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Clinical negligence: Can we afford it?

I am sorry to keep harping on about this but, as I pointed out in an earlier article,[1] the Government has now set aside £65 billion to provide for clinical negligence liabilities, taking into account the present and future predicted costs of claims. According to John Hyde,[2] Meg Hillier, the chairman of the Public Accounts Committee, believes that there is a prevailing attitude of defensiveness among National Health Service (NHS) Trusts, and that this contributed to the escalating clinical negligence costs, which have risen from £400 million in 2006/7 to £1.6 billion in 2016/7.

In addition, Anthony Barej[3] describes how Amyas Morse, head of the National Audit Office (NAO), reports that "The cost of clinical negligence in trusts is significant and rising fast, placing increasing financial pressure on an already stretched system. NHS Resolution (NHSR, the NHS litigation authority) and the Department of Health (DoH) are proposing measures to tackle this, but the expected savings are small compared with the predicted rise in overall costs." He added: "At £60bn, up from £51bn last year, the provision for clinical negligence in trusts is one of the biggest liabilities in the government accounts, and one of the fastest growing." Morse said that curbing these growing costs would require "significant" activity in policy and legislation.

The NAO warned that the cost of clinical negligence claims was rising at a faster rate, year on year, than NHS funding. This is adding to the financial pressures already experienced by many trusts, and could affect patients' access to services and quality of care. Morse noted that not only were the number of claims rising, but also that the individual claims were each getting more expensive. This is obviously going to be fuelled further by the recent reduction in the discount rate from 2.5% to -0.75%.[4] The jump in claims accounted for 45% of the overall increase in costs, while rising payments for damages and claimants' legal costs accounted for 33% and 21%, respectively.

Claimants' legal costs have seen the fastest percentage rise (631%) from £77 million to £486 million over the past ten years. Compensation payments are expected to hit £3.2 billion by 2020/21. The NAO said that proposed actions to contain the rising cost of clinical negligence claims were unlikely to stop this growth because, even if they were implemented, they were likely to save only £90 million a year by 2020/21. The report stated: "The government lacks a coherent cross-government strategy, underpinned by policy, to support measures to tackle the rising cost of clinical negligence." However, the NAO report finds no evidence that the rise in clinical negligence claims is related to declining standards of patient safety, but rather that it is closely associated with reforms to legal services and market developments – in particular, the migration of lawyers from personal injury to clinical negligence.

Not surprisingly, clinical negligence lawyers everywhere are affronted by such a suggestion and have been disappointed, albeit not entirely surprised, with the findings from the long-awaited NAO report. James Bell[5] puts forward the proposition that the NAO have approached this issue with a needlessly narrow focus and with scant recognition of the recommendations they made to the NHS to reduce clinical incidents in 2001. The predictable headlines that followed blamed the rise of clinical negligence costs on 'ambulance-chasing' clinical negligence lawyers. Yet, the continued focus on claimant lawyers as a solution for all of the NHS's financial ills, he thinks, is misguided and disproportionate.

Bell believes that the reality is that solicitors' fees are already tightly controlled, capped, and limited due to recent reforms; they have to be "reasonable and proportionate" before they are paid, and the courts rightly already hold the power to reduce any bill found to be excessive.

He also points out that clinical negligence lawyers everywhere know that delays caused by trusts and NHS Resolution can be unrelenting and are hugely distressing to clients. Often, legal bills are massively increased as a result of both the NHS's failure to admit fault at an early stage and their way of conducting cases. Bell feels that while the narrative remains solely on claimant lawyers, nothing will change.

According to the *BMJ* in December of 2017,[6] the Public Accounts Committee have decreed that the Department of Health, NHS Resolution, and the Ministry of Justice (MoJ) should, "review the adequacy of current legislation – which requires damages awarded to assume that patients will require private care, even if they will receive free NHS care – and report back to the Committee by April 2018."

Paul Goldsmith, at the Centre for Policy Studies,[7] believes that the root cause of the problem is section 2 (4) of The Law Reform

(Personal Injuries) Act 1948, which requires the body or individual paying compensation to disregard the availability of NHS care. This means that the compensation payable is quantified on the basis that the claimant will use the award only for private health care, even if they use the NHS. Goldsmith believes that this should be repealed. He may have a point.

Although, as I have stated, the amount of compensation payable is quantified on the basis that the claimant will use the award only for private health care, there is no obligation for that to happen once the compensation is paid. There may have been some logic to this back in 1948, as the NHS had only recently been formed and more chronic disease management and rehabilitation was not well developed. The medical injury cases that were inevitably at the forefront of people's minds at that time are the most severe ones, and it was considered unsafe to rely on the newly formed NHS to provide an appropriately high level of care. Interestingly, this element of the Act was introduced to overcome opposition from doctors to the 1946 National Health Service Act because they feared the loss of their private income! Nowadays, we have a level of care that is unrecognisable from 1948. Furthermore, the Act did not foresee that some recipients of financial awards would continue to use state-funded care, or find that their disability improved after the conclusion of the case.

Many people continue to raise the issue of the introduction of a no-fault compensation system such as exists in New Zealand. Goldsmith makes the point that we are close to having the solution in the UK because we have the ultimate no-fault scheme, the NHS. If you break your leg playing football, the NHS will treat you, even though you voluntarily took the extra risk of playing football. Similarly, someone who doesn't keep fit or has an unhealthy lifestyle still gets treated in exactly the same way as someone who takes care of their health much more fastidiously.

However, the answer to the question proposed in the title is surely *no*. We cannot afford to continue to fund clinical negligence claims, the costs of which are rising, at the current levels. At a recent talk that I gave to a combined audience of doctors and lawyers at a medico-legal society meeting, the lawyers were very unhappy with the suggestion that negligence was becoming unaffordable. They were, not surprisingly, very resistant to the idea of no-fault compensation. The message from the legal profession was that it was time that we put our own house in order and treated patients properly, avoiding all these unnecessary errors. Peter Walsh,[8] the Chief Executive of Action against Medical Accidents (AvMA), believes that, "There are an unacceptable number of negligent mistakes being made that ruin peoples' lives with inappropriate denials and defence of claims which should have been recognised as valid much earlier. 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."

This seems at odds with the changes that I have seen in clinical practice in the UK since I became a consultant in January 1989. We have guidelines, protocols, World Health Organization (WHO) checks in the operating theatre, never-event reporting, and, more recently, duty of candour and the Getting It Right First Time (GIRFT) programme. I do not believe that we have ever made such rigorous attempts to avoid clinical errors. Yet, according to the lawyers, we are still not doing enough and the costs of clinical negligence continue to rise.

We will await with interest the response of the DoH, NHSR, and MoJ to the questions posed by the Public Accounts Committee. It does seem that, in addition to reassessment of the recent cut in the discount rate, attention may have to be given to repealing the 1948 Law Reform (Personal Injuries) Act and possibly also to the way that earnings-related compensation is assessed.

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