



National Audit Office

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## **Report**

by the Comptroller  
and Auditor General

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## **Department of Health**

# Managing the costs of clinical negligence in trusts

# Summary

**1** Clinical negligence is the breach of a legal duty of care to a patient by members of the healthcare professions or by others acting on their decisions or judgements, which directly caused harm to the patient. If clinical negligence has taken place, a patient or their representative may claim for damages against the clinicians or their employers. The NHS is legally liable for any clinical negligence by its employees. It must pay compensation (damages) to the claimant, and pay their legal fees. This requirement covers NHS trusts and NHS foundation trusts (trusts) but not general practitioners, who are private contractors rather than NHS employees, and are legally liable for any clinical negligence claims they might receive.

**2** Since 1995, NHS Resolution (the operating name of NHS Litigation Authority from April 2017) has provided indemnity cover for clinical negligence claims against trusts in England, through its Clinical Negligence Scheme for Trusts. NHS Resolution is responsible for dealing with claims on behalf of its members, including funding defence costs, and for any legal costs or damages that become payable. The scheme is not mandatory, but all 234 trusts pay NHS Resolution an annual contribution to receive indemnity coverage. The total contribution is set on a pay-as-you-go basis to cover the payments due in each year. Other members of the scheme include about 80 private sector providers, clinical commissioning groups and arm's-length bodies of the Department of Health (the Department). The Department oversees NHS Resolution and develops policy to manage the costs of clinical negligence cases.

**3** As part of the NHS, NHS Resolution aims to ensure that patients who suffer clinical negligence are appropriately compensated, by settling valid claims fairly and quickly, and that it defends claims that are without merit or where the damages sought are disproportionately high, to help protect NHS resources. It also aims to help trusts learn from past claims to improve patient safety and reduce the need for future claims.

## Focus of our report

**4** Between 2006-07 and 2016-17, the number of clinical negligence claims registered with NHS Resolution each year, under its Clinical Negligence Scheme for Trusts, doubled from 5,300 to 10,600. The cost of this scheme has increased significantly, with NHS Resolution's annual cash spending rising from £0.4 billion in 2006-07 to £1.6 billion in 2016-17. The provision for existing or potential clinical negligence claims through this scheme was £60 billion in 2016-17. The implication of the rising costs of clinical negligence claims is that in an already constrained financial environment, this reduces the proportion of the health budget available to deliver healthcare to patients. It also creates an increasing cost on public finances for future years.

5 Given this context, this report assesses the government's efforts to understand and manage the rising costs of the Clinical Negligence Scheme for Trusts, while ensuring that patients who suffer clinical negligence are appropriately compensated. It examines:

- what is causing the rising costs of clinical negligence claims (Part Two); and
- whether NHS Resolution and the Department are taking effective action to understand and control the costs, and are working effectively with other bodies to reduce the need for future claims (Part Three).

6 This report examines how clinical negligence claims against trusts are managed, but does not cover how individual clinical negligence claims are handled. We use claims managed through the Clinical Negligence Scheme for Trusts as proxy for clinical negligence claims against trusts. Claims against trusts account for 97% of all claims managed, and 99% of the damages awarded, through the scheme. The report does not cover other schemes managed by NHS Resolution, such as the existing liabilities scheme for incidents occurring before April 1995 and non-clinical schemes for trusts including those for public liability and employers' liability claims. All references to the number of, and cost of, clinical negligence claims in this report relate to claims managed through the Clinical Negligence Scheme for Trusts, unless otherwise stated.

7 The report also does not cover the management of clinical negligence claims against general practitioners, dentists or community pharmacies. Part One provides an overview of clinical negligence in trusts. We set out our audit approach in Appendix One and our evidence base in Appendix Two.

## **Key findings**

The strategy to tackle the rising cost of clinical negligence claims

8 **The cost of clinical negligence claims is rising at a faster rate year-on-year, than NHS funding.** Between 2010-11 and 2015-16, the average percentage of a trust's income spent on contributions to pay for the Clinical Negligence Scheme for Trusts increased from 1.3% to 1.8%. Our analysis indicates that this percentage is likely to rise to about 4% by 2020-21. The increasing costs of clinical negligence are adding to the significant financial pressures already faced by many trusts. Trusts spending a higher proportion of their income on clinical negligence are significantly more likely to be in deficit. For example, in 2015-16, all 14 trusts which spent 4% or more of their income on clinical negligence were in deficit. As our 2016 report *Financial sustainability of the NHS* showed, there are indications that financial stress faced by trusts has an impact on patients' access to services and quality of care (paragraphs 1.15 and 1.16).<sup>1</sup>

1 Comptroller and Audit General, *Financial sustainability of the NHS*, Session 2016-17, HC 785, National Audit Office, November 2016.

**9 Even if successful, NHS Resolution and the Department's current actions are unlikely to stop the growth in the cost of clinical negligence claims.** These two bodies have tried a variety of measures to reduce existing costs, and the Department has proposed two new major schemes to contribute to reducing clinical negligence costs. These are setting fixed recoverable legal costs for low-value cases, and a voluntary alternative compensation scheme for birth injury cases. The Ministry of Justice is also considering widening the scope of fixed recoverable legal costs for personal injury cases. All of these are discussed further below. The Department estimates that the current proposals, including the proposal to introduce fixed recoverable costs, which mainly affect claimants' legal costs, could save an estimated £90 million a year by 2020-21. The scheme for birth injury cases could deliver savings in the long term but the Department is not expecting any savings from the scheme until after 2020-21. By contrast, NHS Resolution's cash spending on clinical negligence is forecast to double in the next four years, from £1.6 billion in 2016-17 to £3.2 billion by 2020-21 (2016 estimate). Without more fundamental change, clinical negligence claims are likely to continue to rise in the next few years (paragraphs 1.12, and 3.17 to 3.27).

**10 The government lacks a coherent cross-government strategy, underpinned by policy, to support measures to tackle the rising cost of clinical negligence.** The Department and NHS Resolution, working with others including the Ministry of Justice, have identified many of the factors contributing to the rising costs of clinical negligence (**Figure 1** overleaf). But some of the biggest factors influencing costs fall within the remit of more than one government department or are largely outside of the health system's control. These include developments in the legal market, the increasing level of damages awarded for high-value claims, and changes in the discount rate used by courts to calculate lump sum payments for future damages. Although some actions have been taken to control costs, such as reforms to 'no-win-no-fee' agreements, ensuring that clinical negligence costs have the minimal impact on the NHS's ability to deliver health services to patients requires concerted and fundamental action across the government, particularly the health and justice systems. But the government has not set out a coherent strategy on how it might stem the rise in clinical negligence costs, or a clear policy to support measures to tackle these costs, while ensuring proportionate redress for affected patients (paragraphs 2.7 to 2.14, and 3.28).

**Figure 1**

## Rising costs of clinical negligence – contributing factors and action taken to address these

The increase in damages is driven by a small number of high-value claims while the increase in legal costs is mainly due to a large number of low- and medium-value claims up to £250,000

Factor	Increase in number of claims	Increase in damages awarded	Increase in legal costs
Contribution <sup>1</sup>	45%	33%	21%
Underlying factors	Increasing NHS activity. Legal reforms such as the introduction and subsequent reforms of 'no-win-no-fee' agreements. <sup>2</sup>	High-value claims, particularly birth injury claims. Increased life expectancy and cost of care. Cost inflation due to elapsed time to report and resolve cases.	Low- and medium-value claims funded by 'no-win-no-fee' agreements.
Proposed or current actions to address rising costs	Safety and learning team to engage with trusts on patient safety issues. Programme to improve maternity care. Repudiating claims without merit.	Alternative dispute resolution schemes (including the voluntary alternative compensation scheme for birth injury cases). Programme to improve maternity care. Settling more cases before court proceedings. Challenge excessive claims in proceedings or through surveillance.	Alternative dispute resolution schemes. Settling more cases before court proceedings. Increasingly challenging excessive legal costs. Proposals to introduce fixed claimant legal costs for claims up to £25,000.

**Notes**

- 1 Percentages may not sum to 100 due to rounding.
- 2 Further legal reforms to contain the excessive use of 'no-win-no-fee' arrangements were introduced in 2013 but their impact on the number of claims and claimant's legal costs is still uncertain.

Source: National Audit Office

## Understanding the causes of the rising clinical negligence cost

**11 The rise in clinical negligence costs is due to increases in average claimant damages and legal costs, and to a higher volume of claims.** The overall cost of claims increased by more than four times between 2006-07 and 2016-17. The increasing number of claims accounted for 45% (£0.70 billion) of the overall increase in costs, while rising payments for damages and claimant's legal costs accounted for 33% (£0.52 billion) and 21% (£0.33 billion) respectively (Figure 1, paragraph 2.2).

**12 The fastest percentage rise was in claimant legal costs.** Over the last 10 years the number of clinical negligence claims where damages were awarded more than doubled, from 2,800 in 2006-07 to 7,300 in 2016-17. The total damages awarded for those claims rose by 316% (from £0.3 billion to £1.4 billion), over the period, mainly associated with the rising damages paid for a small number of high-value, mostly birth injury-related, claims. In 2016-17, 590 claims (8% of all successful claims) with a value above £250,000 accounted for 83% of the total damages awarded. Conversely, the 533% rise in claimant's legal costs (from £77 million to £487 million) was mainly due to an increase in both the number of low- and medium-value claims up to £250,000 and their average cost. In 2016-17, the claimant's legal costs exceeded the damages awarded in 61% of successful claims (paragraphs 2.2, 2.11, 2.16 and 2.17).

**13 NHS Resolution has identified what is driving the rising costs of clinical negligence, but many of the contributing factors are hard for it to influence directly.** Factors identified include: rising activity in the NHS; increasing life expectancy and cost of care, contributing to the increase in damages awarded for a small number of high-value claims; and an increase in the number of low- and medium-value claims up to £250,000, contributing to increasing legal costs. Many of the factors identified are difficult for NHS Resolution to influence, as they are driven by hospital activity, patients' attitudes towards claims, and the external legal environment. NHS Resolution and the Department have carried out work to understand the underlying causes and look at options for controlling costs (paragraphs 2.2 to 2.17, 3.2 and 3.3).

**14 The rise in the number of claims and claimants' legal costs for clinical negligence is closely associated with recent legal reforms and market developments in legal services.** Since 2006-07, most of the increase in the number of claims and claimant legal costs has been in claims funded through 'no-win-no-fee' agreements. These agreements were introduced in 1995, helping to remove the financial barriers to individuals accessing legal services. Further amendments made in 2000 also reduced the risks for lawyers, who could claim up to twice their legal fees for cases they win. In addition, in 2010 legal fees were capped for road traffic accident claims, which led to more legal firms moving into the clinical negligence market. However, following the introduction of measures in 2013 to restrict the growth in legal costs due to 'no-win-no-fee' agreements, the number of new claims has reduced slightly over the last three years. In addition, for small claims up to £25,000 funded through 'no-win-no-fee' arrangements, the ratio of average claimant legal fees to average damages awarded for these claims fell from 2.9:1 under the pre-2013 arrangement, to 1.8:1 under the post-2013 arrangement. However, the long-term effect of the 2013 reform remains uncertain because many of the more complex claims under the post-2013 arrangement have yet to be concluded (paragraphs 2.7 to 2.17).

**15 The relationship between patient care, patient attitudes and clinical negligence claims is poorly understood.** Trusts that treat more patients tend to report a higher number of incidents and to have a higher number of claims. However, when adjusting for the number of people treated, we did not find any significant correlation between the level of incidents reported and the number of claims by individual trusts. The profile of patients who make claims differs significantly from those who suffer adverse events. For example, at a national level, older people (aged 65 and over) experience 53% of harmful incidents reported, but they only make 23% of all claims. Only a small proportion (less than 4%) of people experiencing a harmful incident will make a claim. Patient attitudes may change over time and a small change in the likelihood of people making a claim could have a big impact on the number of claims. However, NHS Resolution and trusts have not systematically commissioned insights on what motivates people to make a claim. NHS Resolution told us that people may make a claim because they are dissatisfied with the response they received from trusts following an incident, but that data on this are limited and largely anecdotal (paragraphs 2.5 and 2.6).

**16 There is no evidence yet that the rise in clinical negligence claims is related to poorer patient safety, but declining performance against waiting time standards is one factor which increases the risk of future claims from delayed diagnosis or treatment.** Although there is no comprehensive measure of safety of care in the NHS, most available indicators suggest that the quality and safety of patient care have either improved or remained stable, while the number of clinical negligence claims has risen. The exception is that where high profile patient safety issues were identified locally, there have been more clinical negligence claims, for example in Mid Staffordshire NHS Foundation Trust. However, the recent decline in the NHS's performance against key waiting time standards may increase the risk of an increasing number of future claims. For example 39% of current claims are related to failures or delays in diagnosis or treatment of a condition, and such occurrences are likely to increase if waiting times are longer (paragraphs 1.7, 2.4 and 2.5).

## Controlling the current costs of clinical negligence claims

**17 NHS Resolution has taken actions to contain the rising cost of clinical negligence claims.** For example, on its internal costs it has reduced the average cost per claim of its claims operations from £721 in 2006-07 to £414 in 2016-17. It has kept the legal costs of defending its cases in line with general inflation. NHS Resolution also challenges excessive charges of claimants' legal firms and excessive damages, and defends trusts against claims where the NHS was not at fault. For example, in 2015-16, NHS Resolution told us that it saved: £144 million by challenging claimants' legal costs; and an estimated £0.5 billion by challenging excessive damages sought by claimants for those cases where it had accepted liability. In addition, it successfully defended claims that had sought an estimated £1.2 billion in damages. However, legal sector regulators, trusts and NHS Resolution do not have routine discussions to share information about trends and lessons learned from such cases (paragraphs 3.4 to 3.12).

**18 It has recently been taking longer to resolve cases, which is likely to increase the legal cost element of clinical negligence costs.** Between 2010-11 and 2016-17, the average time taken to resolve a claim following notification increased from 300 to 426 days. Our analysis indicates that, on average, an extra day taken to resolve a claim is associated with an increase in legal costs of more than £40. However, there needs to be a balance between resolving cases quickly, to minimise the distress caused to patients, limit potential legal costs and avoid inflation of damages, and robustly defending against unmerited or excessive claims, which can also reduce the legal costs and damages awarded. It is not clear whether or not the time taken to resolve cases is optimal. There are no data against which NHS Resolution's performance can be benchmarked and the optimum time to take will vary on a case-by-case basis. Resolving clinical negligence claims is adversarial in nature, leading to differing views on whether the time taken to resolve cases is optimal. NHS Resolution has limited control over some barriers to resolving cases more quickly, such as the time taken by the court to process its cases. NHS Resolution is required to remain within its annual cash budget agreed with the Department, and so must manage the pace of settlements to remain within this limit (paragraphs 3.4, 3.6, 3.7, 3.16 and Figures 18 and 19).



## Actions to reduce future claims and costs

**19 The Department and NHS Resolution are now proposing additional actions to tackle the biggest drivers of cost increases within their control.** In April 2017, NHS Resolution published a five-year strategy that set out its ambition to resolve more clinical negligence cases before they go to court, and committed to working with trusts more proactively in handling adverse events. On the increasing damages costs associated with high-value birth injury cases, the Department, supported by NHS Resolution, has consulted on a proposal to introduce a voluntary alternative compensation scheme for infants who have suffered avoidable neurological injury at birth. This scheme aims to avoid the costly court process for these claims. NHS Resolution has also required trusts to notify it of incidences of brain damage at birth within 30 days, in order to speed up resolution of these cases. In April 2016, the Department also launched a programme to improve the safety of maternity care across the NHS, which aims to help reduce the number of maternity claims (including high-value birth injury claims) in future. On increasing claimant legal costs, particularly in low-value cases, it has consulted on a proposal to introduce fixed recoverable legal costs for clinical negligence claims with a value of up to £25,000, to reduce the number of low-value claims with disproportionately high legal costs (paragraphs 3.22 to 3.24).

**20 NHS Resolution aims to reduce the number of future claims by helping trusts to learn from past claims, but current data on claims management and its capacity to analyse these data are still limited.** In 2015, NHS Resolution established a team to engage with trusts on patient safety issues. This has been welcomed by trusts. It has also established initiatives to make better use of its claims data. For example, a review of its maternity claims has informed the new programme to improve the safety of maternity care, set out above. However, to date, NHS Resolution has not had the required capacity to analyse its claims data systematically to draw out trends and clinical insights. In addition, data on claims, incidents and complaints cannot yet be linked to gain meaningful insights such as whether the quality of complaints handling in trusts influences the number of clinical negligence claims. NHS Resolution aims to work more proactively with trusts in handling incidents, complaints and negligence claims. It is currently working with a number of trusts to explore how they might better collect and share data in future (paragraphs 3.18 to 3.21, and 3.26).

## Conclusion on value for money

**21** The cost of clinical negligence in trusts is significant and rising fast, placing increasing financial pressure on an already stretched health system. NHS Resolution and the Department are proposing incremental measures to reduce existing costs. But expected savings from these schemes are small compared with the predicted rise in the overall costs and liabilities of clinical negligence. The government needs to take a stronger and more integrated approach to fundamentally change the biggest drivers of increasing cost across the health and justice systems. It will require significant activity beyond my scope, in the areas of policy and legislation.

## Recommendations

- a The Department, together with the Ministry of Justice and others, should, by September 2018, clearly set out a coordinated strategy to manage the growth in the cost of the Clinical Negligence Scheme for Trusts.**  
The strategy should:
- set out what it hopes to achieve, for example, by identifying the balance that government wants to strike between access to justice and access to health services, and what is a proportionate response to harm;
  - address all factors contributing to the costs of rising clinical negligence claims that can be influenced by the government, including the number of claims, legal costs and damages awarded; and
  - assign accountabilities and set realistic performance measures for organisations for achieving these ambitions.
- b NHS Resolution should work with its members and other bodies, such as NHS Improvement, to promote better and more consistent data for complaints, incidents and negligence claims across the system.** This includes establishing consistent definitions of speciality and locations of harm or incidents across all datasets. Once in place, NHS Resolution should ensure that its data on claims can be used in conjunction with others' data, to gain insights to help improve the management of clinical negligence across the system.
- c NHS Resolution should build its capability to analyse and provide greater insights on the causes of clinical negligence claims.** It should work with trusts and the legal firms representing claimants to better understand what motivates people to make a claim, and clarify how it can best provide the information that trusts need and apply its resources accordingly. It should also put in place mechanisms to monitor the effectiveness of this action.
- d NHS Resolution should work more closely with NHS Protect, the Solicitors Regulation Authority and other relevant regulators to ensure that risks to its claims operations and to NHS resources are shared and addressed systematically.** NHS Resolution has achieved significant savings from contesting unmerited or excessive claims and legal charges. However, data are not always shared with or addressed by relevant regulators. NHS Resolution and the legal services regulators should routinely exchange information on risks identified, and feed back actions taken as a result.