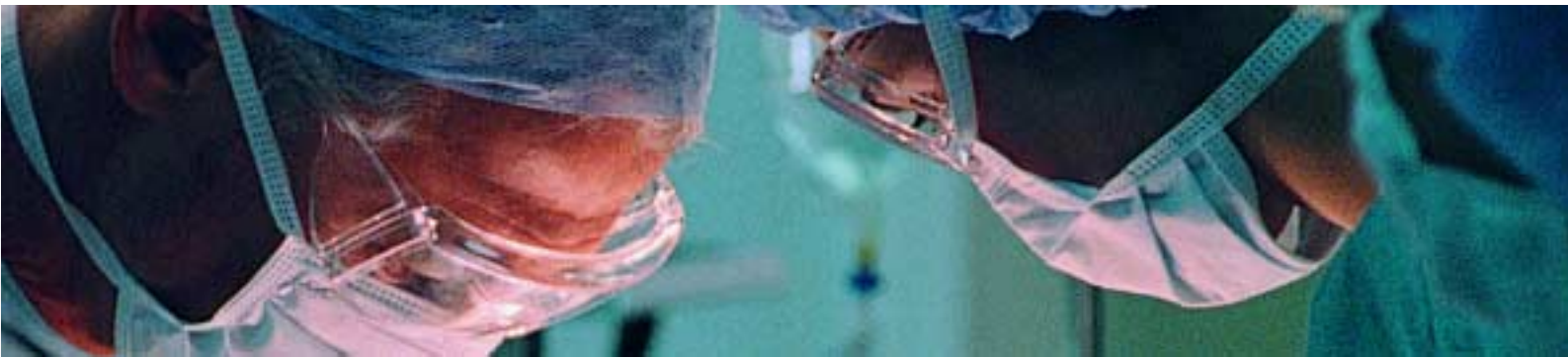


Handling clinical negligence claims in England



REPORT BY THE COMPTROLLER AND AUDITOR GENERAL
HC 403 Session 2000-2001: 3 May 2001

executive summary

Executive Summary and Recommendations

Introduction

- 1 The NHS is legally liable for the clinical negligence of its employees, including hospital doctors, arising in the course of their employment.¹ The NHS takes responsibility for dealing with any claims, including funding the defence of the claim, and for any legal costs or damages that may become payable. The majority of patients who make claims are publicly funded through the legal aid scheme.
- 2 There has been concern at the scale of the current and likely future costs of settling clinical negligence claims and the time taken to resolve them. In the past, a significant number of claims were handled poorly resulting in delays and additional costs. For patients or relatives making claims and clinicians accused of negligence, delay in resolving claims can cause further distress and increase costs. Because of the cost and unpredictability of pursuing claims, few people were able to do so unless they qualified for legal aid. In practice, most of those that did not qualify for legal aid were excluded from access to legal process.



Key Facts

- Around 10,000 new claims were received in 1999-2000.
- At 31 March 2000, provisions to meet likely settlements for up to 23,000 outstanding claims were £2.6 billion. In addition, it was estimated that a further £1.3 billion would be required to meet likely settlements for claims expected to arise from incidents that have occurred but not been reported.
- Only 24 per cent of claims funded by the Legal Services Commission are successful.
- The total annual charge to NHS income and expenditure accounts for provisions for settling claims has risen seven-fold since 1995-96.
- Cerebral palsy and brain damage cases account for 80 per cent of outstanding claims by value and 26 per cent of claims by number in the largest negligence scheme.
- For claims closed in 1999-2000 with settlement costs in excess of £10,000, the average time from claim to payment of damages was five and a half years.
- In 65 per cent of settlements in 1999-2000 below £50,000, the legal and other costs of settling claims exceeded damages awarded.

¹ This excludes General Practitioners, who are self-employed. Claims against GPs are handled by the Medical Defence Union, the Medical Protection Society, the Medical and Dental Defence Union of Scotland or commercial insurers and settlements funded by those bodies.

- 3 The NHS, the Legal Services Commission (formerly the Legal Aid Board) and the Lord Chancellor's Department have introduced a number of initiatives to address these issues:
- The NHS Litigation Authority was formed in 1995 to administer the Clinical Negligence Scheme for Trusts and, from 1996, the Existing Liabilities Scheme, schemes the Department of Health had set up to fund settlements of claims for clinical negligence. The Litigation Authority now oversees the management of 42 per cent of claims and exerts a powerful influence over how defence solicitors handle claims;
 - Both the Litigation Authority (by appointing and closely managing a panel of specialist solicitors) and the Legal Services Commission (through its franchising – now quality mark – scheme) have attempted to improve the management of claims by using or funding those solicitors that meet quality criteria;
 - The Lord Chancellor's Department has taken steps to widen access to justice beyond those in receipt of legal aid by making conditional fee (no win, no fee) agreements more attractive to claimants and their solicitors. Since April 2000, claimants' solicitors have been able to add to their charges a success fee of up to 100 per cent of their costs if the claimant wins the case and this uplift is recoverable from the losing side; and
 - From April 1999, following a review by Lord Justice Woolf, new Civil Procedure Rules were introduced. Those rules set out a timetable for the conduct of claims before they go to court. The Woolf report also recommended that non-litigious solutions should be explored before proceeding to litigation.

Why we undertook this examination

- 4 We undertook this examination in response to concerns, including those expressed by Lord Woolf in his 1996 Access to Justice report and the Public Accounts Committee in their 5th Report Session 1999-2000, about the lack of publicly available information on claims and whether the system for dealing with those involved in clinical negligence was cost-effective, quick, efficient and humane. Our report examines:
- the number of claims, the costs of settling them and the time taken;
 - patients' access to remedies²; and
 - how patients' claims are managed.
- 5 Our methodology is set out at Appendix 1.
- 6 This report does not examine measures taken to prevent negligent incidents from happening. At the time of our study, some initiatives, such as the clinical governance programme, were underway but many strands were in their early stages of implementation. Other elements, for example the recording and reporting of adverse incidents, were being expanded. Appendix 2 summarises the main initiatives taken by the NHS in England since 1997. We plan two further studies to examine the success of these initiatives; one will look at clinical governance in hospitals, the other at clinical governance in primary care.



² In this report we have used the term "patients" to denote claimants and their representatives.

Conclusions

(a) The number of claims, the costs of settling them and the time taken

- 7 The rate of new claims per thousand finished consultant episodes rose by 72 per cent between 1990 and 1998. In 1999-2000 the NHS received some 10,000 new claims and cleared 9,600. At 31 March 2000 there were an estimated 23,000 claims outstanding. The estimated net present value of outstanding claims at 31 March 2000 was £2.6 billion (up from £1.3 billion at 31 March 1997). In addition, there is an estimated liability of a further £1.3 billion where negligent episodes are likely to have occurred but where claims have not yet been received.
- 8 Clinical negligence is not an issue for England alone. As at 31 March 2000, provisions to meet outstanding claims were £2.6 billion for England, £38 million for Scotland, £111 million (including creditors) in Wales and £100 million in Northern Ireland.
- 9 Because of the time lag between incidents, claims and settlements, it will take a long time for the full impact of any reforms to become apparent. There are, however, already indications that the initiatives taken are having a positive impact. For example, the number of claims closed (settled or dropped) in the main negligence scheme has increased from 660 in 1997-98 to over 3,200 in 1999-2000.
- 10 On average, claims still take a long time to settle. Excluding claims for cerebral palsy and brain damage injuries, those closed in 1999-2000 had taken, on average, five and a half years to settle after receipt of the claim; and claims still outstanding are already on average 8.3 years old, with 22 per cent over 10 years old. As yet there are no action plans or targets to address these older claims but, following receipt of this report, the Department have decided to ask the Litigation Authority to review the backlog of claims on an annual basis and report to them on the findings.
- 11 Many of these claims are funded from legal aid and therefore resolving these longstanding claims is clearly a key issue for both the Litigation Authority and the Legal Services Commission. While it would be inappropriate and contrary to policy for them to review jointly cases on an individual basis, the two organisations share an interest in dealing with cases in a cost-effective and timely manner. Both organisations would prefer an early settlement because that is what most patients want, and because costs tend to increase as time goes on. But neither body can force a claimant to a resolution where the claimant wishes to delay a case, as often happens while for example developing their claim, or to access the appeals process. Up to February 2001, the two bodies had not shared information about the thousand or so cases over five years old that appear to be supported by legal aid, but in the light of our work they have shared this information and are now assessing the next steps.

Recommendations

- (i) The Litigation Authority should draw up an action plan with quantified targets and performance measures to address claims that have been open for more than five years.
- (ii) The Legal Services Commission should, similarly, monitor the progress of cases over five years old, and take steps to bring them to a timely conclusion.
- (iii) The Litigation Authority and the Legal Services Commission should hold regular meetings to consider general concerns in concluding cases.

(b) Patients' access to remedies

- 12** Patients may not claim because they do not know that they have grounds for doing so. It is the Department of Health's policy that patients should be told where they have suffered an adverse medical incident and should be offered remedial healthcare, a factual explanation and an apology. But the Department of Health have told us that they do not see it as the business of the NHS to advise patients that there might on the face of it be grounds to believe an adverse medical event may have been due to negligence, or suggest patients seek legal advice, or admit liability. There is, however, no clear departmental guidance to staff about this policy and there are cases where staff give indications to patients that there are grounds for suspecting negligence was a factor in an adverse incident or advise them to consult a solicitor.
- 13** Patients may also have been deterred from claiming because they could not afford to do so. Clinical negligence claims are very expensive and unpredictable to pursue and in the past few people were able to pursue them without the support of legal aid. To widen access to justice, the Lord Chancellor's Department has taken steps to make conditional fee (no win, no fee) agreements more attractive by enabling claimants' solicitors, from April 2000, to charge a success fee recoverable from the losing side if the case is won. It is too early to say whether this will encourage more claims, although the number of insurance products backing conditional fee agreements has grown since the Access to Justice Act. The Lord Chancellor's Department is monitoring the success of solicitors' firms in using conditional fee agreements, and the use and development of other private funding and insurance products. The Government will consider whether the availability of legal aid for clinical negligence claims should be ended in the light of that monitoring.
- 14** It is unlikely that conditional fee agreements will be appropriate for small value claims because of the high costs of obtaining initial information about the viability of a claim. And, under the Legal Services Commission's funding code, claims less than £10,000 are unlikely to receive legal aid funding. Our analysis indicates that for settlements up to £50,000 the costs of reaching the settlement are greater than damages awarded in over 65 per cent of cases. These factors show that the current system is an inefficient way of resolving small and many medium size claims, except that it might discourage claims with no legal merit. We consider that there is a need for new ways of resolving low value claims, for example by using regional panels that would apply the current legal criteria

for determining whether clinical negligence had taken place. Such panels would be empowered to award compensation to a given ceiling, and to recommend non-financial remedies. In March 2001, the Lord Chancellor announced that, in future, Government departments will only go to court as a last resort. The Lord Chancellor's Department published a formal pledge committing Government departments to settle legal cases by alternative dispute resolution techniques whenever the other side agrees to it.

- 15 Research has indicated that claimants often want a wider range of remedies than litigation is designed to provide, for example, an apology, an explanation or reassurance that it would not happen again; but they say they were not offered them. The Litigation Authority has issued guidance promoting the giving of appropriate apologies and information. We saw examples where claims managers had ascertained what patients' requirements were and provided creative solutions to satisfy them. These solutions included providing detailed technical explanations, assurance about how recurrences would be prevented and undertakings to give future remedial healthcare and assistance with transport and childcare; and paying for a patient's legal costs to enable them to obtain an independent assessment of the financial compensation the Trust had offered. In this way, Trusts avoided claims escalating into costly litigation. This approach – an example of which is at Case Study 1 – could be adopted more widely, provided the claims managers are competent and authorised to operate this way. However, the Department of Health have a policy of not permitting complaints to be pursued where the patient wants financial compensation. This can make it difficult for the NHS to enter into such a dialogue with patients who want something in addition to money. It can thus deprive patients and their families of the potential benefits of solutions tailored to meet their needs.

Recommendations

- (iv) The Department of Health should give clear guidance to NHS Trusts on what information they may give to patients who have suffered adverse incidents, including those who may have suffered negligent harm.
- (v) The Department of Health, the Lord Chancellor's Department and the Legal Services Commission should further investigate alternative ways of satisfactorily resolving small and medium sized claims, for example through the offering of the wider range of non-financial remedies that patients say they want, setting up regional panels and offering mediation where appropriate.

Case Study 1

Application of the package approach

In January 1998, a patient remained awake for five minutes during a hysterectomy. This was due to the anaesthetic circuit being connected incorrectly. When the patient mentioned the incident to the nursing staff the following day, the anaesthetist discussed the situation with her and explained how the error had arisen. Although the patient initially declined an offer of counselling, she began to suffer from nightmares. The Trust arranged and paid for intensive psychological counselling over four weeks at a cost of £2,000. The Trust remains willing to arrange further counselling but this has not been necessary.

Three months after the incident, the patient met with the psychologist, the Head of the anaesthetic department and the Trust's Risk and Litigation Manager. The patient was given a full explanation of how the incident had occurred and what

steps had been taken to prevent a similar occurrence from recurring. The Trust accepted full responsibility and apologised to the patient.

The patient had made a request for compensation. The Risk and Litigation Manager discussed the range of settlements in similar cases and an offer of £5,000 was made, along with advice to seek independent legal advice. The patient did discuss the amount with a solicitor but was happy to accept the offer of £5,000. There were no legal costs for either the Trust or the patient.

Source: NHS Trust

(c) Managing patients' claims

- 16** We estimate that at March 2000 the Litigation Authority was handling about 42 per cent of clinical negligence claims made against the NHS. The remainder, including many low value claims, were handled by Trusts. Some Trusts handle low volumes of claims; because of this many claims handlers are not in a position to develop expertise. In addition, the costs of handling claims at Trusts are higher because economies of scale are not achieved. These factors point to the need for a reorganisation of the claims handling functions currently carried out at Trusts.
- 17** The Department of Health are about to examine the organisation of claims handling for claims relating to post-April 1995 incidents. Several options should be considered, including one Trust acting as agent for others; formation of consortia; or the Litigation Authority managing all claims, either from London, or from regional offices. Each option has advantages and disadvantages. Key issues are providing a financial incentive to Trusts to reduce incidents involving negligence (this is absent if they do not pay for them); if a regional organisation is chosen, how to manage those aspects of claims handling that are best performed at local level, including providing non-financial remedies and securing the co-operation of clinicians; and the cost-effectiveness of a particular pattern of claims handling.
- 18** Obtaining an effective service from solicitors is crucial if claims are to be resolved satisfactorily and in a timely and economical way. The Legal Services Commission and the Litigation Authority have each taken their own action to secure a good quality service from solicitors, and can point to some success following those changes. In the case of the Legal Services Commission, although only 24 per cent of claims with legal aid backing were successful, the success rate for claims that proceed beyond the initial investigation rose from 46 per cent in 1996-97 to 61 per cent in 1999-2000. And the Litigation Authority has increased the rate at which claims are closed (paragraph 9). But both bodies make little use of quantified performance measures in managing solicitors. For example, measures such as outcome compared to cost and time estimates have not yet been employed in a systematic way.

Recommendations

- (vi) In considering any organisation of the claims management function currently performed within Trusts, the Department of Health should take into account not just cost but also how to provide Trusts with financial and other incentives to reduce incidents that lead to claims and how best to deliver those functions that need to be carried out locally.
- (vii) The Litigation Authority and the Legal Services Commission should each develop quantified measures of performance for the solicitors they instruct or fund and incorporate these into selection procedures, contracts and monitoring arrangements.
- 19** The Department of Health, the Lord Chancellor's Department and the Legal Services Commission have accepted our recommendations.