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Handling clinical negligence claims in England

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



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John Bourn **National Audit Office**
Comptroller and Auditor General **27 April 2001**

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For further information about the National Audit Office please contact:

National Audit Office
Press Office
157-197 Buckingham Palace Road
Victoria
London
SW1W 9SP

Tel: 020 7798 7400

Email: enquiries@nao.gsi.gov.uk
Website address: www.nao.gov.uk

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executive summary

Executive Summary and Recommendations

Introduction

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



Key Facts

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

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

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

Why we undertook this examination

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



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

Conclusions

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

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

Recommendations

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

(b) Patients' access to remedies

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

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

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

Recommendations

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

Case Study 1

Application of the package approach

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

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

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

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

Source: NHS Trust

(c) Managing patients' claims

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

Recommendations

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

Part 1

Introduction

Clinical negligence

- 1.1 The NHS has a duty of care towards those it treats. People who consider they have suffered harm from a breach of this duty can make a claim for compensation. The financial compensation they seek may relate to quantifiable financial loss, arising for example from loss of earnings through incapacity, or to the cost of continuing care where the claimant's level of incapacity is such as to require it, or to general damages for pain, suffering and loss of amenity.
- 1.2 In order for a claim to succeed, the claimant must prove four things:
- that they were owed a duty of care (this should be relatively easy to prove for most patients under the care of medical staff);
 - that the duty was breached. The issue here might be simple negligence for an act or an omission. But the general test for clinical negligence, the Bolam test, affords a defence to a clinician "if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art"³;
 - the breach of duty caused, or contributed materially to, the damage in question; and
 - the consequences and effect of the damage.
- 1.3 In general, under the Limitation Act 1980, claims have to be made within three years from the date of the injury, or alternatively three years from the date that the claimant knew they had suffered an injury. In the case of minors, the three years limitation period does not start until they reach the age of 18. People under a mental disability have unlimited time in which to make a claim.
- 1.4 Claims are made concerning the whole range of clinical work although high value claims mainly relate to birth-related injuries, principally cerebral palsy and brain damage. Examples of claims are at **Figure 1**. In most cases successful claimants receive their damages as a lump sum. This can oblige the NHS, when it is the losing party, to pay the full settlement value at once to allow the successful claimant to invest the money and thus provide for future costs of care, if necessary, typically in high value settlements. In March 2000 the Lord Chancellor's Department issued a consultation paper⁴ to explore the advantages, disadvantages and alternatives to lump sum awards, for example court-imposed structured settlements that involve periodic payments. The consultation period closed on 31 May 2000 and the Department is currently considering its position.

1 Examples of claims and settlements

- In November 1990 a patient suffered brain damage following allegedly negligent management of septicemia. The hospital received a claim for £1.5 million in September 1993. The claim was settled for £252,000 in November 1999 with defence costs of £60,000 and claimant's costs of £90,000.
- In October 1990 a patient attended hospital where there was a failure to diagnose a fractured to diagnose a fractured wrist. The hospital received a claim in March 1996, which was settled in March 1999 for £7,800, with claimant's costs of £6,800 and defence costs of £3,700.
- In April 1993 a patient underwent a sterilisation procedure. The operation was not a success and a child was born in January 1995. Subsequently, a further sterilisation was performed at another hospital where it was found that there was no filshie clip on the right tube. A claim was received by the first hospital in July 1995. The claim was settled in March 1999 for £40,000, with claimant's fees of £21,300 and defence costs of £18,200.

Source: NHS Litigation Authority Existing Liabilities Scheme database

³ *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582. In *Bolitho v City and Hackney Health Authority*, the House of Lords modified this by stating that in rare cases it would be negligent to act in accordance with a professional opinion that "is not capable of withstanding logical analysis".

⁴ *Damages: The Discount Rate and Alternatives to Lump Sum Payments*, Lord Chancellor's Department, March 2000

1.5 Involvement in clinical negligence claims can have a severe impact on both patients and clinicians. Apart from the consequences of any harm they have suffered, patients can find it difficult to come to terms with what happened to them until the claim is settled. Even then, many are dissatisfied because they do not get all of what they want out of the process. Research has shown that claims can cause clinicians great stress.⁵

Public bodies' involvement

1.6 Three public organisations are directly involved in clinical negligence claims: NHS healthcare providers, the NHS Litigation Authority and the Legal Services Commission (Figure 2).

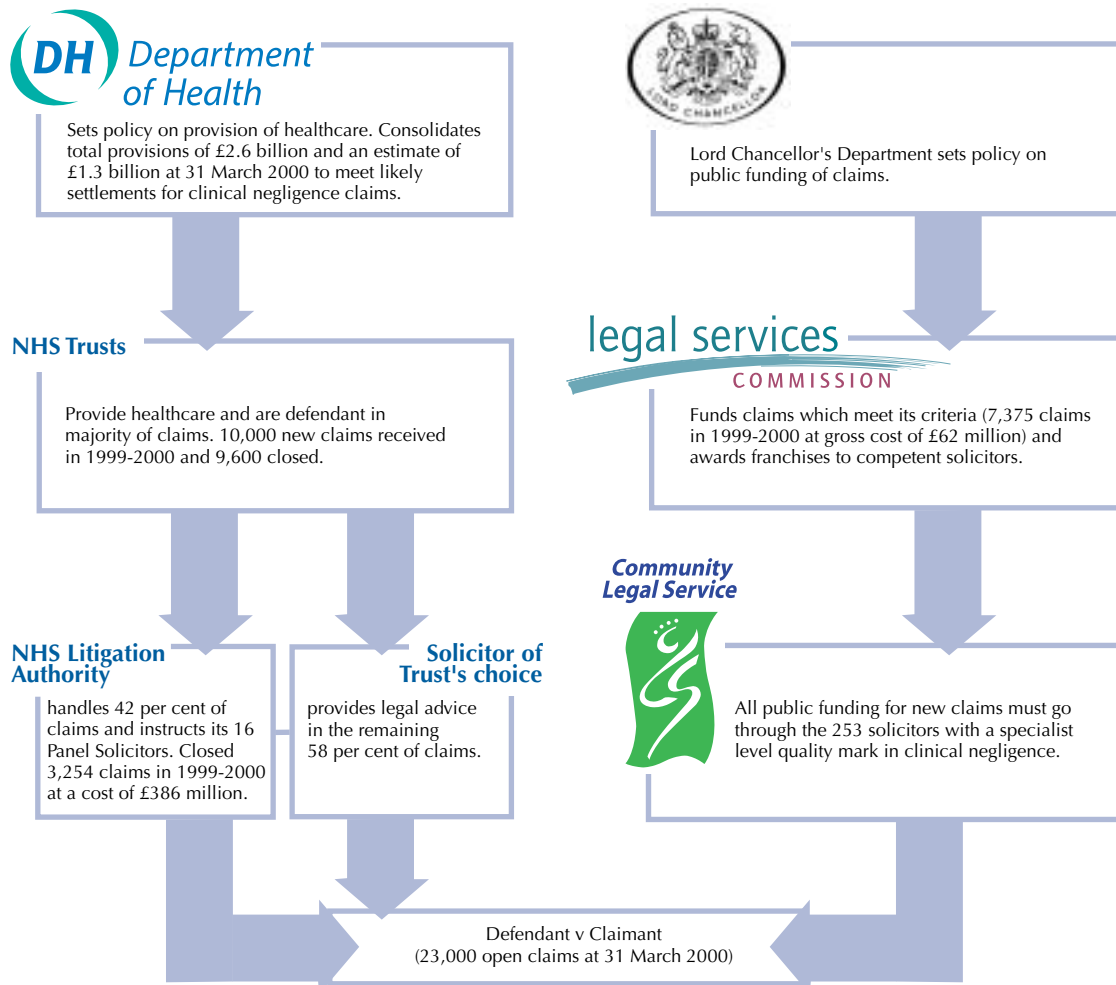
NHS healthcare providers

1.7 Until 1989, individual practitioners were responsible for claims for clinical negligence against them. Practitioners insured themselves against the potential costs through the Medical Defence Union, Medical Protection Society

and the Medical and Dental Defence Union of Scotland. NHS indemnity was extended in 1990, and the NHS took over responsibility for all outstanding and future clinical negligence claims involving medical and dental staff employed by health authorities, but not general medical or dental practitioners. A transfer of funds from the defence bodies to the NHS accompanied this transfer of responsibility.

1.8 NHS Trusts are liable for claims for incidents occurring after their establishment (health authorities occupy that position for claims in respect of earlier incidents). They undertake the initial investigation and assessment of adverse medical incidents. The extent of their further involvement in dealing with the claim depends on its scale, and when it arose. How the NHS handles and funds a claim depends on the scheme to which it relates (Figure 3). At March 2000, there were some 12,000 claims being handled by Trusts and health authorities, although in 2000-01 the NHS Litigation Authority took over all claims for incidents before April 1995.

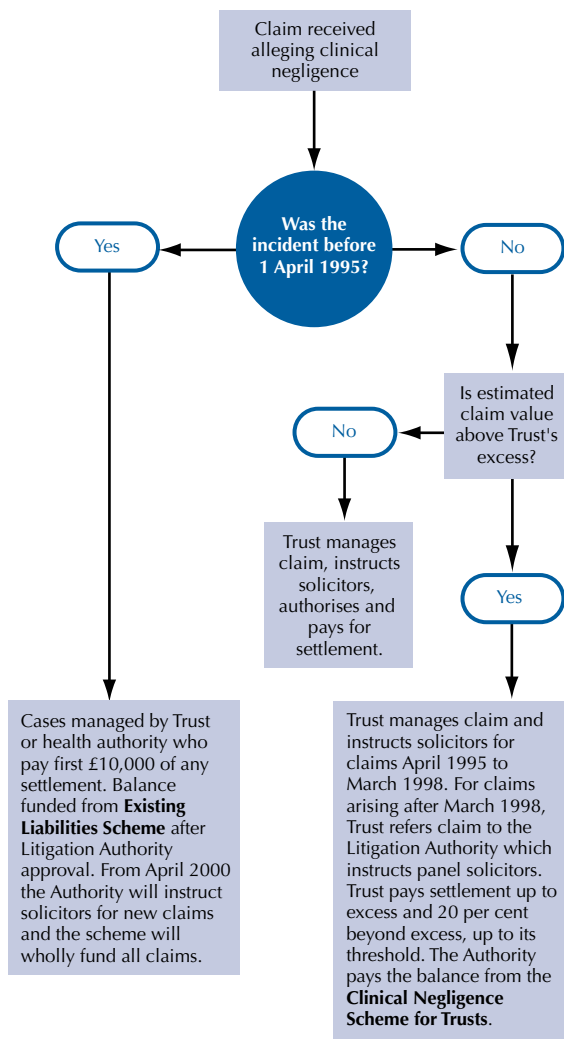
2 Parties to clinical negligence claims



Source: National Audit Office survey of trusts

5 An organisation with a memory, Department of Health, 2000 paragraph 2.15

3 The main funding avenues available to NHS bodies to meet clinical negligence settlements



Source: National Audit Office

The NHS Litigation Authority

1.9 The NHS Litigation Authority, a special health authority, was set up in 1995 to administer the Clinical Negligence Scheme for Trusts, and took on the administration of the Existing Liabilities Scheme when the scheme was established in 1996:

The **Clinical Negligence Scheme for Trusts** is a pooling arrangement. It was introduced as a voluntary scheme to limit the liability of member Trusts for clinical negligence claims where the incident occurred after March 1995. By 31 March 2000, all but one Trust had joined the scheme. From April 2000, Primary Care Trusts have been eligible to apply for membership; and to date all have joined the scheme.

As at May 2000, it had 4,700 claims outstanding, totalling £1.5 billion. These figures will grow as the scheme matures. Trusts fund the scheme by paying the equivalent of premiums, and in return receive assistance with the costs of cases above a certain amount – their 'excess'. Trusts are free to choose from a range of excess levels, although – as with insurance – the size will affect the contribution payable. Scheme members pay all costs of settlements below their excess level and 20 per cent of costs above it, up to a threshold. The Litigation Authority pays the balance on behalf of the scheme. The scheme operates on a 'pay as you go' basis and does not build up funds, in the way a commercial insurer must. The scheme also has clinical risk management standards against which member Trusts are assessed (paragraphs 1.12 to 1.14).

The **Existing Liabilities Scheme** initially covered all NHS bodies' liabilities for each claim for incidents that occurred before April 1995, where the estimated settlement costs were above £10,000, and is funded by the Department of Health through the Litigation Authority. As at May 2000, the scheme had 6,800 claims, totalling £3.4 billion, outstanding. The scheme is currently the more active of the two, but will dwindle in size with the passing of time because of the cut-off date. Before April 2000, Trusts and health authorities were responsible for managing many claims but after that date the Litigation Authority took responsibility for managing and funding all claims.

1.10 In addition, in 1996 the Litigation Authority took over on behalf of the Secretary of State for Health responsibility for clinical negligence claims against the former Regional Health Authorities (known as the Ex-RHA Scheme). These claims, of which there were fewer than a thousand, mainly arose from the activities of postgraduate teaching hospitals.

1.11 In administering the pooling schemes for clinical negligence, the overall aims for the Litigation Authority are to promote the highest possible standards of patient care and to minimise the suffering resulting from any adverse incidents that do occur. The detailed objectives include a requirement that the Litigation Authority ensure that, where actual clinical negligence has occurred, patients have appropriate access to remedies including, where proper, financial compensation.

1.12 Since 1997, the Clinical Negligence Scheme for Trusts has had risk management standards for members in England. The purpose of those standards is to ensure that risk management is conducted in a focused and effective fashion, and thus to make a positive contribution towards the improvement of patient care. There are now 12 standards (Figure 4). The Litigation Authority plans to develop existing standards in 2001-02 to incorporate key aspects of the Department's Controls Assurance Infection

4 Risk management standards set by the Clinical Negligence Scheme for Trusts

- 1 The board has a written strategy in place that makes their commitment to managing clinical risk explicit. Responsibility for this strategy and its implementation is clear.
- 2 A clinical incident reporting system is operated in all medical specialties and Clinical Support Departments.
- 3 There is a policy for rapid follow-up of major clinical incidents.
- 4 An agreed system of managing complaints is in place.
- 5 Appropriate information is provided to patients on the risks and benefits of the proposed treatment or investigation, and the alternatives available, before a signature on a consent form is sought.
- 6 A comprehensive system for the completion, use, storage and retrieval of medical records is in place. Record-keeping standards are monitored through the clinical audit process.
- 7 There are management systems in place to ensure the competence and appropriate training of all clinical staff.
- 8 A clinical risk management system is in place.
- 9 There are clear procedures for the management of general clinical care.
- 10 There is a clear documented system for management and communication throughout the key stages of maternity care.
- 11 There are clear systems for the protection of the public and service users in trusts providing mental health services.
- 12 There are clear procedures for the management of clinical risk in trusts providing ambulance services.

Source: NHS Litigation Authority

5 Achievement of Clinical Negligence Scheme for Trusts' risk management standards at 31 March 2000

CNST achievement	Number of Trusts (percentage)	Discount on contributions
No level	80 (24 per cent)	Nil
Level 1	217 (66 per cent)	10 per cent
Level 2	33 (10 per cent)	20 per cent
Level 3	1 (0 per cent)	25 per cent
Total	331 (100 per cent)	

Source: NHS Litigation Authority

Control Standard and of Health Service Circular 2000/02. This is in response to a recommendation from the Committee of Public Accounts in its report on The Management and Control of Hospital Acquired Infection in Acute NHS Trusts in England⁶.

1.13 The scheme assesses Trusts' performance against the standards, and has given each feature of the standards a priority level. Level 1 features represent basic elements of risk management that should be easily attainable; and levels two and three are assessed progressively when a Trust has been notified that it has achieved the previous level. Those meeting the standards in part or wholly are allowed discounts against their subscription to the scheme, according to the level attained. The numbers of Trusts achieving the various levels and enjoying the resultant discounts on contributions are shown at **Figure 5**.

1.14 The Auditor General for Wales' report, *Clinical Negligence in the NHS in Wales*⁷ set out measures the Welsh Risk Pool have put in place to reduce the risk of negligence occurring in hospitals throughout Wales. At the time of fieldwork for this report, the Welsh Risk Pool had developed standards in 16 areas, in most cases where there are known to be high levels of risk. Eleven of those areas are generic, covering aspects such as patient records, complaints, adverse incident reporting and supervision of junior staff, and five relate to clinical specialist areas, including maternity, operating theatres and accident and emergency. Underpinning each standard is a list of procedural areas for assessment. Since 2000, Trusts' performance against the risk standards has determined the rate of excess they pay against claims.

The Legal Services Commission

1.15 The Legal Services Commission is a new executive non-departmental body created under the Access to Justice Act 1999 to develop and administer two schemes in England and Wales. These are the Community Legal Service, which replaces the scheme of civil legal aid; and the Criminal Defence Service, which will from April 2001 replace the system of criminal legal aid.

1.16 The overall aim of the Legal Services Commission is to deliver access to justice. It funds any claimant able to satisfy its means, merits and cost-benefit tests, as set out in its funding code. In practice the majority of people who meet those criteria are either in receipt of state benefits or are children. Claims must have at least a 50 per cent chance of success, as estimated by the claimant's lawyer and satisfy cost-benefit criteria. Those criteria will generally be based on the estimate by the claimant's solicitor.

⁶ *Forty-second report, 1999-2000, recommendation (iv)*

⁷ *Clinical Negligence in the NHS in Wales, February 2001*

1.17 The Commission operates a quality assurance scheme for solicitors' offices providing legal advice to claimants. The purpose is to provide an accessible and quality assured service to clients, while at the same time delivering improved value for money for taxpayers. It involves awarding a quality mark to solicitors' offices that meet criteria for competence and management. These criteria include a requirement that the practitioner is a member of one of the two clinical negligence panels run by the Law Society and Action for Victims of Medical Accidents. From 1999, the Commission has only provided legal aid in new cases where the firm instructed has had a specialist level quality mark in clinical negligence (formerly known as a franchise). In 1999-2000 the Commission funded 7,375 new claims and had gross expenditure of £62 million for closed claims.

Developments in handling claims for clinical negligence

1.18 Since 1998, there have been important changes that affect the handling of clinical negligence claims, including:

- to improve the quality of legal advice it obtains, the Litigation Authority has appointed a panel of solicitors and then selected named partners and fee-earners within those practices. It manages claims on the basis of regular reports from its solicitors and attendance at conferences with counsel;
- the Legal Services Commission has extended its quality assurance scheme to the specialist area of clinical negligence and has made the award of a specialist quality mark (formerly a franchise) a prerequisite to receiving legal aid funding;

- in April 1999, the Woolf Reforms of the civil justice system incorporated the Pre-action Protocol for the Resolution of Clinical Disputes in court rules and procedures for the high court and county courts. The protocol aims to encourage a climate of openness when something has "gone wrong" with a patient's treatment or the patient is dissatisfied with that treatment and/or the outcome; and to increase the prospects that disputes can be resolved without resort to legal action. It provides general guidance on how a more open culture might be achieved when disputes arise. And it recommends a timed sequence of steps for claimants and healthcare providers (and their advisers) to follow when a dispute arises. If proceedings are issued, it will be for the court to decide whether non-compliance with the protocol should merit sanctions. The Lord Chancellor's Department's emerging findings of the revised court rules and procedures suggest that pre-action protocols are working well to promote settlement before issue of proceedings and are reducing the number of ill-founded claims; and
- from April 2000, the Access to Justice Act has allowed solicitors to claim a success fee when running a conditional fee agreement. This can be recovered from the losing side if the claim is successful. People ineligible to receive legal aid for financial reasons may use this facility to pursue clinical negligence claims without public funding.

Why we undertook the study

1.19 Provisions⁸ to meet the costs of clinical negligence claims have doubled from £1.3 billion in 1996-97 to £2.6 billion in 1999-2000, partly because of better accounting for such provisions, and partly because of increases in the scale of damages awarded following judgements in *Wells v Wells*⁹. Further, there is a trend towards increased litigiousness on the part of patients, as evidenced by a research finding that the rate of clinical negligence claims increased by 72 per cent in one region between 1990 and 1998.¹⁰ In his 1996 Access to Justice report, Lord Woolf stated that it was in the area of medical negligence that the civil justice system was failing most conspicuously to meet the needs of litigants in a number of aspects. In their 5th report of Session 1999-2000, the Committee of Public Accounts concluded that the system for dealing with those involved in clinical negligence claims must be cost-effective, quick, efficient, fair and humane. In addition, we established that there was little information on the total number of claims. And there was very little aggregated information about the time it takes to settle claims and the costs that have been incurred.

⁸ The accounting term for an estimate of a future settlement arising from a past event. Since the financial year 1999-2000, it indicates the likely settlement sum, discounted to show the net present value.

⁹ *Wells v Wells* (1999) 1 AC 345

¹⁰ Current cost of medical negligence in NHS hospitals: analysis of claims database, Fenn, P. Diacon, S. Gray, A. Hodges, R. and Rickman, N., *British Medical Journal* 2000; 320: 1567-1571. This states that the rate of claims per 1,000 finished consultant episodes rose from 0.6 to 1.03 between 1990 and 1998.

1.20 Clinical negligence is not just an issue for the NHS in England. It is also an issue for the National Health Services in Scotland, Wales and Northern Ireland, which have also made financial provisions to meet likely future costs. As with the NHS in England, no aggregated information has previously been available on the time and cost taken to settle claims in those countries. For this reason, as well as the different legal environments or organisational arrangements in Scotland, Wales and Northern Ireland, it has not been possible to make meaningful comparisons of the position in the four countries.

1.21 On 23 February 2001 the Auditor General for Wales published his report *Clinical Negligence in the NHS in Wales* which, for the first time, provides information on the time and cost of settling claims in that country. Where available, we have used this comparative information in our report. The Northern Ireland Audit Office is also working on a study of clinical negligence in Northern Ireland. That report is due to be published later in 2001, so has not been reflected in this report. On 18 December 2000, the Auditor General for Scotland published his report *Overview of the National Health Service in Scotland* which set out the rising trend of financial provisions to meet clinical negligence claims. His report referred to, but did not focus on, the time or cost of settling claims.

Scope and methodology

1.22 We examined:

- the number of claims, the costs of settling them and the time taken (Part 2);
- patients' access to remedies¹¹ (Part 3); and
- how patients' claims are managed (Part 4).

1.23 The study was restricted to claims against NHS hospitals in England. Many claims for clinical negligence are against general medical and dental practitioners. But we did not examine those claims because the financial consequences are not borne directly by the NHS and the NHS does not handle them.

1.24 Neither have we reviewed the merits of a no-fault compensation scheme (a scheme where personal injury victims are compensated without the requirement that they prove their injuries were the fault of somebody else). Such a scheme is supported by the British Medical Association. The government, however, opposes it on a number of grounds. It considers that the burden of proving that negligent medical treatment had caused injury should be no less than for negligence in other personal injury cases; that such schemes do not deliver what patients say they want (an explanation and an apology); and that such a scheme would encourage even greater numbers of claims, and therefore be significantly more costly than the current arrangements. As this policy is clear, we have not considered the merits of the arguments in this examination.

1.25 We were greatly assisted in the course of our study by an expert panel representing all constituencies in the field of clinical negligence, to whom we record our thanks (Appendix 3). Our methodology is set out at Appendix 1.

1.26 This report does not examine measures taken to prevent negligent incidents from happening. At the time of our study, some initiatives, such as the clinical governance programme, were underway but many strands were in their early stages of implementation. Other elements, for example the recording and reporting of adverse incidents, were being expanded. Appendix 2 summarises the main initiatives taken by the Department of Health since 1997. We plan two further studies to examine the success of these initiatives: one will look at clinical governance in hospitals, the other at clinical governance in primary care.

¹¹ In this report we have used the term "patients" to denote claimants and their representatives.

Part 2

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

2.1 This part examines:

- the number, value, type and causes of claims;
- how long claims have taken to settle;
- the costs of settlement; and
- addressing the backlog of claims.

The number, value, type and causes of claims

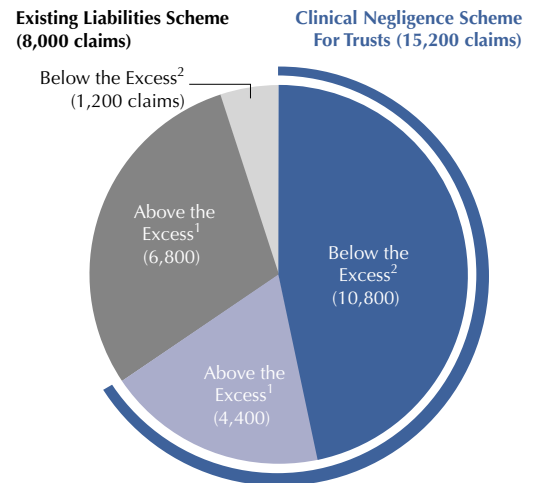
(a) Number of claims

2.2 Neither the Litigation Authority nor the Department of Health know how many claims there are at any one time. This is because individual Trusts and health authorities hold information on open claims (that is, those not yet resolved) below their excess. However, the Litigation Authority holds information on all other claims, both open and closed. Under the terms of their membership of the Clinical Negligence Scheme for Trusts, Trusts are required to provide the Litigation Authority with details of all claims they settle below their excess level but in practice this is done inconsistently. We estimate that at 31 March 2000 there were some 23,000 open claims (Figure 6) and that the NHS received 10,000 new claims for clinical negligence in 1999-2000.

(b) Value of claims

2.3 Information on the total financial provisions made for claims and the amount paid out in any one year is included in the NHS's Summarised Accounts. These accounts are prepared in accordance with accounting conventions, and show the discounted present value for all claims on an expected value basis, that is, adjusted for the probability of settlement. In 1999-2000, the Summarised Accounts¹² showed that the provision for

6 There were some 23,000 clinical negligence claims outstanding against the NHS at 31st March 2000



Source: 1. The NHS Litigation Authority
2. National Audit Office Survey of Trusts and health authorities

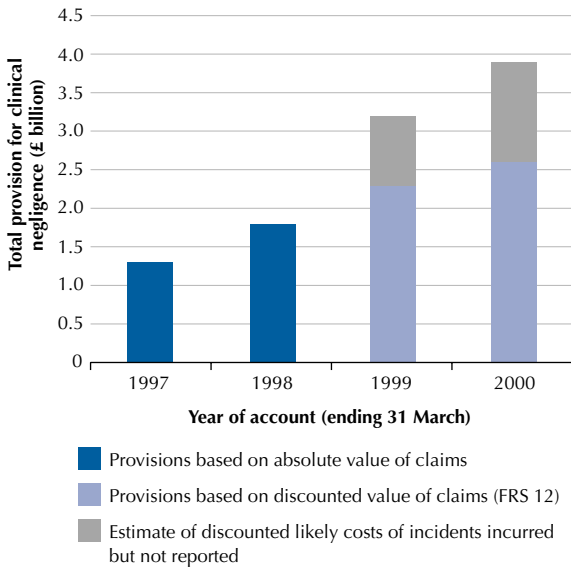
clinical negligence claims was £2.6 billion. 1999-2000 provisions to meet outstanding claims for the NHS in Scotland were £38 million, in Wales they were (including creditors) £111 million and in Northern Ireland £100 million.

2.4 The Litigation Authority's databases record the predicted settlement value of all claims it knows about. The total value of outstanding claims with a 50 per cent or higher chance of succeeding at 31 March 2000 was £4.3 billion. This figure differs from the provision in the Summarised Accounts for 1999-2000 because, in accordance with Financial Reporting Standard 12, the provisions linked to claims represent the value of claims discounted from the expected dates of settlement to their present value and is calculated on an expected value basis. It is, however, comparable with provisions for previous years, and it shows an increase of 230 per cent since 1996-97 (Figure 7).

¹² At the time of publication, the NHS Summarised Accounts for 1999-2000 were unaudited.

7 Provisions made to cover the likely costs of settling claims for clinical negligence

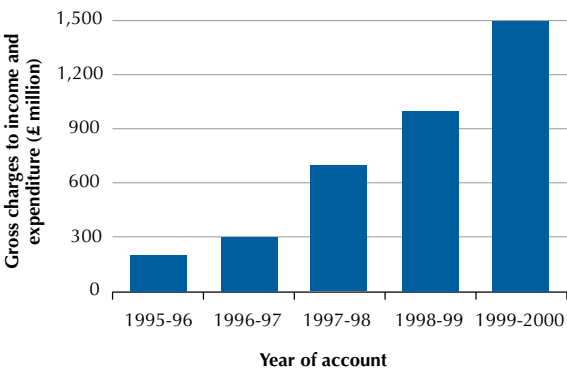
Provisions made to cover the costs of settling claims for clinical negligence doubled in the last four years.



Note: 1 The effect of Financial Reporting Standard 12 is shown in the bars for 1998-99 and 1999-2000 when it was applied to the NHS.
 2 There are no discounted estimates for incidents incurred but not reported for 1996-97 or 1997-98.

Source: Summarised Accounts for England, 1996-97 to 1999-2000.

8 Total charges to income and expenditure accounts for provisions for clinical negligence



Note: The accounts were not prepared on a comparable basis.

Source: Summarised Accounts for England, 1995-96 to 1999-2000.

2.5 Because claims can be lodged several years after the event to which they relate, the Comptroller and Auditor General's Report on the Summarised Accounts for England for 1998-99 recognised additional potential liabilities of around £1 billion. Latest actuarial estimates commissioned by the Litigation Authority suggest that these likely liabilities have now risen to £1.3 billion.

2.6 Total charges to NHS income and expenditure accounts for financial provisions to reflect the future cost of clinical negligence claims have increased very significantly from £200 million in 1995-96 to £1.5 billion in 1999-2000 (Figure 8). This increase is strongly related to the number of claims received in any one year, but it also includes increases in provisions made before a claim is settled. These usually arise as the facts of a claim become apparent or when the level of court settlements shows the need for upward adjustments in existing provisions. The 1998 judgement in *Wells v Wells*¹³ ruled that claims for future loss, including care, should assume that compensation would be invested in index-linked gilts, rather than equities. The result was that the scale of many of the larger birth-related claims against the NHS increased by between 25 per cent and 40 per cent, depending on the life expectancy of the child.

(c) Type of claims

2.7 The largest volume of claims reported to date under the Clinical Negligence Scheme for Trusts arises where claimants allege that negligence has led to a fatality. This category accounts for 14.1 per cent of all claims still unresolved at 31 May 2000. Under the Existing Liabilities Scheme the most common category of injury is that of cerebral palsy, at 16.9 per cent of all open claims, and fatalities account for only 7.4 per cent of open Existing Liabilities Scheme claims. These differences are largely explained by the fact that the Existing Liabilities Scheme is a mature scheme and the Clinical Negligence Scheme for Trusts is only five years old and will not have the full range of claims until around 2007. In particular, claims relating to brain damage and cerebral palsy will be under-represented as they can be submitted up to 21 years after the date of the incident, and in some cases there is no limitation on submission.

2.8 Claims for incidents leading to brain damage or cerebral palsy are by far the most expensive for the NHS, both for outstanding and recently closed claims. This is because if negligence is proven the amount of the settlement will take account of the cost of private education and care for the patient for the rest of their life.

13 *Wells v Wells* (1999) 1 AC 345.

2.9 The relatively small proportion of claims that are in respect of cerebral palsy and brain damage account for a high proportion of the total value of claims:

- Eleven per cent of claims closed in 1999-2000 arose from cerebral palsy or brain damage injuries;
- They accounted for 44 per cent of settlements by value; and
- For open Existing Liabilities Scheme claims, the 26 per cent of claims for cerebral palsy or brain damage injuries represented 80 per cent by value.

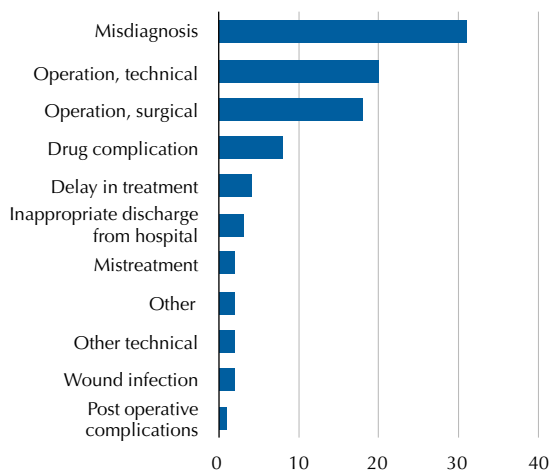
This means that the bulk of claims (89 per cent of those closed in 1999-2000 and 74 per cent of open Existing Liability Scheme claims) account for a relatively smaller proportion of the total value of claims.

(d) Causes of claims

2.10 Although the Litigation Authority holds data on the causes of incidents that lead to the claims it handles, there is no single source of information about claims managed by individual Trusts. This is one of the areas we plan to cover in our forthcoming examination of clinical governance. The Auditor General for Wales has, however, reported on the causes of claims made in Wales.

2.11 In his report "Clinical Negligence in the NHS in Wales", the Auditor General for Wales examined a sample of 94 claims relating to adverse medical incidents. This found that the most frequent alleged or admitted cause of such incidents was negligence due to misdiagnosis, which often leads to either delay in treatment or inappropriate treatment. Negligence was also often alleged or admitted to have been caused due to technical or surgical mistakes made before, during, or after the operation (Figures 9 and 10).

9 Frequency of alleged or admitted causes of clinical negligence found in Wales



Source: Auditor General for Wales, analysis of 94 claims

10 Main alleged or admitted causes of negligence in Wales, and the events leading to them

Main cause	Events contributing
Misdiagnosis	<ul style="list-style-type: none"> ■ Doctor fails to take an x-ray ■ Doctor underestimates patient's concerns ■ Failure to recognise signs of illness ■ X-rays not being read properly, or being difficult to read ■ Poor communication between clinicians
Operation, technical	<ul style="list-style-type: none"> ■ Failure to listen to the patient's requests ■ Failure to perform pre-operative checks ■ Failure to provide pre- or post-operative explanations ■ Inadequate supervision of instruments - dislodged or not removed ■ Unnecessary or inappropriate operation – in some cases due to inadequate supervision of clinicians ■ Wrong or faulty use of anaesthetic ■ Poor communication between clinicians
Operation, surgical	<ul style="list-style-type: none"> ■ Damage to organs, muscles, or nerves ■ Failure to administer appropriate drugs during operation ■ Incomplete operation ■ Poor post-operative care – pain and suffering ■ Miscommunication between patient and doctor – patient never consented to operation or failure to alert patient to risks involved
Drug complication	<ul style="list-style-type: none"> ■ Drugs administered to person with known allergies or person on known other medication ■ Drugs administered inappropriately – intravenously, orally etc. ■ No information provided to patient on side effects of medication ■ Failure to listen to patient's concerns
Delay in treatment	<ul style="list-style-type: none"> ■ Administrative error ■ Lack of continuity of care - changing of doctors and nurses
Other, technical	<ul style="list-style-type: none"> ■ Doctor/nurse misreading medical notes ■ No correct instruments available
Wound infection	<ul style="list-style-type: none"> ■ Inadequate cleansing of wound
Other	<ul style="list-style-type: none"> ■ Potential accident in the waiting room
Inappropriate discharge from hospital	<ul style="list-style-type: none"> ■ Poor communication between clinicians

Source: Auditor General for Wales, analysis of 94 claims

2.12 The National Audit Office Wales analysis also found that a significant contributor was the incidence of potentially avoidable errors by clinicians and others, associated with administrative, communications, or wider systems issues, as opposed to strictly clinical judgement or technical error. Such "non-clinical" errors ranged from breakdowns in communication – between clinicians, patients and non-clinicians – to straightforward administrative failings such as losing patient records. There was evidence in 39 of the 94 claims examined of non-clinical errors (Figure 11). And while it is not always straightforward to distinguish between clinical and non-clinical errors, the analysis suggested that within the 39 claims there were 15 cases where non-clinical errors were either the direct cause of the alleged or admitted negligence or they were the sole reason for a settlement.

Time taken to settle claims

(a) The Clinical Negligence Scheme for Trusts

2.13 The scheme covers only claims where the related incident occurred after April 1995, and has relatively few closed claims. There is therefore not yet a reliable picture of how long it takes to settle the full range of claims under the Clinical Negligence Scheme for Trusts. By May 2000, 1,153 claims had been closed, of which claimants had withdrawn 83 per cent.

(b) Existing Liabilities Scheme

2.14 The Litigation Authority's database of Existing Liabilities Scheme claims does not include reliable information about when all claims were made against Trusts or health authorities, or when they were settled. This is largely because, when the Authority took on the scheme, it was not considered essential for the future management of claims to record the date when the Trust or health authority first received the claim. The Litigation Authority was at that time a new and developing body; and the Department of Health told it that the priority of dealing with the backlog of claims took precedence over all other work. It is not possible, therefore, to calculate the precise length of time that claims have taken to settle without going back to Trusts and health authorities on a case by case basis. The database does, however, provide reliable data about when the incident giving rise to the claim occurred, and when the Litigation Authority reimbursed the Trust or health authority for money paid to patients. Using the methodology set out at Appendix 1 we estimated the average time taken from receipt of claim to settlement.

11 Analysis of non-clinical errors in Wales

Type of non-clinical error	No. of instances
Poor documentation of clinical procedures undertaken	15
Poor communication between clinicians	12
Poor communication between clinician and patient	11
Poor documentation of communications with patient	8
Inappropriate person giving advice to patient	3
Inadequate supervision of clinicians	2
Inappropriate person undertaking clinical procedure	1

Note: Some cases featured more than one type of non-clinical error.

Source: Auditor General for Wales, analysis of 94 claims

2.15 We estimate that for claims closed in 1999-2000 the average time taken from claim against the Trust or health authority to payment of damages was five and a half years, and the average total time from incident to payment of damages was just over seven years (Figure 12). Eight and a half per cent of cases where damages were paid took more than 10 years from claim to settlement. These averages exclude cases of cerebral palsy and brain damage, where claims took an average of 12.1 and 10.3 years respectively from incident to payment of damages.

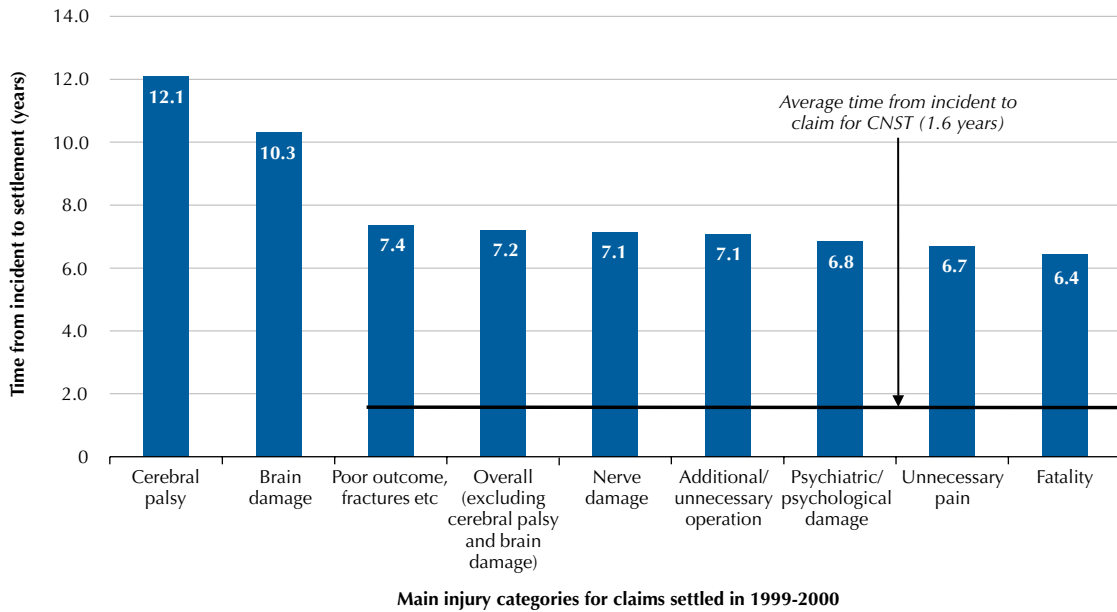
2.16 In Wales the average time from claim to payment of damages for claims closed in 1999-2000 was two and a half years.¹⁴ This figure is not directly comparable with that for England, because:

- As noted at paragraph 1.9, the Existing Liabilities Scheme covered only claims above £10,000 arising from incidents that occurred before April 1995. The Welsh figure was drawn from a sample of claims closed in 1999-2000 irrespective of the date of occurrence and comprised 78 per cent claims above £10,000 and 22 per cent below £10,000. The Litigation Authority believes that the NHS in England settles claims valued at below £10,000 more quickly than it does those valued above that figure, and therefore that, if they were included in the English calculation, the resulting average time from claim to settlement would be shorter;
- The Litigation Authority is still dealing with a backlog of old claims that were made before it was established, and were originally handled by health authorities and NHS Trusts. This means that settlements, both in 1999-2000 and in future, are likely to include a disproportionate number of claims that have been outstanding for a long time. The

¹⁴ Clinical Negligence in the NHS in Wales, February 2001, paragraph 3.31

12 Average time from claim to settlement for claims settled during 1999-2000

We estimate that, for claims closed in 1999-2000, other than those for cerebral palsy or brain damage, the average time from claim to payment of damages was just over five and a half years.



Source: National Audit Office analysis of Existing Liabilities Scheme database

presence of these long outstanding claims means that the average time taken to settle claims will be raised above the time it now takes to clear claims that have been made since the establishment of the Litigation Authority. The average age of open claims at 31 May 2000 was 8.3 years. Twenty two per cent of open claims had been open for more than 10 years; and

- The average value of settlements in 1999-2000 was £87,000 in England (excluding brain damage and cerebral palsy claims), compared with £44,000 in Wales. Higher value claims tend to require more detailed examination and analysis, and to be more vigorously contested.

2.17 The resolution of claims for clinical negligence through litigation is a complex, sensitive and adversarial process. There are a number of reasons why it can take a long time after the incident for claims to be received by the NHS. It may take the patient some time to suspect that any injury was caused by negligence. Once the person realises the injury may have been caused negligently they may pursue their suspicions through the complaints process to establish the facts of the case. The Lord Chancellor's Department and the Association of Personal Injury Lawyers have both pointed out to us that the process of fully disclosing all relevant medical records can take a long time, even with the introduction of the pre-action protocol which sets a timetable for disclosure. Some 38 per cent of Trusts with obstetrics

services told us that they do not monitor compliance with the pre-action protocol.

2.18 Under the terms of the Existing Liabilities Scheme, claims against Trusts and health authorities were initially dealt with by those bodies. From April 1996, the Litigation Authority assumed responsibility for funding settlements, but Trusts and health authorities were allowed to continue to manage claims locally without input from the Authority or its approved panel solicitors. The Litigation Authority has since become more directly involved in dealing with Existing Liabilities Scheme claims, culminating in the call in during 2000-01 of all claims under that scheme. The rate at which those claims are being closed has increased from 661 claims with a total settlement value of £50 million closed in 1997-98, to 1,400 (totalling £107 million) in 1998-99 and 3,254 (totalling £386 million) in 1999-2000.

2.19 From our survey, we estimate that Trusts and health authorities received 10,000 new claims in 1999-2000 and cleared 9,600. Trusts told us that 62 per cent of claims cleared were abandoned by the claimant or otherwise resolved without financial outcome and the remainder had a financial settlement in the patient's favour. Similarly, in Wales 60 per cent of claims closed during 1999-2000 had no payment of damages to the patient.¹⁵

The costs of settling claims

2.20 Information about the full costs of settling individual claims is not collected. For example, administrative and staff costs in the NHS are not recorded or attributed against negligence claims. Records are, however, kept of the other settlement costs including damages paid to the claimant, the costs of defence and claimants' solicitors and of obtaining expert opinions and court fees. These can be substantial. **Figure 13** illustrates the large gap between the average cost for cerebral palsy and brain damage injuries and those for all other claims. It shows that, for the very large claims, defence and claimants' costs account for a relatively small proportion of the total cost of settlement. **Figure 14** shows that in 1999-2000 the average settlement for claims other than for cerebral palsy and brain damage injuries was £87,000, of which £27,000 was for costs. For Existing Liabilities Scheme claims settled in 1999-2000, costs were greater than damages in 44 per cent of settlements (**Figure 15**).

2.21 The picture varies according to types of injury. As **Figure 15** shows, legal costs exceed damages paid to patients in more than half of all claims for several of the most common categories of injury. And, for unnecessary pain, costs exceed damages in almost two-thirds of claims. On the other hand, for some categories where settlements are substantial, such as cerebral palsy, costs exceeded damages in only six per cent of settlements. The Litigation Authority has pointed out that high costs to some extent reflect the claimant's right to go to law.

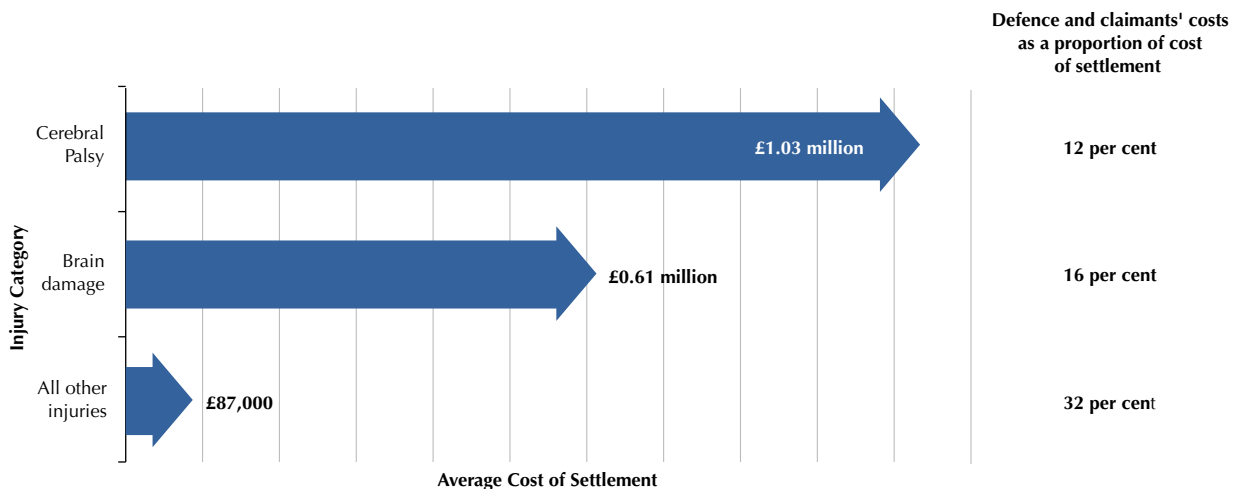
When claimants do so, the Authority is obliged to incur disbursements and legal costs to respond to those claims, whether that leads to repudiation, compromise or settlement (**Case Study 2 on page 20**).

Addressing the backlog of claims

2.22 As set out in paragraph 2.16, excluding claims for cerebral palsy and brain damage injuries, the average age of claims unresolved in the Existing Liabilities Scheme is over eight years from the incident to which they relate. Thirty one per cent of claims relate to incidents that occurred 10 years or more ago, although some claims will have been made much more recently. Resolving these old claims is clearly a key issue for both the Litigation Authority and the Legal Services Commission as both organisations would prefer an early settlement because that is what patients want, and because costs tend to increase as time goes on. But neither body can force a claimant to a resolution where the claimant wishes to delay a case, as often happens while, for example, developing their claim, or to access the appeals process. While it would be inappropriate and contrary to policy for the two bodies to review jointly cases on an individual basis, they share an interest in dealing with cases in a cost-effective and timely manner. Up to February 2001, they had not shared information about the thousand or so cases over five years old that appear to be supported by legal aid, but in the light of our work the two bodies have shared this information and are now assessing the next steps.

13 There is a large gap between the average cost of settlement of claims for cerebral palsy and brain damage and those for all other injuries

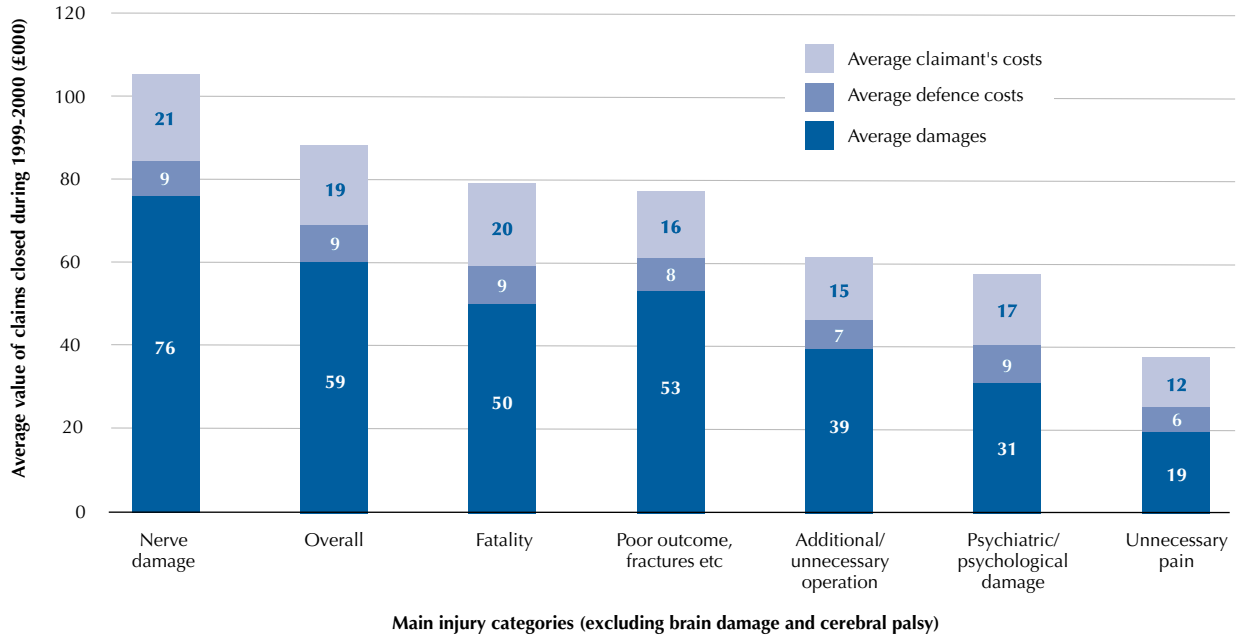
In addition to illustrating the large gap between average settlements for cerebral palsy and brain damage and those for all other injuries, this Figure demonstrates that for those large settlements, legal costs account for a relatively low proportion of the total cost of settlement



Source: National Audit Office analysis of the Existing Liabilities Scheme database.

14 Cost of settlement for claims closed during 1999-2000 (excluding brain damage and cerebral palsy claims)

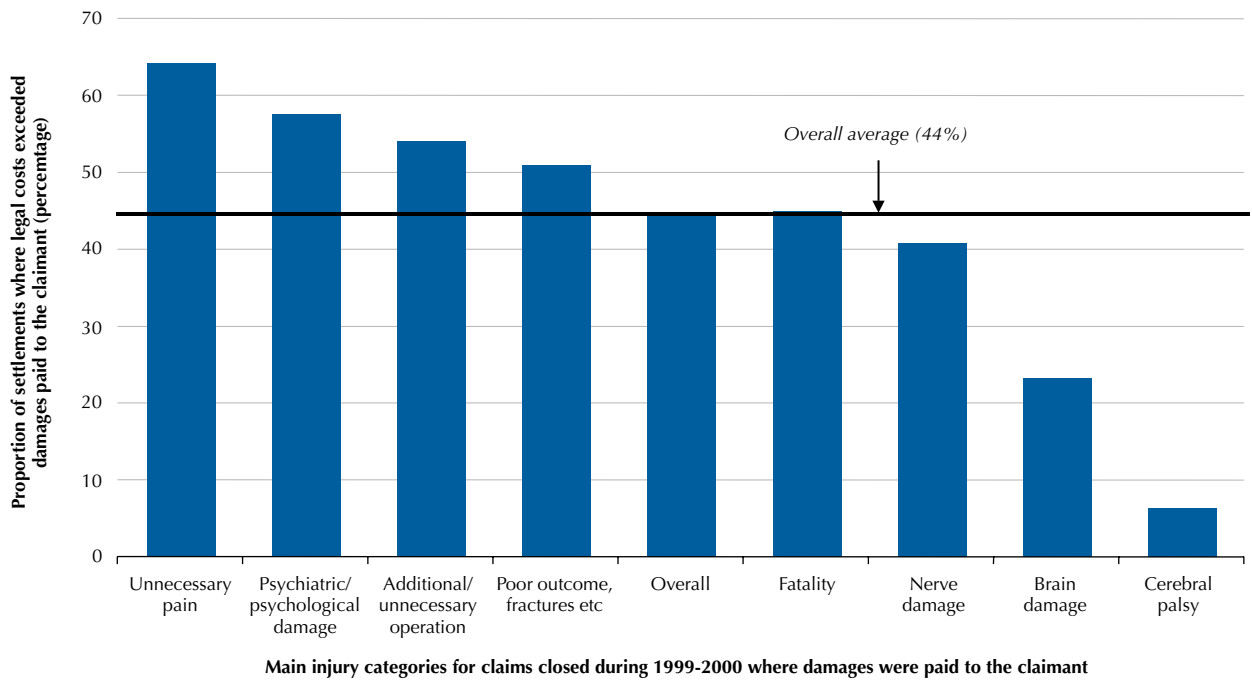
The average settlement for Existing Liabilities Scheme claims settled during 1999-2000 was £87,000 (excluding settlements for brain damage and cerebral palsy claims).



Source: National Audit Office analysis of Existing Liabilities Scheme database

15 Percentage of claims closed in 1999-2000 by injury categories, where legal costs exceed damages to claimant

Where claimants received damages in Existing Liabilities Scheme claims closed during 1999-2000, legal costs exceeded damages in 44 per cent of claims. For some categories of injury, for example unnecessary pain, this occurred in almost two-thirds of settlements.



Source: National Audit Office analysis of Existing Liabilities Scheme database

2.23 The Litigation Authority is using a smaller number of specialist solicitors to handle these claims and has, since April 2000, brought under its direct supervision many claims previously handled by Trusts and health authorities. The Authority and the panel solicitors review quarterly each claim at letter before action or any stage of litigation. They consider that these measures should promote the swifter resolution of claims. Currently, the Department of Health have not asked the Litigation Authority to come forward with action plans to address these older claims; and there are as yet no agreed targets. Following receipt of this report, however, the Department have decided to ask the Litigation Authority to review the backlog of claims on an annual basis and report to them on their findings. However, there are factors outside the control of the NHS that can cause claims to remain outstanding. For example, group litigation actions account for some hundreds of claims that cannot be closed on an individual basis. **Case Study 2** also shows an extreme example of how claims can remain open for other reasons, and illustrates the difficulties defendants can face.

2.24 Full use cannot yet be made of the material in the Litigation Authority's Clinical Negligence Scheme for Trusts database because it is immature; or of the Existing Liabilities Scheme database, because it is incomplete. From April 2001, the Litigation Authority will have complete data about all Existing Liabilities Scheme claims, and about all settlements since 1996 under both schemes. The Litigation Authority provides each Trust with a quarterly report on its Clinical Negligence Scheme for Trusts claims experience, but for the reasons given does not supply any comparative information drawn from other Trusts, or from the combined databases for the two schemes. The Authority intends eventually to provide Trusts with routine information on

claim patterns, volumes and comparisons. The Authority also provides the Medical Royal Colleges with aggregated anonymised data to inform their protocols and risk management initiatives. The scale of data thus supplied has increased following the creation of the Professional Advisory Panel.

2.25 As the Chief Medical Officer's report "An Organisation with a Memory" has pointed out, the database and associated material would also be a good source of learning and reference material for claims handlers and in preventing recurrence of adverse incidents. The Litigation Authority is working on the Chief Medical Officer's recommendations for joint education and training initiatives with the Medical Defence Organisations. Building a Safer NHS For Patients, published in April 2001, sets out the Government's plans for promoting patient safety following the Chief Medical Officer's report.

Case Study 2

Example of a long outstanding claim

A patient had a stillbirth in 1973, leading to a sub-total hysterectomy. In 1990 she began action against the health authority for damages for the loss of the prospect of children which was subsequently struck out because the claim was judged to be time-barred. This decision was then appealed, eventually successfully, and a further claim added for the cost of surrogacy treatment. An offer was made in respect of the first claim, whose refusal led to withdrawal of legal aid in 1998, though this was later reinstated. At trial the patient won judgement in respect of the first claim but this was appealed by the defendants and a further offer made out of

court and rejected. The Court of Appeal upheld the judgement and a payment was then made into court to settle the claim. At trial on quantum the award given was less than the sum paid into court, and nothing awarded in respect of the surrogacy claim. The Court of Appeal has since allowed new evidence on the surrogacy claim, and the appeal was heard and judgement was reserved in March 2001 – almost eleven years after the initial claim. During that period the claimant has instructed nine separate firms of solicitors

Source: NHS Litigation Authority

Part 3

Patients' access to remedies

- 3.1 The number and value of claims is increasing. It is likely that there are people who suffer negligent harm but do not submit a claim for damages. The Government has stated that those who are damaged as a result of negligence should be able to obtain appropriate and adequate compensation¹⁶.
- 3.2 This part of our report examines:
- how many patients suffer negligent harm;
 - how barriers to making claims might be lessened; and
 - whether litigation delivers to patients the remedies they want.

How many patients suffer negligent harm?

- 3.3 There is no direct information on the number of potential claims there are, or how this converts into actual claims. There has been only limited research in the United Kingdom on the number of negligent incidents. However, a pilot study conducted in two London hospitals found that about 10 per cent of patients admitted to acute hospitals¹⁷ experienced an adverse event, about half of which were preventable with current standards of care. The study did not, however, examine whether any of those incidents resulted from care that would be judged negligent.

How might barriers to making claims be lessened?

- 3.4 There are two sets of barriers that may deter patients who might wish to bring claims from doing so. These are where (a) patients lack information about whether they have grounds for a claim, or about how to pursue claims; and (b) they lack access to mechanisms that will deliver appropriate resolutions to their problems in a timely and efficient way. This section does not deal with those patients who may have been negligently harmed but decide not to claim because they do not wish to sue the NHS, or they are litigation averse. Barriers to making claims are not relevant to these people.

- (a) Do patients receive sufficient information from the NHS about potential claims?

Should patients be told if they have been harmed through negligence?

- 3.5 The NHS's systems for identifying and investigating adverse incidents are already providing a considerable amount of information about instances where a patient may have grounds for a clinical negligence claim. At present there is no clear guidance to staff about what NHS staff should tell patients or their representatives if the information available suggests that patients may have been harmed through negligence. There are instances where hospitals do give some indication that such may be the case. Many clinicians and claims managers want to be as open as possible but are reluctant to say anything that invites claims on the grounds that they divert resources from healthcare.

¹⁶ Memorandum responding to the Sixth Report of the Health Select Committee (1998-99 Session) on Procedures related to adverse clinical incidents and outcomes in medical care, paragraph hh

¹⁷ Adverse incidents in British hospitals: preliminary retrospective record review, Vincent, C., Neale, G., and Woloshynowych, M., *British Medical Journal* 2001; 322: 517-519.

- 3.6 NHS employees do not have a legal duty to inform patients that an adverse outcome may have occurred through negligence. But Lord Woolf pointed out, in his inquiry into the civil justice system in England and Wales, that it can be argued that such an obligation exists under common law.¹⁸ In 1997, the Litigation Authority, with the support of the Department of Health, issued a circular to all NHS bodies encouraging them to provide patients with factual explanations of, and apologies for, adverse outcomes. The General Medical Council advises doctors that, if a patient under their care has suffered serious harm through misadventure or for any other reason, the doctor should act immediately to put matters right, if that is possible, be open and honest with the patient and apologise where appropriate; the NHS should explain fully to the patient what has happened and the likely effects; and, where appropriate an apology should be offered. Admitting there has been an adverse medical incident is not the same as admitting liability for a particular claim. The Department of Health consider that admissions of liability should only be made if the conditions set by the Bolam test (paragraph 1.2) have been met, and after taking appropriate advice.
- 3.7 Patients are told where they have suffered an adverse incident and should at that stage be offered remedial healthcare. They are not told, however, if the Trust believes that they may have been harmed through negligence and they may therefore be unaware that they might have grounds for pursuing a claim. Information created for the dominant purpose of seeking legal advice or to assist with the conduct of litigation is not provided to the patient even if they ask for it. Material generated as a result of investigating adverse incidents is, however, discoverable unless it is prepared with litigation in view.
- 3.8 It is the Department of Health's policy that NHS bodies should not advise patients where there might on the face of it be grounds to believe an adverse medical event may have been due to negligence, or suggest patients seek legal advice, or admit liability. The Department take the view that medical staff and NHS managers are not able to make this judgement in particular cases on the basis simply of an internal investigation. They say that any other approach would put the NHS in a unique position before the law. Claims for clinical negligence are dealt with under the same legal framework as those for any other civil wrong, and no such obligation exists for other parties under common law.
- 3.9 The Department also take the view that taking any steps by which patients may be more inclined to consider claiming – as distinct, that is, from making it generally known that claiming is always an option for those who may feel that they have just cause – would inevitably increase further the proportion of NHS resources that is spent on payment of damages and legal costs, much of it on defending speculative claims and reducing

exaggerated ones. The Department feel it would properly be criticised if it did not do its utmost, consistent with maintaining the standards of honesty and propriety to be expected of the NHS and other public bodies, to ensure that the resources voted by Parliament for patient care are not diverted unnecessarily to defend and pay speculative claims, or those that do not meet the tests set by the courts.

- 3.10 They therefore take the view that their role in this area is to settle quickly those claims that have merit, ensuring that those affected and their carers have full access to the necessary information and to every means of redress that it is open to the NHS to offer them. They also believe, however, that their duty to ensure the optimum use of resources on behalf of all NHS patients requires them to resist strongly those claims – that is, the majority – that have no legal merit.

Does the NHS give patients information on what to do if they wish to take matters further?

- 3.11 Patients need clear guidance on the options available to them if they wish to take matters further, for example to obtain further information, obtain an apology, make a complaint, or claim compensation. At present, there is no comprehensive guidance to patients, and, as the Select Committee on Health found, the systems in place are confusing to patients and difficult to navigate¹⁹. Each option exists for a specific purpose, and no one process necessarily provides all remedies. If patients want more than one remedy:

- it is not possible to pursue a complaint that includes a claim for financial compensation through the complaints procedure, (Figure 16); and
- the claims process, because it is adversarial and focused solely on deciding financial claims, does not necessarily deliver apologies or full explanations.

(b) Do patients have access to mechanisms that will deliver appropriate resolutions to their problems in a timely and efficient way?

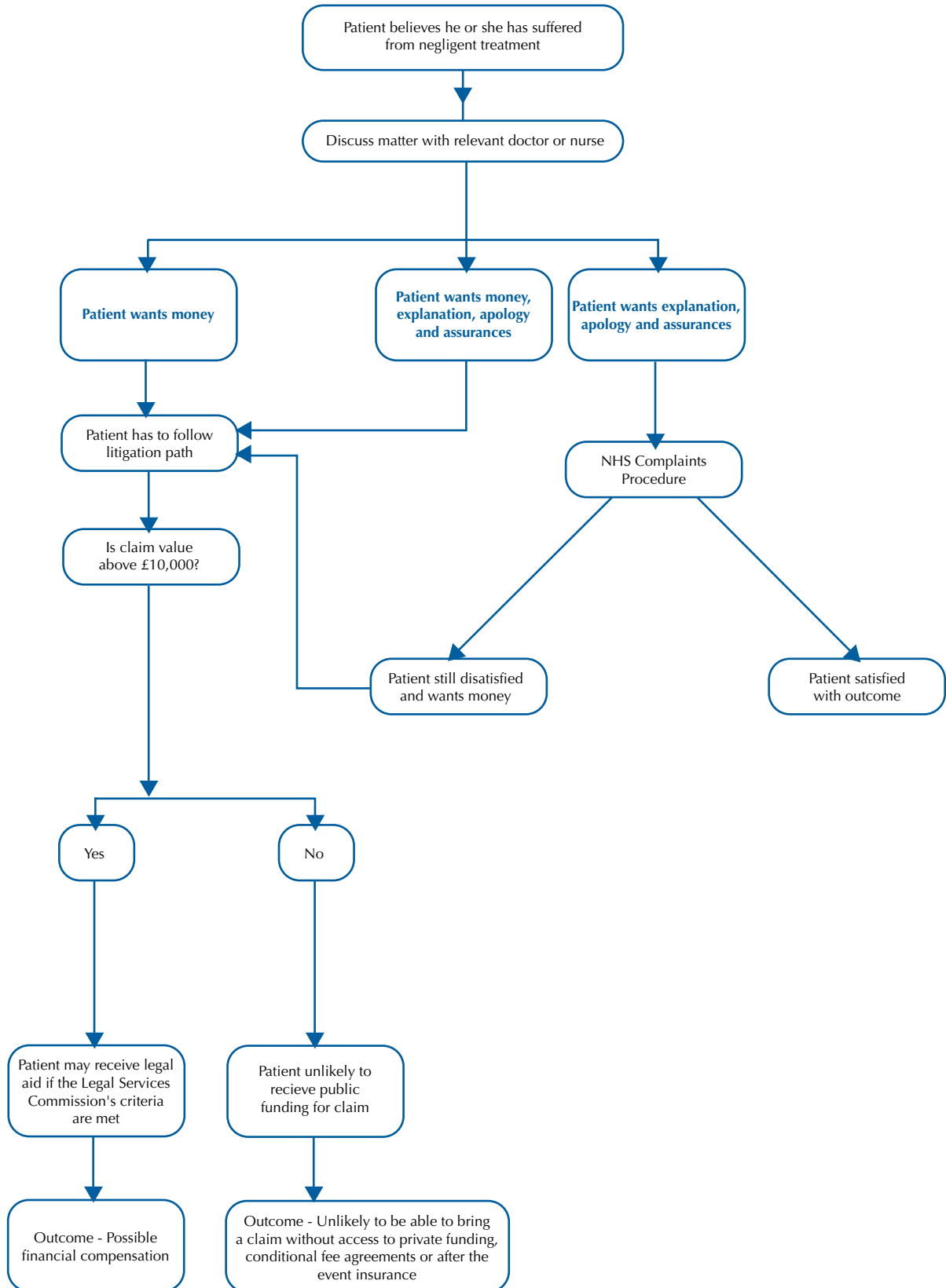
- 3.12 Clinical negligence poses particular problems when compared with other types of litigation. Distinguishing negligent harm from unavoidable outcomes or acknowledged risks when treating a patient sufficiently ill to require intervention is neither simple nor quick. It is likely that expert medical opinion will be required, along with legal expertise to measure the facts of the case against the Bolam test (paragraph 1.2). For these reasons, the legal burden of proof in cases of alleged negligence is not easily satisfied.

¹⁸ Access to Justice, Chapter 15, paragraphs 34-36

¹⁹ Health Select Committee 'Procedures related to adverse clinical incidents and outcomes in medical care', 6th Report of Session 1998-99, paragraph 72.

16 Formal routes to remedies for patients who believe they have suffered negligent treatment

The diagram shows the main avenues available to patients seeking remedies when they believe they have suffered negligent treatment in an NHS hospital. As soon as the patient expresses a desire for financial compensation they will be excluded from the NHS complaints system which excludes financial compensation as a possible outcome.



Source: National Audit Office

3.13 Patients who wish to take legal action alleging negligence may be deterred from making claims because the process is risky and expensive. Those who do wish to make claims face the demanding and proper obligation to satisfy the burden of proof referred to above (paragraph 3.12). In particular, the risks and cost of bringing legal actions are such that most people are prepared to do so only if they have legal aid. The Legal Services Commission supports 74 per cent of all claims brought. But only 48 per cent of the adult population, along with children, are eligible for legal aid for such cases. New arrangements may lead to wider use of conditional fee agreements, but litigation is an uneconomic way of resolving smaller claims.

Conditional fee agreements

3.14 In order to address this situation, and to enable claims to be made without public funding, the Lord Chancellor's Department introduced in April 2000 arrangements that are intended to make conditional fee agreements more attractive. In conditional fee agreements (no win, no fee agreements), lawyers share the risk of litigation with the client by agreeing to work without a fee if the case is lost. If successful, the lawyer is entitled to claim a success fee in addition to, and worth up to 100 per cent of, the normal fees. The solicitor assesses the level according to the prospects of success. If the claimant is unsuccessful, he will be liable to pay the defence costs. To meet this risk the claimant will be obliged to take out insurance cover.

3.15 The Lord Chancellor's Department is monitoring the success of solicitors' firms in using conditional fee agreements and the use and development of other

private litigation funding and insurance products. The Government will consider whether the availability of legal aid for clinical negligence should be ended in the light of that monitoring.

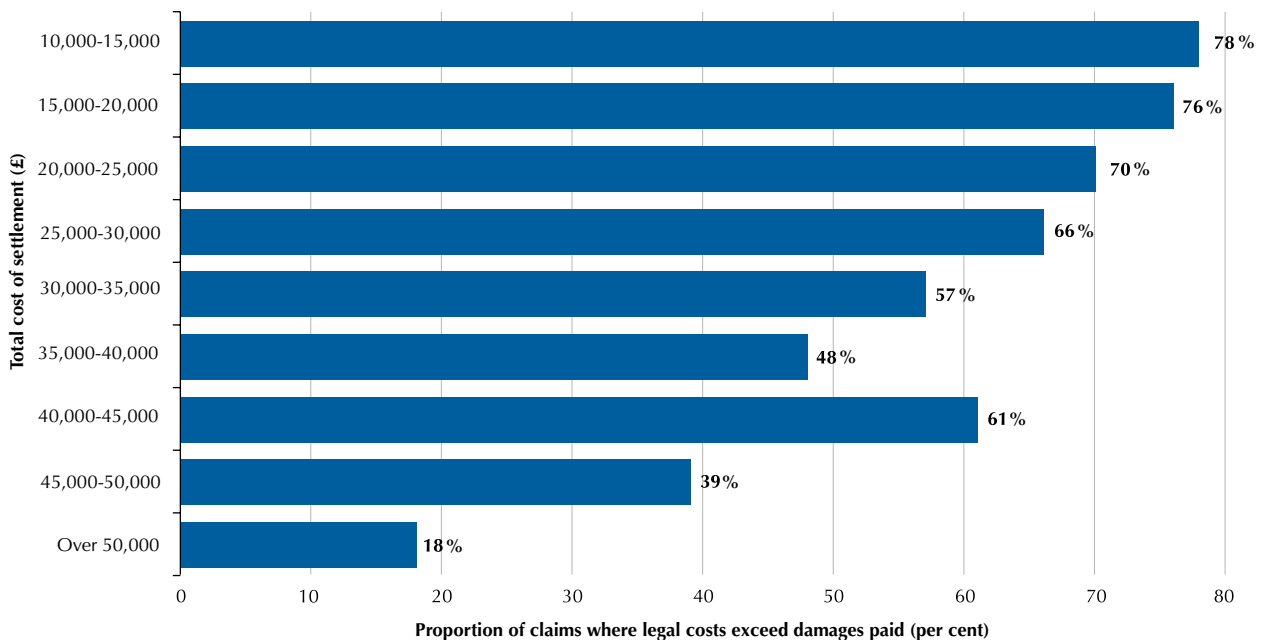
3.16 The new arrangements have been in place for only a short time, and there has not yet been any research into their impact. They could increase or decrease the volume of claims. Wider use of conditional fee agreements would remove, at a price, the risk for financially better off people who wish to make claims and could thus increase the number of claims made. On the other hand, their use is likely to lead to cases that have a lower probability of success being weeded out at an early stage. And, if solicitors prove to be risk averse (or if insurance is difficult to obtain), the number of claims may fall, although those remaining would be strong.

3.17 Conditional fee agreements pose an increased risk to the NHS. If the NHS loses a case, it will be liable to pay not only the claimant's solicitor's costs, but also the success fee and the claimant's insurance premium. And if the NHS wins, it may recover its costs. Where claims have merit, conditional fee agreements make it even more important that the NHS reach an early settlement.

Small and medium size claims

3.18 The Legal Service Commission's funding code effectively rules out supporting most clinical negligence claims under £10,000. The code states that help for claims for damages is only available where the claim is likely to exceed £5,000; and likely damages must exceed likely costs where prospects of success are 80 per cent or more. Where the prospects for success

17 The costs to the NHS of litigation frequently exceed the value of damages paid to patients



Source: National Audit Office analysis of the Existing Liabilities Scheme database.

are between 60 per cent and 80 per cent, the likely costs must be no more than two-thirds of the likely damages, and between 50 per cent and 60 per cent they must be no more than one half. Because of their complicated nature, claims for clinical negligence normally require extensive investigation before the prospects for success become clear, and conditional fee agreements do not offer a remedy for small claims.

3.19 The costs of litigation to the NHS frequently exceed the value of settlements, particularly in the case of small and medium sized claims (Figure 17). Where the NHS loses cases, it has to bear both defendants' and claimants' costs. Of claims closed in 1999-2000 where the total cost of the settlement was under £20,000, over 75 per cent cost more in amounts paid to lawyers and in other expenses than was received by claimants in damages; and, of those under £50,000, some 65 per cent cost more. As noted at paragraph 2.21, it is sometimes necessary to incur these costs in order to arrive at a fair settlement.

3.20 These factors show that litigation is an inefficient way of resolving small, and many medium size, claims for clinical negligence, except that it might discourage claims with no legal merit.

3.21 One option for handling lower value claims would be to move to a system as used by the NHS in handling complaints. Under this approach, a claim would be considered, as it is now, by the Trust. A full explanation and, if appropriate, an apology and offer of compensation would be made. Use could also be made of wider remedies (as set out at paragraphs 3.25 to 3.28). If the offer was not acceptable to the patient, they could take their claim to a regional panel who would apply the current legal criteria for determining whether clinical negligence has occurred (paragraph 1.2). That panel would be empowered to award compensation up to a given ceiling, and to recommend non-financial remedies. This system has advantages and disadvantages, and would be a significant departure in terms of practice. It would therefore require wide consultation before it was adopted.

Does litigation deliver to patients the remedy they want?

3.22 Research funded by the Department of Health²⁰ found claimants often want a wider range of remedies than litigation is designed to provide. The claims and litigation process has traditionally been adversarial and neither side usually gets all that it set out to achieve. For example, two separate studies (Figures 18 and 19) show a striking consensus about what patients say they want: compensation, an admission of fault, the prevention of

18 What claimants wanted at the start of their claims

An admission of fault	✓✓✓
To prevent recurrence	✓✓✓
An investigation	✓✓✓
An apology	✓✓
To make them understand	✓✓
To be told what happened	✓
The defence to show they care	✓
To improve quality	✓
Money	✓
To hear the other side	✓

✓✓✓ 50 per cent or more
✓✓ 40-49 per cent
✓ 30-39 per cent

Source: *Mediating medical negligence claims: an option for the future*, Mulcahy, The Stationery Office, 2000

19 People took legal action alleging clinical negligence to secure...



Source: *Why do people sue doctors? A study of patients and relatives taking legal action*, Charles Vincent, Magi Young and Angela Philips, *The Lancet*, June 1994

²⁰ *Mediating medical negligence claims: an option for the future?* Mulcahy, The Stationery Office, 2000.

future incidents and an explanation and apology. Patients perceive that they do not get the things they wanted through litigation.

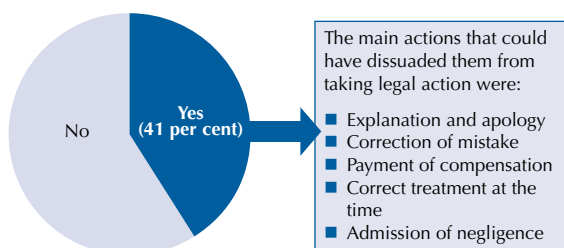
- 3.23 The Litigation Authority considers that claimants' dissatisfaction is minimised where their lawyers manage their clients' expectation of what they can realistically expect to achieve through litigation. Claimants' lawyers consider that greater openness in explanations and quicker disclosure of medical records by NHS bodies would help greatly in lessening claimants' frustration and dissatisfaction with the litigation process.
- 3.24 The Department of Health's policy is that Trusts are responsible for rectifying adverse outcomes, where possible. Some claims handlers use particular approaches to resolution that aim to deliver an outcome that satisfies more than purely financial expectations. This section of our report examines (a) the "package" approach; and (b) the use made of mediation.

(a) The "package" approach

- 3.25 There is evidence from research that offering remedies in addition to financial compensation can help avoid expensive litigation and gives greater satisfaction for the patient (Figure 20). The Litigation Authority has issued guidance promoting the giving of appropriate apologies and information. Trusts have not, however, routinely offered non-financial remedies as part of the process of settling claims. Our investigation found a number of examples where patients have been satisfied because their non-financial as well as their financial needs were addressed. We characterise this as the "package" approach.
- 3.26 The package approach addresses the claim as a clinical dispute rather than as purely a claim for money. Indeed, some claims managers see this approach as an extension of care rather than just as a legal process. The advantage is that claims managers can be creative and flexible in meeting the needs of the patient.

20 Action that could meet patients' needs and avoid litigation

The responses of patients who had taken legal action for clinical negligence to the question "once the original incident had occurred, could anything have been done which would have meant you did not feel the need to take legal action?"



Note: The research did not ask whether claimants would forgo financial remedies if all non-financial remedies were provided.

Source: *Why do people sue doctors? A study of patients and relatives taking legal action, Charles Vincent, Magi Young and Angela Phillips, The Lancet, June 1994*

Case Study 3

Application of the package approach

A patient who was due to have a series of joint replacement operations was given incorrect anaesthetic. This effectively paralysed her during the operation so she could not move or communicate, but left her completely conscious of pain for the first 30 minutes of the operation. Understandably she was traumatised by this experience, particularly given that she was facing more surgery in the future. The claims manager, with the senior anaesthetist, went to see her a few days after the incident to explain what had happened. Over the next few weeks the claims manager kept in touch with her and found out what could be done to help her situation. In this case she and her husband wanted a very detailed explanation both in laymen's terms and a full technical report. An explanation was given of what would be done to prevent recurrence and the patient revisited the operating theatre to gain reassurance of this. An additional assurance was given that in future operations the senior anaesthetist, whom the patient had come to trust, would be in attendance. When it was clear that the patient wanted compensation an offer was made to her and it was suggested that she seek legal advice, which the Trust paid for. After taking advice the patient accepted the offer of compensation. This process took a few weeks and avoided costly litigation.

As a consequence of the care she received after the incident the patient later wrote to the Trust saying that she was able to forgive them and she thanked the claims manager for the help she had received.

Source: NHS Trust

Case Study 4

Application of the package approach

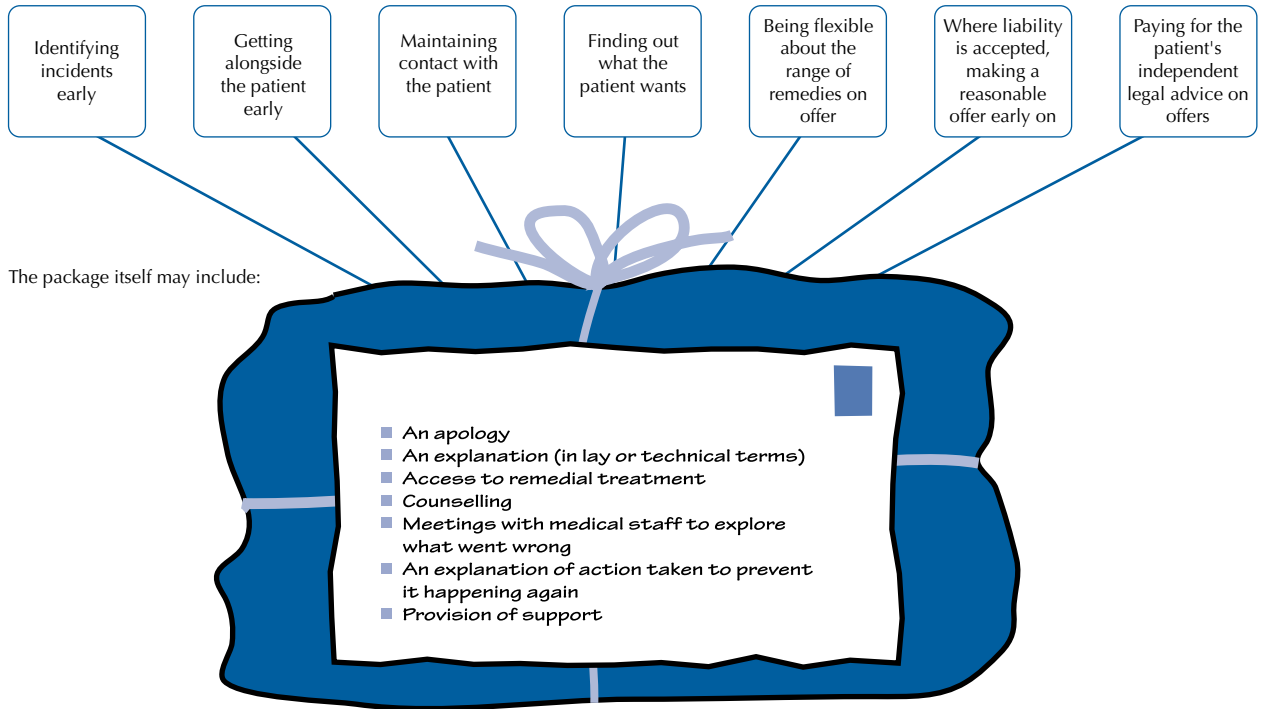
During an operation a teacher's arm was damaged negligently. The Trust, after discussion with her, organised for her to have a subsequent operation quickly, arranged for a taxi to bring her to the hospital and for childcare to be provided while she was away from home. Later on the Trust organised early physiotherapy sessions that the teacher could attend before work.

A small claim was settled quickly and the patient expressed satisfaction with the way the issue had been handled.

Source: NHS Trust

21 The package approach

Features of the package approach to resolving clinical negligence claims may include:



Source: National Audit Office

Case Studies 3 and 4 give examples. **Figure 21** sets out the elements of the package approach. This creativity would of course have to be exercised within existing legal powers and corporate governance requirements.

3.27 Our survey of Trusts found the package approach was not widely used as part of the claims process. For example, over 80 per cent of Trusts told us that, when handling claims, they rarely or never offer meetings with clinicians, offer remedial healthcare, or pay for remedial healthcare outside the Trust. There is no information on whether Trusts offered these before claims were made.

3.28 The main barriers to wider use of packages are:

- a) claimants' solicitors ask for money rather than for non-financial remedies;
- b) claims managers are not accustomed to offering packages of remedies; and
- c) providing packages of remedies requires considerable expertise on the part of local claims managers. Many lack either the training or authority to use them, or awareness of their successful use.

(b) Mediation

3.29 For some claimants, mediation might offer a satisfactory resolution of their problems. Mediation is essentially where a neutral third party intervenes to facilitate negotiation. The power to agree a solution lies with the parties rather than the mediator, who cannot impose a solution on them. Mediation is a private process that seeks to maximise the parties' interests and can take into account remedies not capable of being granted by the courts.²¹

3.30 The results of a pilot study²² highlighted a number of potential difficulties when applying the process to clinical negligence such as the tendency of solicitors to adopt unnecessarily adversarial stances and that it was not necessarily less expensive than litigation. The success of the study itself was, however, limited by low take-up of the scheme and practices within the mediation process.

3.31 Our survey shows that claims managers do not use mediation very much. Two per cent of Trusts usually offer mediation, but the rest rarely or never do. From June 2000, the Litigation Authority has required its solicitors handling claims to offer mediation wherever appropriate and to provide details of the number of

21 *Mediating medical negligence claims: an option for the future? Mulcahy, The Stationery Office, 2000 Executive Summary indent 4*

22 *Mediating medical negligence claims: an option for the future? Mulcahy, The Stationery Office, 2000*

cases they recommend for mediation and the number recommended by claimants' solicitors. So far, of those cases recommended for mediation, only 16 per cent have been accepted as suitable by the claimants' solicitors. The Legal Services Commission's funding code states that, if mediation is offered, and is rejected by the claimant, their legal adviser must be able to justify the refusal, otherwise funding may be refused or discontinued.

3.32 Mediation is not suitable in every case. For example, it is unlikely to be appropriate in cases where damages are likely to be high, such as brain damaged baby cases, where the point at issue is a point of law, or where there simply is no real case. And the incentive to mediate can be low where either party feels it has a strong case. In addition, mediation is not necessarily a cheap option. The pilot study indicated that costs were on a par with, or were greater than, those for the normal litigation process although this was based on the small number of claims examined. It also noted that it is important for there to be an equality of information; and that this is particularly difficult to achieve in clinical negligence cases, as most of the information and expert opinion resides in the NHS. However, claimants frequently seek their own independent opinions from medical experts, who may also work in the NHS.

3.33 In March 2001, the Lord Chancellor announced that, in future, Government departments will only go to court as a last resort. The Lord Chancellor's Department published a formal pledge committing Government departments to settle legal cases by alternative dispute resolution techniques whenever the other side agrees to it.



Part 4

Managing patients' claims

4.1 This part of our report examines:

- the way the NHS organises its handling of claims from patients;
- options for delivering improved claims handling; and
- how the Legal Services Commission and the NHS Litigation Authority select and manage their solicitors.

How does the NHS organise its handling of claims from patients?

4.2 Claims handling within the NHS is organised in different ways for the Existing Liabilities Scheme and the Clinical Negligence Scheme for Trusts. From April 2000, the Litigation Authority started to call in and handle all open claims under the Existing Liabilities Scheme. The Authority effectively completed the call-in by the end of

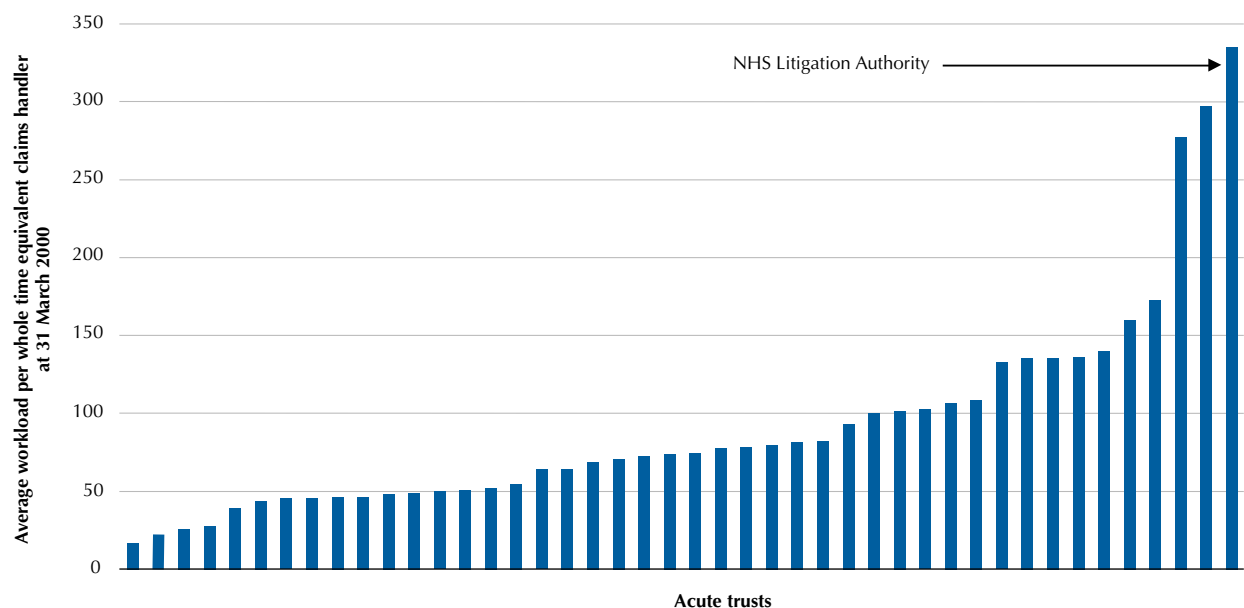
the 2000-01 financial year. Under the Clinical Negligence Scheme for Trusts, the Litigation Authority handles all claims above Trusts' excess levels. Trusts handle the rest, although support and guidance from the Litigation Authority is available.

4.3 The extent of Trusts' involvement depends on local policy and requirements. Some acquire in-house legal and other expertise and retain management of claims; some employ external solicitors and retain management of claims; and others employ external solicitors to provide legal advice and to manage claims.

4.4 We estimate that at March 2000 the Litigation Authority was handling about 42 per cent of clinical negligence claims made against the NHS. The remainder, including many low value claims, were handled by Trusts. Some Trusts handle low volumes of claims; because of this many claims handlers are not in a position to develop expertise (Figure 22). In addition, the costs of handling

22 Open claims per whole time equivalent claims handler at 31 March 2000

For acute trusts the comparable workload of open claims per whole time equivalent claims handler ranges from 17 to 297 claims per handler. At the NHS Litigation Authority the comparable figure is 335 claims per handler.



Source: National Audit Office survey of Trusts

claims at Trusts are higher because economies of scale are not achieved (Figure 23). These factors point to the need for a reorganisation of the claims handling functions currently carried out at Trusts.

23 Claims handling workload

	NHS Litigation Authority	NHS Acute Trusts with obstetrics and gynaecological services	Other Trusts
Number of claims handlers (whole time equivalent)	16	248	41
Average number of open claims per claims handler	335	74	12
Total cost of handling Clinical Negligence Scheme for Trusts claims	£1.1 million	£5.6 million	£1 million

Source: National Audit Office survey of Trusts and NHS Litigation Authority

Options for delivering improved claims handling

4.5 The Department of Health are about to examine the organisation of claims handling for claims under the Clinical Negligence Scheme for Trusts. The main models for the future handling of claims are:

- Present system: each Trust handles all claims against it, up to its excess. The Litigation Authority handles all claims above Trusts' excesses.
- Central control of all claims: this would focus on the strengths of the current system.
- Dealing centrally with all claims above a specified value: this model could set a standard claim value, above which the Litigation Authority would deal with all claims, and below which Trusts would deal with all claims, regardless of individual Trusts' excess levels. It would lead to consistent treatment of all claims above the specified value.
- Local claims consortia: under this model, Trusts would combine for the purpose of funding and managing a joint claims handling service. This would concentrate local expertise without breaking the local link.

- Agency arrangements: this arrangement represents a variation on the consortium model. In this case, a Trust would provide other, probably neighbouring, Trusts with a claims management service. Although the local link would not be intact, this model would also have the merit of concentrating local expertise.

4.6 Key issues in considering those options are:

- the need to provide financial incentives for Trusts to reduce incidents involving negligence (this is absent if they do not pay for them);
- if a central or regional organisation is chosen, how to manage those aspects of claims handling that are best performed at local level, including providing non-financial remedies; how to deliver the necessary local work on evidence gathering, investigations, liaison with clinicians and disclosure of records; and how to integrate claims handling into local clinical governance structures. Protocols for all local work and information fed back from a central body would address these concerns, as they do for Existing Liabilities Scheme and Clinical Negligence Scheme for Trusts claims managed centrally;
- the cost-effectiveness of a particular pattern of claims handling;
- the need for effective communication between the Litigation Authority and Trusts; and
- the need for consistent treatment of claims.

How do the Legal Services Commission and the NHS Litigation Authority select and manage their solicitors?

4.7 Solicitors are generally responsible for much more than the provision of legal advice. They can play a key role in the day to day management of cases. The quality and timeliness of their work therefore can have a direct bearing on how long a case takes, its outcome and its cost. The cost of legal advice to both claimant and the NHS is considerable, frequently greater than the value of the settlement (paragraphs 2.20 and 2.21). It is therefore essential that the Legal Services Commission and the NHS select legal advisers who will provide an expert service; and manage those advisers effectively to ensure that claims are settled fairly within a reasonable time, and total costs are kept under control.

The Legal Services Commission

4.8 In 1996-97, the total net cost to the Legal Services Commission of clinical negligence was £27 million. The Legal Services Commission considered the success rate unacceptably low, with 51 per cent of claims being abandoned after the initial investigation and less than half of the remainder resulting in agreement to pay or an award of damages. And they also had concerns about rising average costs. In response to such failings, the Legal Services Commission have taken steps to improve the quality of legal advisers.

Selection of legal advisers

4.9 Legal advisers applying to the Legal Services Commission for funding to pursue claims provide the crucial initial assessment of the legal merits of a claim. That assessment determines whether the Commission will support a case, and thus commits it to a stream of expenditure. The Commission also aim to secure good quality legal advice for recipients of legal aid. They therefore need assurance that the firms providing advice on clinical negligence claims are competent to do so.

4.10 Up to February 1999, any solicitor with a practising certificate, a legal aid account number and eligible clients could undertake clinical negligence work regardless of experience or expertise. The Legal Services Commission considered that this arrangement did not secure good quality legal advice for all recipients of legal aid.

4.11 From August 1999, as part of wider reforms of the legal aid system, the Commission have restricted their funding of new clinical negligence claims to solicitors' offices that have acceptable quality standards. They have done so by extending their quality assurance scheme to clinical negligence. The purpose of the Quality Mark (formerly franchising) Scheme is to provide an accessible and quality assured service to clients, while at the same time delivering improved value for money for taxpayers. It involves accrediting solicitors' offices that meet criteria for competence and management standards, and restricting legal aid-supported clinical negligence work to those offices.

4.12 At August 2000, 253 solicitors' offices had full franchises for clinical negligence, 25 had temporary franchise licences, nine were at various stages of the application process and 24 had been rejected or had withdrawn. Although other firms were still active on claims that had started before August 1999, this level of participation represents a substantial reduction from 1996-97, when 3,261 solicitors submitted clinical negligence bills to the Legal Services Commission.

4.13 The results of the increasing concentration of work on solicitors who were members of the Action for Victims of

Medical Accidents or Law Society clinical negligence panels can be seen in the results of cases closed during 1996-97 and 1999-2000, the first full year when the Legal Services Commission's clinical negligence franchise was in operation. **Figure 24** shows that there was an increase in the proportion of claims that were found to lack legal merit, and were discontinued after the initial investigation, from 51 per cent in 1996-97 to 60 per cent in 1999-2000. In addition, there have been improvements in the success rate for claims that proceeded beyond the initial investigation. Sixty one per cent of such claims were successful in cases closed in 1999-2000 compared with 46 per cent in 1996-97.

Management and monitoring

4.14 To gain assurance that franchised firms are maintaining standards, the Legal Services Commission monitor the performance of solicitors receiving public funding to pursue claims. They do so by conducting audits of the effectiveness of firms' systems and controls, and monitoring the work done.

4.15 The franchising (now Quality Mark) scheme envisages the Commission carrying out a post-franchise audit within a year of awarding the franchise, and annually thereafter. This covers management standards and a review of files against transaction criteria. The file review is a formalised process requiring measurable answers to 83 multi-part questions (the transaction criteria) in respect of at least five files. The results are available to the solicitors concerned.

4.16 At present, the programme is running behind timetable. The pressure of other legal aid reforms has meant that other aspects of the Commission's work have had to take priority. Of the 158 firms that obtained their franchise by April 1999, the Commission had audited only 87 by April 2000, although they planned to deal with the backlog by 2001.

4.17 The Commission monitor franchise holders' performance against two aspects of work (administration and competence) and firms are expected to be better than the average in their geographical area. The measure of performance is the proportion of each firm's applications for legal aid certificates that the Commission reject because they contain insufficient information (administration measure) or because the case is insufficiently strong (competence measure). The Commission recognise that, now all new work is undertaken by quality assured solicitors, it is unrealistic to retain targets that require firms to beat the average. They intend to set absolute targets from April 2001, and to incorporate targets in their contracts with firms, but expect this process to take longer because of the amount of data they will need to collect to establish appropriate standards.

24 The Legal Services Commission's franchising and quality mark programmes have led to improvements in the success rates of legally-aided claims

The Legal Services Commission's franchising programme whereby only competent solicitors could act in clinical negligence claims has led to improvements in the success rate for claims and an increase in the proportion of claims not pursued after the initial investigation. Some 61 per cent of litigated claims were successful in cases closed in 1999-2000 compared with 46 per cent in 1996-97, and the proportion of claims not proceeding to litigation rose from 51 per cent to 60 per cent.

Outcome of Claim	1996-97 ¹			1999-2000		
	Law Society/ AVMA panel members	Non-panel members	Total	Franchise holders	Non-franchise holders	Total
Total volume of claims	2,632	8,777	11,409	3,296	5,821	9,117
Not pursued beyond initial investigation	46%	52%	51%	59%	60%	60%
Claims proceeding to litigation ²	1,411	4,184	5,595	1,339	2,306	3,645
Successful in litigation (as a proportion of all claims)	31%	20%	23%	27%	23%	24%
Unsuccessful in litigation (as a proportion of all claims)	22%	28%	26%	14%	17%	16%
Successful in litigation (as a proportion of litigated claims)	58%	42%	46%	65%	58%	61%

¹ A figure of 17 per cent has been widely quoted as the success rate for claims closed in 1996-97. Comparable figures for cases closed in 1999-2000 are not yet available, but for cases where results were reported during the year the proportion which was settled with costs in full or which resulted in a judgement in favour including costs and/or damages was 24 per cent, compared with 23 per cent in 1996-97.

² Litigation refers to those claims that proceeded with a legal aid certificate beyond the initial investigation of the claim.

Source: Legal Services Commission

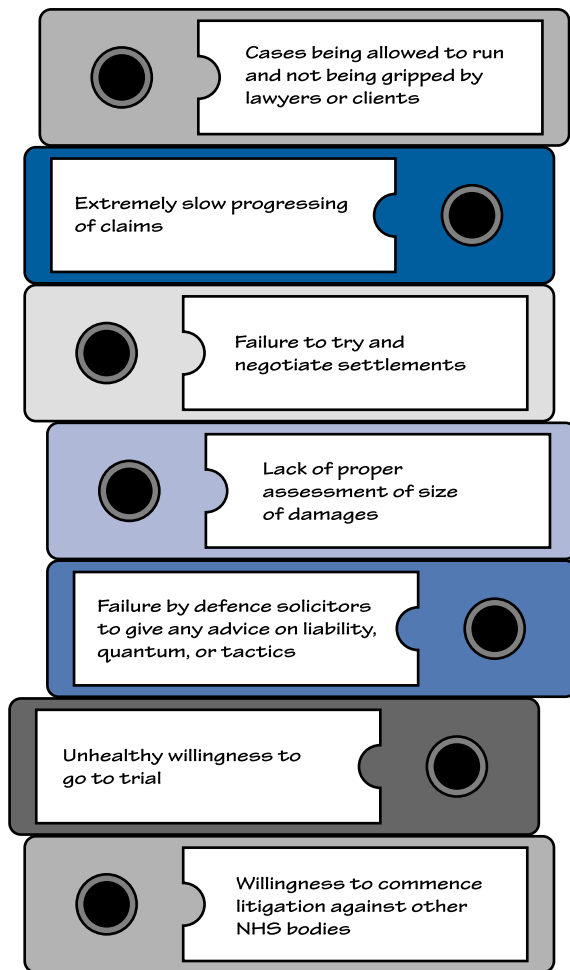
4.18 The Legal Services Commission do not set targets to control the time taken to conclude individual cases. They intend that case duration will feature in the mix of performance measures they will develop. But they point out that direct control over the management of individual cases is necessarily handed to their specialist solicitors, because they believe that they are best placed to advise on how and when to conclude individual cases.

The NHS Litigation Authority

Selection of legal advisers

4.19 Before the establishment of the Litigation Authority, each health authority or Trust (or grouping of those bodies) appointed its own legal advisers. In 1996, the newly created Litigation Authority reviewed the quality of legal services being received by Trusts and health authorities. At that time, approaching 100 firms were providing advice to the NHS. Practice varied across those legal advisers, as did the quality of advice they offered. **Figure 25** sets out common problems the Authority found.

25 Common problems the NHS Litigation Authority found in inherited claim files



Source: NHS Litigation Authority Report, 1996

4.20 The Authority took two major measures to deal with problems presented by the number and variability of firms. It appointed "gatekeeper" solicitors while recruiting staff and, later, a panel of legal advisers.

(a) Gatekeepers

4.21 In 1996, the Litigation Authority appointed Trowers & Hamblins solicitors as gatekeeper to the Existing Liabilities Scheme. Their role was to review proposed settlements and legal defence strategies on behalf of the Authority and was equivalent to a loss adjuster rather than a second solicitor for the claim.

4.22 Later in 1996, the Authority assessed the gatekeeping abilities of five invited solicitors, including Trowers & Hamblins, by evaluating how they handled claims on a pilot basis. Following this evaluation, Trowers & Hamblins and three other solicitors were appointed as gatekeepers by March 1997. The total value of the gatekeeping work in the three years 1997-98 to 1999-2000 was some £15 million.

(b) The panel of legal advisers

4.23 The Authority concluded that it could only fulfil its statutory obligations by taking firmer control of the litigation process. It therefore decided to create a panel of legal advisers to be instructed on all future claims under the Clinical Negligence Scheme for Trusts. In early 1998, after a formal selection process, the Authority appointed 18 solicitors (later reduced to 16 by withdrawals) initially for three years from April 1998. Selection was based on qualitative factors. Competition on cost was not the key factor, although the Authority did consider further the position of any firms that were markedly more or less expensive than their competitors. From April 1998, only panel solicitors have been instructed on all new cases that require them, including those covered by the Existing Liabilities Scheme. In late 2000, the Authority carried out a review of the panel firms, with the result that 15 firms of solicitors were appointed to the panel effective from April 2001.

Management and monitoring

4.24 The NHS Litigation Authority has a protocol for the provision of legal services that specifies how the panel solicitors should operate. This sets out such matters as the extent to which the solicitors should consult and report to the Authority; what action they should take; how quickly they should respond at various stages of the litigation process; and invoicing arrangements. The Authority has three approaches to monitoring the work and quality of its legal advisers: through use of its gatekeepers (paragraph 4.25); by rating the performance of firms, and of partners and fee-earners within those firms, on individual cases (paragraph 4.26); and by conducting audits of panel solicitors (paragraph 4.27).

4.25 The gatekeepers monitored performance of the legal advisers employed by Trusts and health authorities and provided reports to the Authority on a case by case basis. In addition, they reported to the Authority's board on progress and on the quality of defence solicitors' work.

4.26 The Litigation Authority started to monitor directly the performance of its panel of legal advisers in late 1999. It required its claims handlers to mark each case against five heads: communication, investigation, handling, estimating/quantum and negotiation/settlement. The absence of objective measurable criteria meant that

there was a strong element of subjectivity in the judgements. The Litigation Authority considers that some of the hard numeric criteria that a commercial insurer might use to measure solicitors' performance might not be appropriate. This is because, as well as being required to defend unjustified actions robustly, the Authority has the objective of ensuring that, where clinical negligence has occurred, patients have appropriate access to remedies.

4.27 The Authority used the results to initiate a series of audits of their panel and gatekeeping solicitors. Some firms have been confirmed as working effectively, and others have been asked to remove named partners from the work, and to make other improvements to their operations. The Authority sees this audit work as part of a continuing and evolving panel management process.

4.28 One enhancement to this process would be to make greater use of quantitative information from the Litigation Authority's database. The information could be used to benchmark solicitors' performance and set targets, and as a basis for targeting audits on those performing poorly. For example, the Litigation Authority has information about individual firms' performance regarding:

- the average time from incident to settlement;
- the average time from claim to settlement;
- the average settlement cost as a proportion of solicitors' original estimate (reserve);
- the defence legal costs as a proportion of damages; and
- the average settlement value for comparable claims.



Appendix 1

Methodology

- 1 We used a variety of methods to collect evidence for this study. The methods were chosen to:
 - provide a mix of qualitative and quantitative data on the arrangements for and outcome of clinical negligence claims handling in the NHS;
 - allow us to obtain examples of good practice; and
 - allow us to compare the arrangements the Legal Services Commission and the NHS have for selecting and monitoring solicitors.

Survey of Trusts and health authorities

- 2 In our preliminary study, we developed our survey questionnaire in consultation with the Department of Health, the NHS Litigation Authority and members of our reference panel and piloted the questionnaire by sending it to 30 NHS organisations. We analysed the preliminary results and agreed with the Department of Health a sample size, and the use to which we might put that sample.
- 3 For the full study we sent the survey to 57 Trusts with obstetrics and gynaecological services, 18 Trusts without such services and 24 health authorities.
- 4 The survey collected data on
 - the number of claims handled by the NHS body;
 - how the Trust managed claims;
 - outcomes of claims against the NHS body;
 - the timeliness of settlements;
 - the costs of managing claims;
 - solicitors used in defending claims; and
 - accountability.
- 5 All recipients returned the survey.

Analysis of databases

- 6 The prime analysis was of two databases of claims held by the NHS Litigation Authority. The first contains information on all claims closed since 1 April 1995 for events occurring before that date - Existing Liabilities Scheme claims. It also contains information under the same categories for all Existing Liability Scheme claims that have been notified to the Litigation Authority, although the Authority believes that set of records to be incomplete as Trusts and health authorities have not been required to notify all existing claims to it.

- 7 The second database held by the Litigation Authority contains all claims reported to it under the Clinical Negligence Scheme for Trusts, that is, for incidents since 1 April 1995.
- 8 Both databases contain information on:
 - details of the injury and hospital;
 - dates of incident, payments, estimates and latest action;
 - value of the claim;
 - claims handlers and solicitors involved; and
 - liability of the various NHS organisations involved.
- 9 Linda Mulcahy of Birkbeck College, University of London, provided a third database. This was collected to support her research into the use of mediation in the NHS, published in January 2000. We are very grateful to Linda Mulcahy, Marie Selwood, Lee Summerfield and Ann Netten for the use of this database.

Estimation of the time taken from receipt of claim under the Existing Liabilities Scheme to settlement

- 10 The Litigation Authority's database of Existing Liabilities Scheme claims does not include reliable information about when all claims were made against Trusts or health authorities, or when they were settled with a payment of damages to the patient. So it is not possible to calculate the precise length of time that those claims have taken to settle. The database does, however, provide reliable data about when the incident giving rise to the claim occurred and when the Litigation Authority reimbursed the Trust or health authority for money paid to patients. Excluding claims for brain damage or cerebral palsy injuries (as these are recognised as taking longer for the claim to be made and for it to be settled), we estimated the average time from claim to settlement by:
 - **calculating the average time from incident to reimbursement.** We analysed the 2,394 claims where reimbursement was made in 1999-2000. The average was 7.9 years.

- **estimating the average time between incident and claim.** We did this by calculating the average time between incident and claim for the 1,610 claims against the Clinical Negligence Scheme for Trusts arising from incidents occurring in 1995-96, the first year of the Scheme's operation. We used Clinical Negligence Scheme for Trusts data because there is no evidence that the claims pattern differed from that under the Existing Liabilities Scheme. And we based our estimate on claims that arose from incidents in 1995-96 because that yielded the most mature and complete claims history available under the Scheme. The average was 1.6 years.
- **estimating the average time from settlement of claim to the Litigation Authority reimbursing the Trust or health authority.** We calculated the average time for the 1,337 Existing Liabilities Scheme cases where the database records both dates. The average was 0.7 years.
- **deducting the estimated average time from incident to claim and from settlement to reimbursement from the average time from incident to reimbursement.** This yielded an estimated time from claim to settlement of 5.6 years, for Existing Liabilities Scheme claims other than those for brain damage or cerebral palsy.

Case studies

- 11 As part of the survey we asked Trusts and health authorities to identify what they believed to be good practice in claims handling, with special reference to improving the timeliness and cost-effectiveness of settlements. We visited certain Trusts to document examples of good practice. We also followed up recommendations from our expert panel, the NHS Litigation Authority and the Legal Services Commission.

Visits to NHS Trusts

- 12 We visited a number of NHS Trusts to pilot the questionnaire survey, follow up good practice and observe the local requirements of claims handling. The Trusts visited were:

- Brighton Healthcare NHS Trust
- Harrogate NHS Trust
- North West London Hospitals NHS Trust
- Oxford Radcliffe Hospitals NHS Trust
- Peterborough Hospitals NHS Trust
- Pinderfields and Pontefract NHS Trust
- Royal Brompton and Harefield NHS Trust
- United Leeds Teaching Hospitals NHS Trust
- Walsgrave NHS Trust, Coventry
- Worcester Acute Hospitals NHS Trust

We are very grateful to all NHS staff who made time to talk to us, including the many who were only contacted by telephone.

Discussions with interested parties

- 13 We had regular comments from and discussions with the main subjects of this report: the Department of Health, the NHS Litigation Authority, the Lord Chancellor's Department and the Legal Services Commission. In addition we held discussions with Action for Victims of Medical Accidents and the Association of Litigation and Risk Management.
- 14 We also sought and received written submissions from defence solicitors, claimants' solicitors and organisations that represent claimants.

Appendix 2

The Department of Health's initiatives to improve clinical governance

1997	The Clinical Negligence Scheme for Trusts introduced risk management standards.
1999	The Health Act, 1999 placed a statutory duty of quality on NHS Trusts and Primary Care Trusts and set up the Commission for Health Improvement.
1999-2000	Implementation of the clinical governance initiative began. This comprises a system of steps and procedures adopted by the NHS to ensure that patients receive the highest possible quality of care.
2000	The Commission for Health Improvement started to operate. Its aim is to improve the quality of patient care in the NHS across England and Wales, by carrying out clinical governance reviews at NHS Trusts and health authorities.
2000	The National Institute for Clinical Excellence started to operate. Its purpose is to define national standards.
2000	The Chief Medical Officer's working party on learning from adverse events recommended introducing a mandatory reporting scheme for adverse health care events and specified near misses, and undertaking a programme of basic research into adverse health care events in the NHS.
2001	The National Clinical Assessment Authority started to operate. It is a Special Health Authority to which NHS organisations can refer doctors for assessment, advice and support where concern has been raised about clinical performance.

Appendix 3

Our expert panel

We set up a reference panel to help us with our work. This consisted of:

Paul Balen, freethcartwright solicitors (claimants' lawyers)

Jane Chapman, Association of Litigation and Risk Management

Professor Paul Fenn, University of Nottingham

Bertie Leigh, Hempsons solicitors (defence lawyers)

Professor Mark Mildred, Nottingham Trent University

Dr Alastair Scotland, Clinical Disputes Forum

Arnold Simanowitz, Action for Victims of Medical Accidents

Surgeon Captain Jim Sykes, Academy of Medical Royal Colleges

Dr Christine Tomkins, Medical Defence Union

Glossary

Adverse health care event	An event or omission arising during clinical care and causing physical or psychological injury to a patient
Bolam test	The legal standard for establishing liability for medical negligence. The test affords a defence to a clinician "if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art".
Claim	A request for remedies following a perceived adverse outcome which includes an explicit claim for financial compensation
Claim value	The latest estimate of the sum that would be paid if the defence against the claim were unsuccessful. Usually provided for the NHS by defence solicitors.
Clinical Negligence Scheme for Trusts	This was introduced in 1995 as a voluntary scheme to limit the liability of member Trusts for clinical negligence claims where the incident occurred after March 1995. Trusts fund the scheme by paying the equivalent of premiums, and in return receive assistance with the costs of cases above a certain amount – their 'excess'.
Complaint	A request for remedies following a perceived adverse outcome which does not include a request for financial compensation
Conditional Fee Agreement (also known as 'no win/no fee agreements')	Lawyers share the risk of litigation with the client by agreeing to work without a fee if the case is lost. If successful, the lawyer is entitled to claim a success fee in addition to, and worth up to 100 per cent of, the normal fees. If the claimant is unsuccessful, he will be liable to pay the defence costs. To meet this risk the claimant will be obliged to take out insurance cover.
Existing Liabilities Scheme	This scheme covers all NHS bodies' liabilities for each claim for incidents that occurred before April 1995, and is funded by the Department of Health. Up to 1 April 2000 it covered only those claims with a settlement value of over £10,000.
Gatekeeper solicitor	A solicitor appointed by the NHS Litigation Authority to review proposed settlements and legal defence strategies on behalf of the Authority for claims under the Existing Liabilities Scheme. Their role was equivalent to that of a loss adjuster rather than a second solicitor for the claim.
Legal aid	Government funding for the provision of legal advice where the applicant and their case meet the qualifying criteria. From 1 April 2000 'legal help' and 'legal representation' replaced legal aid. The phrase 'legal aid' in this report refers to public funding for claims alleging clinical negligence.
Legal Aid Board	From 1 April 2000, the Legal Services Commission replaced the Legal Aid Board. For the purposes of this report the two organisations are regarded as identical.
Panel solicitor	From 1 April 1998 the NHS Litigation Authority appointed a panel of solicitors who would act in all new claims under the Clinical Negligence Scheme for Trusts where legal advice is required.
Patient	For the purposes of this report, 'patient' includes individuals who may make claims on their own behalf and also those seeking damages on behalf of another, for example, a minor or person with mental incapacity.
Provision	The accounting term for an estimate of a future settlement arising from a past event. Since the 1999-2000 financial year, it indicates the likely settlement sum, discounted to show the net present value.
Reimbursement	If a claim has been settled with payment of damages to the claimant, the NHS body will usually be entitled to funding from the Existing Liabilities Scheme or the Clinical Negligence Scheme for Trusts. The timing of this reimbursement is dependent on when the NHS body asks for the funding.

Settlement

Claims alleging clinical negligence do not always result in a payment of damages to the claimant. 'Settlement' refers to the final resolution of the claim. If a claim is successful it will refer to the payment of damages to the claimant.

Specialist Quality Mark

The Quality Mark is the quality standard operated by the Legal Services Commission and represents achievement in the specialist area of clinical negligence. It succeeds the franchise for clinical negligence, introduced in February 1999.