Handling clinical negligence claims: implications for the NHS

In May this year, the National Audit Office issued its latest report on handling clinical negligence claims in England (National Audit Office, 2001). It made chilling reading. As at 31 March 2000, the outstanding bill for negligence claims stood at £3.9 billion — £500 million up on the previous year.

Since 1995/96, the annual charge to the NHS account for provisions for settling claims has risen seven-fold.

In the introduction, the report cites a few further key facts. Around 10 000 new claims were received in 1999–2000, and only 24% of claims funded by the Legal Services Commission (the successor to the Legal Aid Fund) succeed. For claims settled in excess of £10 000 in 1999–2000, the average time from claim to payment of damages was 5.5 years. Cerebral palsy and brain damage cases accounted for 80% of the cost of outstanding claims but make up just 26% of the total. In 65% of settlements of less than £50 000 achieved in 1999–2000, legal costs exceeded the damages awarded to injured patients.

NEW CLAIMS

Ten thousand new claims in a year sounds a lot, but it is just a fraction of the estimated number of adverse incidents in our hospitals, published in the Chief Medical Officer's paper *An Organisation with a Memory* (Department of Health, 2000). Research-based estimates suggest that adverse events resulting in harm to patients occur in approximately 10% of admissions, which amounts to more than 850 000 such incidents per year.

The cost of hospital-acquired infections is estimated to be £1 billion per year, and the cost of other adverse incidents is approximately £2 billion in additional hospital stays alone. Against this background, 10 000 new claims a year is just the tip of the iceberg.

WHAT IS CLINICAL NEGLIGENCE?

For a claimant to succeed in a negligence claim, three criteria must be satisfied. First, the claimant must be owed a duty of care by the hospital. Second, the hospital must breach that duty of care and third, the patient must suffer harm as a result of the breach of duty.

There is very rarely any dispute over the existence of a duty of care. As soon as there is a therapeutic relationship between hospital and patient, the duty is established. Far more difficult is determining whether the duty was breached and what harm flowed from identified deficiencies in care.

The standard of care is judged by the Bolam test [*Bolam* v *Friern Barnet Hospital Management Committee* 1957], which essentially states that a doctor is not guilty of negligence provided that he or she has acted in accordance with accepted medical practice. That sounds pretty straightforward but there is often heated debate between experts about whether individual aspects of care are acceptable in given circumstances.

The last and frequently most difficult point is to determine exactly what harm a patient has come to as a result of substandard care. This is crucial as it determines the sum of damages to be awarded, the aim being, insofar as money can, to restore the patient to the position he or she would have been in had no negligence occurred. Consequently, it is the degree of injury suffered by the patient and not the seriousness of the error which is reflected in the compensation award.

One other point worth noting is that damages are based on providing any continuing care needs privately and not on the NHS, which is why brain damage cases result in awards calculated in millions.

THE COST OF BRAIN DAMAGE CASES

Compensation awards comprise two main components: general damages for pain, suffering and loss of amenity, and special damages to compensate for specific losses and cost of future care. In the worst cases, general damages will amount to no more than £200 000. In a £3 million or £4 million award, special damages will make up all the rest, and the categories of compensation will include adaptations to the home, nursing care, physiotherapy and occupational therapy, the purchase and maintenance of suitable transport, other aids and equipment as well as medical fees, clothing, heating and other travel expenses.

Given that a one-off payment must provide for all the needs of the claimant for his or her lifetime, it is hardly surprising that individual awards are in the millions and that the total costs of these cases makes up such a large proportion of the total bill.

CLAIMS FUNDED BY THE LEGAL SERVICES COMMISSION

The rules governing state legal aid to potential claimants have been radically overhauled in recent years. Given the long time lag in clinical negligence cases, the full impact of reform is not yet evident. However, the restriction of state funding to solicitors meeting certain quality criteria has already resulted in early discontinuance of cases lacking sufficient merit, with a higher proportion of those cases which are pursued being successful.

TIME FROM CLAIM TO PAYMENT

Clinical negligence claims have, to date, been notoriously slow to reach a conclusion. Following the civil justice review in England and Wales, various

innovations should result in speedier resolution. The introduction of a pre-action protocol for clinical negligence claims means that many are now resolved quite quickly — within a matter of months — but clinical negligence claims will always give rise to complex issues which take both claimants and defendants time to deal with. It is in everyone's best interests to resolve claims as quickly as possible. Claims are stressful for both patients and doctors, and the associated costs rise the longer litigation is drawn out.

LEGAL COSTS EXCEED DAMAGES AWARDED

Solicitors and barristers are expensive and their fees attract VAT at the standard rate. It does not take long to run up a large bill, and in cases that go to trial or settle close to trial, many hours have been spent poring over documents, sometimes in the company of experts, who will also submit substantial fee notes. The problem here is that small claims can be more complex than large ones. The cost of smaller claims, as highlighted in the National Audit Office report, featured briefly in the election campaign with the suggestion from the Prime Minister for a tariff scheme to deal with these cases which would be outside the court system and less reliant on lawyers. The Chief Medical Officer has been tasked with reviewing options to the current tort-based system, including the option of no-fault compensation, with a view to producing a White Paper early in 2002.

In any event, the impact of such reform will be minor compared with the overall cost of NHS negligence claims given the high proportion of costs attributable to cerebral palsy and brain damage cases.

RECOMMENDATIONS

The National Audit Office report makes a number of recommendations to bring claims outstanding more than 5 years to a timely conclusion and to explore alternative means of managing smaller claims and setting up performance measures. Those recommendations stem from the brief of the National Audit Office, which is to report on the handling of clinical negligence claims in England.

More fundamental is the drive to reduce the number of adverse incidents in England's hospitals resulting in harm to patients. To this end, the Department of Health has published a number of documents including *An Organisation with a Memory* (Department of Health, 2000) and *Building a Safer NHS for Patients* (Department of Health, 2001), which sets out the government's plans for promoting patient safety. This includes the establishment of the new National Patient Safety Agency, which will develop a national system for reporting failures, mistakes and near-misses in the health service. It will run a mandatory reporting system to log all mistakes with the intention of promulgating the lessons learnt throughout the NHS.

CONCLUSION

The cost of clinical negligence in human and financial terms is immense. We can strive to reduce the incidence of adverse incidents, but inevitably some patients will suffer harm as a result of inadequate care and must be properly cared for subsequently. In addition to minimizing error, the provision of continuing care for profoundly damaged patients is key. If these patients can be cared for in the NHS rather than privately, compensation awards can be reduced overnight and savings transferred to dedicated NHS facilities caring for all profoundly damaged patients and not just for victims of clinical negligence. HM

Gerard Panting
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KEY POINTS

- The cost of clinical negligence claims is rising and currently stands at £3.9 billion for English NHS trusts.
- Brain damage cases amount for 80% of this figure.
- The 100 000 new claims in 1999/2000 amount to just a tiny fraction of the number of adverse incidents in the same year.
- Alternatives to the current tort system are to be examined by the Chief Medical Officer's Working Group.
- Department of Health initiatives aim to reduce the number of adverse incidents.

Bolam v Friern Barnet Hospital Management Committee [1957] 1 WLR 582
Department of Health (2000) *An Organisation with a Memory.* Report of an expert group of learning from adverse events in the NHS. The Stationery Office, London
Department of Health (2001) *Building a Safer NHS for Patients. Implementing an Organisation with a Memory.* The Stationery Office, London
National Audit Office (2001) *Handling Clinical Negligence Claims in England.* Report by the Comptroller and Auditor General HC 403 Session 2000-2001. National Audit Office, London

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