

1. To familiarise ourselves with the pre-claim and claims process, and to understand the scale of the problem, we undertook a review of the literature and created a process map summarising what we found.
2. BIT surveyed 728 past claimants. In the survey BIT asked claimants about the incident(s) which led them to make a claim, how they felt their incident and complaint (if they made one) were handled, their motivations to claim and the outcome of their claim.
3. We conducted one-hour telephone interviews with 20 past claimants, who had provided their contact details through the survey.

We present our findings from this work in this report. **Section 2** details methodology employed and **Section 3** sets out the process map and describes the study population. **Section 4** presents findings from both the survey and interviews in terms of learning about incidents, apologies and explanations received. **Section 5** details how respondents perceived the complaints process. **Section 6** presents findings about participants’ decisions to make a claim. This section focuses on the conditions which make it likely that people will pursue a claim.

2. Methodology

Process map

BIT began by reviewing the volume of incidents, complaints and claims which are handled by the NHS on an annual basis. We also explored the relevant literature at this stage. The outputs of this are presented at the start of the next section in Figure 1.

Survey

10,000 past claimants were invited by NHS Resolution to respond to a survey asking about the experiences which led them to make a claim. An invitation letter provided past claimants with informed consent to opt-in participate in the survey.

Target survey population details:

- Of the 10,000 invited to participate, 5,000 had claims which resulted in a damages payment, and 5,000 had claims which did not result in a damages payment.
- Claims concerning a fatality, claims on behalf of children and claims for adults who did not manage the claim themselves were all excluded.
- Only claims settled or valued at £100,000 or less were included.

516 people responded fully to the survey. A further 212 people responded partially to the survey (adding up to 728 responses in total).

Respondents were asked about:

- The incident the claimant experienced and its handling by NHS staff
- If they made a complaint
- The factors which played a part in their decision to make a claim
- The outcome of the claim
- A few demographic questions

The survey responses were collected via SmartSurvey and the raw data was analysed in-house by BIT using Stata.

Interviews

BIT conducted interviews with 20 past claimants, randomly selected from the pool of people who responded to the survey and gave permission to be contacted for an interview. The opportunity to opt-in to the interview pool was preceded by written informed consent at the end of the survey.

The interviews each took up to one hour to conduct. All interviews were audio recorded and transcribed following verbal consent from interviewees.

We took a structured approach to the interviews; the same questions were answered by all interviewees. The interview questions were informed by our prior work during the phases described above. We deviated from the interview protocol at times to clarify interviewees' responses or to understand case-specific details. This structured approach meant the interview remained focused; we captured data consistently and ensured all participants views were sought across the same topics.

We asked all claimants about:

- The incident they experienced within the NHS
- The reactions of the NHS staff towards them after the incident, and if the claimant had received an apology
- If they had made a formal complaint to the NHS (asking more details about this if they had)
- Their decision to make a claim

As these interviews touched on very personal and sensitive information, BIT took every opportunity to reduce or avoid distress for interviewees. The interviewers explained what the question topics would cover before asking them and reminded interviewees that they could ask to stop the interview at any point, or skip to the next section of questions. Interviewers were also careful to offer breaks or pauses at particularly sensitive points in the interviewee's story. BIT has a safeguarding protocol that interviewers were ready to engage with should any concerning admissions be made by interviewees.

Notes taken during the interviews themselves and the interview transcripts were analysed. The emerging themes were coded across all the interviews using a Grounded Theory approach to qualitative analysis.¹ This means that we used the interviewees' own responses to build up a pattern of themes which could be identified across several of the interviews. The transcripts were read and various sections of them coded in several iterations as the list of themes emerged. Where a theme was reported by a single interviewee, but provided a particular insight which could be transferable, we are careful to highlight this in the results section. All other themes were raised by several interviewees. We report on each of these themes in chapters 4, 5 and 6 of this report.

Study limitations

We made every effort to ensure that this research was as thorough and fair as possible. However, certain factors remained out of our control. As such, the limitations of our work include:

- **Low response rate:** Of the 10,000 people who received the paper invitation to contribute to the survey, a total of 728 did so. This is a small response rate (7%) and the survey's findings are therefore subject to selection bias (see below). Practical barriers will have contributed to this: in particular, whether or not the claimant's current address was up to date according to NHS Resolution's records. An element of 'friction costs'² (or 'hassle') was also present in the process as NHS Resolution does not hold email addresses on file of past claimants. As a result, letters inviting people to go online to respond was the research team's only option for collecting survey respondents. Given that the recipient of the letter was not necessarily online at the time of receiving it, the response rate will have been affected by this friction cost.
- **Selection bias:** We compared the demographic characteristics of respondents to this survey with anonymised NHS Resolution's datasets held on the total number of people with claims closed over the last two years (2016/17 and 2017/18). We identified that (compared to the actual population of recent claimants) this survey sample had an older age profile. Respondents to this survey may have been more likely to be literate or computer literate and have easy access to a computer. They may be less likely to be working or to have caring responsibilities and therefore had the time to respond to the survey. They may also have been more frustrated by their experiences and therefore more motivated to respond to this feedback opportunity. Alternatively, they may have experienced a more satisfactory outcome to their claim and therefore felt prepared to engage with this NHS Resolution initiative. All of these factors mean that the responses of this sample cannot be directly generalised to the wider claimant population, though the sample proportions are somewhat aligned with it.
- **No counterfactual group:** This study only surveyed and interviewed people who had decided to make a claim. We did not access any data in regards to, survey or speak with people who had experienced incidents yet decided not to make a claim. As a result, we cannot comment on any factors that may dissuade people from pursuing a claim.
- **Poor recall:** With the majority of incidents occurring several years ago, there is a need to interpret the responses to the questions with care as many people will have forgotten the specific details of their experiences. We did not fact-check any of their reports.
- **Motivated reasoning and affect:** People's motivations³ and moods⁴ may influence how they recall and judge events pertaining to the incident and the decision to make a claim. This may result in inaccurate or altered accounts of true events and sentiments.

- **Hindsight and outcome bias:** ⁵ Hindsight and knowing the outcome of the claim may influence how interviewees now view their decision to claim. One can easily imagine that not winning a claim might make a person believe that their original decision to claim was a bad choice. Had we asked them at the time itself, we may have learned different things about the person's motivation to make a claim.
- **Social desirability bias:** People tend to report their views and actions in a way that they believe will be interpreted more favourably by the person collecting these details.⁶ This response bias may have affected survey and interview responses in our research, with claimants potentially emphasising their desire to improve the system for others motivating their claim rather than financial compensation, for example.

In summary, BIT conducted three streams of work (desk-based research, survey and interviews) to gain a better understanding of factors that motivate people to make a clinical negligence claim. In the next section, we discuss the study population in further detail.

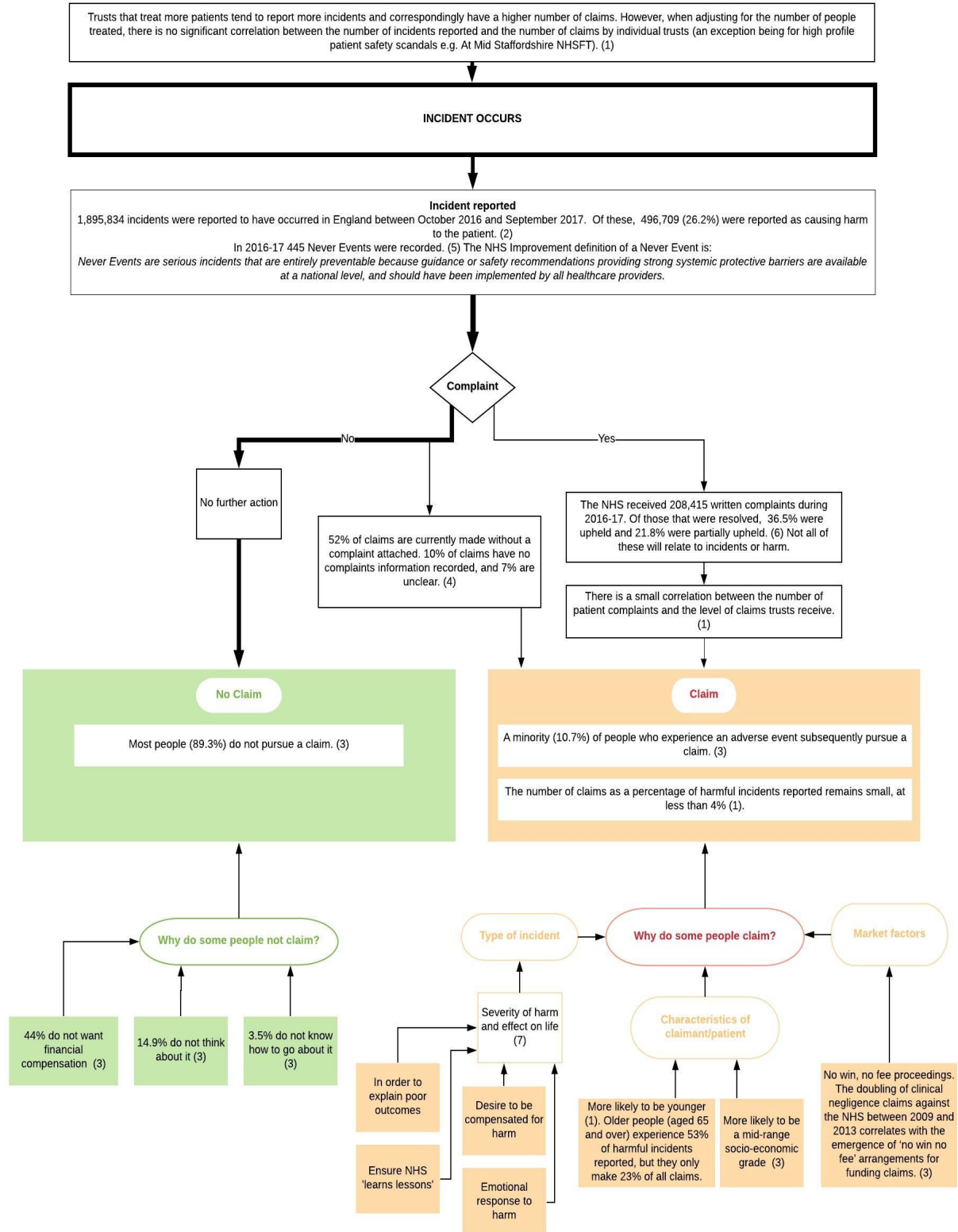
3. Overview of the study population

3.1. Mapping incidence: incidents, complaints and claims

The following infographic maps the incidence of incidents, complaints and claims using the latest data available in each domain. We also summarise the main themes arising in the literature in relation to motivating factors for why people do or do not claim.

The observations from this mapping exercise informed the development of the survey and interview protocols

Figure 1. Incidents, complaints and claims incidence map



Infographic references overleaf

1. NAO (2017). 'Managing the costs of clinical negligence in trusts. Retrieved from <https://www.nao.org.uk/wp-content/uploads/2017/09/Managing-the-costs-of-clinical-negligence-in-trusts.pdf>
2. NHS Improvement (2018). NRLS national patient safety incident reports: commentary. Retrieved from https://improvement.nhs.uk/documents/2543/NAPSIR_commentary_FINAL_data_to_December_2017.pdf We note that more incidents occur each year than are reported. A recent report by the Patient Safety Translational Research Centre states that 'patient safety issues are dangerously under-reported'. Retrieved from https://www.imperial.ac.uk/media/imperial-college/institute-of-global-health-innovation/IMPJ4219-NRLS-report_010316-INTS-WEB.pdf
3. Fenn, P., Gray, A., Rickman, N., Vencappa, D. (2016). Funding clinical negligence cases Access to justice at reasonable cost? Nuffield Foundation. Retrieved from http://www.nuffieldfoundation.org/sites/default/files/files/Funding_clinical_negligence_cases_Fenn_v_FINAL.pdf
4. NHS Resolution year to date data showing the proportion of reported claims which had a complaint attached (as at 31/01/2018), shared with the research team. This dataset spanned 10 months. This finding is consistent with previous years' data.
5. NHS Improvement (2018). Never Events reported as occurring between 1 April 2016 and 31 March 2017 – final update. Retrieved from https://improvement.nhs.uk/documents/2347/Never_Events_1_April_2016_-_31_March_2017_FINAL_v2.pdf
6. NHS Digital (2017). Data on Written Complaints in the NHS 2016-17 Report. Retrieved from https://digital.nhs.uk/media/32535/Data-on-Written-Complaints-in-the-NHS-2016-17-Report/pdf/Data_on_Written_Complaints_in_the_NHS_2016-17_Report
7. Forthcoming "Understanding the drivers of litigation in health services" paper. Similar findings were found 15 years ago in the Department of Health's paper: (2003). 'Making Amends: A consultation paper setting out proposals for reforming the approach to clinical negligence in the NHS. A report by the Chief Medical Officer'. The proportions of patients reporting a desire for different outcomes will depend on the severity of the incident they experienced. http://webarchive.nationalarchives.gov.uk/20120809195448/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4060945.pdf page 75.

3.2. Survey respondents

We received 728 survey responses (including 212 partial responses).

Demographic details

60% of respondents who were willing to answer questions on demographic details were female. More than 60% of respondents indicated they were between 50-79 years old. Further details regarding respondent demographics are included in Table 1.

Table 1. Demographics of survey respondents.

	Total (Completed + Partial responses)
Gender^a (n)	534
Male	40% (213)
Female	60% (317)
Age group (n)	534
18-34	6% (35)
35-49	20% (105)
50-64	35% (190)
65-79	32% (169)
80+	6% (35)
Income bracket (weekly before tax) (n)	533
Less than £99 (£4,999 per year)	13% (68)
£100 - £230 (£5,000 - £11,850 per year)	29% (157)
£231 - £665 (£12,000 - £34,500 per year)	42% (226)
£666 - £999 (£34,600 - £51,999 per year)	9% (49)
Above £1000 (£52,000 per year)	6% (33)

About the claims

Within the survey responses, Orthopaedics and General Surgery were the two specialties under whose care incidents most frequently occurred (see Figure 2). 'Other' was the most frequently cited specialty, perhaps indicating that

^a In response to the question about gender, one person recorded their gender as non-binary. Three people responded with "prefer not to say"

incidents happened across specialties, or that respondents were unsure how to categorise the speciality.

These findings should be interpreted with care and are included here to indicate who responded to the survey, not to indicate the level of claims within these specialities. It is possible that respondents selected 'General Surgery' when their incident was something to do with surgery in general, rather than under the care of the 'General Surgery' specialty. Similarly, we identified that, compared to the actual population of recent claimants, the survey sample had an older age profile. Older individuals are perhaps more likely to require orthopaedic surgery, and thus this data may over-represent incidents pertaining to orthopaedic care.

Incidents began before 2013 in over 40% of cases (see Figure 3). The most frequent type of incident leading to claim was failed, delayed or incorrect diagnosis (see Figure 4). More than 60% of respondents indicated their claims were settled with financial compensation (see Figure 5).

Figure 2. Incident specialty

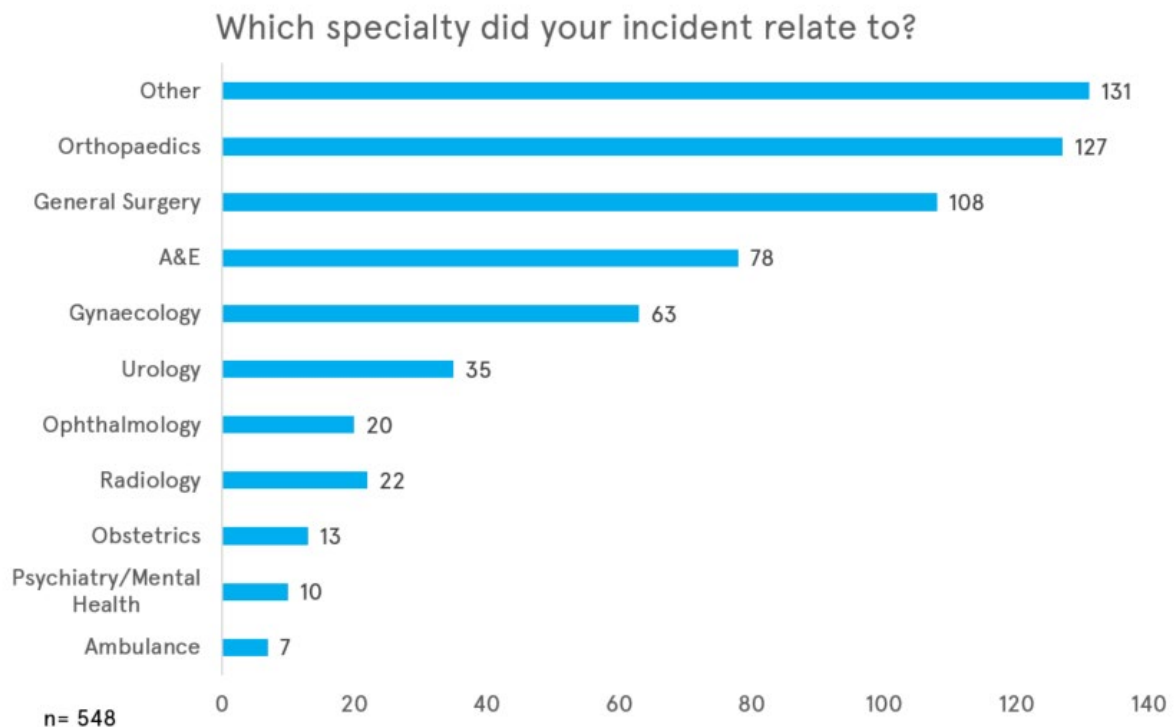


Figure 3. When did the incident take place?

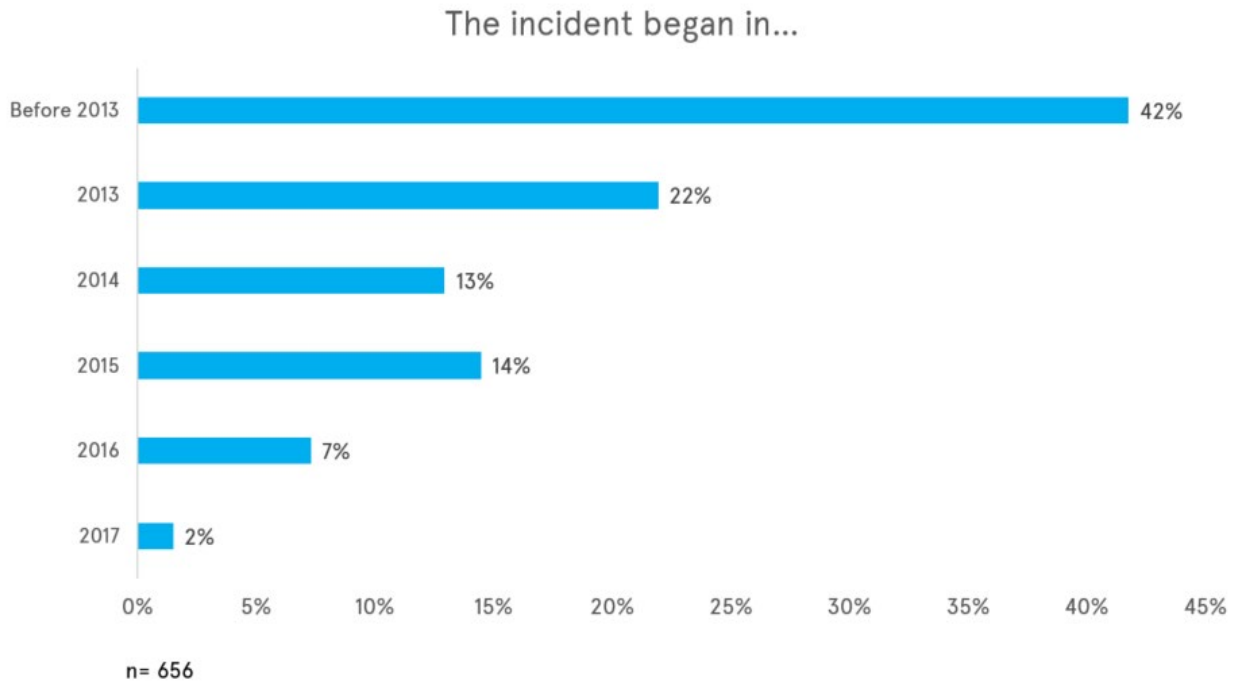


Figure 4. Incident domain

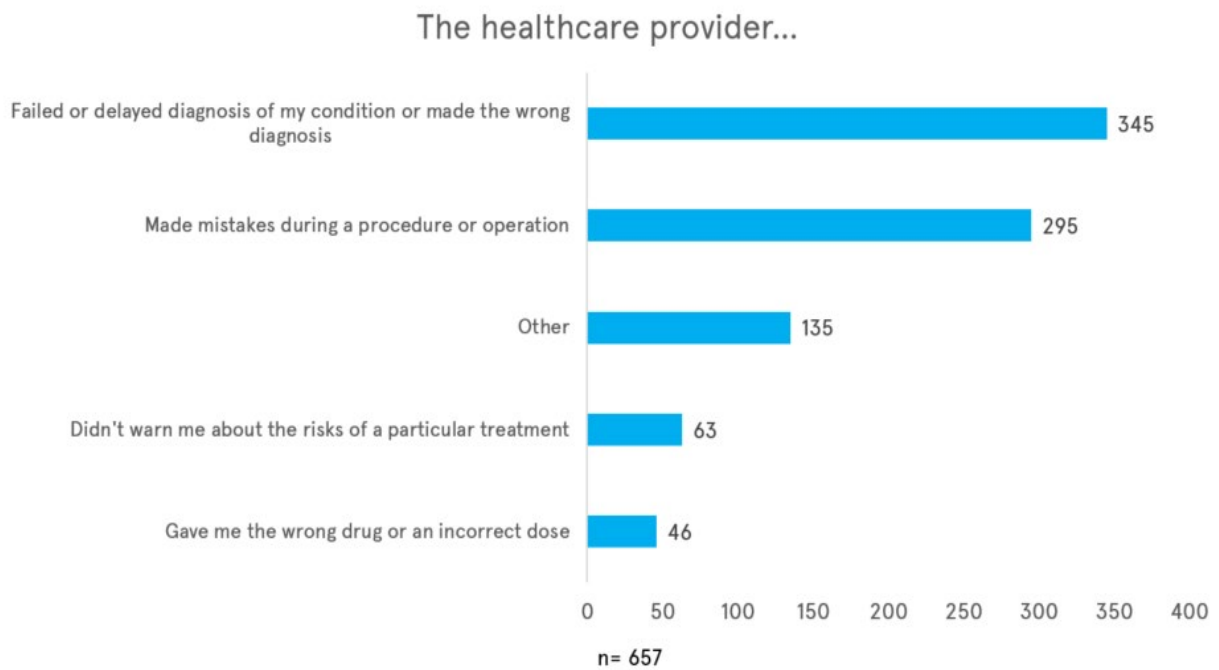
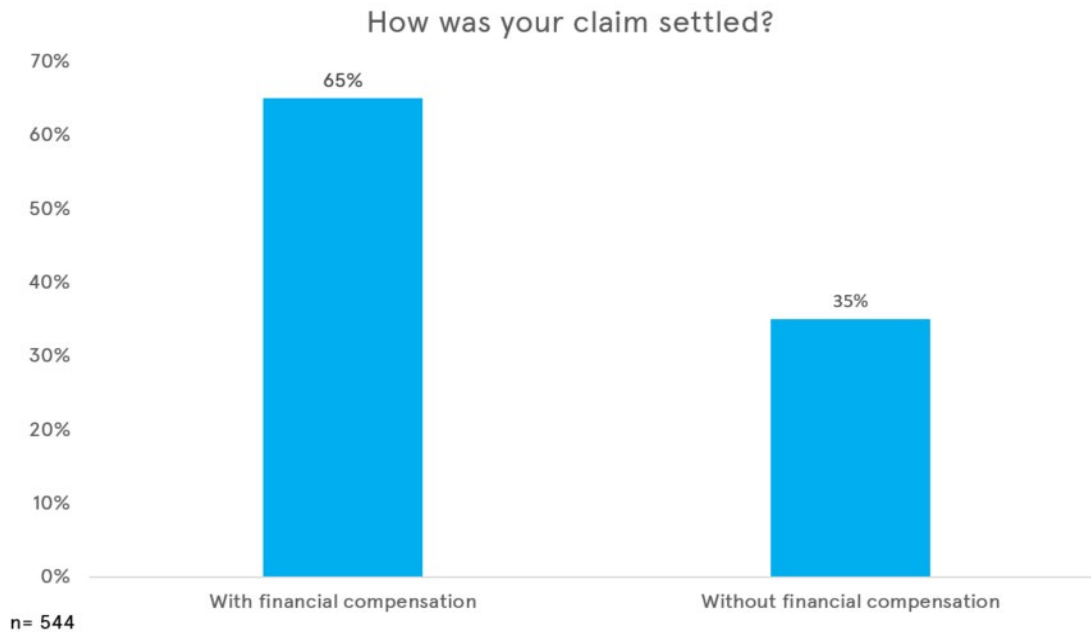
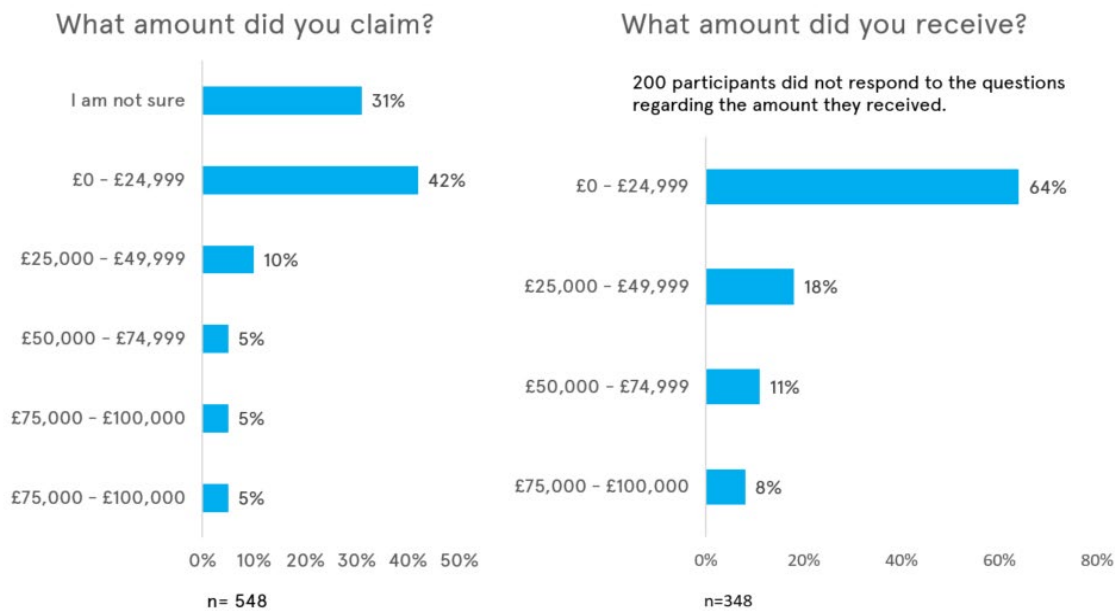


Figure 5. Claim settlement details

a. How was your claim settled?



b. What amount did you claim? What amount did you receive?



3.3. Interviewees

We interviewed 20 claimants. These interviewees were recruited by the means outlined in the Methodology section above. Table 2 summarises some of the key facts about our interviews.

Table 2. Overview of claimant interviewees, their incidents and claims

Number of interviewees	20
Gender	11 male (55%)
Settled in claimant's favour	14 (70%)
Claim specialty	5 x Orthopaedics 4 x General Surgery 2 x ENT surgery 2 x Endocrinology 2 x Urology 1 x General Medicine 1 x Endocrine surgery 1 x A&E 1 x Obstetrics (maternity) 1 x Gynaecology

The remainder of this report will present the findings of the survey and interviews. The survey findings are presented in this report in summary form.

4. Study findings: Incidents, explanations and apologies

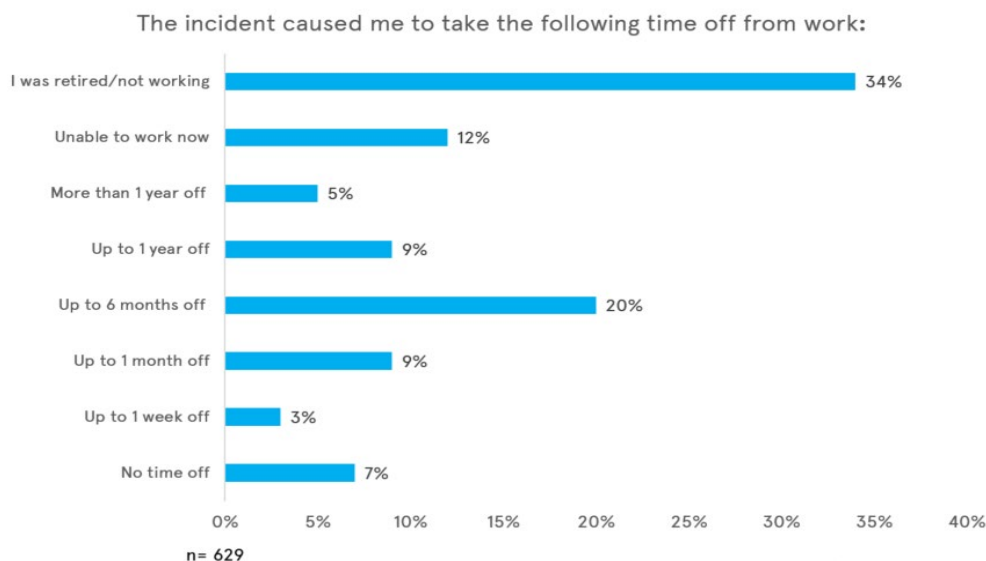
4.1. Survey findings

Summary

- Almost two thirds (63%) of survey respondents felt that no explanation was given to them. The majority of those that did receive an explanation waited 10 days or more to receive it following the incident.
- Less than one third (31%) felt they received an apology. A minority of those who did receive an apology rated that apology highly.
- The majority (71%) of respondents did not think that their healthcare provider undertook any actions to investigate the incident in the first instance.
- Of those who did report that their healthcare provider investigated the incident, around half (49%) of respondents were invited to a meeting to discuss the findings, while the remainder (51%) were not. 36% of respondents reported being invited to a meeting and attending. 8% were invited but could not attend. 5% stated they had to call for a discussion to take place.
- Only 6% of respondents felt that actions were taken that would prevent the same incident happening again.

Figure 6 provides an indication of the severity of the incident experienced by the survey respondent.

Figure 6. Severity of incident



4.2. Interview findings

Summary

- Themes emerging from the interviews identified that staff reactions fell below the standards expected.
- Explanations or apologies were deemed to be rare or insufficient when they were given.
- Several interviewees remarked that, had these initial processes been handled better, they may not have pursued their claim.

4.2.1. Staff reactions did not meet the standards expected by patients

Several interviewees described staff responding poorly in the immediate aftermath of their incident. Several described **reactions lacking compassion**.

“We bumped into this doctor [who had missed signs of obstetric complication] in the corridor... and she just had no sympathy. She kind of just said, ‘these things happen’, that was her term, ‘these things happen.’” (Interviewee 1)

“Another thing that was quite an upset on the ward was just the nurses’ attitude. Whenever I tried to question anything...The nurses were just non-existent on every ward that we had been on. It was like that they just didn’t care.” (Interviewee 11)

Several interviews described NHS staff reactions that greatly **lacked in professionalism**.

Some felt the behaviour of the staff was **unprofessional**:

“[The consultant] physically removed me from his clinic so no one else could see that this had happened to me. And when I had [an orthopaedic problem], on the way to theatre, he hid round a corner. Unfortunately, my wife and I could see him trying to hide so that he didn’t see me because he was so embarrassed that he had made such a mistake... He said I was his nemesis” (Interviewee 14)

Some felt **coerced** by staff:

“But it was a very odd feeling [after the surgery which went wrong], he was really squeezing my knee and saying it very loudly and I felt, really odd. My husband said ‘he was trying to get you to say [that the problem pre-dated the hospital admission]’ ... it just felt really odd. I know it sounds stupid, but we just felt really concerned about that. Then he said okay, I’ll give you a free round of IVF. Come and see me in my private clinic and we’ll sort this out. It just rang all these alarm bells.” (Interviewee 20)

Others felt the professionals’ attitude was **inappropriate**:

“I wanted to know what happened, and I wanted to know how the procedure took place. He was very ambivalent in a way, very flippant about it...I felt like I was bullied into having the procedure” (Interviewee 7)

4.2.2. Explanations and apologies were rare or insufficient

It was rare that any of the interviewees described receiving an explanation of the events that had taken place, and their causes, which they felt to be satisfactory. Interviewees described explanations as:

- **Non-existent**

“I’ve had apologies, I’ve not had explanations.” (Interviewee 4)

“...there was absolutely no explanation and they were just leading my family up the garden path.” (Interviewee 5)

- **Inadequate or inappropriate**

“He [the doctor] didn’t lie; he just was very evasive.” (Interviewee 13)

“He [the doctor] said ‘sometimes that happens’, and I said ‘what?’.

Again, he was very nonchalant about it, almost like ‘what do you expect me to do’.” (Interviewee 7)

“...they were trying to justify everything. The only thing that they did acknowledge was [the missed diagnosis component of the incident] but everything else was just no, it was just passing the buck really.” (Interviewee 19)

“[We felt] totally fobbed off.” (Interviewee 5)

- **Dishonest**

“...he’s covering up” (Interviewee 3)

“People are human; they make mistakes. What I don’t expect is it to be covered up.” (Interviewee 14)

“If somebody had been honest with me from the get-go, I wouldn’t have even complained. It was just the dishonesty, the secrecy.” (Interviewee 13)

- **Incomprehensible**

“Really they were sort of baffling me, sort of telling me things I didn’t understand in any case...they are trying to baffle themselves...I mean like you know, they’re sort of saying this and that and you ain’t got a clue have you.” (Interviewee 18)

Similarly, interviewees were infrequently satisfied with the apologies they received. This was because:

- **The apology was deemed inadequate**

“...a very guarded apology if you can call it an apology.” (Interviewee 7)

“Just wasn’t adequate because they were apologising for doing things wrong, but not giving any information about how they were going to put it right. As I was taught as a child, apologising means that you will do something to make sure that you don’t do it again. Whereas, they were just apologising on the assumption that an apology puts everything right.” (Interviewee 4)

“Very, very half-hearted and only after the event, and very carefully phrased in such a way that they don’t take any legal responsibility for their actions.” (Interviewee 10)

One interviewee felt his **apology did not address the matter he was upset by**, indicating that the individual had not been adequately listened to and the most serious matter in his case (as he perceived it) was being disregarded:

“The problem was that he [the surgeon] offered an apology, not based on the fact that he had [carried out wrong site surgery]. But more importantly, he just offered an apology that at the same time he couldn’t [carry out the agreed surgical procedure], and that somebody else would do the surgery in a few weeks’ time.” (Interviewee 2)

- **The apology was felt to be insincere**

“We felt that the apologies never particularly felt sincere; they felt like a formality.” (Interviewee 1)

“There was no sincere apology for any of it.” (Interviewee 11)

“Insincere. Sort of matter-of-fact that these things happen.” (Interviewee 12)

Some interviewees reported that they **did not receive an apology at all**:

“But unfortunately, in the NHS they don’t want to say that [sorry], because as soon as they say that they’re worried that someone is going to take action against them. Because if you say you’re sorry you must have done something wrong.” (Interviewee 14)

“I said, they won’t do it [apologise] because they seemed to say [if they] apologise I will sue them, but if they didn’t apologise I wouldn’t.” (Interviewee 12)

These findings are similar to those identified in the survey, which found that only 31% of respondents felt they received an apology, and only a minority of those who did receive an apology rated that apology highly (see Figure 7).

Figure 7. Survey findings: Claimant impressions of apologies received



n= 180-182 (some participants accidentally selected more than one Likert scale response for the same item, so they had to be removed from the sample)

4.2.3. Possible missed opportunities to avoid claims

Several interviewees suggested that **more appropriate reactions, explanations and apologies would have prevented the need for a claim going forward**. Some examples of words to this effect are quoted below:

“That’s crucial. If I got a proper apology of just saying ‘hands up, we’ve got this wrong’ and if it was a plausible excuse you know, ‘we are so inundated because of - I don’t know what, a major plane crash in the middle of London’ or something, which didn’t happen - or a reasonable excuse... I would have left it there... Also, what would have helped enormously if actually that the main protagonists, the one main doctor that accused me of being a hypochondriac, if he had actually... given me a genuine one-to-one genuine apology, that would have killed it [the claim].”
(Interviewee 10)

“If they had turned around and said in the beginning within the first six months: yes we got that wrong, we are sorry about it, this

is what we have done to change things, and I felt that those things they were going to change would address the root cause then I would have closed it all down, because I would have got what I wanted.” (Interviewee 4)

“I would have liked a proper apology from the people who made the mistake and then I would have just been able to say, oh well it’s one of those things that happens and just get on with your life.” (Interviewee 12)

“If somebody would have actually sat down with me and had a follow-up and had apologised that would have been a completely different ball game.” (Interviewee 20)

“To be honest with you, if the surgeon came up to me and said ‘very sorry, we have made a mistake’, shaken my hand I wouldn’t have bothered. It was just their flippant, “stick together”, “we didn’t do anything” attitude and I thought why not, I’ve nothing to lose.” (Interviewee 9)

In summary, our survey and interview findings emphasise the importance of staff putting effort and compassion into their actions, and reactions, following an incident. Interviewees highlighted the importance of clear and thorough explanations of events and authentic apologies.

Interviewees frequently expressed that they understood that the NHS was experiencing pressure, and they rarely expected exceptional levels of ‘customer service’ in these instances. Instead, they described a sense that the service was not achieving certain basic levels of communication, compassion and customer service. It is difficult to dispute these sentiments and we do not wish to.

It would, however, be overly-simplistic to conclude from this theme that better responses from staff in the aftermath of an incident could prevent a future complaint and claim in all instances.

The limitations of this research which we outline in section 2 above need to be taken into account in the interpretation of this theme. We spoke to people following lengthy and often stressful claims processes. As such, they could only tell us retrospectively and with the benefit of hindsight that they would have followed a different chain of events. We cannot, however, be sure that improved explanations and apologies at the time of the incident would actually have affected their decision to make a claim at the time. We have no counterfactual group with which to investigate this, i.e. we did not also interview 20 people who decided not to pursue a claim.

5. Study findings: Complaints

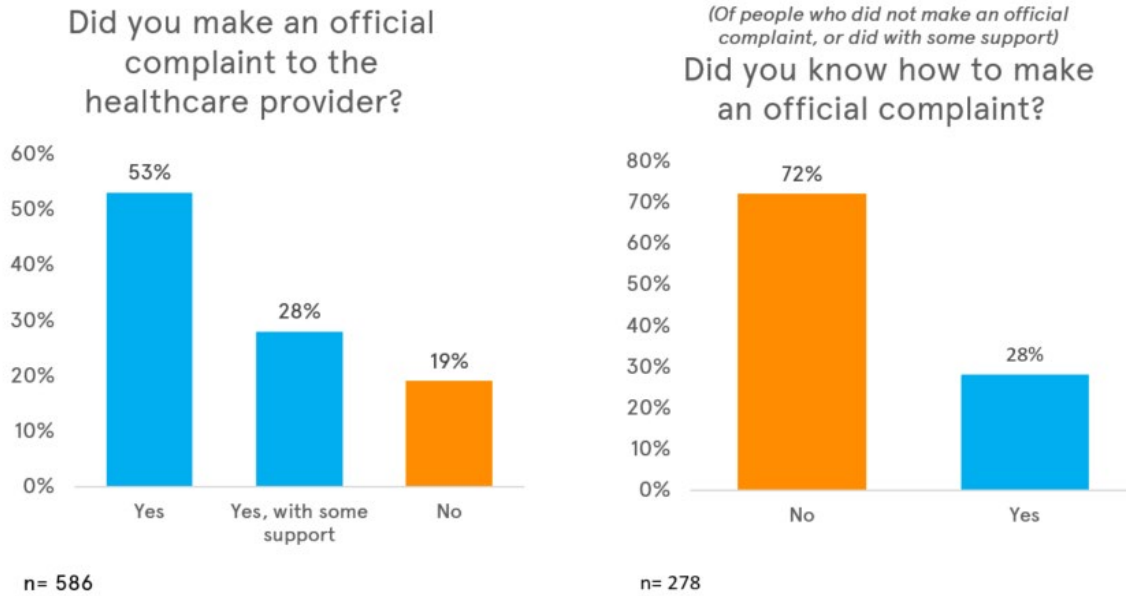
5.1. Survey findings

Summary

- In the survey dataset, 81% of people report making a complaint. Note that in the wider population, only 52% of claims are submitted with a complaint attached.^b Over a quarter (28%) reported needing some assistance to do so.
- Of those who did not make a complaint, the majority (72%) report not knowing how to make a complaint (see Figure 8).
- Around half of the respondents (49%) reported that the politeness of the response to their complaint was 'adequate, good or very good' (see Figure 9).
- The majority (69-75%) rated the response to their complaint as 'poor or very poor' in terms of:
 - Accuracy
 - Empathy
 - Speed of the response
 - Level of detail of the response

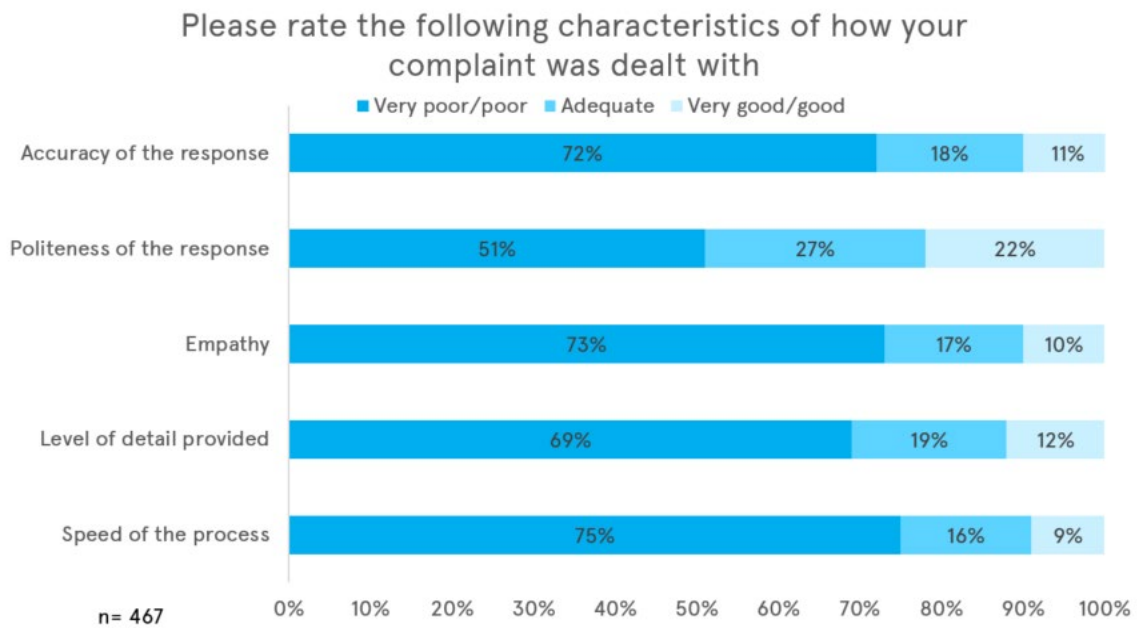
^b NHS Resolution year to date data showing the proportion of reported claims which had a complaint attached (as at 31/01/2018), shared with the research team. This dataset spanned 10 months. This finding is consistent with previous years' data.

Figure 8. Initiating a complaint is not an obvious or easy process



One of the interviewees described this experience. She noted: “I felt I was very confused as to how to go about it [make a complaint], and I’m not unintelligent.” (Interviewee 20)

Figure 9. Responses to complaints are unsatisfactory



5.2. Interview findings

Similar themes emerged from the interviews.

Summary

- Overall, complainants were not satisfied by the complaints handling process.
- Interviewees described poor communication: the complaints process was opaque, impersonal and lacked compassion for some.
- Interviewees reported lacking confidence that their complaints resulted in any meaningful outcomes.
- Interviewees had mixed reactions to meetings arranged in the wake of an incident, and described different degrees of satisfaction and success.
- Interviewees described ways in which their claim might have been avoided.

Overall, complainants were not satisfied by the complaints handling process. Some examples of words to this effect are quoted below:

“That’s one of the many failings, is the complaint procedure is rubbish. It doesn’t get anywhere and it doesn’t do anything, and it’s cold-blooded. The whole stance... is ‘we can do no wrong’. That is an attitude that stinks quite frankly.” (Interviewee 10)

“They passed it around, they didn’t respond in the timescales, they procrastinated, they provided information that was incorrect.” (Interviewee 4)

“I don’t think they actually listened to a word I was saying... I don’t think they actually looked into it at all, to be honest... I just think it’s futile to keep going backwards and forwards with somebody who is not looking at it in the first place.” (Interviewee 19)

“I just felt like they were trying to brush it off to get rid of it as soon as possible.” (Interviewee 19)

“That was a joke as well [the complaint handling]. I think originally I got an email back to say that it would take 14 days – I can’t even remember the time limit. But basically it took them about six months and all I kept getting was letter after letter to say that we are still dealing with it. There are missing files, people are on holiday, and a complaint I should have received answers to in 28 days or whatever. It took about six months for me to get, well, I wouldn’t even say answers to, but to get a response.” (Interviewee 11)

“It wasn’t [handled], not really. It was like I was doing the talking and nobody was giving me any feedback.” (Interviewee 7)

In relation to the complaints process, particular themes emerged from the interviews around poorly written communications, a lack of sharing meaningful outcomes and poor handling of meetings.

5.2.1. Poor communication

One of the dominant themes to emerge about complaint handling within the NHS referred to **poor communication**. The following themes emerged. In the interviewees’ cases:

- **The complaints process was opaque.** Interviewees described long periods of time passing without updates regarding progress towards responding to or resolving the complaint. Complainants reported having to chase responses, sometimes with little success:

“...they’d say they would be ringing me and they never did, and it was me doing the ringing...every time I rang it [the number to ask questions about the investigation report], it was just going onto voicemail. I never got anything back, and I had to just keep ringing the number all the time.” (Interviewee 16)

“I would just say, ‘is there any update on this?’ or after the meeting, ‘we had this meeting three months ago, is that any information and has anything happened since?’ I feel like I asked the most questions, and they might have thought that I was the awkward person, but deep down I just wanted to make a change.” (Interviewee 1)

“I probably would have liked them to have responded to me when they said they would have done rather than me having to chase them up on a monthly basis... them telling me what was happening, before me having to keep asking them all the time.” (Interviewee 11)

- **The communications lacked appropriate tone and compassion.**

“...it feels like the emotion side isn’t quite there, or the, or the sympathy wasn’t there. It’s, it’s just like it’s been reported or just printed off.” (Interviewee 16)

“I probably felt as though I was being treated as much of a professional claimer if you will when I was trying to make a point of something serious. I was just getting the brush off really.” (Interviewee 19)

“[Communications made complainant feel] angry and, and even more helpless because I didn’t feel that they were taking it seriously.” (Interviewee 14)

“[Complaint handled] Dismissively, like well you know these things happen. You know, what more do you expect. You know, your [site of surgery] was a bit of a mess anyway. You know, you should be lucky that actually we’ve managed to do something...” (Interviewee 14)

“...it made me feel like they weren’t, they weren’t that bothered...” (Interviewee 16)

- **The complaints process was impersonal.** This compounded incidents where patients described poor demonstrations of compassion in their direct care.

“...the Chief Executive signed a letter that was obviously drafted by somebody else, and it was passed to the complaints team...it was just a generic letter...a stock letter. It’s a template that’s held on somebody’s server, and all they do is they put your name into it. It’s got a template from the Chief Executive’s signature, the stamp on the bottom and it’s just issued. It’s just simply a tick the box process... I think what would have helped earlier that if somebody from the NHS... would have taken the time to pick up the phone or write to me in a personal nature addressed... rather than just issue a stock template letter. I think this is where the [NHS] falls down.” (Interviewee 2)

“I felt that I wanted to send it [the complaint letter] to somebody, and whether it made any difference or not it made me feel better that I sent it to him [the hospital’s Chief Executive].” (Interviewee 1)

“...it [response letter] was completely impersonal it was probably

being sent out to hundreds of people before, it was signed by a secretary, you know, don't care. They don't care." (Interviewee 15)

- **The communications were incomprehensible to lay people.**

"...this report... I don't even know what half of it is. So unless I speak to somebody about it, I just don't know...using half of these abbreviations in it, I'm no, no wiser to what- how I should feel." (Interviewee 16)

5.2.2. No perceived meaningful outcomes

Interviewees also reported lacking confidence that their complaints resulted in any meaningful outcomes.

"Even although they did this investigation I couldn't see that they were going to change anything" (Interviewee 1)

"... they were the ones that made the commitment that they then didn't follow through on." (Interviewee 4)

"They couldn't give me answers in the hospital when I asked for them, and they still couldn't do it by me writing and complaining." (Interviewee 11)

"... there were several recommendations that came out of the report. I followed it up after three months. I thought that we would just give it some time just to see what had happened and things hadn't happened. We just knew that despite this nothing had really changed... so clearly I just didn't feel like there was a process in place for the recommendations from the complaint to be followed up." (Interviewee 1)

5.2.3. Meetings

Several of the interviewees were invited to attend meetings in the wake of the incidents they experienced. It seems some of these meetings were organised as part of the complaints handling process, while others were organised directly through the departments in which the incidents had occurred. Interviewees described mixed reactions to these meetings, with different impressions of satisfaction and success.

Many interviewees felt the meeting was a **negative experience** because:

- They felt the **meeting achieved nothing**

“... after we had the long meeting and we had spoken to this consultant, we just came out and said nothing is going to change.” (Interviewee 1)

“There were action points that said they would do such and such by such and such a meeting, and then when you see the next version of the action list two or three months later there were no further updates to that point.” (Interviewee 4)

“It was like I wasn’t there. As I said, I did all the talking, they did a lot of nodding, and I didn’t come out of that meeting any better off than I went in.” (Interviewee 7)

- In one case, hospital representatives **failed to attend**

“...so that meeting had to be cancelled because it was the Department Head of the diabetes department that was, as far as we were concerned, the senior person in charge of the meeting and he just didn’t show.” (Interviewee 4)

- In another case, hospital representatives were **poorly prepared**

“They sent the senior surgeon, who I had met during my time in the hospital and I knew he is a well-respected surgeon. But for some reason, he came to the meeting that he had arranged with absolutely no information on the case. He listened to what we said, and he ended up saying that I’ll go away and find out what I can about it. I didn’t think that was good preparation, and he should have at least found something out about the case, but he didn’t and he said he would be in touch. That was it, and that was the last I ever heard from the [hospital] from anyone.” (Interviewee 5)

However, it seems as though elements of the meetings were positive for some of the other interviewees. We should note that in neither case was the meeting sufficiently well-handled to avoid further claim proceedings:

- **Staff admitted fault**

“They did make some key admissions, which was quoted back to them when we put our case to the NHS saying that you have got this wrong.” (Interviewee 10 - this interviewee attended this meeting after having been in conversations with lawyers for quite some time. The meeting was arranged with the intention of avoiding court)

- **Staff apologised**

“ I had this official meeting when they sat down – that was when I realised they were accepting the complaint, when the lady that was with the consultant surgeon, she sat there and she said, ‘We are so sorry’, that’s how she opened the meeting.” (Interviewee 13 - this interviewee then went on to say “It was just like, we’ve said sorry, you can go away now, and I thought, the more I kept thinking about it. I just got cross. So, I went to see a solicitor who said, you know you have got such a strong case.”)

Other interviewees were not offered a meeting. A few reported that they thought this would have been useful:

“Well, to meet us would have been good, to actually talk through what had happened to acknowledge that things haven’t gone well and that you know, they need to potentially be some lessons learned from what had happened.” (Interviewee 14)

“I would have liked them to have them sit there and tell me exactly why it – why it happened the way that it did.” (Interviewee 16)

5.2.4. Possible missed opportunities to avoid claims

Several of the interviewees reported that **better complaint handling may have prevented them from going on to make a claim**, though again, it is difficult to assess the validity of these statements in the absence of the investigation of counterfactual cases. Aspects of the complaints process that were identified as requiring improvement by interviewees included:

- **Correcting mistakes relating to the individual’s case**

“I wouldn’t have made a claim or nothing if they had have put it right [operative complication].” (Interviewee 3)

“I would have liked them to have sorted out the scar.”
(Interviewee 12)

“I think understanding and acknowledgement by the hospital itself that a mistake had happened, and they should make some effort to correct it and help you through the problems that had been caused.” (Interviewee 15)

- **Correcting mistakes in processes to assure the individual that the same incident would not recur in the future.** A number of interviewees did not feel it was sufficient to only address their experience as if it had happened in isolation from the healthcare provider’s day-to-day processes, procedures and staff norms:

“I would definitely probably [have] just accepted a small amount of compensation, and something being put in place to make sure that no one else went through the same thing.” (Interviewee 8)

“If somebody would have said, come and talk to us and go through everything and felt like they showed a bit of interest, and actually shown a bit of interest in making things better in the hospital. I mean you couldn’t make it better for me now. But if they actually had shown a bit of interest about getting those things right in the hospital, I would have been there... I probably would have just said right, leave it at that now and get on with it.” (Interviewee 19)

- **A better apology and explanation following investigation**

“I don’t think I would have made the claim if as I say somebody had invited me into meeting in the hospital and said, we’ve made a mistake, and we are terribly sorry. Tell us what we can do to help you...” (Interviewee 15)

“[If] they had come back with that report and said right, we’ve acknowledged your complaint, this is the outcome, this is what happened and unfortunately [this is what happened]. I’d have– I’d have accepted that and I wouldn’t have proceeded it any further, but it was because I never got anywhere that I had to keep pushing, I had to keep asking.” (Interviewee 16)

- **More honesty and transparency**

“Had they not lied to me. Had they followed through on their actions. Had they shown some genuine concern about my wellbeing. It was like dealing with a faceless organisation. They have obviously got a complaints procedure, they did not follow that complaints procedure.” (Interviewee 4)

“It was just that it dragged on and on. It was as though if we don’t do anything, she’ll go away. That’s how it felt.” (Interviewee 13)

- **Better communications skills: listening and responding with compassion**

“...you know they are not going to listen until you do something to show them [meaning, pursue a claim].” (Interviewee 19)

“... perhaps if they would have been more understanding. It’s like I was a procedure that was finished and they have no more use of me. It’s like you were pushed aside, like what happened didn’t matter.” (Interviewee 7)

“Just a bit of honesty, and a bit of humanity about it would have made a lot of difference.” (Interviewee 10)

“...if I would have got a more sincere response from the hospital, I wouldn’t have taken it further.” (Interviewee 11)

This section has detailed many aspects of the complaints process which were not not satisfactory for complainants. The complainants themselves suggested a number of ways in which this could be improved. We have used these thoughts to develop our recommendations, laid out in Section 7 later in this report.

6. Study findings: Claims

The preceding sections have described people’s experiences in the time between an incident happening and their decision to make a claim for clinical negligence. They suggest a number of opportunities which, with the benefit of hindsight, they thought could have averted their decision to make a claim.

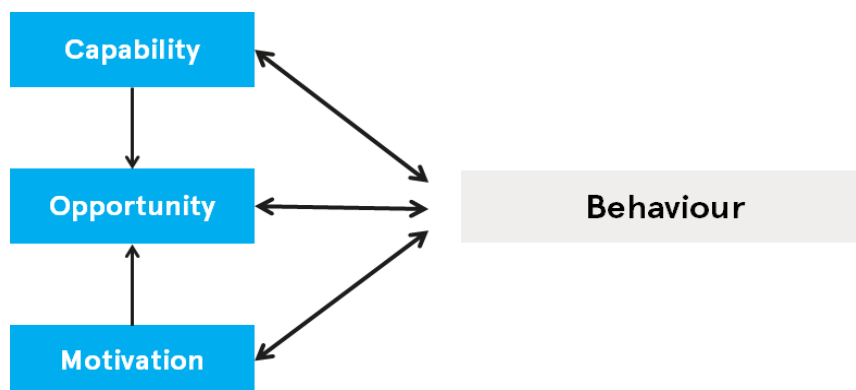
Previous researchers in this area have identified that the majority of people who experience an incident (and who plausibly may have experienced similar instances of poor explanations, apologies and complaint-handling as detailed above) do not go on to make a claim. An estimated 89.3% of people who have experienced an incident do not opt to bring a claim for clinical negligence (see Figure 1).⁷ As noted throughout this report, this study cannot comment with

any authority on the experiences of this group (in a sense, the ‘counterfactual’ group, who experienced similar incidents to this study’s group of interviewees, but a different outcome).

What we seek to do in this section, however, is to provide a detailed analysis of the drivers of the decision to make a claim (the focus of this study), using the reports of this study’s interviewees. In analysing the behaviour related to making a claim, we draw heavily on the COM-B theory of behaviour.⁸ This theory states that for a behaviour to occur, three main factors need to be present:

- **Capability:** someone must have the knowledge and skills required to carry out the behaviour.
- **Opportunity:** external factors may encourage or enable a behaviour.
- **Motivation:** people’s conscious goals, habits and emotional responses will play a role in behaviour exhibited.

Figure 10. The COM-B theory of behaviour



We will use this framework to organise our insights in this section.

6.1. Claims behaviours: Capability

All of the interviewees were, by definition, capable of making a claim because they made one. However, it is possible that the claims procedure is not accessible for everyone: certain skills or experience may make the process more or less achievable. This is discussed in further detail in this section.

Certain skills are required for someone to be capable of making a claim. For example, the claims process is only really possible for people who are literate enough to navigate the process of making a claim: securing legal representation, making their case and reviewing documents.

Other skills, or experience, may assist an individual in pursuing their claim, or encourage them to pursue it in the first place. Prior experience of making a claim, either by the individual themselves or by a close contact, may make an individual more capable of making a claim. The prior experience may demystify the process, and positively reinforce the intention to claim if the prior experience was successful.

“I mean my daughter had previously – she just had a claim settled from a major accident in which she nearly died, a car accident with someone.” (Interviewee 13)

“But basically I just went to [the solicitor]... they were our solicitor from before just with the house and other things and they were absolutely lovely” (Interviewee 20)

We did not ask interviewees directly whether they had experience of making clinical negligence claims themselves previous to the one in question (which was their most recent closed claim). Several were keen to point out, however, that they rarely complained or made claims when having received poor service in other instances in the past. One interviewee explained that he was unjustly labelled “a professional claimer” (Interviewee 19).

In contrast, one interviewee described herself as “a pretty good complainer”, but this was in the context of seeking to encourage services to improve for the good of other service users “when it’s really important”.

Several interviewees referenced their **professional experience** in their conversations with us. This experience influenced their expectations of the NHS’s handling of their incident, enabling them to confidently identify what they perceived to be negligent practice in their case.

“I think maybe I was aware because of me working in a hospital previously. I was aware that obviously these policies existed” (Interviewee 1)

“The thing that angers me is in my business if a member of staff falls off a chair, and I haven’t told them how to sit on the chair properly they can claim £2000, £3000, £4000 off me.... I [experienced an orthopaedic incident], and the NHS fights tooth and nail not to say sorry. Not to acknowledge that they made the mistake. Not to

acknowledge the impact upon my life, and to dismiss it and give me not £50 and be prepared to fight, and fight and fight not to give me a penny... And I thought this isn't particularly fair" (Interviewee 14)

"I work in a solicitor's office. I know how it goes with claims and things like that, and I've never been a person to put in claims like that; they don't interest me. But I needed somebody to know what had happened. That was the only way I could think of doing it." (Interviewee 19)

"I used to be a manager and I always made it a point that when something went wrong, when I had done something wrong, I apologised and I explained things from my point of view. Whether they accepted it or not and some of them didn't, but I would make it a point to apologise and explain. They didn't do anything like that." (Interviewee 5)

"If I did something wrong in my profession, you apologise and put it right and if you have to pay damages, you have to pay damages. In the medical profession, they close ranks and they haven't done anything wrong" (Interviewee 9)

Broader factors were also identified as playing a role in an individual's capability to make a claim. Support from family and friends, along with psychological and financial support are factors that one interviewee viewed as essential to be able to claim.

"And that's another thing, this whole process is based on you having support: a support network around you to pick you up, private [psychological] counselling because otherwise I think you'd go mad, and financial means." (Interviewee 20)

Other interviewees checked facts with their partners during or in anticipation of our phone conversations, indicating that this support had been present for them during their claim proceedings.

6.2. Claims behaviours: Opportunity

A number of external factors played a significant role in the interviewees' decisions to make a claim. External factors described by interviewees included suggestions from NHS staff that a claim would be appropriate, advertising, and conversations with friends, family and colleagues. Some of these factors acted as prompts for the individual to seriously consider pursuing a claim. For some people, these were the instances they cited when telling us about the period in which they decided to initiate a claim.

6.2.1. Prompts from NHS staff or bodies to make a claim

In the survey, 29.9% of the respondents indicated that they were advised to pursue a claim by ‘the healthcare provider’. This finding was corroborated by the interviews: several of the interviewees said that they made a claim because NHS staff suggested they should.

“I was told to do it [by a governing body which approves the funding of operations], to make the claim so I could get the operation. That was the motivation. It wasn’t to sue them and line my pockets, it was just to try and get the money so that I could afford – and for some strange reason they said no to. That was it and end of.” (Interviewee 3 - the claim was dropped because the interviewee’s solicitor believed that additional evidence invalidated the interviewee’s claim)

“I went down the claims route because the hospital told me that the only way that we’ll take it seriously is if someone takes it down the claims route. So, I went down the claims route because the hospital Director told me to” (Interviewee 4 - the claim was dropped as the interviewee’s solicitor did not feel the case met standards of clinical negligence)

In some cases, these staff members will have accurately assessed the chance of these cases being settled in the claimant’s favour - resulting in fair resolution for the individual. It is not possible for this research to comment on the advisability of these actions on the part of NHS staff in general, however. In other cases (such as the examples provided above) it seems to be a defensive tactic whereby certain decision-making bodies are using the claims route as a kind of triage process which enables them to postpone making a decision themselves. There is clearly a risk (as transpired in both of the above examples) that some staff are advising patients to pursue a course of action which may not in fact result in the resolution they desire and which is costly for both sides.

In other cases, it was the involvement of healthcare staff as credible judges or messengers of the severity of the harm which prompted patients to consider theirs a case of clinical negligence:

“The hospital didn’t send my notes to my GP and he was in the dark for so long. I think it was more that I had my notes and yeah, he was really shocked when he got them.” (Interviewee 20)

“[What do you think it was that first made you decide to pursue your claim?] My GP, my fertility consultant and my – the medical advice I got from my brother, so from a medical professional, not that he told me to claim; he would never have said that. He’s to, what’s the word – he had too much integrity and he is more objective. So it would have been what was right for me and nothing else. But because I had those people around me that didn’t say don’t do it, not that they pushed me in any shape or form. But I had a support network that thought it needed to be highlighted in order to perhaps for those errors not to be made again.” (Interviewee 20)

“Part of... what made me make the complaint [and claim] was... a couple of doctors did make comments off the record..., ‘that shouldn’t have happened [at] all’... and Dr [X] saying and agreeing that yes my kidney was knackered [when the surgeon involved in the original incident had denied that anything was wrong]... That made me cross, and because I was cross, I think I did it.” (Interviewee 13)

6.2.2. Advertising of attractive ‘no win, no fee’ funding arrangements

Advertising is widely present in our environment (e.g. ‘no win no fee’ adverts) and as such is likely to play a latent role in the decisions people make to claim in cases classed as clinical negligence situations. Several of our interviewees noted this in their interviews. However, only a minority of interviewees stated that advertising was a direct influence in their decision to make a claim.

“Advertising probably did play a role, because you wouldn’t be aware of all of these claims that you can make, like clinical negligence and all of them sort of things if it wasn’t for the advertising around you.” (Interviewee 1)

“I obviously looked at no-win no fee arrangements because I’m not wealthy. I knew it was going to be a lengthy process, and I thought if I don’t get no-win no fee there’s no way I can afford to do this. So in that sense there has been since I’ve been injured an awful lot of advertising about no-win no fee. I guess that must have been on my mind when I first started looking.” (Interviewee 6)

“I saw it in the paper. This is the one and only time I’ve ever seen the advert that said, that people with [the same orthopaedic implant complication] could make a claim so I chose them from that.” (Interviewee 17)

In this final quote, it was clear that the specificity of the advert made a difference. The interviewee in question saw the name of his particular type of implant listed, which gave him stronger confidence that it could be worthwhile to pursue the legal route.

6.2.3. Word of mouth

For some of the interviewees, the decision to make a claim was prompted by **conversations** with friends or family members, or colleagues at work. These external influencers may also have been influenced by advertising, of course, as discussed in section 6.2.2 above.

“It is almost by accident that I have a friend who works in London for a firm of solicitors, and she said that we specialise in medical negligence. It might be a good idea if you just contacted them with some details and see what they think.” (Interviewee 6)

“I met someone whose wife was a lawyer with one of these no win no claim outfits and I thought why not... He said why don't you give her a ring and I said okay. Had I not met him I probably wouldn't have.” (Interviewee 9)

“I was exposed to solicitors all the time because of my work and they, of course, saying to me you really ought to make a claim about this.” (Interviewee 13)

“And I phoned the solicitors that I know very well, and he said my wife has a lot of problems with [a doctor]... He said go and see [solicitor used by his wife].” (Interviewee 18)

Interviewees also mentioned **other external factors** that resulted in them making a claim. In the following instances, proactive marketing, or arrangements which made it especially straightforward to initiate a claim likely had an influence, given that the interviewee otherwise described their motivation for initiating proceedings as low at this stage in their recalled experience:

“I had a phone call from someone like you get the “ambulance chasers”... I get this conversation out of the blue and I thought I will tell him and I can't lose anything if I say something to him. In a way, I had almost given up in taking it further” (Interviewee 7)

“I was very reluctant to do it, and if my household insurance hadn't covered it I would never have gone out and found a solicitor to deal with it.” (Interviewee 8)

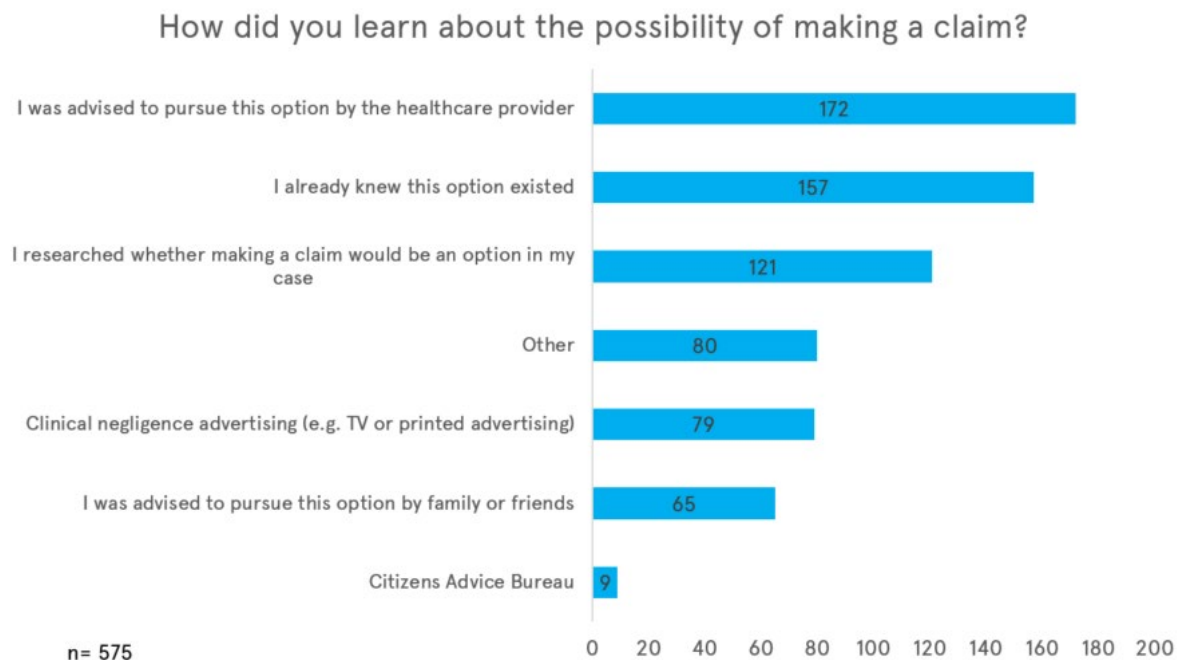
Several interviewees also described the **reactions of friends, family members and colleagues** to their incidents. These reactions took place in the period when people were still processing the impact of their changed circumstances following the incident. These timely conversations may have further influenced the claimants to pursue a claim.

“About the claim, I had gone back to work by then, and I spoke to colleagues about it, and some of the colleagues were saying you know you really should be making a claim about this. It shouldn’t be allowed to happen.” (Interviewee 13)

“But the claim was much more a separate thing of actually people saying, this shouldn’t have happened to you and encouraging you to do it, as opposed to anger residing with the people who had treated you.” (Interviewee 13)

These interview findings closely mirrored the responses we received in the initial survey of several hundred claimants (see Figure 11).

Figure 11. Survey results: From which sources claimants learnt they could make claim.



6.2.4. Identifying a solicitor

In terms of identifying a solicitor, local practices or straightforward internet searches enabled these. Once the claims process was initiated, interviewees noted that it was very easy to proceed (in contrast to the complaints process). We expect that this will have enabled initial conversations with legal teams to process quickly into official claims (as it will be in the interests of competitive legal businesses to make it easy for their customers to do so).

“It was really straightforward. But basically I just went to [the solicitor]... they were our solicitor from before just with the house and other things, and they were absolutely lovely and just took loads [of notes] – well in fact because my brother had annotated everything [medical notes], I just gave them the pack of post its, gave them a very brief timeline, kind of like what we have done today, and they took it from there. They did everything, and so I didn’t have to worry about it whatsoever.” (Interviewee 20)

In contrast, several of our interviewees expressed dissatisfaction with the NHS’s legal team.

“I mean that’s the other reason you go to a solicitor because the people that handle claims at hospital won’t talk to you. They will only talk to solicitors...” (Interviewee 15)

“The very first thing that happened is they make out a letter, and send it to [the NHS] and they have 90 days to reply. My solicitor said that they normally drag their feet little bit, so expect it a month later. In fact by the time they answered 11 months had gone by... It seemed to me that throughout the process is they were hoping I would die... I honestly felt throughout the entire process that they simply wanted me to die to save money.” (Interviewee 6)

6.3. Claims behaviours: Motivation

In this section, we identify a number of elements of the interviewee’s lived experiences which may have provided them with the motivation to make a claim. These encompass the emotions they felt particularly strongly at the time (so called ‘hot state’ instances), intrinsic motivations and cognitive biases which can exert a motivational ‘pull’ on our behaviour.

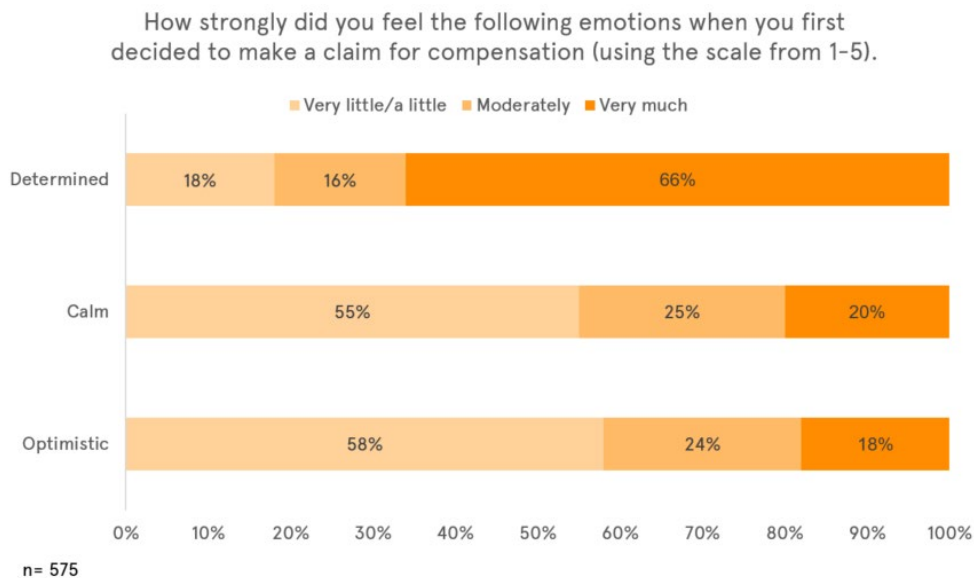
6.3.1. 'Hot state' and emotional responses: frustration and anger

A hypothesis which predates the start of this study was that frustration with the handling of the incident and/or complaint could be a factor in motivating claims.⁹ We investigated this in detail in the initial survey and found some evidence for this. Interviewees also used different words for describing their emotions at the time of deciding to make a claim - most notably anger. We explored this theme with these additional nuances in more detail in the interviews. We present the full findings from both the survey and the interviews below.

Survey findings

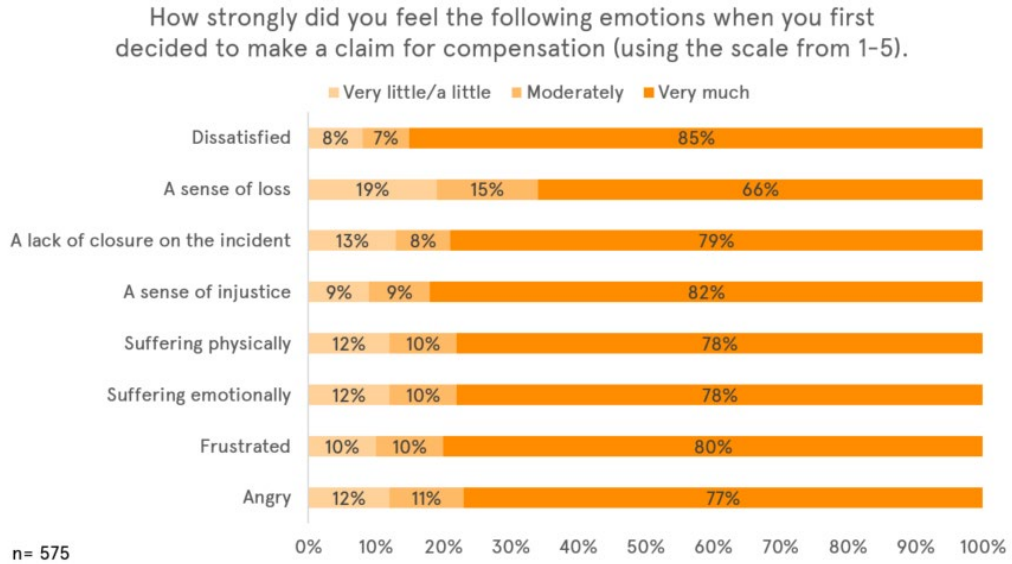
Figure 12. Intensity of emotions experienced by respondents at time of decision to make claim

a. Positive emotions



Most notable in this diagram above is that the majority of people describe feeling both calm and optimistic at the moment of initiating their claim. This may reflect the service and expectation-setting which claimants received from their legal representation during their early conversations together. It may also reflect a sense that for this stage of the process at least, the claimant themselves felt in control of the course of events. Whilst other things (e.g. the incident, the response to the complaint, the explanation or apology they received) were 'done to' them, this was an opportunity to 'do something' themselves.

b. Negative emotions

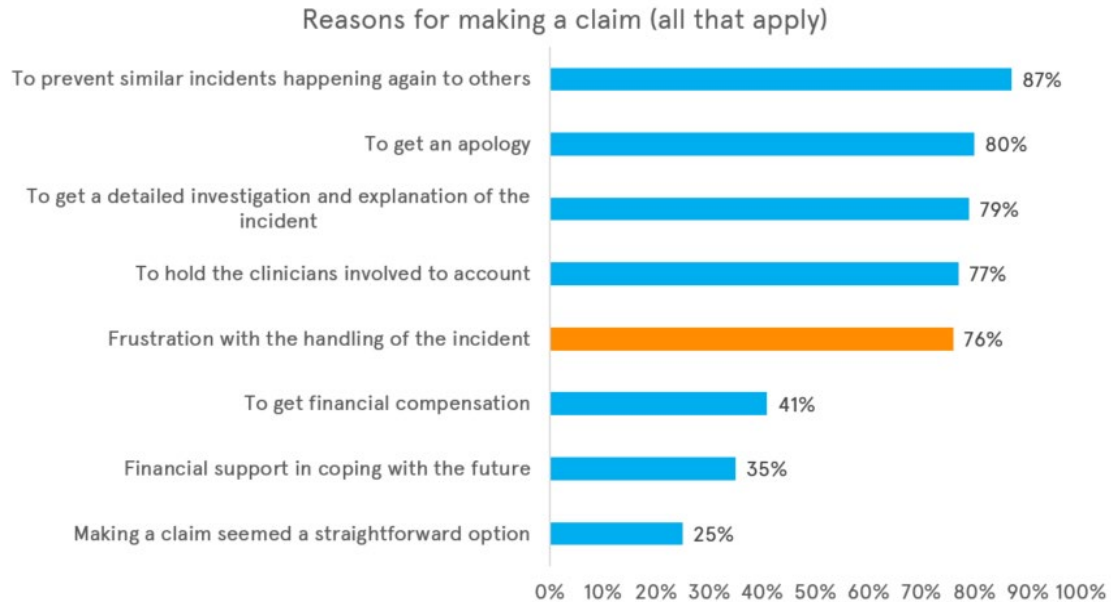


In this survey, there is a risk that respondents report a sense of frustration and indeed the other emotional factors which were presented to them, simply because the option for them to do so exists (i.e. one of the multiple-choice questions offers people the chance to tick the ‘frustration’ box).

We asked questions about various motivations (including frustration) for making a claim. We asked if claimants felt frustration (in the layperson’s sense) in three different ways:

1. **When asked to select all the reasons for making a claim which applied, 76% of respondents included ‘Frustration with the handling of the incident’ in their responses (see Figure 13).**

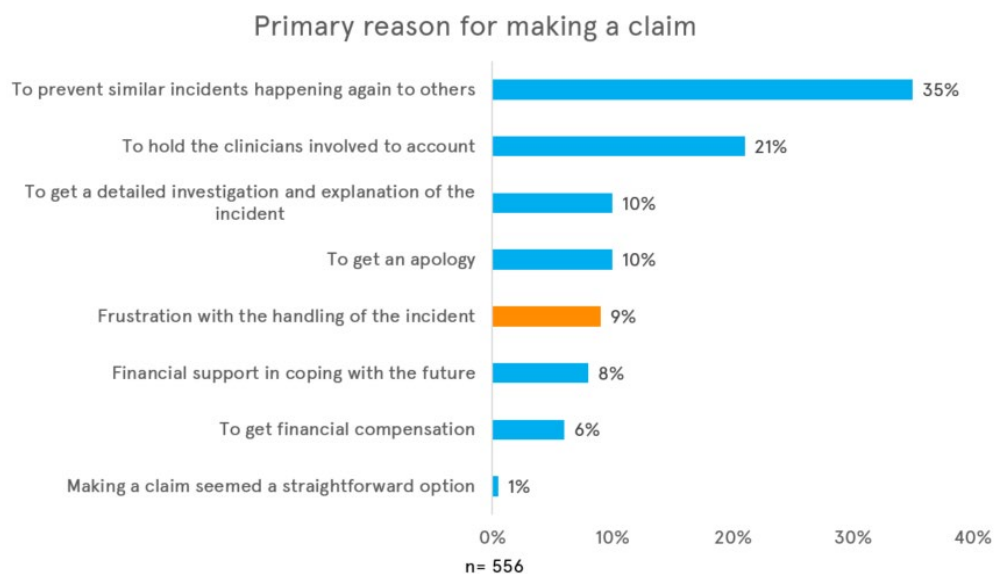
Figure 13. Reasons for making a claim



n= 556

- When asked about the primary reason for making a claim, 9% of respondents selected the “frustration” option (see Figure 14 below). This result indicates that, while frustration motivates people to make a claim, it is the primary reason in fewer than 1 in 10 of our survey respondents.

Figure 14. Primary reason for making claim



3. List question

In order to try to establish the proportion of people who might be selecting the 'frustration' box when this option was available to them, we also included a list question in the survey.

List questions are used in surveys in order to give respondents an opportunity to record that they hold a certain perspective on a question, without requiring them to explicitly state which perspective (of a number listed) they hold. It is commonly used to elicit perspectives on taboo subjects (e.g. whether race of a particular political candidate influences their voting behaviour for example).¹⁰

In this case, we used the list question for a slightly different purpose. We used it to try to work out the proportion of respondents who claim they felt frustrated when the survey gives them the option to do so, and so to isolate that proportion for whom frustration did not seem to be a factor in their decision to claim.

When respondents reached this point in the survey, they were randomised into two groups. Half saw one version of the question (which contained a list). The other half saw a slightly different list (see below). Both were asked how many of the items on the list applied to them.

List question: Control condition

Q. Take a moment to think back to when you first decided to make a claim for compensation. What were your reasons?

- Getting an apology
- Preventing similar incidents happening again to others
- Getting a detailed investigation and explanation of the incident
- Getting financial compensation
- Making a claim seemed a straightforward option
- Getting financial support to help cope with the future
- Holding the clinicians involved to account.

How many of the following reasons were relevant at the time? (0-7)

List question: Treatment condition

Q. Take a moment to think back to when you first decided to make a claim for compensation. What were your reasons?

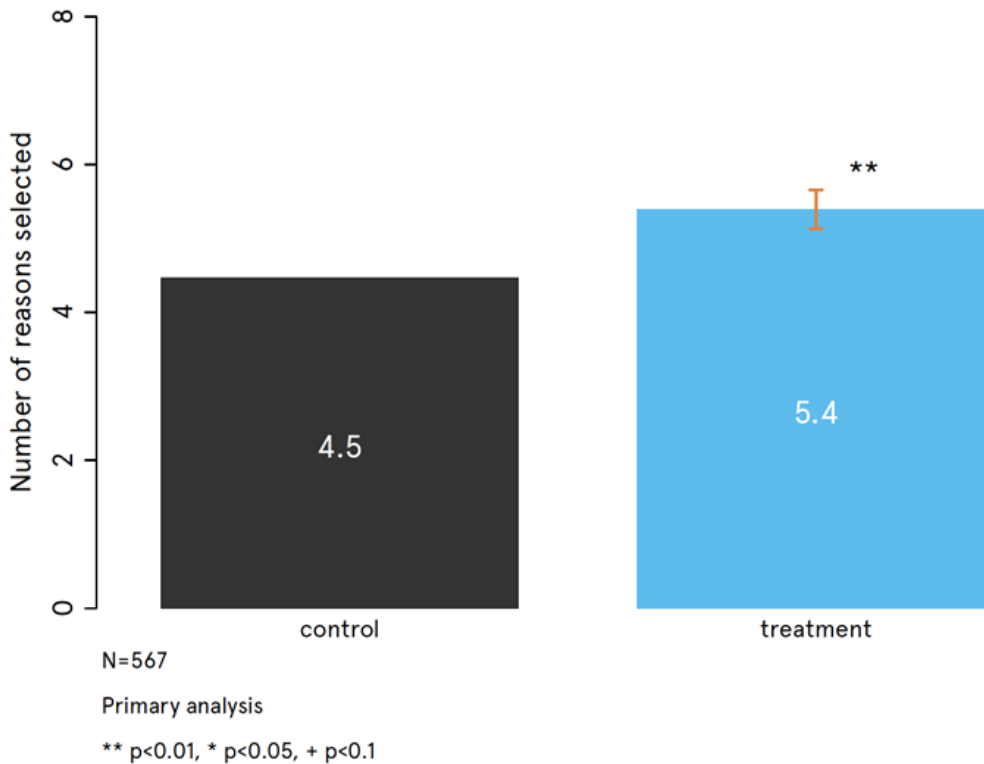
- Getting an apology
- Preventing similar incidents happening again to others
- **Feeling frustration with the handling of the incident**
- Getting a detailed investigation and explanation of the incident
- Getting financial compensation
- Making a claim seemed a straightforward option
- Getting financial support to help cope with the future
- Holding the clinicians involved to account

How many of the following reasons were relevant at the time (0-8)?

In analysing the responses to this question, we compared the difference between the average response between the two groups. This is referred to as a difference-in-means estimator.

We used this estimator to provide insight into the proportion of the individuals for whom frustration is a significant driver in the decision to make a claim. When asked to count all the reasons for making a claim, we found that treatment participants select an average of 5.4 options from the list while control participants select an average of 4.5 options (see Figure 15).

Figure 15. List question results



Our calculation for the proportion that would select frustration when it's available to them alongside other descriptors of a 'frustrated' claims process is 93%. Alternatively, only around 7% of participants, or less than 1 in 10 do not identify a feeling of frustration as a factor in their decision to claim when given the opportunity to do so in combination with other elements of a 'frustrated' incident process.

We reach this figure by the following means: In the treatment group, imagine no one includes the 'frustration' option in their list: the average count reported would be 4.5 (i.e. the result we see in the control group). If everyone in the treatment group were to respond including the 'frustration' option, 5.5 would be the result (4.5+1). So the proportion of people which we assume included the frustration option in their list is the difference between treatment and control averages: $5.40 - 4.47 = 0.93$ or 93%.

Clearly, a sense of frustration is likely to accompany sub-standard handling of the incident/complaint review process and it is virtually impossible to tease the co-existence of these things apart. Nonetheless, from the survey findings, we can state that:

- A sense of frustration with the handling of the incident seems to be experienced by around 8 out of 10 respondents.
- A sense of frustration does not appear to have been a factor in the decision to make a claim in fewer than 1 in 10 cases.

Interview findings

During the interviews, we also found that interviewees described a sense of frustration with the handling of their incident and/or complaint when they decided to make a claim; similar numbers described feeling angry at the time.

“I was frustrated. Absolutely frustrated with the treatment that had been given. They totally ignored us.” (Interviewee 5)

“But, at the time you're- unless you are going through something like that yourself, you don't know how angry things can get, and the frustration and why things happen the way they do. It – it is upset – it's upsetting” (Interviewee 16)

“Because I was so angry with the NHS basically.” (Interviewee 9)

“At the time [of making the claim] I felt very upset, very emotional, very angry...” (Interviewee 11)

“[Hospital communications made claimant feel] Angry. It took me a long time to get to angry.” (Interviewee 12)

“Well I was angry. I was angry at the position – I was angry that they hadn't said sorry. I was angry at the financial position I had been put in, and I was angry at the impact it was having upon my family.” (Interviewee 14)

“I was furious. I was absolutely livid that nobody had done anything or been to see me.” (Interviewee 6)

6.3.2. Other intrinsic motivations

Survey findings

Anger and frustration were not the only motivations noted by both survey and interview respondents.

Indeed, as Figures 13 and 14 above outline, the motivations for making a claim most frequently identified by survey respondents included:

1. To prevent similar things happening to others
2. To get an apology
3. To get a detailed investigation and explanation of the incident
4. To hold clinicians involved to account

These motivations were ranked as more important than frustration by respondents.

Interview findings

The interviewees described intrinsic motivations similar to those documented by the survey respondents. The following themes related to intrinsic motivation emerged from the interviewees' description of their case.

- **Conscientiousness.** Several interviewees described a sense that they were the **only ones keeping track of the errors** in their case.

“We literally went through the report, which was 10 pages long, highlighting bits saying that this isn't accurate, and this didn't happen.” (Interviewee 1)

“I documented all of the actions that had been agreed into an Excel spreadsheet so we could track what had been answered and what hadn't which I shared with the hospital. There were actions on that where the hospital provided updates that we will do this by [X date] that still had to be done. There were action points that said they would do such and such by such and such a meeting, and then when you see the next version of the action list two or three months later there were no further updates to that point.” (Interviewee 4)

They described a sense of responsibility in highlighting this to the system such that it could be avoided in future.

“I think you know, nobody is perfect. The NHS is not perfect... We learn by our mistakes otherwise we don't improve.... [I wanted] to make sure that procedures are put in place that where people come into hospital for surgery, and they have pre-existing conditions that it is readily acknowledged. And that the proper treatment and care plan is put in place.” (Interviewee 2)

“I've always worked on the basis that if you don't tell somebody, they'll never know... I hope I made a noise. I hope I had brought something to somebody's attention.” (Interviewee 19)

“... thought it needed to be highlighted ... for those errors not to be made again... we hoped they would just to see where errors could be avoided in the future.” (Interviewee 20)

“I’m a pioneer for justice. Sometimes, bringing it to somebody’s attention in a way like this [making a claim], it’s the only way to change.” (Interviewee 7)

Several also wanted to hold to account the people involved in what they perceived to be poor care.

“Interviewer: Were you hoping with making a claim would lead to some disciplinary action against him? That is exactly it. I didn’t want anybody else to be put into the same position.” (Interviewee 5)

“I had rather hoped that some senior manager somewhere would haul these doctors over the coals... What I really wanted was to know that these people weren’t going to just mess up again.” (Interviewee 10)

- **Altruistic sentiments.** Many of our interviewees were philosophical about ‘human error’ or the ‘fact that people make mistakes’, so they did not necessarily blame the staff involved in their care. They did, however, want something positive to come out of their case, in particular not wanting this to happen to others in future.

“I wanted to be like this wouldn’t happen to somebody else, and by making a litigation claim I was hoping that would trigger it to a higher level and that something would change.” (Interviewee 1)

“You know, accidents happen and we all make mistakes, and I think it was just one of those days where there was probably a lot going on and probably all tired, and these things happen.” (Interviewee 8)

“To hope that people in my mum’s situation who can’t communicate don’t get treated like this.” (Interviewee 11)

“I just wanted to put my point across that it shouldn’t happen going forward to anybody else.” (Interviewee 16)

“Everyone makes mistakes, everyone is tired at the end of a shift so I can’t blame any of them at all and I think I could accept all of that and at the end of the day I’m alive because of them.” (Interviewee 20)

- **A desire to reduce uncertainty.** People are typically averse to uncertainty¹¹ and few amongst the interviewees had received a clear explanation of what had caused the incident when they set out on legal proceedings. Several interviewees noted a desire to make sense of what had happened to them when recalling the moment they decided to initiate claim proceedings.

“You have done something to me, you’re not giving me enough information to how and why or even a sorry.” (Interviewee 7)

“Well I was wanting to understand why they did it the way they did it... “I wanted to understand why they were so aggressive [in their treatment plan]” (Interviewee 12)

- A desire to **attract attention to their case** when engagement with their complaint or other interactions to date had been minimal.

“I was fed up and nobody cared.” (Interviewee 7)

“I think it was let’s draw attention to the fact that these people made a mistake and have made very little effort to correct it” (Interviewee 15)

“I just wanted them to listen...they had made so many errors and they really just weren’t listening. I just thought it shouldn’t happen and it shouldn’t happen to anybody else. I just want them to listen.” (Interviewee 19)

“We went down the route because we just felt like we weren’t listened to and just felt that this could happen to somebody else.” (Interviewee 1)

- **Financial compensation.** Whilst this motivation was not expressly mentioned in all cases, several interviewees noted that the requirement for financial payment was a primary motivator at the time.

“It wasn’t to sue them and line my pockets, it was just to try and get the money so that I could afford [corrective surgery following his incident]” (Interviewee 3)

“[Motivation to claim included] The fact that I was severely out of pocket and the care that had been provided to me because it just wasn’t fit for purpose.” (Interviewee 4)

“[Primary motivation was] I was just very depressed because I had lost a huge amount of money” (Interviewee 9)

“[I] thought, right, I need to try and do something here because I need some money to be able to manage for what is going to be the rest of my life.” (Interviewee 14)

We also note, however, that (in retrospect) few interviewees felt that the costs of the process were justified. Several resented the legal fees incurred by both sides and, even where their claim was successful, they wished they could have reached this conclusion without the involvement of expensive legal representation on the NHS side - so as to avoid NHS funding being spent on legal fees (acknowledging nonetheless that this may be unrealistic).

“But I know it [legal proceedings] costs the NHS about £60,000, and I just think that’s wrong. But you are not aware of that when you

enter this and £60,000 would have paid for two nurses... I just think that money could have been spent on much better things... I just think the only winners are the legal side... If people are motivated because they have been in my position and they want to make a difference, then actually the biggest difference they can make is to leave the money in the NHS.” (Interviewee 1)

“... it’s [the claims process is] long, drawn out, it’s stressful and the only people that profit here out of litigation is obviously the legal counsel, the legal representatives. They make 57% of any claim in legal fees.” (Interviewee 2)

“I wasn’t comfortable with suing the NHS at all... You know, they could have paid me £5,000 [directly, without involvement of lawyers] and it would have saved the NHS £40,000 or whatever it was. It’s crazy, but it always has to be done and that’s the way it is.” (Interviewee 8)

“I didn’t want money as such. I mean money would have been nice but you know, who wouldn’t want money. But, I – I did feel guilty about suing the NHS and I do still feel that, I feel I shouldn’t have had to do it.” (Interviewee 12)

“I also feel that what a shame that the NHS had to pay out big chunks of money you know, it’s our money after all. It’s taxpayers’ money.” (Interviewee 15)

Only one interviewee reported that a long period of poor care; sub-standard incident handling and a sense of insufficient accountability resulted in him feeling more mercenary towards the NHS. This man decided to sue the NHS 1.5 years after he first experienced an incident in the NHS. This involved knee-replacement surgery which became infected, ultimately resulting in bone infection and amputation.

He later experienced subsequent medication error and life-limiting complications of the bone infection:

“In the end I just wanted screw the people involved and get as much money out of them as I possibly could in the end.” (Interviewee 6)

We note that this sentiment may not have been expressed more often by the interviewees as it risks portraying the interviewee in a less attractive light (in relation to the researcher). This element of social desirability bias may have been present in other interviews and altered their reporting of their experiences and motivations.

- **Cognitive biases.** Cognitive biases are systematic errors” of thinking, that recur predictably in particular circumstances.¹² People are not aware that they succumb to cognitive biases as they are

typically unconscious. As such, interviewees would have been unlikely to describe the effect of these on their decision-making and memory. Indeed, none were mentioned to us during the course of our interviews. However, there is robust evidence (cited below) to suggest that these biases exist and influence cognitive processing, and as such we can hypothesise that they may play a role in the claims context:

- **Sunk costs.** Sunk costs are costs, which can include time, energy or money that have already been incurred which can make us feel strongly invested in a process. Rationally, they should be disregarded when contemplating a new decision or future course of action. However, people tend to (irrationally) weigh sunk costs in their decision to pursue a given course of action, and sunk costs tend to make people all the more determined to achieve their original goal, even if the costs of doing so continue to accrue.¹³ Although not explicitly described by interviewees, it is possible that that this could have motivated some to make a claim (having put time into a complaints process which did not go well).
- **Loss aversion.** One of the fundamental insights of behavioural science is that people are averse to incurring losses, and tend to take risks in order to avoid this.¹⁴ Although not explicitly stated by interviewees, this may be relevant in the claims context. Claimants who have experienced an incident, and potentially poor complaints handling in the NHS, are in a state of loss. As a result, they become risk seeking to reverse that loss. They choose to make a claim and gamble their continued time and efforts in the hope of achieving their desired compensation.
- **Optimism bias.** People tend to believe they are at less risk of experiencing a negative outcome than others.¹⁵ In other words, people tend to overestimate their chances of having a positive outcome. This might be relevant in the claims context: people may overestimate their chances of success and so be more willing to make a claim.

In summary, a variety of factors may influence an individual's decision to make a claim. Claimants must be capable of pursuing this process. Some will be motivated by internal factors (conscious and subconscious); others will be influenced by external factors and will decide to claim when they are presented with the opportunity or means to do so.

6.3.3. Summary of findings: the COM-B model

Contributing factors		Could this be influenced to reduce claims that add little value to either the claimant or the system?
Capability	Essential skills e.g. English language fluency/literacy	N/A
	Relevant experience e.g. prior experience of claims or relevant professional experience	N/A
	Broader factors e.g. familial support	N/A
Opportunity	Claims suggested by NHS staff	Yes
	Advertising	Maybe, involving legislative changes
	Word of mouth	No
Motivation	Emotional responses	Yes
	Wanting to avoid recurrence	Yes
	Wanting better apology/explanation	Yes
	For responsible clinicians to be held to account	Maybe
	Financial compensation	No
	Cognitive biases	Yes

7. Conclusion

BIT undertook this research, funded by NHS Resolution, to understand the factors that motivate people to make a clinical negligence claim against the NHS.

We developed insights about this subject through desk-based research, a survey responded to by 728 past claimants, and interviews with 20 past claimants.

We found that research participants were, in general, not satisfied with the reactions of NHS staff following their incident or how their complaint was handled within the NHS. A number of intrinsic motivators made participants want to claim against the NHS. In addition, certain external factors prompted, or even triggered, individuals to pursue a claim.

8. Acknowledgements

We would like to thank Christine, a former claimant, and AvMA who commented on the survey design. We would like to thank Anna Manning (NHS Resolution), for her management of this research. We would also like to acknowledge the input of Rachel Kneale and Lauren Stanley of Weightmans in shaping the research design and interpretation.

Finally, we would like to thank all of the individuals who responded to NHS Resolution survey and to the interviewees, who generously gave us their time and to share their experiences with us.

References

- ¹ Glaser, B. G., Strauss, A. L., & Strutzel, E. (1968). The discovery of grounded theory; strategies for qualitative research. *Nursing research*, 17(4), 364.
- ² The Behavioural Insights Team (2014) EAST: Four Simple Ways to Apply Behavioural Insights
- ³ Kunda, Z. (1990). The case for motivated reasoning. *Psychological bulletin*, 108(3), 480.
- ⁴ Schwarz, N. (2000). Emotion, cognition, and decision making. *Cognition & Emotion*, 14(4), 433-440.
- ⁵ Baron, J., & Hershey, J. C. (1988). Outcome bias in decision evaluation. *Journal of personality and social psychology*, 54(4), 569.
- ⁶ Edwards, A.L., 1957. The social desirability variable in personality assessment and research.
- ⁷ Fenn, P., Gray, A., Rickman, N., Vencappa, D. (2016). Funding clinical negligence cases Access to justice at reasonable cost? Nuffield Foundation. Retrieved from http://www.nuffieldfoundation.org/sites/default/files/files/Funding_clinical_negligence_cases_Fenn_v_FINAL.pdf
- ⁸ Michie, S., van Stralen, M. M., and West, R. (2011) The behaviour change wheel: a new method for characterising and designing behaviour change interventions. 'Implementation Science.' 6(1), 42
- ⁹ NAO (2017). 'Managing the costs of clinical negligence in trusts. Retrieved from <https://www.nao.org.uk/wp-content/uploads/2017/09/Managing-the-costs-of-clinical-negligence-in-trusts.pdf>; Public Administration Select Committee Report (2015). Investigating clinical incidents in the NHS. Retrieved from <https://publications.parliament.uk/pa/cm201415/cmselect/cmpublicadm/886/886.pdf>
- ¹⁰ Glynn, A. N. (2013). What can we learn with statistical truth serum? Design and analysis of the list experiment. *Public Opinion Quarterly*, 77(S1), 159-172.; Imai, K. (2010). Eliciting Truthful Answers to Sensitive Survey Questions: New Statistical Methods for List and Endorsement Experiments.
- ¹¹ Ellsberg, D., 1961. Risk, ambiguity, and the Savage axioms. *The Quarterly Journal of Economics*, pp.643-669.
- ¹² Kahneman, D., & Egan, P. (2011). *Thinking, fast and slow* (Vol. 1). New York: Farrar, Straus and Giroux.
- ¹³ Staw, B. M. (1976). Knee-deep in the big muddy: A study of escalating commitment to a chosen course of action. *Organizational behavior and human performance*, 16(1), 27-44.
- ¹⁴ Kahneman, D. (1979). Prospect theory: An analysis of decisions under risk. *Econometrica*, 47, 278.
- ¹⁵ Sharot, T. (2011). The optimism bias. *Current biology*, 21(23), R941-R945.