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What is happening to clinical negligence claims in the NHS?

A financial crisis for the future?

The National Health Service Litigation Authority (NHSLA) was rebranded as National Health Service Resolution, or NHSR, on 03 April 2017. The stated aim of the rebranding process, according to the National Health Executive (NHE),[1] is to combine the three operating arms of NHSLA, the National Clinical Assessment Service, and the Family Health Service Appeals Unit in order "to assist the NHS to resolve litigation concerns fairly, as well as share lessons learnt to improve clinical practice and preserve resources for patient care." The NHE document points out that "Central to the change is the need for trusts across the country to learn from litigation cases and share experiences."

What then can we learn from the latest report on clinical negligence claims in the NHS, published this year by NHSR?[2] During the last year, 17 338 claims were settled. In 67.8% (11 759) of those claims, resolution was achieved without issue of formal court proceedings. Damages were paid in 5226 cases (30.1%), and no damages were paid in 6533 cases (37.7%). In the former group, one assumes that the evidence for liability was clear, with compensation being paid for commercial or other reasons. Formal court proceedings were issued in 5498 claims (31.5%), with 4400 (25.4%) resulting in damages being paid and 1058 (6.1%) resulting in no damages. It is interesting that, of the 17 338 settled claims, only 121 (0.7%) ended up in court, with 49 (0.3%) resulting in payment of damages and 72 (0.4%) successfully defended.

The projected expenditure for settlement of negligence claims in 2017/18 is £1.95 billion, representing a 17.5% increase compared with that of 2016/17. This latest increase does not take into account the effect of the change in the discount rate from 2.5% to -0.75% in March 2017.[3] This affects the value placed on future losses when paid out as a lump sum, so NHSR expects the cost of current settlements to increase significantly. In the Spring Budget 2017, the Chancellor of the Exchequer took this into consideration when he announced additional funding across government of around £1.2 billion a year for this change in the discount rate. However, later in the report (p. 71) it is pointed out that, "reduction in the personal injury discount rate (PIDR) has increased the value of our liabilities for claims arising from incidents up to 31 March 2017 by £4.7 billion."[2]

There were 10 686 new claims in the last year, a fall of 2.5%. This was the third year in a row that the number of negligence claims had fallen. The fall is related, in part, to the change in funding arrangements that was introduced in 2013/14, where success fees in successful claims under conditional fee arrangements ceased to be recoverable from the NHS.

As in previous years, orthopaedic surgery continued to give rise to the largest number of claims (13% of the total). However, in terms of claims value, orthopaedics only accounted for 5% of the total amount of the £4.37 billion claimed in 2016/17. Of the total value, 50% was related to obstetric claims.

NHSR has indicated that it will respond firmly to any case where they suspect exaggeration and fraud. They give examples of two cases that illustrate the effectiveness of their robust anti-fraud and claims validation process. One of these was an orthopaedic case (SM *v* NHS Commissioning Board) where a 48-year-old claimant underwent arthroscopic surgery to her knee following a road traffic collision. The surgeon identified two meniscal tears, which were duly repaired. Four months later, the patient underwent a

repeat arthroscopic procedure to relieve joint pain, which she then said failed, and she later issued proceedings alleging that the first operation was negligent. The patient said that the surgery had left her with a permanent limp and chronic pain, and meant that she was unable to work, needed a crutch at all times, could not walk or stand for long periods, and had been forced to move to single-storey accommodation as a result of being unable to climb stairs. She claimed £150 000.

Orthopaedic experts who examined the claimant were sceptical, finding her symptoms incompatible with the medical evidence. As a result, the NHSLA (as it was then called) decided to undertake surveillance. On one day, the claimant was seen attending a medical examination in a wheelchair pushed by a friend, but a week later was observed on several days walking unaided and without difficulty. She was seen with a full range of movement and observed driving a car without difficulty. When presented with the surveillance evidence, the claimant offered to accept £8000, but in the face of a refusal of any payment withdrew her claim entirely. This a situation that all of us who carry out personal injury or negligence work see from time to time, and I can't help thinking that people who proceed with and perpetuate claims like this should themselves be prosecuted. Recently, a couple who falsely claimed from insurance companies for holiday illness were jailed for nine and 15 months for their dishonest behaviour.[4] Perhaps we will see this happening in similar spurious personal injury scams?

The report then goes on to consider the bigger picture and the figures become mind-bogglingly large. In their finance report, they state that the total provision for liabilities that arise from the indemnity schemes that they operate has increased significantly from £56.4 billion to £65 billion over this financial year. Of this total provision, £39 billion relates to liabilities where no claim has yet been received, based on past claims history and experience. Putting all this into context: according to NHS Choices,[5] when the NHS was launched in 1948, it had a budget of £437 million (roughly £15 billion at today's value). For 2015/16, the overall NHS budget was around £116.4 billion and NHS England is managing £101.3 billion of this. Therefore, the potential cost of such claims is staggering.

CapX,[6] an online news site founded by the Centre for Policy Studies, describes provisions for medical negligence claims as the third biggest drain on the Treasury after pensions and nuclear decommissioning. They report statistics from Diederich Healthcare in the United States that estimate that $3.9 billion was spent on payouts for medical negligence in 2016, which works out at around £9 per citizen. They compare this with the equivalent figure in England, reported as £24 per citizen, suggesting that the United Kingdom is now more litigious than the United States.

A recent report from the Medical Protection Society (MPS)[7] also expressed concerns about this: "the NHS is diverting a significant amount of its funding away from front-line patient care towards claims. At a time when the NHS is facing tough financial pressures and must make difficult decisions about how it allocates its limited and precious resources, there is an urgent need to review the money spent on compensation for clinical negligence." They also made the very pertinent point that, "Medicine is not an exact science and sometimes adverse incidents do occur. It is important that there is reasonable compensation for patients following clinical negligence, but this must be balanced against society's ability to pay. If the balance tips too far, the risk is that the cost becomes unsustainable."

There are, of course, two sides to every story. According to van der Luit-Drummond in the *Solicitors Journal*,[8] Action against Medical Accident (AvMA), a patient support organisation, was not convinced by MPS's recommendations. "These proposals ignore the main reasons for the high cost of clinical negligence to the NHS", said AvMA's Chief Executive, Peter Walsh. "These are firstly, the unacceptable number of negligent mistakes being made that ruin people's lives, and secondly the inappropriate denials and defence of claims which should have been recognised as valid much earlier. Collectively, they amount to either an ignorant or cynical attack on access to justice for injured patients. We hope that the Government will recognise them as such and concentrate on preventing these mistakes in the first place and preserving access to justice for the victims of clinical negligence."

In its report, the MPS argue that it is simplistic to assume that a singular focus on improving patient safety and enhancing the quality and reliability of care delivery will alone result in a significant reduction in clinical negligence litigation and complaints. They believe that our understanding of the reasons behind clinical negligence claims needs to improve in order to develop and improve prevention strategies. The report calls for more UK-based research on what causes patients to sue their treating clinician, hospital or Trust. They believe that there is an information gap on recent UK experience. The definition of what constitutes an adverse outcome or patient safety incident is evolving, and tends to be viewed from different perspectives by the patient and the doctor.

The MPS recommendations include:

- Increased understanding of clinical negligence drivers
- Increased understanding of specific risks
- Increased focus on education and risk management
- Improvement of the culture and systems for dealing with concerns
- Limit on future care costs, based on the realities of providing home-based care. A tariff would be set for annual care costs, dependent on injuries, with an overall cap
- Limit on the level of future earnings that should be recognised for calculation of compensation, with a link to national average weekly earnings
- Consideration of a minimum threshold for cash compensation for pain, suffering and loss of amenity (PSLA) in clinical negligence claims
- Introduction of a system of fixed recoverable costs (FRC) for all clinical negligence claims up to a value of £250 000

The aim of saving the NHS money is a laudable one, with which, given the numbers alluded to above, I am sure we would all agree. The way to do this is to look more closely at the drivers of clinical negligence claims and try to put in place whatever systems are required in order to stop the errors occurring in the first instance. The difficulty is that this needs to be done without subjecting healthcare professionals to overly stringent guidelines and protocols. In the quest for the holy grail of increased safety, better patient outcomes, and reductions in expenditure costs on medical negligence claims, we must ensure that the art of medicine is preserved, and that individual choice and innovation are not stifled.

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