

House of Commons  
Committee of Public Accounts

**HANDLING CLINICAL  
NEGLIGENCE CLAIMS IN  
ENGLAND**

Thirty-seventh Report of Session  
2001–02

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*Report, together with  
Proceedings of the Committee,  
Minutes of Evidence and an Appendix*

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### **Footnotes**

In the footnotes of this Report, references to oral evidence are indicated by ‘Q’ followed by the question number; references to the written evidence are indicated by the page number as in ‘Ev .....’.

## TABLE OF CONTENTS

	<i>Page</i>
<b>THIRTY-SEVENTH REPORT</b>	
Introduction and list of conclusions and recommendations .....	5
Reducing the incidence of clinical negligence .....	8
Addressing patients' needs .....	11
Speeding up the handling of claims .....	13
Reducing the cost of dealing with claims .....	15
PROCEEDINGS OF THE COMMITTEE RELATING TO THE REPORT .....	17
EVIDENCE ( <i>Wednesday 17 October 2001</i> ) (HC 280-i, Session 2001–02)	
WITNESSES	
Sir John Bourn, KCB, Comptroller and Auditor General .....	Ev 1
Mr Glenn Hull, Second Treasury Officer of Accounts .....	Ev 1
Sir Hayden Phillips, KCB, Permanent Secretary, Lord Chancellor's Department, and Clerk of the Crown in Chancery; Mr Nigel Crisp, Permanent Secretary, Department of Health and Chief Executive, National Health Service Executive; Mr Stephen Orchard, CBE, Chief Executive, Legal Services Commission; Mr Stephen Walker, Chief Executive, National Health Service Litigation Authority .....	Ev 1
APPENDIX	
1 Supplementary memorandum submitted by the Department of Health .....	Ev 21

### LIST OF REPORTS PUBLISHED IN SESSION 2001–02



# THIRTY-SEVENTH REPORT

The Committee of Public Accounts has agreed to the following Report:

## HANDLING CLINICAL NEGLIGENCE CLAIMS IN ENGLAND

### INTRODUCTION AND LIST OF CONCLUSIONS AND RECOMMENDATIONS

1. The NHS is legally liable for the clinical negligence of its employees, including hospital doctors, arising in the course of their employment. 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. Since 1995 the NHS Litigation Authority has taken an increasing role in handling claims against the NHS and since April 2002 they have responsibility for all claims. Over 70 per cent of patients who make claims are publicly funded through the legal aid scheme. The Lord Chancellor's Department sets the policy on this and the Legal Services Commission funds eligible claims.<sup>1</sup>

2. There has been concern at the scale of 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. Delay in resolving claims can cause further distress for patients or relatives making claims and clinicians accused of negligence, and also increase costs. Because of the cost and unpredictability of pursuing claims, few people were able to do so unless they qualified for legal aid. Figure 1 below outlines some key facts about the handling of clinical negligence claims.<sup>2</sup>

<p>Around 10,000 new claims were received in 1999–2000.</p> <p>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.</p> <p>Only 24 per cent of claims funded by the Legal Services Commission are successful.</p> <p>The total annual charge to NHS income and expenditure accounts for provisions for settling claims has risen seven-fold since 1995–96.</p>	<p>Cerebral palsy and brain damage baby cases account for 80 per cent of outstanding claims by value and 26 per cent of claims by number in the largest negligence scheme.</p> <p>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.</p> <p>In 65 per cent of settlements in 1999–2000 below £50,000, the legal and other costs of settling claims exceeded damages awarded.</p>
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<sup>1</sup> C&AG's Report, para 1 and Figure 2

<sup>2</sup> *ibid.*, para 2

3. On the basis of a Report by the Comptroller and Auditor General,<sup>3</sup> we looked at steps being taken to reduce the incidence of clinical negligence, to address patients' needs and to speed up, and reduce the cost of, claims' handling.

4. In the light of this examination, the Committee draws three overall conclusions:

- Clinical Negligence involves considerable human costs. Patients who have suffered injury through negligence often face a long and difficult process pursuing their claims and achieving damages. Important steps have been taken to improve access to justice, for example through the introduction of conditional fee arrangements and to speed up the processing of claims. But the fact remains that in England there were over 23,000 cases outstanding at the end of March 2000, and excluding complex cases claims were taking on average over five years to resolve, and in eight per cent of cases over ten years. This represents a clear failure of the NHS and the legal system to deal with patients with speed and compassion.
- The NHS is also suffering. The value of claims is rising, and in 2000–01 provisions for future payments had risen to £4.4 billion and there are also significant administrative costs. In 65 per cent of settlements below £50,000 the legal costs exceed the sums paid to claimants. These costs are a drain on scarce resources for improving patient care, and unless the issue is tackled vigorously could reduce the impact of the increased funding for the NHS announced in the budget. We are also concerned that the increase in the funding made available for the NHS in the budget might encourage people to make more claims.
- The first major need is to reduce the incidence of negligence in the first place, and the C&AG is planning to report on the effectiveness of the new NHS clinical governance arrangements next year. While major changes have already been made to help improve access to justice, speed up claims and reduce costs, the current review by the Chief Medical Officer offers an important further opportunity to look for radical solutions to deal with these system failures. His report should address in particular:
  - ▶ improving the way NHS Trusts handle the interface between complaints and claims, to ensure that patients are offered the package of remedies they need and are not forced too early into litigation;
  - ▶ the benefits of a no-blame solution;
  - ▶ alternative ways of handling claims up to £50,000, to speed them up and cut costs.

5. Our more specific conclusions and recommendations are as follows.

*On reducing the incidence of clinical negligence*

- (i) The Department of Health have launched an array of initiatives to improve clinical governance in the NHS. These include creation of the Commission for Health Improvement, the National Institute for Clinical Excellence, the National Clinical Assessment Authority and the National Patients' Safety Agency. We look forward to the Comptroller and Auditor General's review of the implementation of these measures, including the impact they are having in trusts, in early 2003.

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<sup>3</sup> C&AG's Report, *Handling Clinical Negligence Claims in England* (HC 403, Session 2000–01)

- (ii) By March 2000, almost a quarter of all NHS Trusts had not achieved even the basic risk management standards set by the Clinical Negligence Scheme for Trusts, and a further two thirds had not achieved more than basic standards. Despite the wide range of actions to improve clinical governance, the Clinical Negligence Scheme for Trusts remains voluntary and the Department merely “hope” that a majority of scheme members will achieve strong standards by 2003-04. The Department should make membership of the scheme mandatory, and set each trust a clear target of raising its risk management standards to the minimum level and then to the highest level.

*On addressing patients’ needs*

- (iii) It is important that patients with valid claims against the NHS understand their rights and have access to a range of remedies, including an explanation, an apology, remedial treatment and where justified financial compensation. The way that many trusts mishandle the tension between the complaints and claims procedures, means that patients can too easily and too quickly find themselves in a position where they have to seek legal remedies. The Department of Health is looking at the scope to manage these two processes better, and we expect them to let us know what action they plan to take later this year.
- (iv) Alternative dispute resolution, including mediation, can assist both trusts and patients in reaching the non-financial remedies which patients often say they seek. The Litigation Authority recognises the importance of these remedies and the part they may play in meeting patients’ desires and needs. It is important that trusts are prepared to consider and, where appropriate, deliver such remedies. The Litigation Authority should introduce a new risk management standard for trusts which will specify, and allow measurement against, policies and procedures for delivering non-financial remedies through alternative dispute resolution.
- (v) While there is good and innovative practice in some NHS trusts, in providing patients with a range of remedies, most patients find the system confusing and difficult to navigate. The Litigation Authority plan to spread best practice through guidance and training, and the Patient Advisory and Liaison Service has a key role in helping people understand the system. All trusts should implement best practice as part of their clinical governance arrangements.
- (vi) There is a difficult balance to be drawn between providing patients with access to litigation and protecting the public purse. This is particularly so where the public sector may be meeting the costs of both parties. The Legal Services Commission is making progress in evaluating potential claims more carefully before awarding legal aid certificates. But while conditional fee agreements have opened up the opportunity for people to pursue claims, the judgement on which claims are most likely to succeed and therefore which to pursue, rests with their lawyers or insurance firms. The review of conditional fee agreements being undertaken by the Lord Chancellor’s Department is therefore important in judging whether it provides sufficient access to those with valid claims, and we look forward to receiving a report from them on the outcome and any action planned later this year.

*On speeding up the handling of claims*

- (vii) Delay in clearing claims for clinical negligence causes uncertainty for all those involved, particularly those patients who have suffered harm and their families. It can also divert scarce NHS resources away from patient care, in administrative costs and higher settlements. While claims can involve complex judgements on

whether negligence has occurred, for most non-complex cases, including those not involving cerebral palsy or brain damage injuries, the evidence from Scotland and Wales suggests that it should be possible to settle within, on average, 2–3 years from receipt of the claim. Progress is being made, and more claims are now being cleared than received. We expect the Litigation Authority and Legal Services Commission to track the outcome of the initiatives to speed up claims handling in England, and report on their performance in their published annual reports.

- (viii) Past failures in claims handling have allowed a serious backlog of cases to build up and it took the Comptroller and Auditor General's work to stimulate the Litigation Authority and the Legal Services Commission to assess the scale of the problem, and look for joint solutions to it. The Department of Health and the Lord Chancellor's Department should review all cases over 5 years old by 31 March 2003, and develop action plans to speed up the clearance of the claims involved. In doing so, the Departments, the Litigation Authority and the Legal Services Commission should continue the closer working relationships forged during the National Audit Office's examination with regular meetings to co-ordinate policy and exchange information, without compromising the confidentiality of patients or defendants.

#### *On reducing the cost of dealing with claims*

- (ix) A number of factors underpin the rising costs of settling claims. Cases settled in the courts have raised the level of general damages, and changed the discount rate that applies to future costs. Labour rates for care, for example education, carers, therapists, have risen faster than inflation. There have also been changes in accounting practice. However, there have been a number of initiatives aimed at improving the quality and efficiency of claims handling. In particular, the Litigation Authority will take charge of all claims from April 2002 and both the Legal Services Commission and the Litigation Authority have implemented initiatives that should improve the quality and efficiency of the way their solicitors handle claims. While it will take some time for the full impact of these initiatives to work through, the Litigation Authority and Legal Services Commission should evaluate progress in reducing costs, and report on progress made in their published annual reports.
- (x) The current system is an inefficient way of resolving small and many medium size claims. For settlements up to £50,000, the costs of reaching the settlement are greater than damages awarded in over 65 per cent of cases, and conditional fee agreements are unlikely to provide the answer for small claims. The Litigation Authority plan to pilot a fast track system, similar to a small claims court, from April 2002. We expect to see a report on the first full year of this fast-track scheme, 2002–03. We also expect the Chief Medical Officer's review to look more widely at alternative solutions, including a tribunal to deal with claims under £50,000 and some form of no-blame arrangements.

#### REDUCING THE INCIDENCE OF CLINICAL NEGLIGENCE

6. The Department of Health do not know accurately how many claims there are against the NHS at any one time. However, the Comptroller and Auditor General estimated that at 31 March 2000 there were some 23,000 clinical negligence claims outstanding (Figure 1) and 10,000 new claims were received in 1999–2000. At 31 March 2000 provisions and liabilities for clinical negligence claims totalled £3.9 billion, and these had increased to £4.4 billion by March 2001.<sup>4</sup>

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<sup>4</sup> C&AG's Report, paras 2.2–2.6 and Figures 6, 7; NHS Summarised Accounts (England) 2000–01

7. Since 1997 the Department of Health have taken a number of initiatives to improve clinical governance in the NHS (Figure 2), which in turn should help reduce clinical negligence. At the time of our hearing, many of these were in the early stages of implementation and it was too soon to look at their impact. The Comptroller and Auditor General is undertaking a follow up study to look at clinical governance in hospitals, to report early in 2003.<sup>5</sup>

<b>Figure 2: The Department of Health's initiatives to improve clinical governance</b>	
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 The Health Authority to which NHS organisations can refer doctors for assessment, advice and support where concern has been raised about clinical performance.
2001	Building a Safer NHS for Patients
2001	National Patient Safety Agency

8. As part of its arrangements for managing claims against NHS Trusts after March 1995, the NHS Litigation Authority established risk management standards (Figure 3). The aim was to ensure that risk management was conducted in a focused and effective fashion, and thus made an effective contribution towards the improvement of patient care.<sup>6</sup> However, by 31 March 2000, only 1 per cent of trusts had reached level 3, and 33 per cent level 2, and 80 trusts (24 per cent) had not even achieved basic standards (level 1).<sup>7</sup>

<sup>5</sup> C&AG's Report, paras 6, 1.26 and Appendix 2

<sup>6</sup> *ibid*, paras 1.11–1.13 and Figure 4

<sup>7</sup> *ibid*, paras 1.13 and Figure 5

<b>Figure 3: Risk management standards for the Clinical Negligence Scheme for Trusts</b>	
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 specialities 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.

9. The Department of Health is committed to reducing the number of adverse incidents. In response to the poor level of compliance with risk management standards, they have taken a range of initiatives, including better training for doctors, better assessment of risks within hospitals and sharing of best practice. They are monitoring the effectiveness of clinical governance much more closely, including through the Commission for Health Improvement. They have introduced new performance ratings for trusts, which gave greater emphasis to quality. They have put in place the National Clinical Assessment Authority, which can require training or supervision for a member of medical staff who might be in trouble. More recently, they set up new arrangements for critical incident reporting through the National Patient Safety Agency.<sup>8</sup>

10. All of these initiatives should be putting pressure on improving quality and reducing the number of incidents, but in the short term could lead to higher numbers of incidents being reported because of the more systematic collection of information. However, the Clinical Negligence Scheme for Trusts remains voluntary and the reorganisation of the

<sup>8</sup> Qs 18, 46, 78–87, 120–128, 161, 179

NHS following *Shifting the Balance of Power*<sup>9</sup> means that there are a number of new organisations – Primary Care Trusts – starting from scratch. Nevertheless, the Department hope to see a majority of scheme members attaining level 3 by 2004–2005.<sup>10</sup>

11. The Department of Health told us that the rising number of claims could be a reflection of a more litigious culture, and to the extent that this meant people were more aware of and more prepared to seek their rights this was a good thing on the whole. However, they are against “ambulance chasing”. The objective has to be to make sure litigation is necessary and worthwhile, while looking to alternatives wherever possible.<sup>11</sup>

12. The Department noted that the number of claims appeared to be growing more slowly in England than some other countries, for example in France. But even where there were similar healthcare systems, such as in Scotland and Wales, it is difficult to compare and reconcile data with other countries, without a more detailed analysis of the legal arrangements, and of the systems in place for clinical audit and risk management.<sup>12</sup>

#### ADDRESSING PATIENTS’ NEEDS

13. There are a number of barriers to patient access to remedies. 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 have 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. Conditional fee arrangements are available to those who are not eligible for legal aid for financial reasons.<sup>13</sup>

14. It is too early to say whether conditional fee arrangements will encourage more claims, but they are intended to give more people access to the lawyers and the courts. The number of insurance products backing conditional fee agreements has grown since the Access to Justice Act: in 1999 litigation insurance had been taken out in over 100,000 cases. Since April 2000 they have made the success fee and the insurance premium recoverable from the losing party, and this has provided a considerable further incentive. They are undertaking a major piece of research into the success of the scheme and expected to report the outcome in 2002.<sup>14</sup>

15. There has been a drop in the number of certificates issued for legal aid, and conditional fee arrangements mean that solicitors might only take on a case that has good prospects of success. Taken together, this could further reduce access to justice. However, the Lord Chancellor’s Department suggested that the reduction in legal aid certificates was a reflection of the action they had taken to increase the quality of work done by solicitors and fund cases much more carefully, focusing on those which have a greater chance of success. This enables people with good cases to exercise their rights while at the same time protecting the public purse. Conditional fee agreements opened up the opportunity for people to pursue good medium-sized and larger cases which they could not pursue before, and their use would pick up as the market developed.<sup>15</sup>

16. Although conditional fee agreements could apply to small claims, the Lord Chancellor’s Department and the Litigation Authority suggested that some approach other than litigation might be more appropriate. They wanted to embed better into the system

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<sup>9</sup> *Shifting the Balance of Power: Securing Delivery*, Department of Health, July 2001

<sup>10</sup> Qs 85–87, 123–126; Ev 21

<sup>11</sup> Qs 64–69, 167–170

<sup>12</sup> Qs 74–75, 77, 91–94; Ev 22

<sup>13</sup> C&AG’s Report, paras 13; Q70

<sup>14</sup> Qs 5, 70

<sup>15</sup> Qs 71–73, 110, 117

processes of alternative dispute resolution, which would enable people to reach a conclusion more quickly. As part of a wider initiative across all government departments, they had issued guidance on mediation in clinical negligence cases. However, mediation only worked through consent and greater progress might be made by developing the complaints procedure or a speeding up of the handling of individual cases to get to the facts earlier.<sup>16</sup>

17. Research shows that claimants often want a wider range of remedies than litigation provides, for example, an apology, an explanation or reassurance that it would not happen again; but they say they are not offered them. The Litigation Authority has issued guidance promoting the giving of appropriate expressions of regret and factual information. The Comptroller and Auditor General noted 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, 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.<sup>17</sup>

18. Some patients may not claim because they were unaware that they had grounds for doing so. The Department of Health's policy is that patients should be told where they have suffered an adverse medical incident and offered remedial healthcare, a factual explanation and an apology. Many complaints are resolved when people met the nurse or doctor involved to discuss the circumstances. Patients should be informed of their rights, and the Department expect to issue further guidance on the complaints procedure. In addition, the Patients' Advisory and Liaison Service will provide help to understand the system. The Department distinguish these steps from an admission of liability, and do not see it as the business of clinicians to advise patients that there may have been negligence, suggest patients seek legal advice, or admit liability. However, this approach could make it more difficult for the NHS to enter into a constructive dialogue with patients who want something in addition to money. It could thus deprive patients and their families of the potential benefits of solutions tailored to their needs.<sup>18</sup>

19. The Department of Health has issued a consultation document around changing the complaints procedure, particularly to look at how the complaints and claims procedures fit together. They are looking at how the NHS handled the early stages of a case so that they can establish what the patient actually needs, and explore a range of remedies.<sup>19</sup>

20. There is a risk that moving the processing of all claims to the Litigation Authority, might make it more difficult for patients to be offered remedies at local level. However, the Litigation Authority assured us that claims managers in NHS Trusts would still have essential roles, investigative roles, local management roles, setting up mediation locally and the delivery of packages of solutions. Relatively few trusts did these things, and the Litigation Authority is promoting this as good practice and are confident that it could train and manage people to do this at local level. However, where patients are seeking substantial sums in compensation, the case has to be handed over to the Authority.<sup>20</sup>

21. The Committee asked whether there was a case for a no-blame compensation scheme. The Department of Health had looked at this in the past, and it was being looked at again in the review of clinical negligence led by the Chief Medical Officer. There were

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<sup>16</sup> Qs 4, 6, 11, 173–174

<sup>17</sup> C&AG's Report, para 15

<sup>18</sup> *ibid*, para 12; Qs 88–90, 130–131, 135–137, 175, 180

<sup>19</sup> Qs 1, 7–9, 170–173, 176

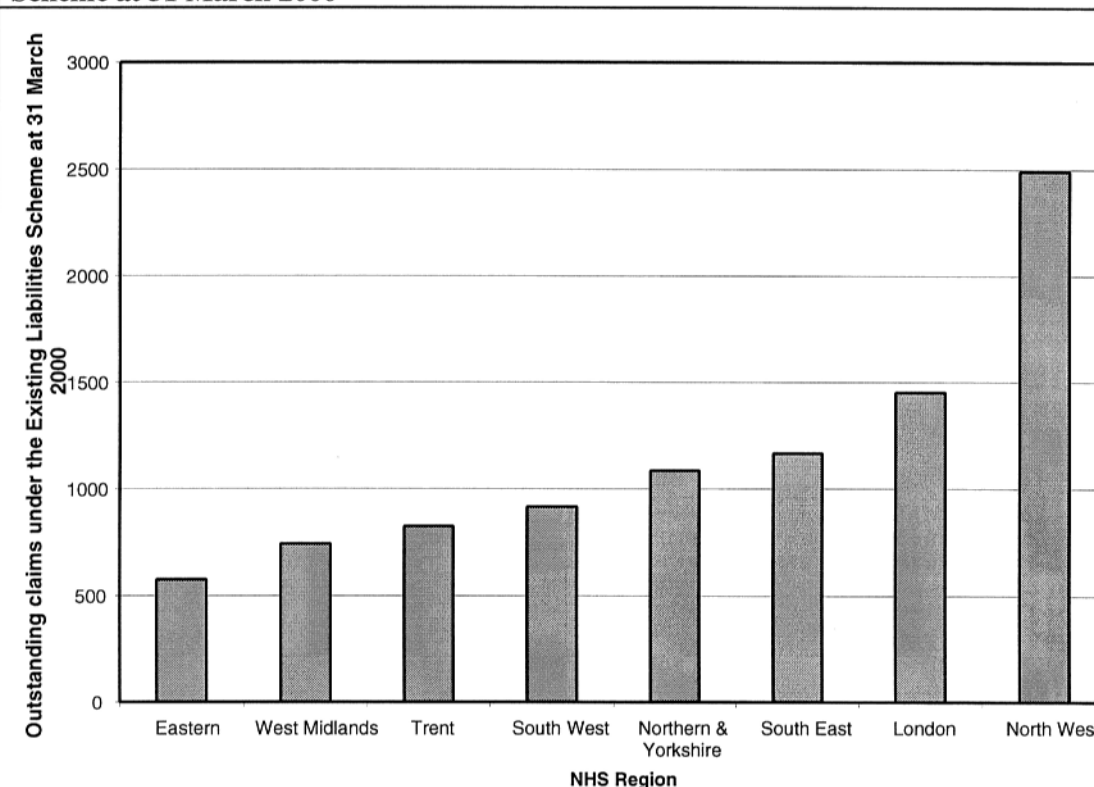
<sup>20</sup> Qs 7–9

arguments on both sides, including the likelihood of an increase in claims and the possibility that the scheme would run quicker and be easier to handle. The Chief Medical Officer's work would include research into how other countries handled clinical negligence and what the costs were, and what the NHS could learn.<sup>21</sup>

#### SPEEDING UP THE HANDLING OF CLAIMS

22. 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 (Figure 4). At 31 March 2000 there were an estimated 23,000 claims outstanding.<sup>22</sup>

**Figure 4: Regional distribution of outstanding claims under the Existing Liabilities Scheme at 31 March 2000**



Source: Department of Health, Ev23 and Q128

Note: This Figure does not include data from the Clinical Negligence Scheme for Trusts, which cover claims for incidents after 1 April 1995. At 31 March 2000 there were 4,400 claims under that scheme known to the NHS Litigation Authority and 10,800 estimated by the C&AG. In 2000-01 there were 4,115 new claims received under that scheme.

23. 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. As a result, claims can take a long time to settle. Excluding claims for cerebral palsy and brain damage injuries, those closed in 1999–2000 took, 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.<sup>23</sup>

<sup>21</sup> Qs 20–21, 112–113

<sup>22</sup> C&AG's Report, paras 7, 2.22 and Figure 6; Q128

<sup>23</sup> C&AG's Report, paras 10, 2.13–2.19 and Figure 12

24. The Department of Health, the Litigation Authority, the Lord Chancellor's Department and the Legal Service's Commission have taken a number of actions to and speed up the handling of claims, including:

- Setting up the Litigation Authority in 1995 to administer schemes to fund clinical negligence, to oversee the management of many claims and influence how defence solicitors handle claims;
- From April 1999, following a review by Lord Woolf, the Lord Chancellor's Department introduced new Civil Procedure rules to set out a timetable of claims before they go to court;
- 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) had attempted to improve the management of claims by using or funding those solicitors that meet quality criteria.<sup>24</sup>

25. The Litigation Authority are trying to speed up their handling of claims and get the average times down but because of the time lag between incidents, claims and settlements, it will take a long time for the full impact of these reforms to become apparent. There are, however, 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 increased from 660 in 1997–98 to over 3,200 in 1999–2000, and in 1999–00, 2000–01 and the first 6 months of 2001–02 far more claims were cleared than received.<sup>25</sup>

26. At face value, it appears that claims are processed more quickly in Scotland (average 3 years) and Wales (average 2.5 years) than England (average 5.5 years). However, the figure for England excludes all claims settled below £10,000 so is not directly comparable. In part, the difference in performance reflects the backlog of cases inherited by the Litigation Authority in 1995. Also, in Scotland all claims are handled centrally, which means consistent and skilled handling by one team, which will be the situation in England from April 2002.<sup>26</sup>

27. These averages exclude the more complex claims, particularly those involving catastrophic injuries and cerebral palsy from obstetric accidents, that claimants do not want to settle quickly for very good reasons. Most medical experts would argue that it is impossible to assess, for example, the development potential of a child until that child is five, six or seven years of age. There is no dragging of feet; indeed because damages awarded are rising very much faster than inflation it is in the NHS' interests to settle quickly. However, once liability has been established interim payments are available. The Chief Medical Officer's review is also looking at how payments are structured, including the merits of periodic payments and lump sums.<sup>27</sup>

28. A major reason for the backlog of claims in the Existing Liabilities Scheme is that prior to April 1995 individual trusts and health authorities handled claims. It was not their core business, and although they were doing the best they could with locally instructed lawyers, for most claims the system was inefficient and inconsistent. The Department therefore set up the Litigation Authority to administer the Clinical Negligence Scheme for Trusts and, from 1996, the Existing Liabilities Scheme.<sup>28</sup>

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<sup>24</sup> C&AG's Report, paras 3, 16–18, 1.18; Qs 1–3

<sup>25</sup> C&AG's Report, paras 9–10; Qs 100–108, 145, 162; Ev 22

<sup>26</sup> Qs 53–54, 92–94; Ev 21–22

<sup>27</sup> Qs 14, 22–24, 31

<sup>28</sup> C&AG's Report, para 3; Q14

29. Despite this improvement, the Litigation Authority lack sound management information on the number and value of older claims and any action plans or targets to deal with them. They also do not know how many claimants died while their claim was progressing, though they think it is small. In addition, up to February 2001, the Litigation Authority and the Legal Services Commission had not shared information about the thousand or so cases over five years old that appeared to be supported by legal aid. However, in the light of the Comptroller and Auditor General's work they have shared this information and started to assess whether these older cases are still live and the next steps. The Department of Health also asked the Litigation Authority to review the backlog of claims on an annual basis and report to them on the findings.<sup>29</sup>

30. The Litigation Authority explained that since they were set up they had dealt with claims in priority order: those in litigation where the courts were involved; those ready to be settled and those, which was the high volume, which were being pursued by claimants. Since then, information provided by the Litigation Authority to the Legal Services Commission on 700 old cases had enabled them to be tracked down to establish their status and what action was needed. Ninety-five per cent of these cases received legal aid, and for 10 per cent of them the legal aid certificate had already been discharged or revoked. In other pre-1999 cases, they had required solicitors to produce case plans. As regards setting targets for the Litigation Authority to reduce the backlog, the Department of Health pointed out that in many cases action rested with the claimant. They did not write them off, but there was a question over whether it was the Authority's role to chase them.<sup>30</sup>

31. We asked what the administrative cost of the delays in clearing claims might be. It was difficult to estimate, but based on estimates of the time it might have taken to review each of the 23,000 cases outstanding each year, the worst case could be as high as £1.5 million.<sup>31</sup>

#### REDUCING THE COST OF DEALING WITH CLAIMS

32. At the time of our hearing, provisions against the likely costs of settling these claims, including incidents incurred but not reported, totalled £3.9 billion. The value of probable liabilities rose again in the year to 31 March 2001, to £4.4 billion and there was a further increase in the annual charge to income and expenditure accounts. (Figure 5)<sup>32</sup>

33. A number of factors underpin the rising costs. Cases settled in the courts have raised the level of general damages, and changed the discount rate that applies to future costs. Labour rates for care, for example education, carers, therapists, were rising faster than inflation. There have also been changes in accounting practice, including the estimate by the National Audit Office for the first time of what might happen to incidents incurred but where no claims have yet been made.<sup>33</sup>

34. The Comptroller and Auditor General's analysis indicated that for settlements up to £50,000, the costs of reaching the settlement were 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.<sup>34</sup>

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<sup>29</sup> C&AG's Report, paras 10–11; Qs 15–16, 25–26, 150–155; Ev 21

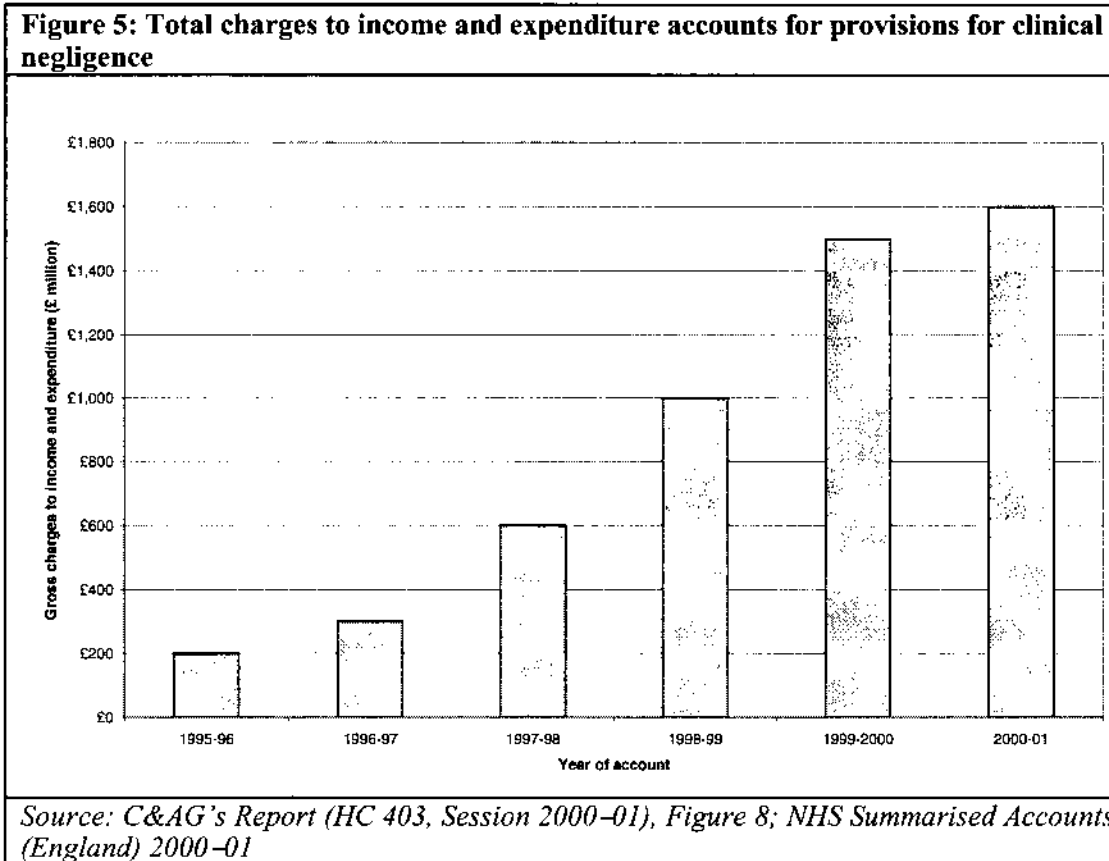
<sup>30</sup> Qs 13, 32–42, 56–57, 114–116

<sup>31</sup> Qs 146–149, 163; Ev 23

<sup>32</sup> C&AG's Report, paras 7, 2.3–2.6, and Figures 7, 8; Qs 168–169

<sup>33</sup> Qs 52, 76–77, 97–99

<sup>34</sup> C&AG's Report, paras 14, 3.19 and Figure 17



35. 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. In addition, under the Legal Service Commission's funding code, claims less than £10,000 are unlikely to receive legal aid funding.<sup>35</sup>

36. The Legal Services Commission noted that if costs were likely to exceed £25,000 the case was subject to an individual contract with the conducting solicitor. The Commission had continuous information on these case and their costs. For smaller claims there is scope to introduce a more streamlined approach to assess the merits of each case, which will speed up the process and significantly reduce costs.<sup>36</sup>

37. Another solution was the development of the equivalent of a small claims court. The Litigation Authority is doing this – a fast track system – from April 2002 through the Clinical Negligence Scheme for Trusts. The scheme will involve fixed fees and a guaranteed timetable, and should dramatically reduce both the timescale and the costs on both sides. The Authority is still considering the threshold to be applied, but it is likely to be in the range £15,000 to £25,000 initially. If it works after a suitable pilot period, then it could be rolled out to encompass high value claims up to £50,000.<sup>37</sup>

<sup>35</sup> C&AG's Report, para 14

<sup>36</sup> Qs 7, 10

<sup>37</sup> Qs 27-28, 63

MINUTES OF PROCEEDINGS OF  
THE COMMITTEE OF PUBLIC ACCOUNTS

SESSION 2001–02

WEDNESDAY 17 OCTOBER 2001

Members present:

Mr Richard Bacon	Mr Edward Leigh
Mr Ian Davidson	Mr George Osborne
Geraint Davies	Mr David Rendel
Mr Barry Gardiner	Mr Gerry Steinberg
Mr Brian Jenkins	Mr Alan Williams

In the absence of the Chairman, Mr Alan Williams was called to the Chair.

The Committee deliberated.

*Resolved*, That the Committee congratulate the Chairman, David Davis, on his appointment as Chairman of the Conservative Party and place on record its appreciation of his significant contribution during his Chairmanship to the work of the Committee, the National Audit Office and the Executive towards improving the value for money delivery of public services.—(*Mr Alan Williams*).

The Committee further deliberated (Election of Chairman).

*Resolved*, That Mr Edward Leigh take the Chair of the Committee in the place of Mr David Davis.

Mr Edward Leigh's relevant interests were noted.

Sir John Bourn, KCB, Comptroller and Auditor General, was further examined.

Mr Glenn Hull, Second Treasury Officer of Accounts, was examined.

The Comptroller and Auditor General's Report on Handling Clinical Negligence Claims in England (HC 403) was considered.

Sir Hayden Phillips, KCB, Permanent Secretary, Lord Chancellor's Department, and Clerk of the Crown in Chancery; Mr Nigel Crisp, Permanent Secretary, Department of Health; Mr Stephen Orchard, CBE, Chief Executive, Legal Services Commission; and Mr Stephen Walker, Chief Executive, NHS Litigation Authority, were examined (HC 280-i).

\* \* \* \* \*

[Adjourned until Monday 22 October at half past Four o'clock.

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WEDNESDAY 22 MAY 2002

Members present:

Mr Edward Leigh in the Chair

Mr Richard Bacon	Mr George Osborne
Mr Barry Gardiner	Mr David Rendel
Rt Hon Frank Field	Mr Gerry Steinberg
Mr Barry Gardiner	Jon Trickett
Mr Brian Jenkins	Mr Alan Williams
Mr Nigel Jones	

Sir John Bourn, KCB, Comptroller and Auditor General, was further examined.

The Committee deliberated.

Mr Brian Glicksman, Treasury Officer of Accounts, was further examined.

\* \* \* \* \*

Draft Report (Handling Clinical Negligence Claims in England), proposed by the Chairman, brought up and read.

*Ordered*, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 4 read and agreed to.

Paragraph 5 postponed.

Paragraphs 6 to 37 read and agreed to.

Postponed paragraph 5 read and agreed to.

*Resolved*, That the Report be the Thirty-seventh Report of the Committee to the House.

*Ordered*, That the Chairman do make the Report to the House.

*Ordered*, That the provisions of Standing Order No. 134 (Select Committees (Reports)) be applied to the Report.

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[Adjourned until Wednesday 12 June at Four o'clock.]