



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

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Department of Health

# Managing the costs of clinical negligence in trusts

Report by the Comptroller and Auditor General

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Sir Amyas Morse KCB  
Comptroller and Auditor General  
National Audit Office

1 September 2017

This report examines whether the costs of clinical negligence are being managed effectively.

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## Key facts

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**10,600**

new clinical negligence claims registered with NHS Resolution, under its Clinical Negligence Scheme for Trusts, in 2016-17 (compared with 5,300 in 2006-07)

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**£1.6bn**

cash spent by NHS Resolution on clinical negligence claims under its Clinical Negligence Scheme for Trusts, in 2016-17

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**£60bn**

provision to pay for future costs of clinical negligence through the Clinical Negligence Scheme for Trusts, in 2016-17

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### All the key facts below relate to the Clinical Negligence Scheme for Trusts

**£3.2 billion** NHS Resolution's expected annual spend on clinical negligence claims, by 2020-21 (2016 estimate)

**590** claims settled with an award of more than £250,000 in 2016-17

**£602 million** spent by NHS Resolution on legal costs, including defending and resolving cases, and paying the claimant's legal costs, in 2016-17

**61%** of successful clinical negligence claims where the claimant's legal costs exceeded the damages awarded in 2016-17

**426 days** the average (median) time taken to resolve claims in 2016-17

**9% a year** growth rate in average damages awarded for high-value birth injury claims for patients with cerebral palsy and brain damage, between 2006-07 and 2016-17

# 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.

# Part One

## Clinical negligence

**1.1** This part of the report describes the accountability arrangements for clinical negligence in trusts in England, how NHS Resolution's Clinical Negligence Scheme for Trusts works, common reasons for claims, how claims are handled, and the scheme's costs.

### **What is clinical negligence?**

**1.2** 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. Currently, NHS bodies are legally liable for any clinical negligence by their employees. They must pay compensation (damages) to the claimant, and pay their legal fees. This arrangement covers employees of all NHS trusts and NHS foundation trusts (trusts) but not general medical or dental practitioners, who are private contractors rather than NHS employees, and are legally liable for any clinical negligence claims they might receive.

### **The Clinical Negligence Scheme for Trusts**

**1.3** NHS Resolution (the operating name of NHS Litigation Authority from April 2017) is a special health authority of the NHS in England. Since 1995, it has provided indemnity cover for clinical negligence claims against trusts, through its Clinical Negligence Scheme for Trusts which is a risk-pooling arrangement. The scheme is not mandatory, but all 234 trusts pay NHS Resolution an annual contribution to receive indemnity coverage.<sup>2</sup> 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). Claims against trusts account for 97% of all claims managed, and 99% of the damages awarded, through the scheme.

<sup>2</sup> There were 234 trusts as at June 2017.



**1.4** The total contribution is set on a pay-as-you-go basis to cover the payments due in each year. NHS Resolution, supported by the Government Actuary's Department, sets the level of contribution for individual trusts. The contribution is based on the trust's claims experience for the last five years and its exposure to future claims, measured by staff numbers and activity levels. To avoid large fluctuations in contributions, it also imposes a maximum and minimum percentage change from year to year.

**1.5** NHS Resolution is responsible for dealing with claims on behalf of trusts, including paying defence costs, and any legal costs or damages that may become payable. 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. **Figure 2** on pages 16 and 17 sets out the organisations that may be involved in a clinical negligence claim and the bodies that oversee these organisations.

**1.6** NHS Resolution also manages a number of other schemes such as the existing liabilities scheme for all incidents occurring before April 1995 and non-clinical schemes for all trusts including those for public liability and employers' liability claims.

### **What types of claims are made**

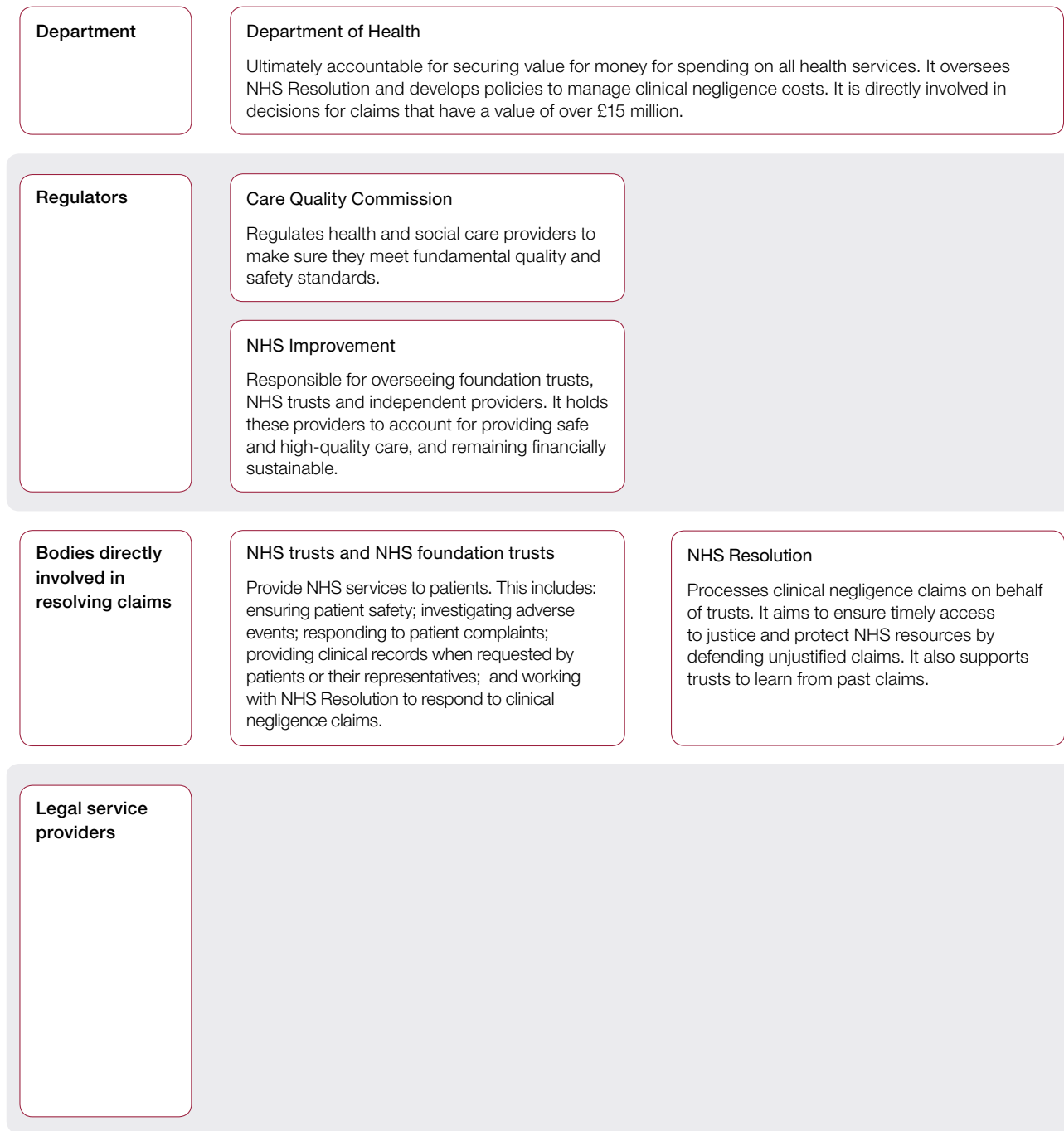
**1.7** Clinical negligence can occur in any care setting within trusts and affects patients of all ages. **Figure 3** on page 18 shows that claims arise from a wide range of specialities within hospitals, although claims may have different characteristics. For example, claims connected with obstetrics (which accounts for the majority of maternity-related claims) are relatively few in number but account for a significant proportion of settlements with high-value damages.

**1.8** There is a broad range of causes of clinical negligence claims against trusts, but the most common reported causes are:

- failure to perform a treatment or a delay in performing it (22% of claims);
- failure to diagnose a condition or a delay in diagnosing it (17% of claims);
- inappropriate treatment (7% of claims); and
- problems during operations (6% of claims).

**Figure 2**

Bodies involved in clinical negligence and the bodies that oversee them



**Notes**

- 1 A patient or their representative can bring a claim for damages directly to a trust or to NHS Resolution. The patient can start the court process at any time, including at the same time as when they notify NHS Resolution of a claim.
- 2 The Law Society is the approved regulator of lawyers and the Bar Council is the approved regulator of barristers. Both organisations are also representative bodies of their members. By law, their regulatory and representative functions have to be separated. In practice, the Bar Council and Solicitors Regulation Authority have been granted the power to be the independent regulators of lawyers, barristers and their firms.

### Ministry of Justice

Responsible for the justice system including the courts. It works in partnership with other government departments and agencies to reform the civil justice system and is responsible for making new laws.

### Legal Services Board

Independent body responsible for overseeing the regulation of lawyers in England and Wales.

### Solicitors Regulation Authority<sup>2</sup>

Regulators of solicitors and law firms, setting principles and a code of conduct for solicitors and their firms, taking enforcement action against those breaching its principles.

### Bar Standards Board<sup>2</sup>

The Bar Standards Board is responsible for setting the standards for barristers and their firms, taking action where the standards have been breached.

### Claims Management Regulator

Licenses firms and individuals to provide claims management services. It also takes action when a regulated firm breaks the Conduct of Authorised Persons Rules, carries out regulatory and criminal investigations and provides advice to consumers.

### Courts

Set the rules for patients and NHS Resolution during formal court proceedings and carry out trials:

- County courts for claims up to £50,000; and
- High courts for claims higher than £50,000.

### Solicitors

**Claimant solicitors:** Provide legal advice to patients, organise funding arrangements and represent patients during clinical negligence claims.

**Defence solicitors:** Solicitors from 10 legal panel firms appointed by NHS Resolution provide legal services to NHS Resolution and trusts.

### Barristers (defence or claimant)

Provide legal advice to patients and NHS Resolution and represent them in court if claims go to trial.

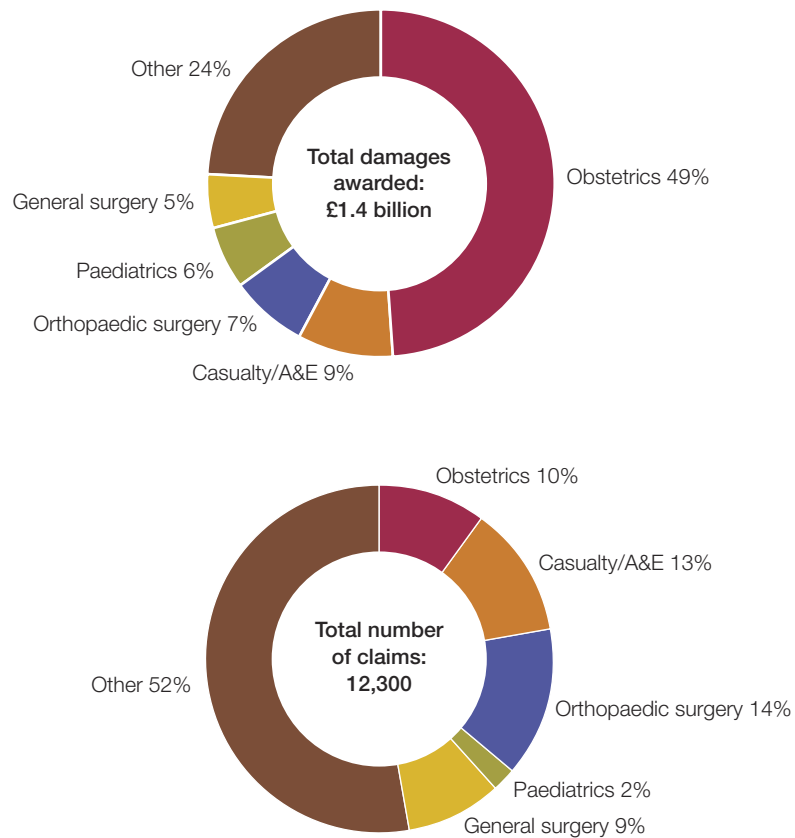
### Claims management companies

Offer services to patients hoping to claim compensation. Also involved in advertising services for legal firms.

**Figure 3**

Clinical negligence claims resolved by treatment speciality, 2016-17

In 2016-17, obstetric claims accounted for 10% of claims by number but 49% of the damages awarded



**Notes**

- 1 Other includes anaesthesia, general medicine, gynaecology, neurology, neurosurgery, radiology, and other aggregated specialities.
- 2 The damages awarded include cash payments made in-year and future periodical payments for those claims. About 2% of the value of claims settled each year are shared with organisations which are not members of the Clinical Negligence Scheme for Trusts, but are partially responsible for the clinical negligence which led to these claims.

Source: National Audit Office analysis of NHS Resolution data

## Claims handling

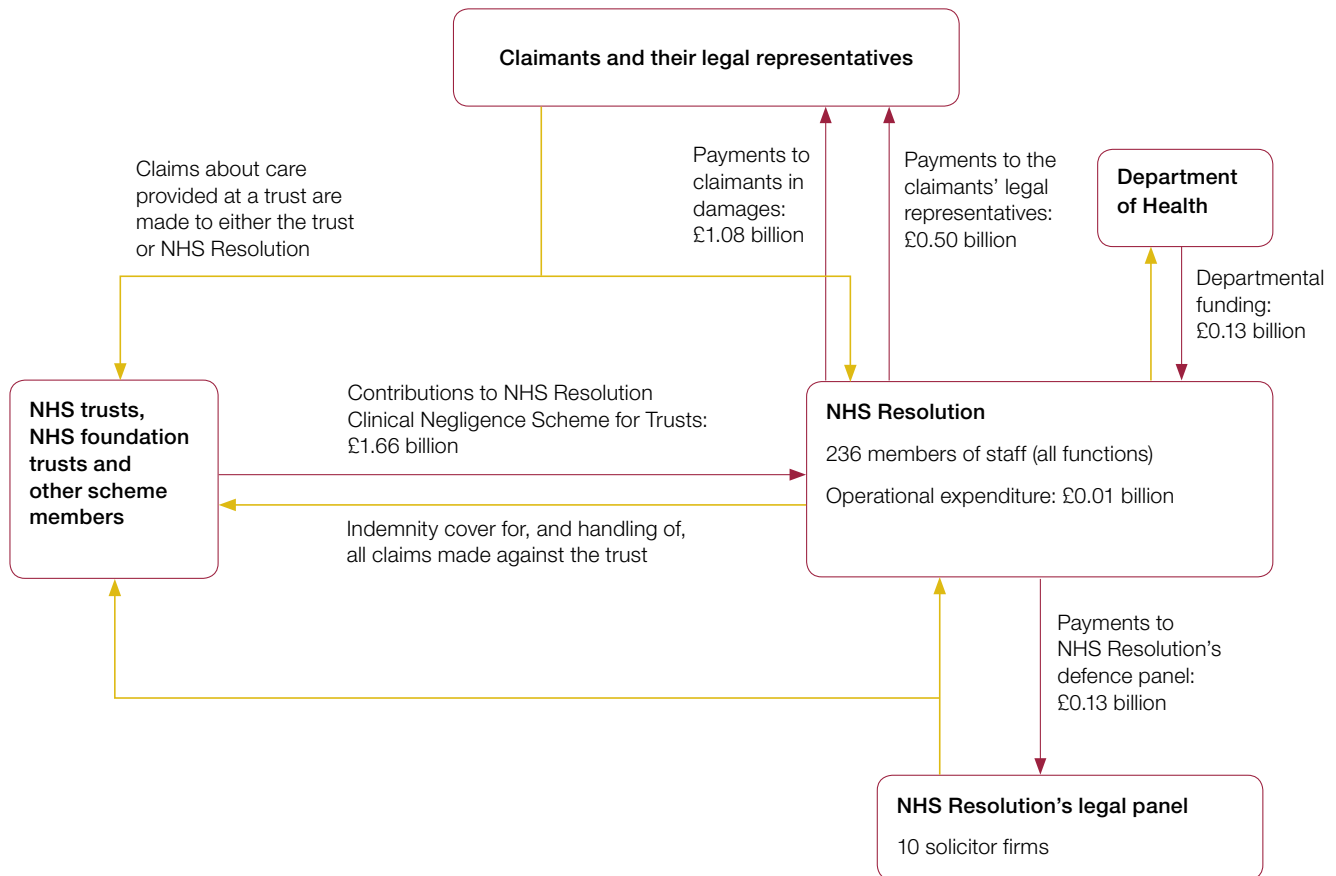
**1.9** On average, it takes two to three years for a patient or their representative to notify NHS Resolution of a claim following a clinically negligent event. A patient who suffers clinical negligence can make a claim either to the trust involved or directly to NHS Resolution.<sup>3</sup> Once NHS Resolution receives a claim, it has a duty to work with trusts closely to resolve justified claims fairly and quickly, and to defend unjustified claims robustly. There are two elements to each clinical negligence claim: whether the person's injury was caused by clinical negligence (liability) and, if so, what amount of damages should be awarded (quantum).

**1.10** NHS Resolution uses in-house claims operators to handle its claims. Most claims staff have a legal or insurance background. Many are qualified solicitors, barristers, and associates or fellows of the Chartered Insurance Institute. There is a claims data system to support day-to-day operations, such as monitoring workloads in real time, and a detailed claims manual. In addition, there are 10 legal panel firms to support and advise NHS Resolution. For complex cases, or cases that may go to trial, NHS Resolution's panel firms contract with barristers on a case-by-case basis. In 2016-17, NHS Resolution spent approximately £10 million on administering clinical negligence claims through all its schemes, with 236 full-time equivalent staff on average across all of its functions (**Figure 4** overleaf).

**1.11** Most clinical negligence cases are settled out of court. In 2016-17, of the 12,300 clinical negligence claims agreed by NHS Resolution, 66% were settled before the start of formal court proceedings, and 34% after. Of the cases for which court proceedings started, only 82 cases were resolved by trial. **Figure 5** on page 21 sets out the process for resolving claims.

<sup>3</sup> In practice, NHS Resolution only requires trusts to inform it about claims that meet certain pre-set criteria. However, trusts' practice varies and NHS Resolution does not know how consistently these criteria are applied by trusts.

**Figure 4**  
NHS Resolution's resources and spending, 2016-17

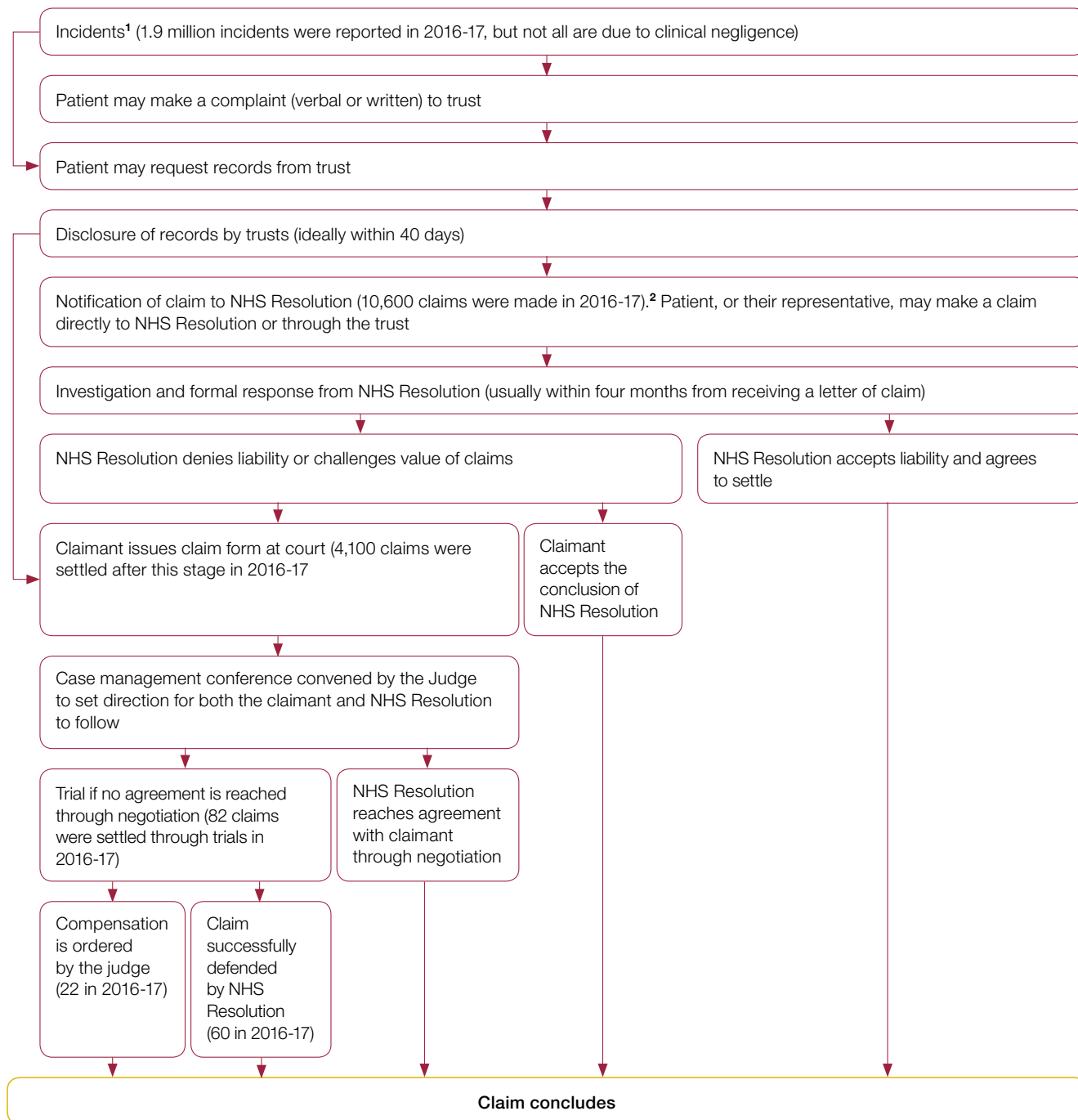


**Notes**

- 1 In addition to the Clinical Negligence Scheme for Trusts, NHS Resolution also administers a number of other clinical negligence schemes and non-clinical schemes. The figures exclude funding and expenditure for non-clinical schemes but includes funding for all other clinical schemes.
- 2 The number of staff includes other functions such as the Family Health Service Appeals Unit, the National Clinical Assessment Service, and non-clinical schemes. In 2016-17, there were 253 members of staff at year end with an average of 236 across the year.

Source: National Audit Office analysis of NHS Resolution data

**Figure 5**  
The process for resolving clinical negligence claims in the NHS



**Notes**

- 1 Many incidents that lead to clinical negligence claims are not included in the incidents reported to, or by, trusts.
- 2 Notification of claims in 2016-17 may have resulted from incidents prior to this year. Resolution of claims in 2016-17 includes claims notified in previous years. In 2016-17, 10,600 claims were made while 12,300 claims were resolved.

## The cost of clinical negligence claims

**1.12** In 2016-17, NHS Resolution spent £1.6 billion on the Clinical Negligence Scheme for Trusts, comprising £974 million on damages, £602 million on legal costs (£480 million on claimants' legal costs and £122 million on defence costs) and £10 million on claims operations.<sup>4</sup> There are two ways of measuring the annual cost of clinical negligence claims. Costs are growing according to either measure (**Figure 6**). Between 2006-07 and 2016-17:

- the annual costs of claims settled in-year increased from £0.4 billion to £2.0 billion. This represents the total defence and claimants' legal costs, and total damages awarded for claims resolved during a given year, including both cash payments already made and reserves estimated for future periodical payments for those claims; and
- annual spending on clinical claims increased from £0.4 billion to £1.6 billion, and is forecast to double again by 2020-21 to £3.2 billion (2016 estimate). This represents NHS Resolution's actual expenditure on the Clinical Negligence Scheme for Trusts, and is used to set the level of contributions for trusts.

**1.13** NHS Resolution estimated that liabilities for existing claims through the Clinical Negligence Scheme for Trusts, that involve future payments or are not yet settled, and potential clinical negligence claims for incidents that have already occurred but not yet made, were £60 billion in 2016-17, up from £51 billion in 2015-16. The total provision across all NHS Resolution's schemes was £65 billion in 2016-17, up from £56 billion in 2015-16. This is the second-largest provision across the whole of government's accounts. Over 60% of these provisions represent an estimate of future costs to the NHS from patient harm that has already occurred, but for which no clinical negligence claim has yet been received.

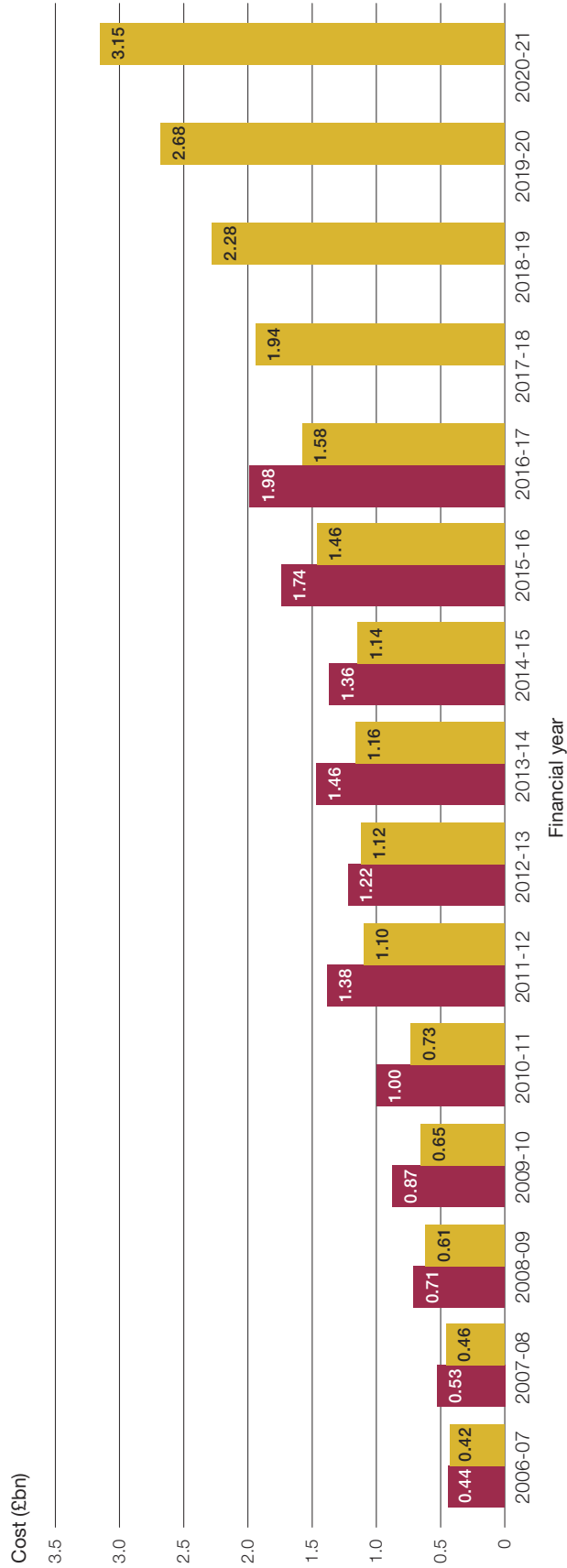
**1.14** The value of the provision is heavily influenced by two discount rates that are applied to claims – one used by HM Treasury to calculate provisions and the other used by the court to calculate the level of damages. For example, in 2015-16, the provision for NHS Resolution clinical negligence claims, rose by £25.2 billion, £22.3 billion of which was solely due to a change in the Treasury's discount rate. This Treasury discount rate is used when estimating future provisions in government accounts to reflect the general principle that money is worth more the sooner it is received, due to its earning capacity. A further change to the Treasury's discount rate in 2016-17 added another £0.6 billion to the provision. The Lord Chancellor's decision, in February 2017, to reduce the discount rate used by the court, to calculate the level of damages, added another £3.5 billion to the provision (see paragraph 2.14). This discount rate reflects the potential interest a claimant could earn from investing the lump sum awarded to compensate for future losses, including loss of earnings and care needs.

<sup>4</sup> In 2016-17, NHS Resolution spent £1.7 billion on all of its clinical negligence schemes.



**Figure 6**  
Annual costs of clinical negligence

There are two ways of measuring annual clinical negligence cost, and costs are growing according to each measure



■ Total costs of claims settled ■ Cash spending on clinical claims (contributed from trusts)

**Notes**

- 1 Total costs of claims settled are the costs for those claims resolved during a given year. The costs include cash payments made in-year and future periodical payments for those claims. About 2% of the costs of claims settled each year are shared with organisations which are not members of the Clinical Negligence Scheme for Trusts but are partially responsible for the clinical negligence which led to these claims.
- 2 Cash spending on clinical claims is NHS Resolution's actual expenditure on the Clinical Negligence Scheme for Trusts.

**1.15** NHS Resolution now settles more claims with a combination of lump sums and periodical payments throughout a claimant's life than it did 10 years ago. This means that trusts only pay an annual payment to reflect in-year care costs rather than for the lifetime costs of claims up front. This arrangement helps to maximise the benefit of taxpayers' money by making available, for patient care now, funds that would otherwise be held as reserves. However, it increases the value of NHS Resolution's provision to make further payments on existing claims in future. By the end of 2016-17, there were 1,300 clinical claims agreed with outstanding periodical payments, with an estimated future cost of £9 billion at present value, included in the provision. These costs may be settled over a long time period, depending on a claimant's life expectancy.

**1.16** The cost of clinical negligence claims is rising at a faster rate year-on-year than NHS funding. As a result, trusts are spending a higher proportion of their income on clinical negligence. Between 2010-11 and 2015-16, the average percentage of a trust's income spent on contributions to the scheme increased from 1.3% to 1.8%, and our analysis indicates that this could rise to about 4% by 2020-21.<sup>5</sup> This means that, as a proportion of their income, trusts will have less money to deliver healthcare to patients. The increasing costs of clinical negligence are adding to the significant financial pressure already faced by many trusts which, on average, were 3% in deficit in 2015-16. Trusts that contribute more of their income to clinical negligence are significantly more likely to be in financial deficit. In 2015-16, all 14 trusts that 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 the financial stress faced by trusts is having an impact on access to services and the quality of care provided.<sup>6</sup>

5 We assumed that the cost of claims for trusts up to 2020-21 would be the same as the forecast spend on the Clinical Negligence Scheme for Trusts, and that the income for trusts would increase at the same rate for the period 2016-17 to 2020-21 as that for the period 2012-13 to 2015-16.

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

# Part Two

## Causes of the rising costs

**2.1** This part of the report examines the causes of the rising costs of the Clinical Negligence Scheme for Trusts.

### Contributing factors

**2.2** Between 2006-07 and 2016-17, the total cost of clinical negligence claims settled in-year increased by £1.54 billion from £0.44 billion to £1.98 billion (**Figure 7** overleaf),<sup>7</sup> of which:

- 45% of the cost increase was due to a rise in the number of claims. The number of claims where damages were awarded rose from 2,800 to 7,300 in this period;
- 33% was due to a rise in the average damages awarded (mainly associated with high-value claims (**Figure 8** on page 27)). The total damages awarded rose by 316% during this period, from £0.33 billion to £1.36 billion; and
- 21% was due to a rise in legal costs (mainly associated with claimant's legal costs for low- and medium-value claims up to £250,000 (**Figure 8**)). Total claimant legal costs rose by 533% during this period, from £77 million to £487 million.

<sup>7</sup> This represents the costs of claims resolved during a given year, including cash payments (lump sums) made in-year and future periodical payments for those claims.

**Figure 7**

Breakdown of the £1,541 million rise in clinical negligence costs settled in-year between 2006-07 and 2016-17

Over 50% of the rise in clinical negligence costs was due to rises in damages and legal costs awarded

Area of costs	Increase in number of claims (£m)	Increase in average damages awarded (£m)	Increase in average legal costs (£m)	Total (£m)
Damages	518 (34%)	516 (33%)	–	1,034 (67%)
Defence costs	56 (4%)	–	42 (3%)	97 (6%)
Claimants' legal costs	122 (8%)	–	288 (19%)	410 (27%)
<b>Total rise</b>	<b>695 (45%)</b>	<b>516 (33%)</b>	<b>330 (21%)</b>	<b>1,541 (100%)</b>

**Notes**

- 1 The cost of claims operations has not contributed materially to the change in costs and was not included.
- 2 Clinical negligence costs settled in-year includes cash payments (lump sums) made in-year and future periodical payments for those claims.
- 3 Totals may not sum due to rounding.

Source: National Audit Office analysis of NHS Resolution data

**Increase in the number of claims**

**2.3** Between 2006-07 and 2016-17, the number of claims against trusts notified to NHS Resolution doubled, from 5,300 to 10,600. **Figure 9** on page 28 sets out what we know about the factors which could have contributed to this increase.

**2.4** Changes in the amount of, or safety of, hospital activity could be one possible explanation for a rise in clinical negligence claims. However, the number of claims has doubled over the last 10 years, whereas the number of people treated only rose by 32% over this period, so this cannot account for all of the rise.<sup>8</sup> On the quality of care, there is no comprehensive measure of safety of care in the NHS. Although the number of reported incidents is rising faster than activity, stakeholders told us they believe this reflects better reporting. Since 2003, the NHS has had several initiatives to encourage trusts to be more transparent in reporting incidents, to help them learn from mistakes and improve patient safety. However, most available indicators of safety, such as maternity-related mortality, hospital-acquired infections and hospital patient surveys, suggest that the quality and safety of patient care has either improved or remained stable over the period.

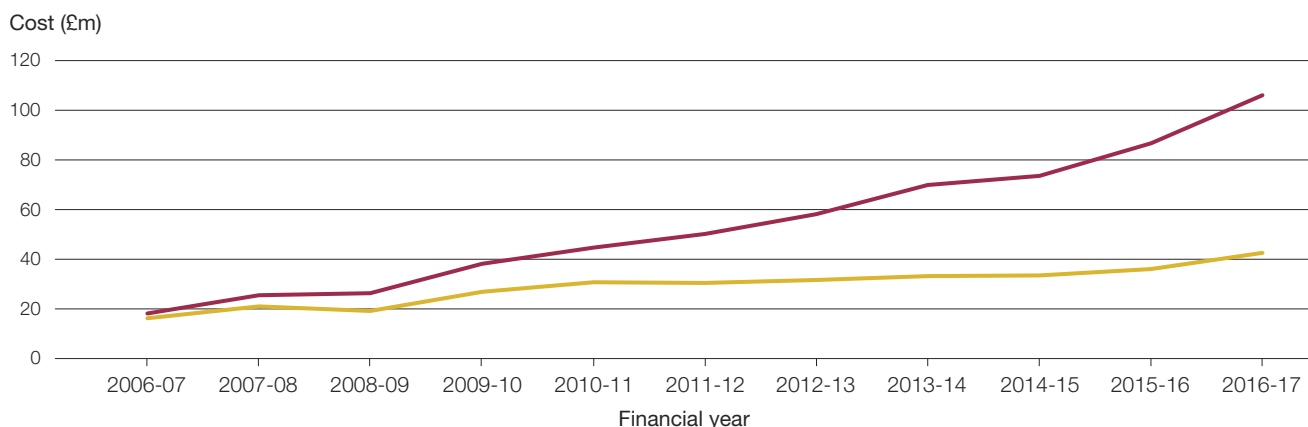
<sup>8</sup> We used the number of hospital admissions as a proxy for the number of people treated. Due to the time lag between an incident and a claim, we used the admissions data for the period 2003-04 to 2013-14.

**Figure 8**

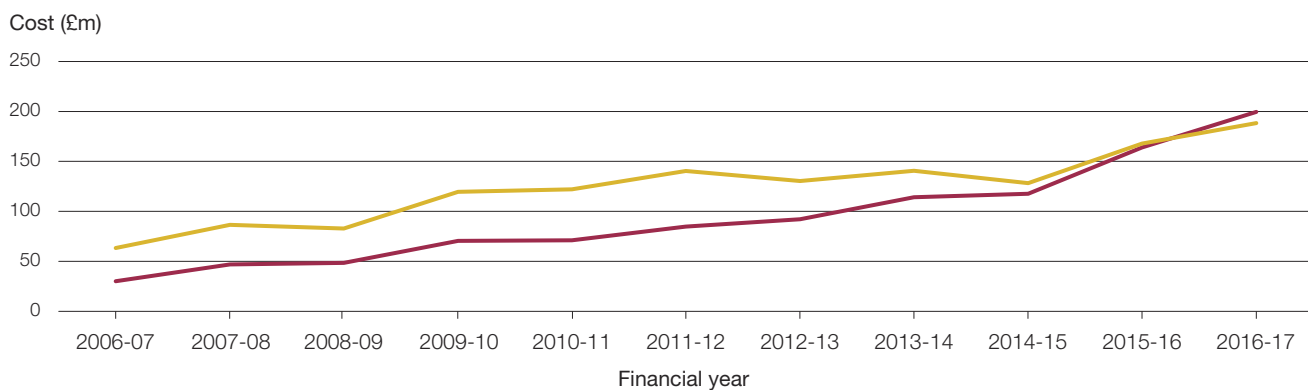
Total damages and claimants' legal costs for low-, medium- and high-value clinical negligence claims, 2006-07 to 2016-17

The rise in costs for high-value claims was mainly due to an increase in damages awarded, while the rise in costs for low-value claims was mainly due to a rise in legal costs

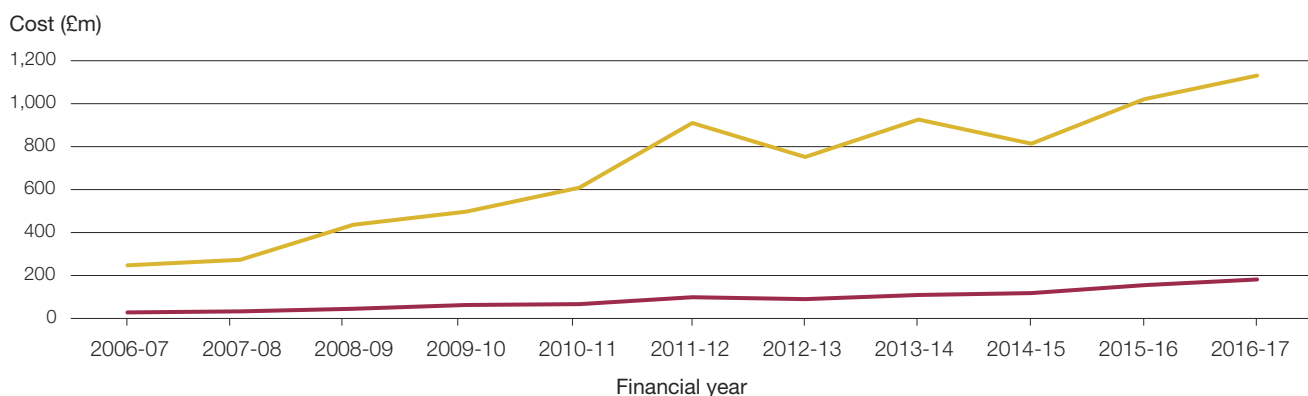
Low-value claims, with damages up to £25,000



Medium-value claims, with damages above £25,000 and up to £250,000



High-value claims, with damages above £250,000



- Total claimant legal costs
- Total damages

Source: National Audit Office analysis of NHS Resolution data

**Figure 9**

Possible factors contributing to the increase in the number of claims between 2006-07 and 2016-17

Factor	Patient			Hospital	
	Change in patient awareness and attitudes to making a claim	Change in patients' access to legal services	Rising NHS activity	Worsening patient safety	Worsening patient experience
Contribution	Unknown	Likely	Partial	Unlikely	Unlikely
Evidence	Increased reporting of incidents arising from sector-wide transparency initiative, but little research on what motivates patients to claim.	Legal reforms, such as the introduction of 'no-win-no-fee' agreements and the development of claims management companies, have improved patients' access to legal services.	Trusts treating more people generally have a higher number of claims made against them. But over this period, the number of people treated by trusts only increased by 32%. <sup>1</sup>	Available patient safety indicators suggest that patient safety in the NHS has either remained stable or improved.	This includes communication with patients during treatment and complaints handling. Overall satisfaction with hospital care has remained high.

**Note**

<sup>1</sup> We used the number of hospital admissions as a proxy for the number of people treated. Due to the time lag between an incident and a claim, we used the admissions data for the period 2003-04 to 2013-14.

Source: National Audit Office

**2.5** Trusts that treat more patients tend to report more incidents and more clinical negligence claims. However, we found no significant correlation nationally between the level of reported incidents which led to harm and the level of claims by trusts, once underlying activity levels were taken into consideration. There was some association between clinical negligence claims and patient safety locally. For example NHS Resolution told us that there was an increase in new claims against Mid Staffordshire NHS Foundation Trust after high profile patient safety concerns there. In addition, given that 39% of current claims relate to failures or delays in diagnosing or treating a condition, increasing pressure in the NHS and the recent decline in NHS performance against key waiting time standards, may increase the risk of future claims.

**2.6** The other main explanation for a rise in the number of claims would be a patient's awareness, ability, or propensity to make a claim. Only a small proportion of people who experience something going wrong currently choose to make a claim against the NHS.<sup>9</sup> The number of claims as a percentage of harmful incidents reported remains small, at less than 4%. Although older people (aged 65 and over) experience 53% of harmful adverse events reported, they only make 23% of all claims. A small change in patient attitudes to making a claim, particularly from older people, could have a large impact on the number of claims. However, NHS Resolution has not systematically commissioned insights on why people choose to make a claim in the first place. We found that, adjusting for the level of activity, there is no significant correlation between harmful incidents reported and patient complaints, but there is a small correlation between the level of patient complaints and the level of claims trusts receive. 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.

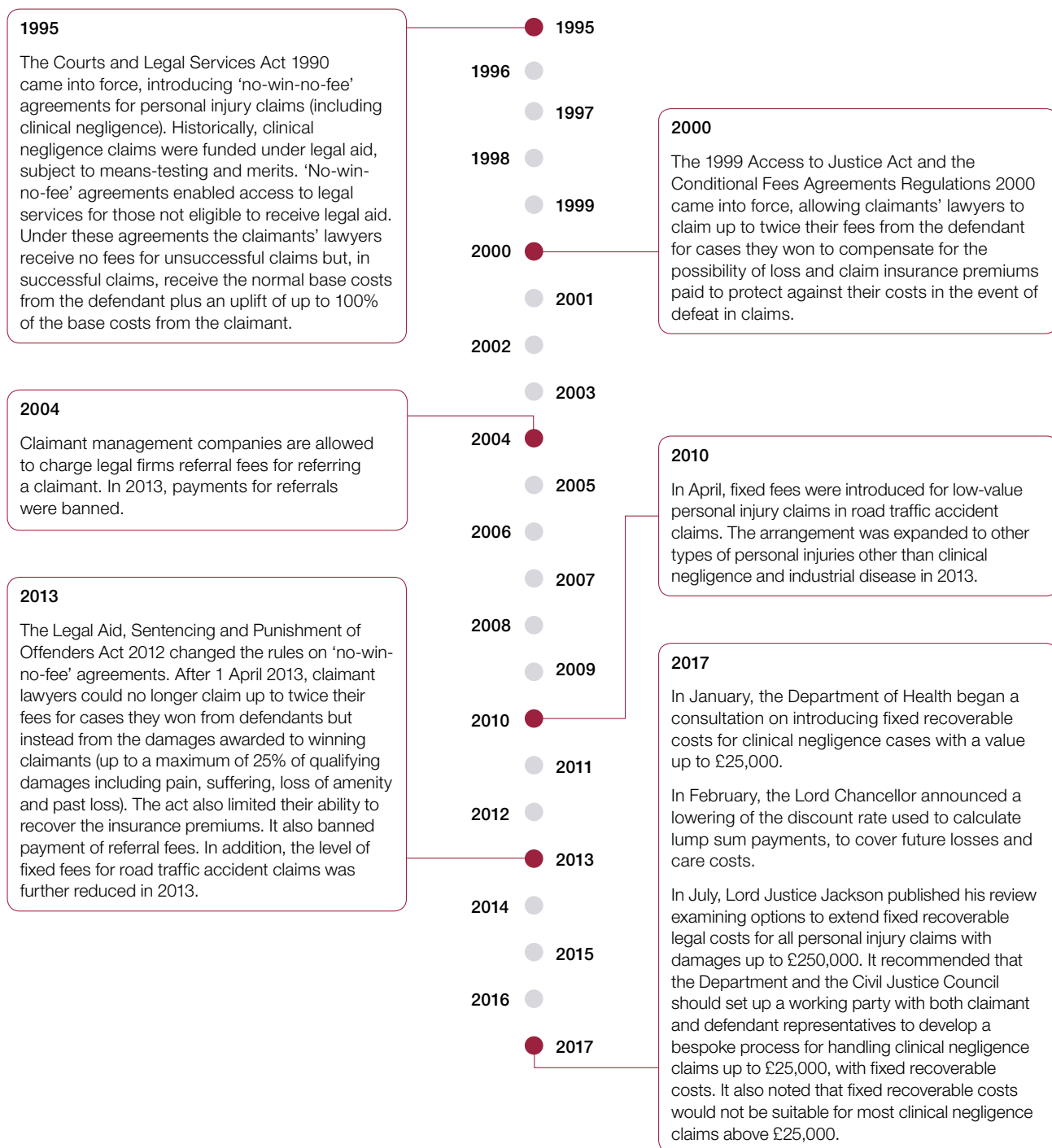
### Improving patients' access through legal reforms and legal market development

**2.7** Over the last two decades, there has been a series of legal reforms which have impacted on access to legal services for patients who have suffered harm (**Figure 10** overleaf). These include: the introduction of 'no-win-no-fee' agreements; the development of claims management companies and the introduction of referral fees to refer potential claimants to legal firms; the introduction of fixed fees for road traffic accident injuries; and the introduction of the Legal Aid, Sentencing and Punishment of Offenders Act 2012.

9 Nuffield Foundation, *Funding clinical negligence cases – access to justice at reasonable costs?* 2016. It reported that 11% of people who experienced adverse events surveyed intended to make a claim against the NHS.

**Figure 10**  
Legal reforms relating to clinical negligence

Successive legal reforms since 1995 improved access to legal services for patients wishing to make clinical negligence claims until a number of restrictions were introduced in 2013





**2.8** These legal reforms have had a significant impact on the development of legal markets and on helping patients who want to make a claim. As such, several have contributed to the increase in the number of clinical negligence claims (**Figure 11** overleaf). For example:

- the introduction in 1995 of 'no-win-no-fee' agreements, the improved terms for these agreements introduced in 2000 and the improved availability of insurance to cover the legal costs of unsuccessful cases reduced the financial risk to claimants and their lawyers of making claims. Since 2006-07, successful claims funded by this type of arrangement have increased more than the rise in the total number of successful claims (**Figure 12** on page 33);
- the introduction in 2010 of fixed legal fees for road traffic accident injury claims resulted in more legal firms expanding to clinical negligence markets. Fixed fees were expanded to other types of personal injury claims in 2013. As a result of these reforms, clinical negligence claims, where legal fees were not fixed, became more attractive. The estimated number of legal firms making claims, recorded on NHS Resolution's database, increased from 760 in 2009-10 to 960 in 2013-14, before dropping to 840 in 2016-17;<sup>10</sup>
- the Legal Aid, Sentencing and Punishment of Offenders Act 2012 led to a spike in the number of claims received immediately prior to the new legislation coming into effect in April 2013. The act aimed to curb the disproportionate rise in legal costs resulting from excessive growth in the use of 'no-win-no-fee' agreements. It also introduced restrictions on the reimbursement of the cost of insurance taken out to protect against unsuccessful claims. Since the introduction of the act, the number of new claims has reduced slightly over the last three years; and
- since 2004, claims management companies have been allowed to refer claimants to lawyers for a fee. This has led to increased market activity including advertising and reports of 'claimant farming' by these companies, for example, through 'cold calling'. This activity has helped to increase people's awareness and access to legal services. Following concerns of market abuse, in 2013, the government banned payments of referral fees to claims management companies. The number of claims management companies and the turnover of those involved in the personal injury market have since declined, which coincides with the leveling off of clinical negligence claims.

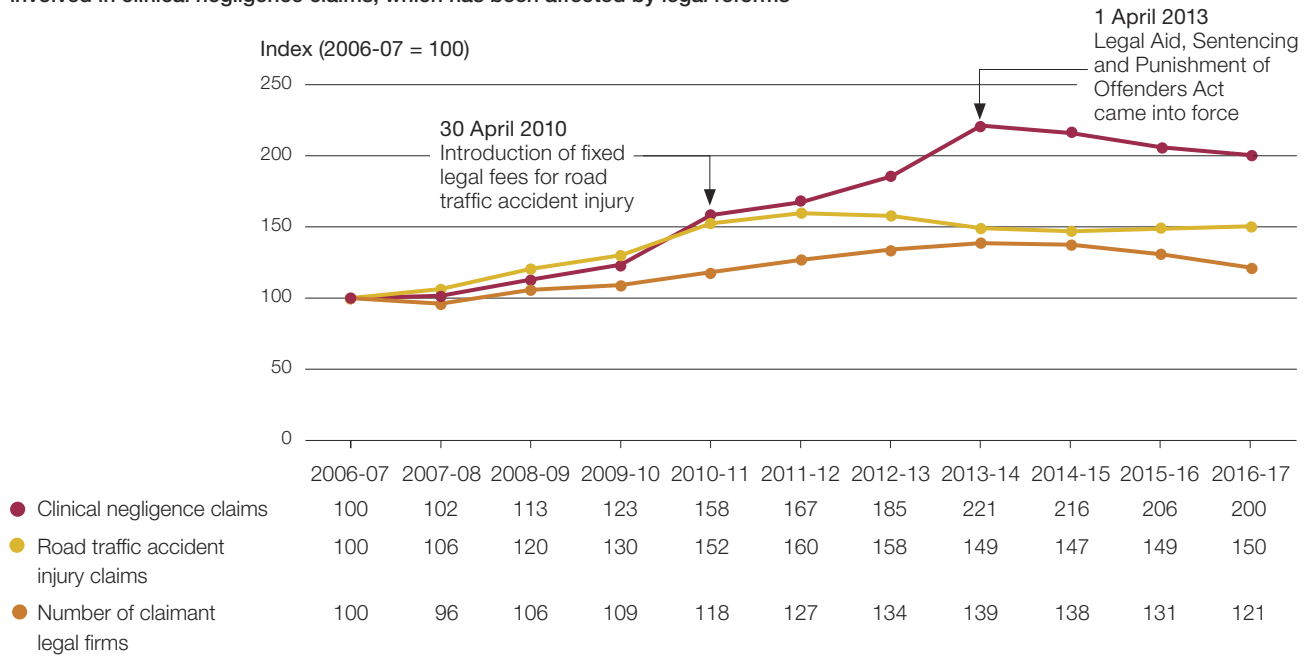
**2.9** Despite the increasing number of claims, the proportion of claims where damages are paid has remained relatively stable. This suggests that these legal reforms have improved access to legal services and encouraged more patients to get redress through claims than had done so previously.

<sup>10</sup> The estimated number of legal firms is taken from NHS Resolution's claims database. The database contains duplicates of firms. For example, it may contain different branches of the same firm or a firm may change its name during the year. We have removed duplicates, where identified, but some duplicates may remain.

**Figure 11**

Clinical negligence claims, road traffic accident injury claims and legal firms involved in clinical negligence, 2006-07 to 2016-17

The number of clinical negligence claims has risen and fallen roughly in line with the number of legal firms involved in clinical negligence claims, which has been affected by legal reforms

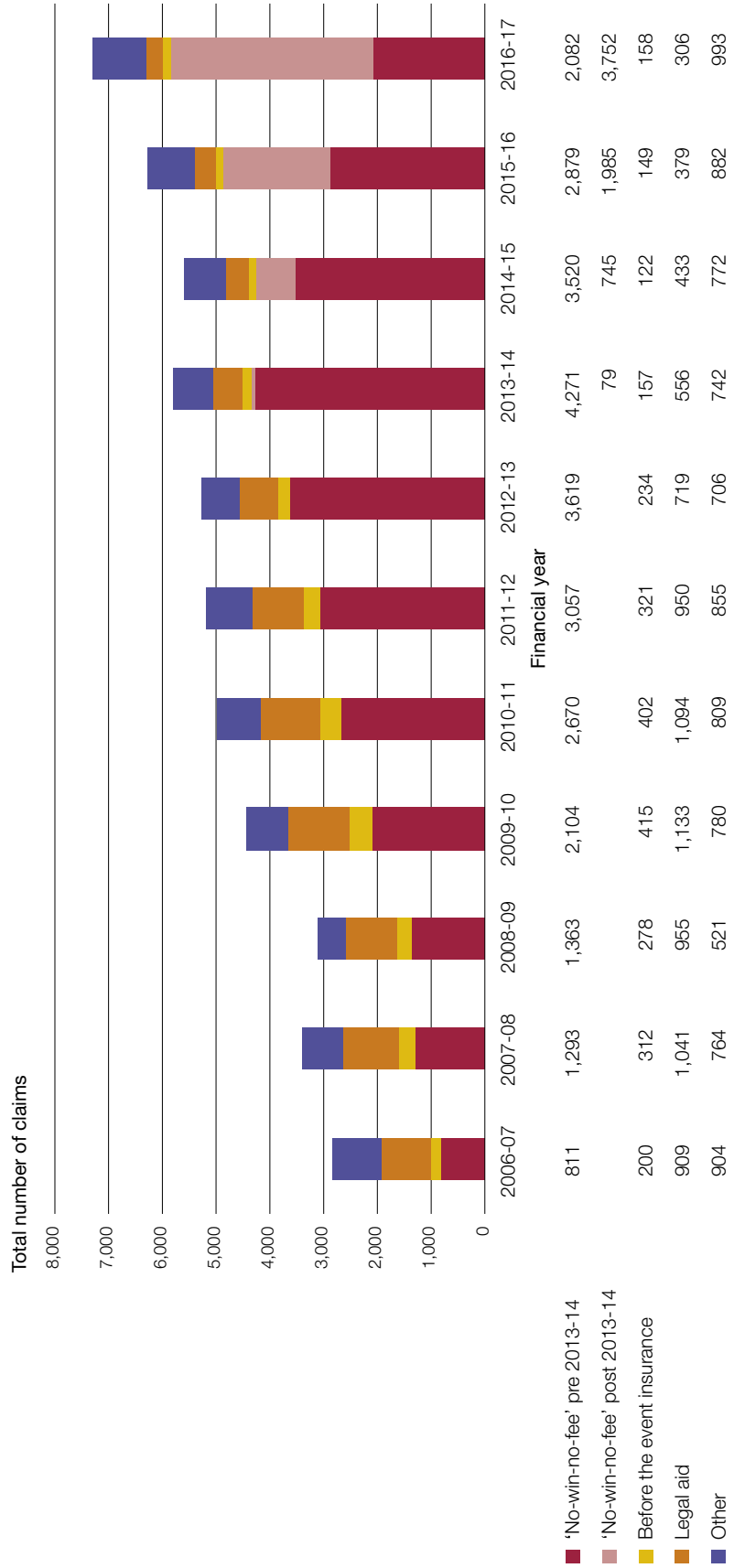


**Note**

1 The estimated number of legal firms is taken from NHS Resolution's claims database. The database contains duplicates of firms. For example, it may contain different branches of the same firm or a firm may change its name during the year. We have removed duplicates, where identified, but some duplicates may remain.

Source: National Audit Office analysis of NHS Resolution data

**Figure 12**  
**Claimants' legal funding arrangements for successful clinical negligence claims, 2006-07 to 2016-17**  
**Claims funded by 'no-win-no-fee' agreements account for almost all of the increase in the number of clinical negligence claims**



**Notes**

- The main funding routes for clinical negligence claims are:
  - 'no-win-no-fee' agreements – the claimant's lawyer does not seek payment of their fees from the claimant if the case is lost, but can claim up to twice the legal fees incurred (for cases before April 2013) or a percentage mark-up from the damages awarded (for cases after April 2013) to compensate for their losses in other claims which they have lost;
  - before the event insurance – legal costs are covered by an insurance arrangement taken out by patients before the clinical negligence happens;
  - legal aid – the Legal Aid Agency (formerly known as the Legal Services Commission) meets most of the claimant's fees and expenses in an unsuccessful case, but imposes criteria and constraints in the proceedings to ensure that the costs are controlled in proportion to the value of the claim; and
  - other – includes self-funding claimants, those with unknown sources and sources still to be determined.
- Claims are those resolved that year.

Source: National Audit Office analysis of NHS Resolution data

### Rising levels of damages awarded and legal costs

**2.10** Between 2006-07 and 2016-17, the average damages, defence costs and claimants' legal costs for successful claims increased by 61% (£116,000 to £187,000), 37% (£11,000 to £15,000), and 145% (£27,000 to £67,000) respectively (**Figure 13**). In comparison, general inflation increased by 19% over this period.

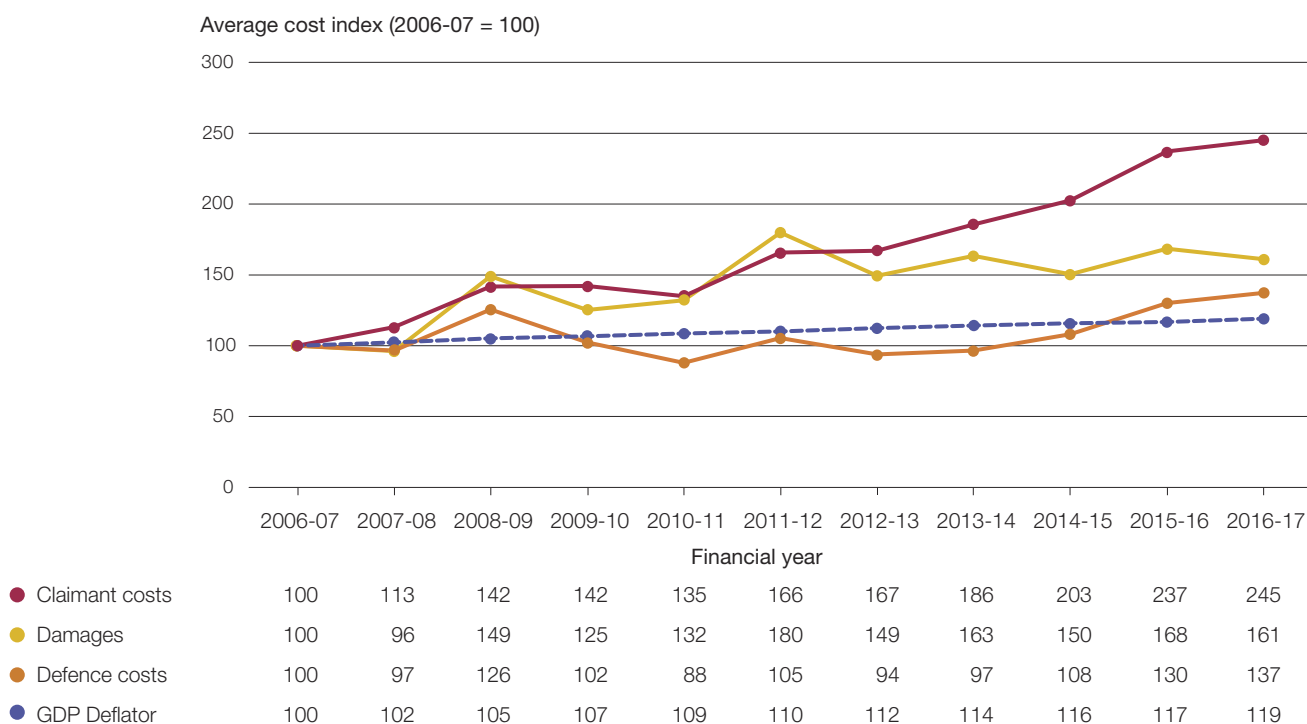
#### The rising level of damages awarded

**2.11** The main factor contributing to the rise in damages awarded has been an increase in the average damages awarded for high-value claims, particularly maternity-related claims (see Figure 8 on page 27). For example, between 2006-07 and 2016-17, the damages awarded for birth injury claims for patients with cerebral palsy and brain damage increased by £449 million (350%). In 2016-17, there were 590 claims with a value above £250,000, representing 8% of the total number of successful claims but accounting for 83% of the total damages awarded. Between 2006-07 and 2016-17, these claims accounted for 85% of the increase in costs of damages awarded (£0.9 billion out of £1.0 billion).

**Figure 13**

Average legal costs and damages awarded, 2006-07 to 2016-17

Average claimant costs and damages have grown much faster than general inflation, whereas defence costs have grown in line with general inflation



Source: National Audit Office analysis of NHS Resolution data

**2.12** Factors that have contributed to the rise in costs of damages awarded for high-value claims include:

- patient-related factors such as increased life expectancy and the increasing costs of care; and
- the increasing time taken to report these cases. Between 2006-07 and 2016-17, for the claims resolved in-year, the average time between an incident and a claim being resolved increased from 6.6 years to 7.5 years. Within this overall increase, the average time between an incident and the claimant notifying NHS Resolution of a claim above £250,000, increased from 2.3 years to 3.5 years. However, the average time between NHS Resolution being notified of the claim and the case being resolved decreased from 4.3 years to 4.0 years. Taking nearly an extra year in total from an incident to resolving a case increases costs, as the damages awarded by courts tend to increase faster than general inflation. For example, the average damages awarded for birth injury claims for patients with cerebral palsy and brain damage have increased by 9% a year between 2006-07 and 2016-17. From 1 April 2017, NHS Resolution has required trusts to notify it within 30 days of an incident of brain damage at birth occurring, to speed up resolution of these cases.

**2.13** The legal environment underpins the level of damages awarded. The current legal principle sets no limit to the amount of damages that can be awarded. Such damages are intended, as far as possible, to put claimants in the same position as they would have been if they had not suffered harm. This is the principle of full compensation. Damages may include past and future losses including the cost of care and lost earnings and a payment for pain and suffering. Legislation currently provides for the amount of damages to be based on private provision even if state-funded NHS medical care is available to the claimant. International evidence suggests that awards for claims and clinical negligence costs tend to be higher when there is no cap on damages.<sup>11</sup>

**2.14** Generally, there is huge uncertainty about the level of need and costs of future care for claimants. However, the level of award is often determined on a once-and-for-all basis as a lump sum. A small change in the assumptions used by the court can have a big impact on the level of damages awarded. For example, the court expects part of the future costs to be covered by the income earned from investing the lump sum awarded. It adjusts the lump sum awarded by applying a 'discount rate', to take account of the annual income expected from this investment. The discount rate had been 2.5% since 2001. In February 2017, the Lord Chancellor lowered the discount rate to -0.75%. This means the lump sum will be larger because the expected income from investing the lump sum is lower. In 2016-17, more than 60% of damages awarded by NHS Resolution was in lump sum awards. NHS Resolution's early estimates indicate that this change will add an additional £500 million to the costs of claims in 2017-18.

<sup>11</sup> Carol K. Kane et al., 'Impact of caps on non-economic damages on pay-outs to plaintiffs: evidence from the PIAA closed claim data', *AMA Economic and Health Policy Research*, January 2008; Charles R. Ellington et al., 'State tort reforms and hospital malpractice costs', *The Journal of Law, Medicine & Ethics*, vol. 38, Issue 1, pp. 127-133, March 2010.

**2.15** In other countries, reforms have reduced the growth in the number, and costs, of clinical negligence claims. Reforms included prohibiting the awarding of damages for economic losses below a particular level, and capping legal costs and non-economic losses. In the US, for example, where states have introduced various legal reforms, the proportion of successful claims and their costs has dropped significantly. For example, the proportion of claims where damages were paid in the US in 2012 was less than half of the 1992 level, and the cost per physician was reduced by 48%.<sup>12</sup>

### The rising level of claimant legal costs

**2.16** As shown in Figure 8, the main contributing factor to rising costs for low- and medium-value claims has been rising legal costs, largely funded by 'no-win-no-fee' agreements. In 2016-17, claims with a value up to £250,000 accounted for 63% of all the legal costs of claimants but only 17% of all the damages awarded. Between 2006-07 and 2016-17, the number of low- and medium-value claims more than doubled from 2,700 to 6,700, and the average legal costs of claimants also more than doubled from £18,100 to £45,500. In comparison to claims funded from other sources, claims funded through 'no-win-no-fee' agreements tend to have proportionally higher legal costs compared with the value of the claims (**Figure 14**). This reflects the fact that lawyers can claim up to twice their legal fees for cases they win to cover the free legal services they provide to patients with unsuccessful claims. Some of these claims would have been funded by legal aid before legal reforms introduced restrictions to this aid. In addition, in 2015, the court increased its maximum charge of registering a claim at a court from £1,920 to £10,000 which is normally paid by claimants as part of their legal costs, although recoverable from NHS Resolution if the claimant wins the case.

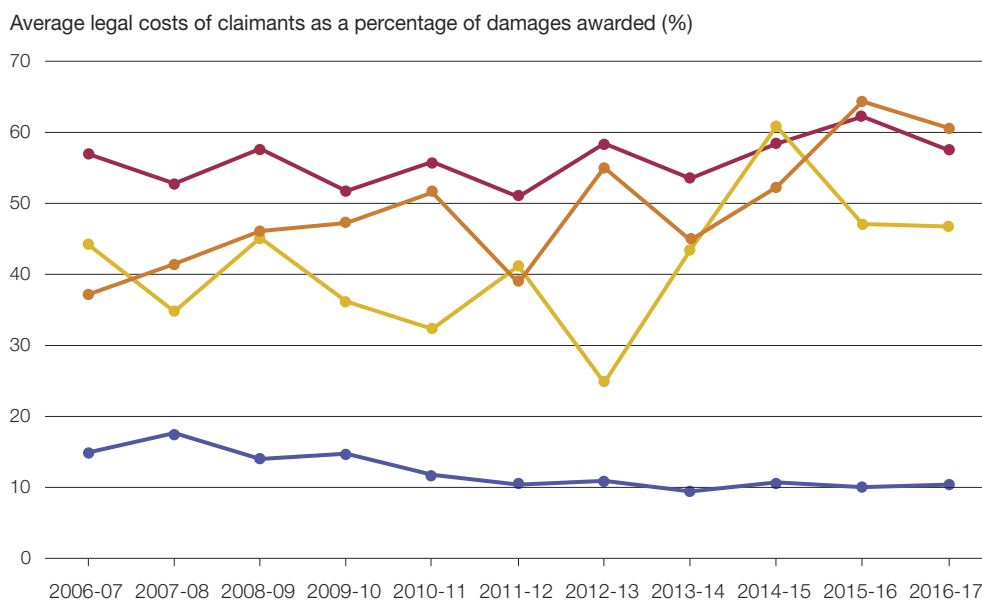
**2.17** Between 2006-07 and 2016-17, the number of claims where the claimants' legal costs were higher than the damages awarded increased from 990 (35% of all successful claims) to 4,420 (61% of all successful claims). Most of these claims tend to be low- and medium-value claims, and most funded by 'no-win-no-fee' agreements. The 2013 Legal Aid, Sentencing and Punishment of Offenders Act was introduced in part to curb the excessive growth in legal costs under 'no-win-no-fee' agreements. Growth in legal fees for claims with a value up to £25,000 has since slowed: between 2013-14 and 2016-17, the ratio of average claimant legal fees to average damages awarded for claims funded with 'no-win-no-fee' agreements 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 more complex claims under the post-2013 arrangement have yet to be concluded.

<sup>12</sup> Myungho Paik et al., 'The receding tide of medical malpractice litigation: Part 1 – national trends', *Journal of Empirical Legal Studies*, vol. 10, issue 4, December 2013, pp. 612–638; Myungho Paik et al., 'The receding tide of medical malpractice litigation: Part 2 - effect of damage caps', *Journal of Empirical Legal Studies*, volume 10, issue 4, December 2013, pp. 639–669.

**Figure 14**

Claimant’s legal costs as a proportion of damages awarded by funding arrangements, 2006-07 to 2016-17

Claims funded through ‘no-win-no-fee’ agreements have higher legal costs as a proportion of damages awarded than other funding arrangements



● 'No-win-no-fee'	57	53	58	52	56	51	58	53	58	62	57
● Before the event insurance	44	35	45	36	32	41	25	43	61	47	47
● Other	37	41	46	47	52	39	55	45	52	64	61
● Legal aid	15	18	14	15	12	10	11	9	11	10	10

**Note**

1 The main funding routes for clinical negligence claims are:

- 'no-win-no-fee' agreements – the claimant’s lawyer does not seek payment of their fees from the claimant if the case is lost, but can claim up to twice the legal fees incurred (for cases before April 2013) or a percentage mark-up from the damages awarded (for cases after April 2013) to compensate for their losses in other claims which they have lost;
- before the event insurance – legal costs are covered by an insurance arrangement taken out by patients before the clinical negligence happens;
- legal aid – the Legal Aid Agency (formerly known as the Legal Services Commission) meets most of the claimant’s fees and expenses in an unsuccessful case, but imposes criteria and constraints in the proceedings to ensure that the costs are controlled in proportion to the value of the claim; and
- other – includes self-funding claimants, those with unknown sources and sources still to be determined.

Source: National Audit Office analysis of NHS Resolution data

# Part Three

## Reducing costs of clinical negligence claims for trusts

**3.1** This part of the report covers what the Department of Health (the Department) and NHS Resolution have done to understand the causes of rising cost of the Clinical Negligence Scheme for Trusts, what they are doing to tackle these causes, and what impact their actions are likely to have on the costs.

### Understanding the causes

**3.2** NHS Resolution has, with the Department and other partners, undertaken a range of activities to better understand the causes of rising clinical negligence costs. They identified the key factors discussed in Part Two and, in particular, highlighted the impact of recent legal reforms on the number and costs of clinical negligence claims. They set up a 'policy lab', which reviewed how other countries managed clinical negligence, including the impact of recent reforms on their clinical negligence costs. There remain a few areas for further research, principally understanding what motivates people to make claims, although NHS Resolution has supported some pilot work on this issue.

### Actions to control the costs of clinical negligence claims

**3.3** NHS Resolution, together with the Department, has taken a number of measures to control the current and future costs of clinical negligence claims (**Figure 15**). However, the Department and NHS Resolution only have limited control over many of the factors influencing those claims.

### Controlling the costs of current claims through NHS Resolution's claims operations

**3.4** Handling clinical negligence claims requires a balance between paying appropriate damages for valid claims quickly and efficiently, while defending the NHS from claims which NHS Resolution believes are without merit, or where the damages sought are not proportionate. Moving too far towards defending claims where the NHS is liable will result in higher legal and administrative costs and more distress for patients and their families, whereas accepting liability in order to settle claims quickly could result in more damages being paid to that patient and may also set a precedent for future cases. Both options would result in NHS Resolution paying more than the optimal amount.



**Figure 15**
**Measures to control the current and future costs of clinical negligence claims**

Areas	Factors	Can be influenced by NHS Resolution or the Department	Can be influenced by wider government and the judicial system	NHS Resolution's schemes to control the costs of current claims	Major initiatives to manage the future costs or number of claims
1 An increase in the total number of claims (45%)	An increase in population, meaning more people are eligible to be treated by the NHS	No	No	N/A	N/A
	An increase in the number of adverse incidents	Limited	No	No	Patient safety initiatives (including maternity)
	An increase in the number of patients claiming damages as a proportion of adverse incidents	Limited	Limited	No	Alternative dispute resolution schemes <sup>1</sup> , and planned earlier intervention by NHS Resolution
	An increase in the number of patients who make a claim but do not recover damages	Limited	Limited	Repudiate unmerited claims	As above
2 An increase in the amount of damages awarded (33%)	Rising lump sums and annual costs over and above inflation, for high-value claims	Limited	Limited	Schemes to challenge unmerited damages claimed	'Policy lab' research, and alternative dispute resolution schemes <sup>1</sup>
	Lower discount rate used by the court for damages	No	Yes	N/A	N/A
3 An increase in the amount of legal costs (21%)	Time taken from incidents to resolution of claims	Limited	Limited	Resolving more cases out of court	Planned earlier intervention by NHS Resolution, alternative dispute resolution schemes <sup>1</sup> , and planned increase in operational capacity
	An increase in the number of low- and medium-value claims up to £250,000 driven by 'no-win-no-fee' agreements	Limited	Yes	No	Proposed fixed legal costs
	In 2015, the court increased the fees for registering claims at a court from £1,920 to £10,000	Limited	Yes	Resolving more cases out of court	No
	Time taken from incidents to resolution of claims	Limited	Limited	Resolving more cases out of court	Planned earlier intervention and support by NHS Resolution, alternative dispute resolution schemes <sup>1</sup> , and planned increase in operational capacity
	Disproportionate claimant legal costs for low- and medium-value claims	Limited	Yes	No	Proposed fixed recoverable legal costs and alternative dispute resolution schemes (such as the mediation service)
	Excessive or fraudulent claims for legal costs from some claimant firms	Yes	Yes	Scheme to challenge excessive legal costs of claimants	Proposed fixed recoverable legal costs (partial)

**Note**

1 Such as mediation, and the voluntary alternative compensation scheme for birth injuries.

Source: National Audit Office

**3.5** NHS Resolution has had some success in controlling costs when dealing with existing clinical negligence claims within the current legal framework. For example, our analysis, and that of NHS Resolution, shows that it has:

- reduced the cost of its own claims operations by £307 per claim on average between 2006-07 and 2016-17;
- challenged claimants' legal charges where it believes they are too high, for example, reducing these costs by £144 million in 2015-16; and
- challenged unmerited or exaggerated damages claimed, leading to 37% of all claims settled without any damages paid between 2006-07 and 2016-17.

**3.6** It is not clear whether or not the time that NHS Resolution takes to resolve cases is optimal. There are no data against which NHS Resolution's performance can be benchmarked and the optimum time 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.

**3.7** Since 2010-11, the average time taken to resolve a case has risen each year. Cases which take longer to settle are associated with higher legal costs (see paragraph 3.16), as well as causing more distress for patients and their families. However, NHS Resolution considers that the damages avoided by challenging excessive claims outweighs the extra cost associated with taking longer to resolve these cases. For example, in 2015-16, NHS Resolution estimated that it had avoided paying up to £1.7 billion in damages by challenging claims, which significantly outweighed the extra cost associated with taking longer to settle cases. The cost of challenging claims is only part of the £0.5 billion legal costs incurred for all claims in 2015-16. However, some stakeholders, including individual claimants, claimant lawyers and commercial insurers, believe that NHS Resolution increases the costs of clinical negligence cases by refusing to settle early, even when the stakeholders believe there to be clear evidence that the NHS is liable to pay damages.

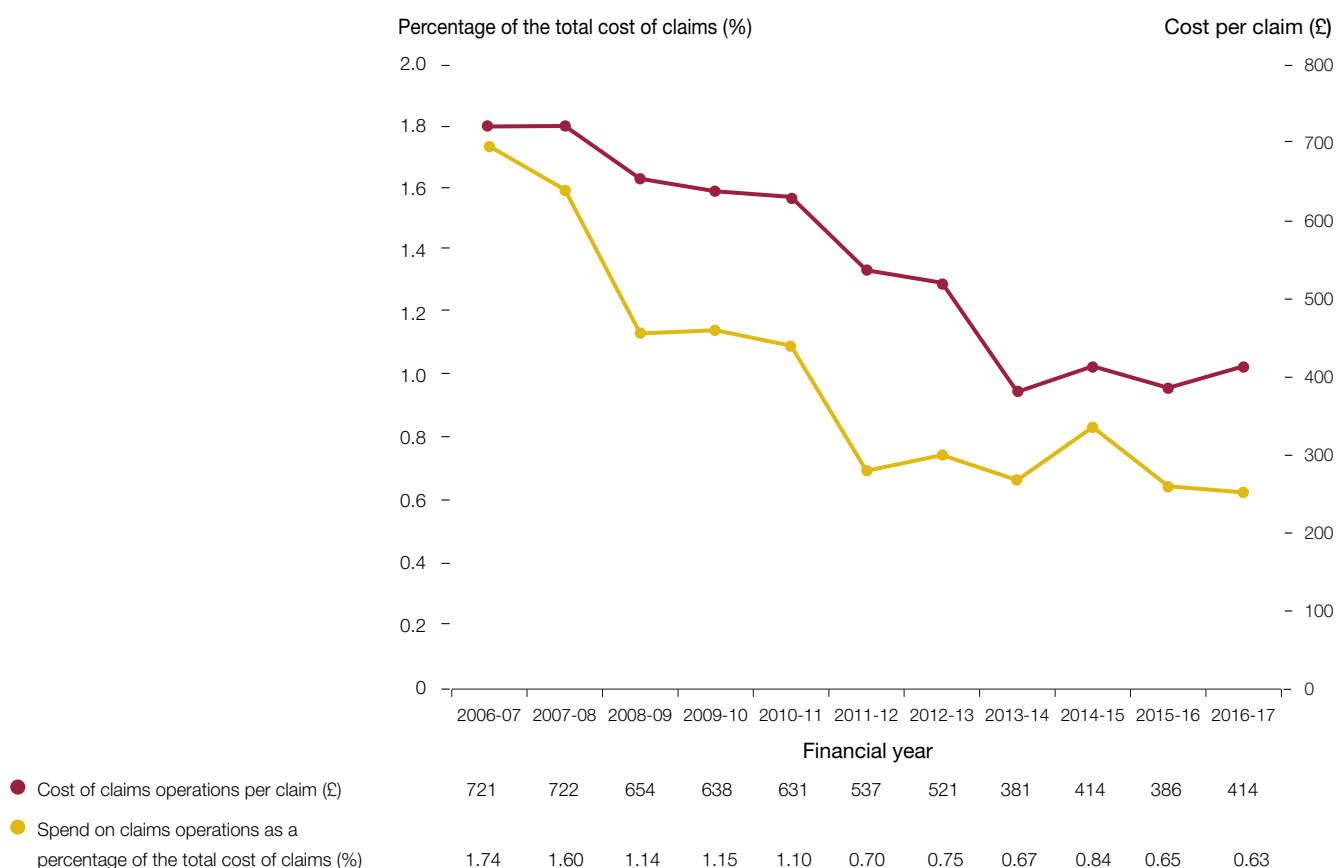
### **Cost of claims operations**

**3.8** Between 2006-07 and 2016-17, NHS Resolution's average operational cost per claim reduced from £721 to £414. Operational costs as a proportion of total spending on all clinical negligence claims also reduced from 1.7% to just over 0.6% during this period (**Figure 16**). In its 2013 procurement of its legal defence panel, NHS Resolution also negotiated a 5% cut in the price it paid to its legal panel firms. The legal defence costs have remained low in contrast to the rise in claimant legal costs (see Figure 13). Between 2006-07 and 2016-17, NHS Resolution's legal defence costs as a proportion of damages awarded, reduced from 11% to 10%, while the proportion for claimant costs increased from 24% to 36%.

**Figure 16**

NHS Resolution's operational costs for resolving claims, 2006-07 to 2016-17

NHS Resolution's claims operations have become more efficient over the last 10 years



Source: National Audit Office analysis of NHS Resolution data

## Claimants' legal costs

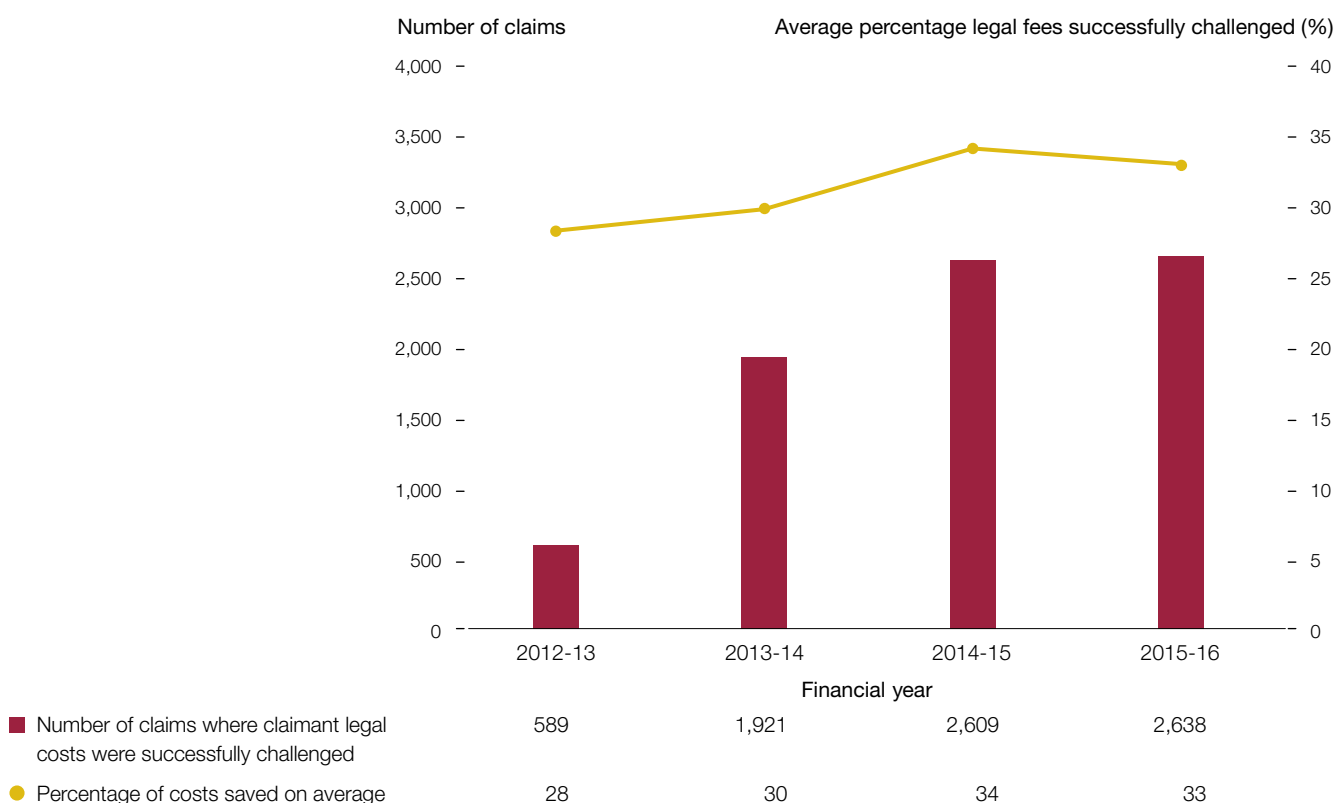
**3.9** NHS Resolution is routinely challenging claims where it believes the claimant's legal costs charged are too high (**Figure 17** overleaf). In 2015-16, NHS Resolution challenged charges for 5,100 claims (82% of all claims with claimant legal costs charged) and successfully reduced the costs for more than 2,600 claims, saving £144 million (one-third of the costs claimed for cases NHS Resolution challenged). In one case, it successfully challenged an £8 million charge by a single legal firm and settled the payment for £500,000.

**3.10** However, lessons learned from these cases are not consistently shared with other relevant regulators and bodies. NHS Resolution reports individual cases and trends in its annual report and shares information with NHS Protect, which leads on work to identify and tackle crime across the NHS. However, NHS Resolution, trusts and legal sector regulators, such as the Solicitors Regulation Authority, do not have routine discussions to share information about trends and lessons learned from cases where costs have been challenged.

**Figure 17**

## Claims successfully challenged for their legal costs

NHS Resolution is challenging the legal costs of more claims and in 2015-16, it reduced the legal costs of these cases by one-third

**Note**

1 Only includes claims reviewed by one of the two contractors NHS Resolution employed to review and challenge legal costs on its behalf. The other contractor started in late 2015 and only reviewed a small number of cases in 2015-16. Only charges from legal firms with a minimum of 15 claims are included in this analysis.

Source: National Audit Office analysis of NHS Resolution data

## Damages

**3.11** NHS Resolution also challenges unmerited or exaggerated claims for damages. In 2015-16, NHS Resolution estimated that it saved:

- up to £1.2 billion by successfully defending claims and paying no damages; and
- £0.5 billion by challenging claims with disproportionately high damages in cases for which the NHS had admitted liability, based on a random sample of cases.<sup>13</sup>

<sup>13</sup> NHS Resolution reviewed a random sample of 61 low- and medium-value cases with total damages awarded of £4.8 million and a random sample of 10 high-value cases with total damages awarded of £76 million. For each sample, NHS Resolution calculated the difference between the highest value sought by claimants and the final damages awarded, as a percentage of the final damages awarded. It then used the lower percentage of the final damages awarded, from high-value cases, to calculate the savings by multiplying this by the total damages awarded in 2015-16.

**3.12** Since 2000, NHS Resolution has sometimes carried out surveillance of suspected fraudulent claimants. Since 2013, 125 surveillance cases have been authorised. For example, in one case where the NHS had admitted liability, it successfully defended the case in court, using evidence acquired through surveillance. It reduced the damages from £2.5 million claimed to £110,000.

### Resolving more cases out of court

**3.13** NHS Resolution aims to solve as many claims as possible before formal court proceedings because resolving claims through formal court proceedings not only takes longer but costs more. In 2016-17, some 80% of all legal costs are accounted for by the 34% of claims that are settled through court proceedings. The proportion of claims that NHS Resolution settled before court proceedings went down from 65% to less than 60% between 2006-07 and 2009-10. Since then, the proportion has increased, and in 2016-17, NHS Resolution resolved 66% of all claims before court proceedings started.

**3.14** We have heard concerns from various claimant representatives that NHS Resolution resolves and loses too many cases in formal court settings, and brings too many cases to court trials. In 2016-17, 4,100 claims (34% of all claims resolved) were resolved after court proceedings started. NHS Resolution paid no damages in around 910 (22%) of these cases. Only 82 claims (0.7% of all claims resolved) were resolved following a trial and NHS Resolution was successful in 60 of these trials (73%). However, we did not find any robust benchmarks to assess whether the current level of claims being brought to court is optimal.

**3.15** NHS Resolution told us that there may be different reasons that it may be required to enter court proceedings:

- some claims must be resolved at court to protect the interests of vulnerable groups, such as children and those with learning disabilities;
- some claims start court proceedings because of a legal requirement to register a clinical negligence case at court within three years of the incident (for most types of claim). NHS Resolution told us that claimants sometimes register their cases at courts at the same time as they notify NHS Resolution of their claims. The number of claims reported to NHS Resolution around three years from the incident accounts for about one-fifth of all claims reported, but one-third of claims that started formal court proceedings; and
- NHS Resolution may accept that the NHS was liable to pay damages, but may still wish to contest the amount requested.

## Resolving claims quickly

**3.16** Our analysis shows that the average time taken to resolve a case has risen by four months since 2010-11. Delays in resolving cases can not only prolong anxiety and financial hardship for those involved, but can lead to higher legal costs for the NHS. Our analysis shows that, other things being equal, an extra day taken to resolve a claim is associated with an increase in legal costs of more than £40. In 2016-17, it took 426 days on average to resolve a claim, up from 300 days in 2010-11 (**Figure 18**). Although the average time taken to resolve a small number of high-value cases has reduced (see paragraph 2.12), the average time taken to resolve a claim for all cases increased from 224 to 303 days for those resolved without court proceedings, and from 567 to 800 days for those that had started formal court proceedings. However, the time taken to resolve cases is influenced by a range of factors, some of which are outside NHS Resolution's control (**Figure 19** on page 46). NHS Resolution also told us that, for some claims, extra time is needed to challenge the excessive damages claimed in order to protect NHS resources.

## Initiatives to reduce future costs and claims

**3.17** A number of initiatives are planned, or being implemented, to reduce the costs of future claims including:

- learning from past claims;
- fixing recoverable legal cost; and
- alternative models of dispute resolution.

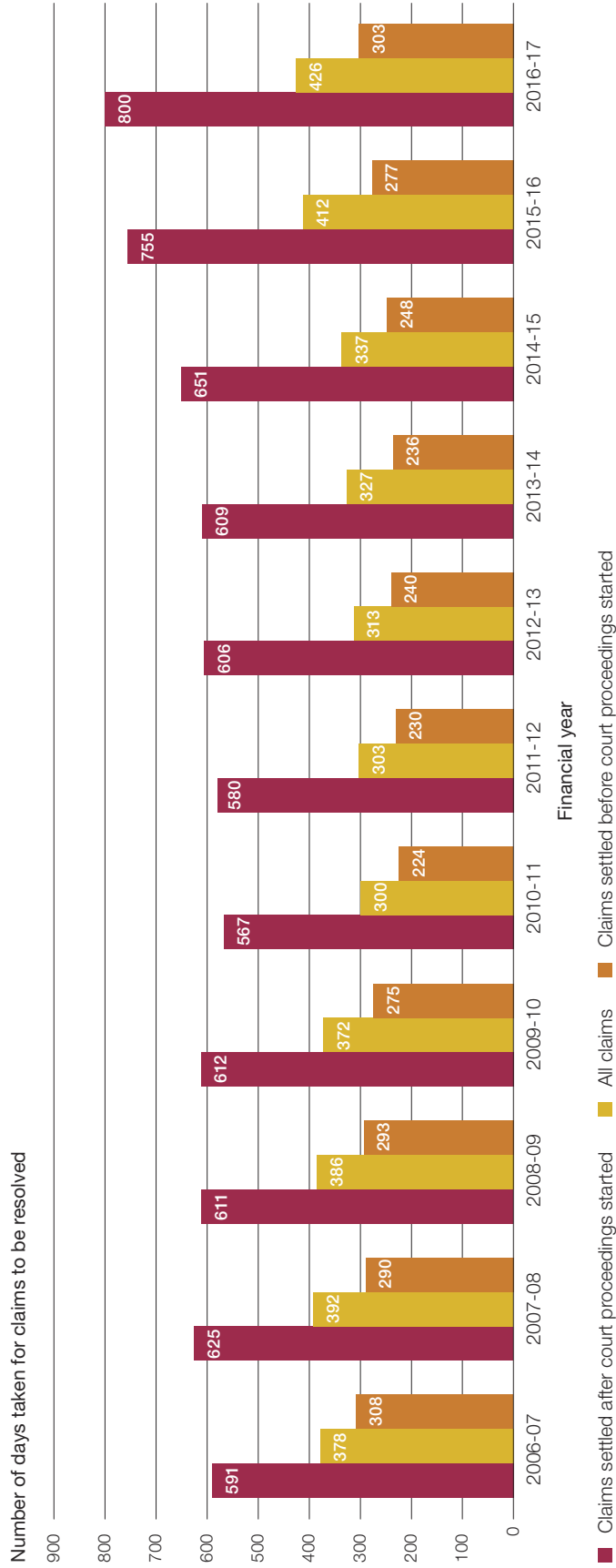
However, the potential impact of these initiatives is much smaller than the expected increase in clinical negligence costs over the next four years.

## Learning from claims

**3.18** Currently, although NHS Resolution handles clinical negligence claims for the NHS, it is not involved in related investigations or communications with patients until a claim has been made. Trusts, which are involved in the earlier stages of a claim, and NHS Resolution do not systematically share information at this stage. Trusts collect data on incidents and complaints, and NHS Resolution collects data on claims. However, it is not yet possible to link these data together to gain meaningful insights to help inform the handling of clinical negligence claims. NHS Resolution told us that its engagement with trusts was until recently limited, but it has developed a strategy to communicate with trusts more proactively. It is currently working with a number of trusts to explore how to improve data sharing between them. NHS Resolution has also introduced an 'early notification scheme' for maternity incidents which are likely to result in severe brain injury, requiring trusts to report these cases early, and is providing support to trusts in engaging with affected families.

**Figure 18**  
Average number of days taken for claims to be resolved, 2006-07 to 2016-17

Since 2010-11, the length of time that NHS Resolution takes to resolve claims, both before and during court proceedings, has got longer



**Notes**

- 1 The average was calculated as the median time taken in each financial year for a claim to be resolved after NHS Resolution was notified of the claim.
- 2 In 2016-17, over 98% of the claims registered at court were resolved before a trial started.

Source: National Audit Office analysis of NHS Resolution data

**Figure 19**

## Factors that impact on how quickly a claim can be resolved

Factor	Examples
Capacity of claims operators	NHS Resolution considers that 250 cases is the optimal number of cases a claims operator can handle effectively. Although caseload has improved since 2013, the average caseload has generally remained over 250. For example, it exceeded 250 for 17 of the 23 months to February 2017. NHS Resolution plans to increase its number of claims operators during 2017-18.
NHS Resolution's annual cash budget	NHS Resolution is required to remain within its annual cash budget, set by the Department, and so must manage the pace of settlements to remain within this limit. In 2014-15, 1,943 fewer cases were resolved compared to the number of new claims registered. NHS Resolution attributed some of this to pressure to remain within the annual expenditure limit.
Availability of information to make informed decisions	NHS Resolution may not be able to settle a case, even if it has admitted liability, due to lack of information. Based on a random sample analysed by NHS Resolution, for 85% of claims, the claimant's lawyers did not notify NHS Resolution of the value of damages when they issued court proceedings. In addition, trusts may not be able to provide information quickly due to staff turnover.
Complexity and uncertainty of claims	Many clinical negligence cases are complex, and establishing causality and the amount of damages involves uncertainties. Negotiating an outcome for these cases can be time-consuming.
Capacity of the courts	The time taken by the court to convene the first case management conference between claimants and NHS Resolution has increased for many cases since 2013, caused by changes to court processes and a shortage of judges.

Source: National Audit Office

**3.19** As well as learning lessons from past claims to improve claims handling, it is also important to ensure that lessons are learned to avoid future patient harm. This in turn will help to reduce the need for future claims. In 2015, NHS Resolution established a safety and learning team to engage with trusts and share insights from its claims data. This has been welcomed by trusts. It now routinely shares data on claims related to each trust and trends on some common clinical negligence incidents which led to claims. For example, its analysis of maternity claims has informed a new programme to improve the safety of care around birth.<sup>14</sup> It also worked with clinicians, through the Department of Health's 'Getting It Right First Time' project, to identify patterns of orthopaedic claims and shared these findings across the NHS. NHS Resolution and the 'Getting It Right First Time' team have now extended this approach to other specialties.<sup>15</sup>

<sup>14</sup> Following a Committee of Public Accounts recommendation in 2014, the Department launch a programme to improve the safety of maternity care, reduce stillbirths and neonatal mortality.

<sup>15</sup> The "Getting It Right First Time" project is now led by NHS Improvement.



**3.20** NHS Resolution has had limited capacity to analyse its claims data to help trusts to improve, although it has developed a strategy for processing and storing data and for carrying out systematic reviews of its claims database. NHS Resolution now routinely shares its data on trusts' claims with the trusts concerned through an online portal. The portal also provides some benchmarking information for trusts to compare with trusts that are similar to them. NHS Resolution has received positive feedback on the portal from its members. However, during our fieldwork, trusts expressed mixed views on the usefulness of the information shared by NHS Resolution. They told us that the data it collects, in its current format, is of limited use in helping clinicians gain insight to help improve patient safety. Trusts told us that they would benefit from a better understanding of national trends in claims, including how their claims experience compares with other providers.

**3.21** The main lever that NHS Resolution has to ensure that trusts learn from past claims, and improve patient safety to avoid future claims, is the trust's level of contribution to the scheme. However, these contributions are based on historic claims and not directly linked to trusts' current activity on patient safety or the effectiveness of trusts' handling of clinical negligence before a claim is made. As a result of consultation with its members in 2016, NHS Resolution has adjusted the way it calculates trust contributions to better reflect the risks to patient safety and future claims. For example, the calculation now places a greater focus on more recent claims experience by excluding those claims resulting from incidents more than 10 years ago. It is also testing an arrangement which incorporates a number of risk indicators, but progress is constrained by limitations in available data. Trusts also told us that they find it challenging to understand how NHS Resolution arrives at their contribution amount, and therefore provides little incentive for them to improve their efforts.

## Reducing legal costs

**3.22** There are proposals to introduce measures to set fixed recoverable legal costs for claims with a low- and medium-value. In 2016-17, claimants' legal costs for claims resolved with a value up to £250,000 (63% of all claimants' legal costs) was £306 million. The Department published a consultation in January 2017, proposing to fix the legal costs that firms can recover for claims with a value between £1,000 and £25,000.<sup>16</sup> It estimates that this could save up to £45 million a year. In addition, in July 2017, Lord Justice Jackson published his review examining options to extend fixed recoverable legal costs.<sup>17</sup> It recommended that the Department and the Civil Justice Council should set up a working party with both claimant and defendant representatives to develop a bespoke process for handling clinical negligence claims up to £25,000, with fixed recoverable costs. It also noted that fixed recoverable costs would not be suitable for most clinical negligence claims above £25,000. These findings are likely to inform future public consultations on reforms in this area.

<sup>16</sup> Department of Health, *Introducing fixed recoverable costs in lower value clinical negligence claims: a consultation*, January 2017.

<sup>17</sup> Right Honourable Lord Justice Jackson, *Review of civil litigation costs: supplemental report fixed recoverable costs*, Judiciary of England and Wales, July 2017.

## Alternative models of dispute resolution

**3.23** NHS Resolution has developed alternative ways to resolve disputes to avoid the costly and often prolonged litigation process. NHS Resolution told us that mediation services help bring parties together to avoid the need for expensive litigation, thereby reducing legal costs and delivering a better and quicker outcome for the patient. Between July 2014 and August 2015, it piloted a mediation service for around 50 claims involving fatal accidents and care claims for elderly patients, most of which were resolved on the day of the mediation. In December 2016, the mediation service became available to all claimants on a voluntary basis. By the end of May 2017, 40 people had taken up the service.

**3.24** The Department, supported by NHS Resolution, has also consulted on a proposal for a voluntary alternative compensation scheme for infants who have suffered avoidable neurological injury at birth.<sup>18</sup> The proposed scheme aims to support a long-term reduction in these harmful events. Although there are only around 100 successful claims each year, these claims account for more than 40% of all damages awarded. Key features of the proposed programme which went out for consultation in March 2017, include:

- early investigation of an incident with a focus on analysis and learning;
- early engagement with parents;
- early support, through dedicated case managers, and compensation for families eligible for compensation; and
- a panel of experts to decide on the compensation package.

**3.25** Through the programme, the Department aims to avoid expensive legal proceedings and improve care for injured patients. The overall compensation package for these cases could also be lower, if settlements are quicker, due to inflation in damages awards over time. Although participation will be voluntary, if the scheme goes ahead the Department hopes that up to 90% of eligible families a year will join the programme.

## Impact of the Department's and NHS Resolution's initiatives to manage the costs

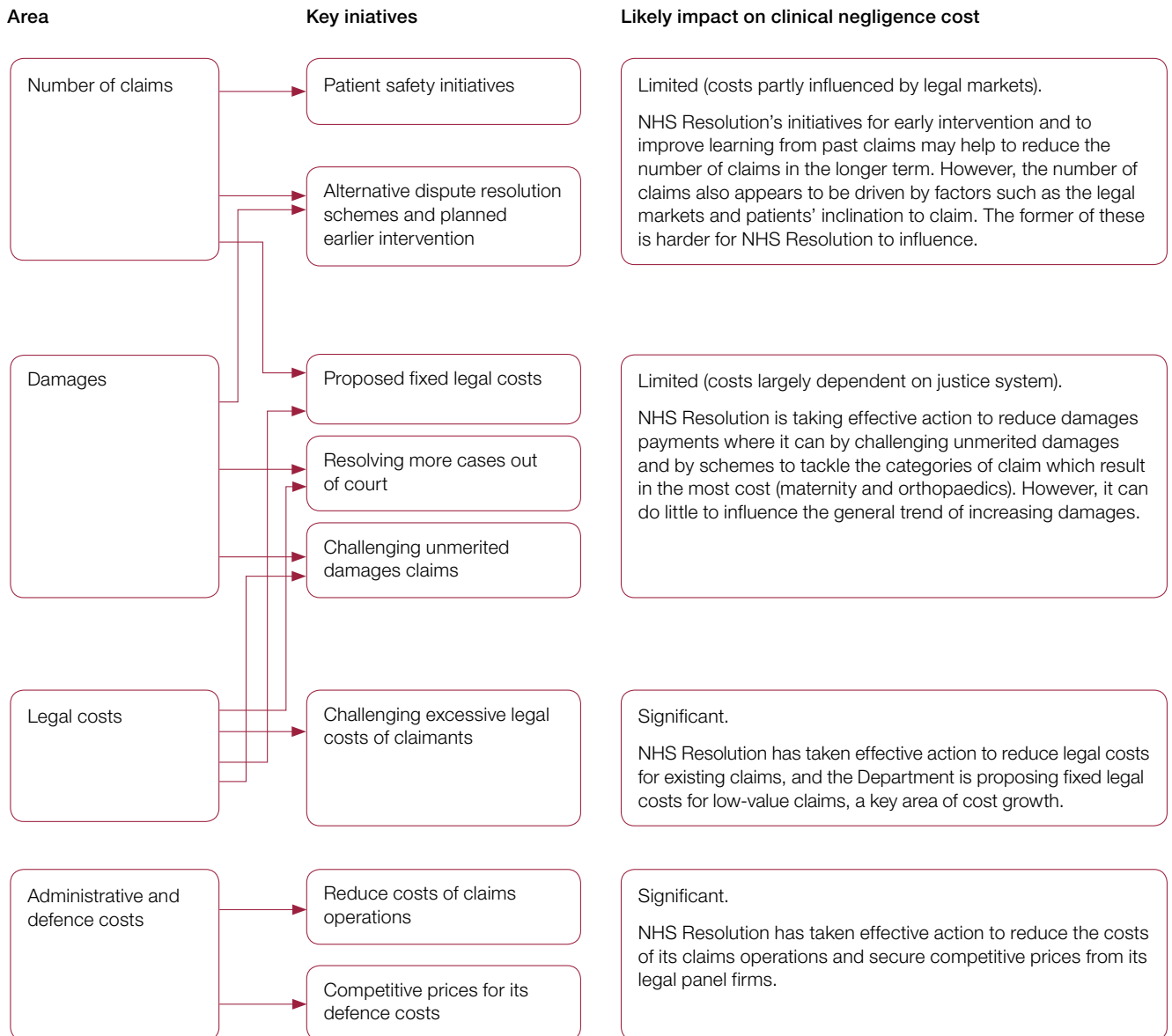
**3.26** **Figure 20** highlights that the Department and NHS Resolution are taking steps to reduce the costs of clinical negligence in many areas where they can. Our analysis in Part Two indicates that they are least developed in understanding how the rising number of claims might be influenced. NHS Resolution published its own strategy for the next five years in March 2017, setting out its ambition to resolve more clinical negligence cases before they go to court, consolidating its ambitions on learning and safety as well as committing itself to being more proactive in engaging with trusts in managing claims.<sup>19</sup>

<sup>18</sup> The Department of Health, *A rapid resolution and redress scheme for severe avoidable birth injury: a consultation*, March 2017.

<sup>19</sup> NHS Resolution, *Delivering fair resolution and learning from harm: our strategy to 2022*, April 2017.

**Figure 20**

Cumulative impact of key initiatives on rising clinical negligence cost



Source: National Audit Office

**3.27** However, all of the Department's and NHS Resolution's initiatives, while helping to slow the growth in the costs of clinical negligence, are unlikely to turn it around in the next few years. The Department estimates that a range of proposals to reduce costs, including the proposed initiative to set fixed recoverable costs for low-value cases, and the proposal to extend the fixed recoverable costs (see Figure 10) for personal injury claims could reduce claimants' legal costs by £90 million a year against expected activity.<sup>20</sup> The Department is not expecting any savings from its proposed voluntary alternative compensation scheme for birth injury cases in the next few years. By contrast, spending by NHS Resolution on clinical negligence claims is forecast to nearly double to £3.2 billion in 2020-21 (based on its 2016 estimate). It may rise by a further £500 million in 2017-18 as a result of changes to the discount rate announced by the Lord Chancellor (see paragraph 2.14).

**3.28** NHS Resolution, along with the Department and other partners, have recognised the lack of limits on the potential costs of claims as one of the main underlying causes of the rising clinical negligence costs. However, the government has yet to take action on how to address this systematically. There is not yet an overarching strategy setting out the level of access to redress that the government believes to be appropriate, what constitutes a proportionate response to an incident of clinical negligence, or how the liabilities for clinical negligence already incurred can be funded without destabilising current hospital services. Such a strategy would require a coordinated policy approach between health and justice bodies.

<sup>20</sup> The £90 million estimate includes potential savings from across NHS Resolution's schemes, both clinical and non-clinical, and assumed that legal costs would be capped for all claims with a value up to £250,000.

# Appendix One

## Our audit approach

**1** The cost of clinical negligence claims increased significantly, with NHS Resolution's annual cash spending on the Clinical Negligence Scheme for Trusts rising from £0.4 billion in 2006-07 to £1.6 billion in 2016-17. NHS Resolution expects annual spending to rise further, to £3.2 billion by 2020-21 (2016 estimate). The provision for existing or potential clinical negligence claims through this scheme was £60 billion. The implication of the rising costs of clinical negligence claims against trusts 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.

**2** 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 focuses primarily on NHS Resolution's role in managing clinical negligence claims on behalf of trusts. It examines:

- what is causing the rising costs of clinical negligence claims; 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.

**3** During the fieldwork for this study, it became clear that managing the costs of clinical negligence requires coordinated action across government, not just NHS Resolution and the Department of Health. We therefore extended our fieldwork to include the Ministry of Justice and a number of its independent regulators, due to the role they have on access to legal services and the costs of clinical negligence.

**4** 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.

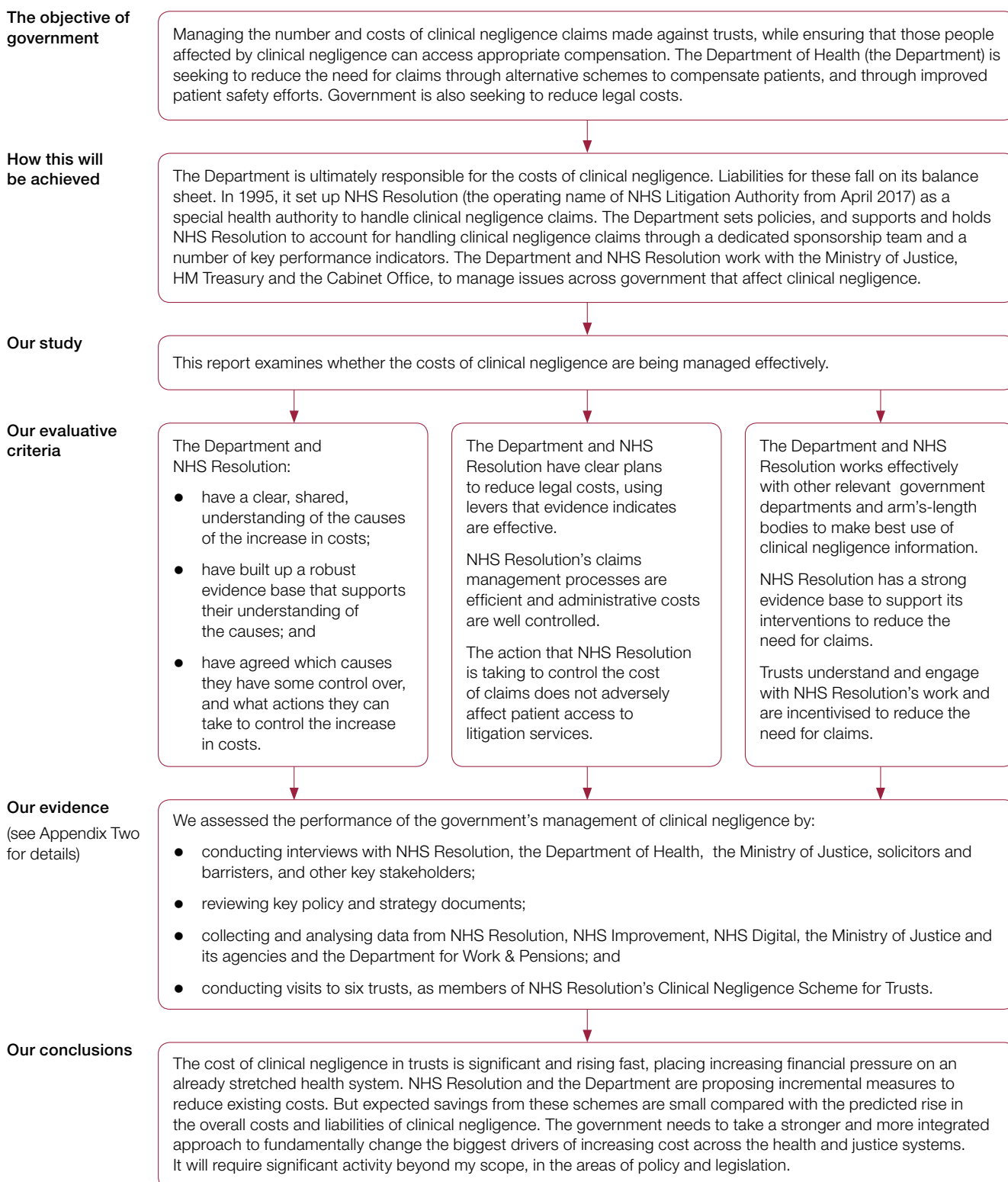
**5** The report does not examine the management of others schemes managed by NHS Resolution such as: the existing liabilities scheme for incidents occurring before April 1995; clinical negligence schemes for claims against former regional health authorities and other abolished health bodies on behalf of the Department; and non-clinical schemes for trusts including those for public liability and employer liability claims. It also does not cover the management of clinical negligence claims against general practitioners, dentists or community pharmacies, who are private contractors rather than NHS employees, and are legally liable for their own clinical negligence.

**6** We applied an analytical framework with evaluative criteria, considering the approach that would be optimal for managing the costs of clinical negligence. By 'optimal' we mean the most desirable possible, while acknowledging expressed or implied restrictions or constraints. A constraint in this context is the increasing demand for services in trusts, leading to a greater likelihood of clinical negligence claims.

**7** Our audit approach is summarised in **Figure 21**. Our evidence base is described in Appendix Two.

**Figure 21**

**Our audit approach**



# Appendix Two

## Our evidence base

**1** We reached our independent conclusions on whether the government has managed the costs of clinical negligence effectively to deliver value for money after analysing evidence collected between November 2016 and May 2017.

**2 We analysed claims data from NHS Resolution.** The claims data covered all claims NHS Resolution had handled since 1995. We analysed the claims data to understand the trends in the number and cost of claims, including claimant legal costs and damages awarded; the time taken to report and resolve claims; and the profile of claimants and legal firms. We also carried out multivariate linear regression analysis to evaluate and quantify the association between legal costs of claims and a number of factors including: the time taken to report and resolve cases; whether a claim is resolved following court proceedings or not and the value of claims awarded. Limitations with the data or the analysis we carried out are noted in the report.

**3 We also reviewed NHS Resolution's performance data.** These included key performance indicators that it submits to the Department of Health and performance data on its own claims handlers and panel of defence solicitors. These performance data, together with the analysis we carried out with the claims data, were used to inform our assessment of NHS Resolution's approach to managing the cost of claims and the performance of its claims handlers and contractors.

**4 We analysed or requested data on personal injury claims, incidents, complaints, patient safety indicators and hospital episode statistics.** We obtained data from the Department for Work & Pensions on personal injury claims, including clinical negligence claims. This allowed us to check whether trends in clinical negligence claims were similar to trends across other types of personal injury claims. We also collated and analysed incidents and complaints data published by NHS Improvement, and a number of patient safety indicator and hospital episode statistics published by NHS Digital. These data are collected for different administration purposes and are not always consistent with each other, for example, specialities and the location of incidents are defined differently which make it difficult to compare data at a more granular level. In addition, it is not clear to what extent the incidents which led to claims were included in the incidents data reported. However, analysis of these data enabled us to triangulate and verify evidence obtained from stakeholder interviews and written submissions by stakeholders.



**5 We reviewed key documents and published literature.** These included: the Department's litigation policy work, consultations and impact assessments from initiatives proposed to control clinical negligence costs; previous reviews of NHS Resolution by the Department of Health and other independent bodies; NHS Resolution's own reports, internal policy documents, guidance, performance reports and board papers; legal market reviews by the Solicitors Regulation Authority, the Legal Services Board, the Claims Management Regulator and the Ministry of Justice; Civil Procedure Rules; key reviews conducted by the Judiciary including the recent review by Lord Justice Jackson; and published and unpublished literature on the impact of legal reforms on clinical negligence claims in England and other high-income countries or countries with similar legal systems to the UK, including Australia, Germany, Sweden and the US.

**6 We interviewed staff from relevant government departments and agencies.**

We carried out semi-structured interviews with staff at:

- the Department of Health, covering litigation policy, sponsorship and accountability for NHS Resolution, fixed recoverable costs, and alternative models of dispute resolution and maternity care;
- the Ministry of Justice, covering clinical negligence and civil litigation more widely, and regulating claims management companies;
- HM Treasury, covering the management of financial risk arising from the costs of clinical negligence; and
- other government agencies and regulators, including the Care Quality Commission, the Law Society, the Legal Services Board, NHS England, NHS Improvement, and the Solicitors Regulation Authority.

**7 We interviewed a range of other organisations involved in, or interested in, clinical negligence.** The interviews were designed to help us understand: the factors contributing to the rising number and cost of clinical negligence claims; the approach taken to preventing clinical negligence incidents; the legal environment around clinical negligence and how NHS Resolution manages this; and trusts' experience of managing clinical negligence, and dealing with NHS Resolution. We carried out semi-structured interviews with:

- Action against Medical Accidents, a charity that provides advice and signposting to members of the public who believe they have experienced medical negligence on their rights, and avenues for possible redress;
- NHS trusts and NHS foundation trusts;
- the Medical Defence Union and the Medical Protection Society, two membership organisations providing their doctor, dentist and other healthcare professional members with medico-legal services which include access to indemnity for clinical negligence claims for GPs and doctors in private practice;
- the Royal College of Obstetricians and Gynaecologists;
- the Society of Clinical Injury Lawyers, a representative group for firms which practice clinical negligence law; and
- two of NHS Resolution's 10 clinical negligence partner firms, two barristers who have represented NHS Resolution at trials, and a service company commissioned by NHS Resolution to challenge the cost of invoices from solicitor firms of some claimants.

**8 We carried out six case studies of acute hospital trusts.** These included a specialist maternity foundation trust, two NHS foundation trusts and three NHS trusts. We selected trusts to provide a range of locations, size by turnover, contribution amounts to the Clinical Negligence Scheme for Trusts as a proportion of turnover, and foundation trust status. The main aim of these case studies was to better understand the challenges faced by trusts in dealing with incidents that lead to clinical negligence claims, their working arrangement with NHS Resolution, and their views of the management of clinical negligence by NHS Resolution. We carried out semi-structured interviews with staff, covering: contributions to NHS Resolution; legal work and liaison with solicitors and NHS Resolution claims handlers; patient safety; and complaints-handling.

**9 We reviewed evidence submitted by a range of organisations and individuals interested in the management of clinical negligence in England.** Evidence was submitted by: academics and researchers; individual solicitors involved in clinical negligence claims; insurance companies; legal firms representing both claimants and NHS Resolution; and patients or their representatives who had experienced clinical negligence or who had previous or current negligence claims. Evidence submitted covered: claimants' experiences; claims-handling; complaints-handling; indemnity arrangements for clinical negligence; and patient safety.

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