

FEATURE

COMPENSATION

Suing the NHS: can the £1bn annual compensation bill continue?

In the first of a series of Features about compensation for clinical errors, **Clare Dyer** looks at how cost saving changes in the law might affect patients and the NHS

Clare Dyer *legal correspondent, BMJ*

Eleven-year-old Joseph O'Reggio won £6m (€7m, \$9m) compensation last October for errors at his birth that starved his brain of oxygen and left him needing care for the rest of his life. Staff at Wolverhampton's New Cross Hospital failed to act quickly enough when his heart rate dropped.

What happened to Joe is a tragedy for him and his family, who battled for a decade to win the payout to secure his future. But the story is a depressingly familiar one: there are thousands of Joe O'Reggios. The same month as his case was settled, a report from the National Health Service Litigation Authority (NHSLA), which handles clinical negligence claims on behalf of NHS hospital trusts in England, found that birth errors landed the NHS with a £3.1bn legal bill between 2000 and 2010, and it warned that the same mistakes were still being repeated.¹

The annual NHS bill for damages and legal costs in clinical negligence claims in England breached £1bn for the first time in 2011-12. The surge to £1.28bn, a rise of more than 45% on the previous year's total of £863m, forced the government to approve an unprecedented bailout of £185m for the NHSLA. The increase in 2011-12 was partly down to a 30% rise in the number of claims made in 2010-11, many of which would have been settled in the following year.^{2,3}

As the number of claims increases, the size of damages awards is also rising relentlessly. The surge has been blamed on no-win, no-fee deals that allow lawyers to claim extra "success fees," better survival prospects for brain damaged babies, and a court judgment six years ago linking compensation for future care to increases in carers' wages rather than inflation. The size and number of compensation payouts are now reaching the point where the NHS can no longer afford them, asserts Christine Tomkins, chief executive of the Medical Defence Union, a mutual indemnity organisation that covers more than half of UK general practitioners and doctors in private practice against negligence claims. (The state took over indemnity for NHS hospital doctors in 1990.)

"What we now have are some of the largest awards for personal injury in the world," she says, pointing out that general

practitioners' subscriptions to the Medical Defence Union for professional indemnity have vastly outstripped rises in inflation, wages, and house prices, increasing from £1 in 1945 to £5500 in 2010. While she accepts that patients who have been negligently injured deserve fair compensation, "compensation to be fair has to be affordable too, and damages just can't keep inflating in a way that bears no resemblance to the financial expectations of ordinary citizens, taxpayers, and users of the NHS—it's unsustainable."

Coming in April 2013, however, is a seismic upheaval in the way clinical negligence and other civil claims are funded in England and Wales. The changes, which stem from a government commissioned report by the appeal court judge Lord Justice Jackson, are predicted to bring substantial savings for the NHS. But solicitors who act for injured patients and the patients' charity Action against Medical Accidents predict that the changes will restrict access to justice for some of the most vulnerable people.

Legal aid was launched in postwar Britain as the second arm of the welfare state, following the NHS. Under the scheme, the state paid the legal costs of launching civil claims for those who met the financial eligibility test. For decades, most of the population was covered. But as the cost ballooned, succeeding governments fought to contain the budget. In 1998 the Labour government removed legal aid from most personal injury cases but retained it for clinical negligence, acknowledging the complexity of the field. Now, in a bid to save £350m, the cash-strapped Conservative/Liberal Democrat coalition has put through legislation—the Legal Aid, Sentencing and Punishment of Offenders Act 2012—abolishing legal aid for most civil claims. The only clinical negligence cases for which aid will still be available, as a result of an amendment the government was forced to accept during its parliamentary passage, will be for injuries around the time of birth.

When the government withdrew legal aid from personal injury cases, lawyers were allowed to step in to take these cases on a no-win, no-fee basis, under conditional fee agreements. They were paid nothing if they lost the case, but if they won they

would get their normal costs plus an “uplift” or “success fee” of up to 100% of their costs. The more risky the case, the larger the uplift, so for complex cases they would be entitled to double their usual fees.

In England and Wales, a longstanding rule in litigation has been that the loser pays the legal costs for both sides. Since clinical negligence claims are the most complex of personal injury cases, the widespread use of conditional fee agreements in clinical negligence cases has landed the NHS with double costs in most successful claims brought on a no-win, no-fee basis. Cases have continued to be funded by legal aid, but successive reductions in eligibility limits meant that fewer and fewer have qualified.

The “loser pays” rule means that claimants also risk having to pay the NHS’s costs if they lose their case. So an “after the event” insurance industry grew up to insure claimants against that possibility, for a premium. If the claimant won, however, they could claim that premium back from the NHS, along with their lawyers’ normal costs and success fee. A Ministry of Justice analysis of a sample of payouts in no-win, no-fee cases in 2010-11 suggests that around half the legal costs paid in cases lost by the NHS were for success fees and insurance premiums.⁴

Under the changes set to come into force in April, claimants who win their cases will no longer be able to claim their lawyers’ success fees from the loser, which will save the NHS millions. They will be entitled to just the normal legal costs. Nor will they be able to claim a refund of the after the event insurance premium—apart from insurance covering the cost of experts’ reports. The flip side of the coin is that claimants who lose will normally no longer be required to pay the defendant’s costs, unless they are very wealthy, or have fraudulently, frivolously, or unreasonably pursued the case.

Any extra reward for the claimant’s lawyer, apart from the normal costs, will have to come out of the damages won by the claimant. There will be a cap on the uplift, which may not exceed 25% of general damages—those for pain, suffering, and loss of amenity—and past losses, such as care provided by the family before the case was settled. Claimants will get by far the biggest elements of their damages—those for future loss of earnings and future care—in full.

General damages will go up by 10%, which will be an extra expense for the NHS, though substantially offset by the other savings. An analysis by the Ministry of Justice estimates the annual savings to the NHS at around £50m.

Since some children who are injured at birth will need paid care into their 70s, Tomkins argues that society can no longer afford the huge payouts and needs to rethink the basis of compensation awards. The Medical Defence Union, which saw an 18% rise in claims against GPs between 2010 and 2011, is calling for repeal of a section of the Law Reform (Personal Injury) Act 1948, passed just before the establishment of the NHS. This laid down that compensation should be calculated to cover the costs of obtaining care privately, whether or not the claimant chooses to opt for private care. Calculating compensation on the basis that future care would be provided by the NHS and not the private sector would save billions, Tomkins argues. “I’m not saying we shouldn’t pay—we would be perfectly happy to buy the optimal package of care for the patient from the NHS, so instead of having money pouring out of the NHS it would have the chance of money going in.” The last Labour government consulted on reforming the act in 2007, but no consensus emerged.

The changes coming in April will bring savings for the NHS, but Peter Walsh, chief executive of Action against Medical Accidents, argues that these will be at the expense of injured

patients, who will find it harder to bring compensation claims. He predicts that clinical negligence will be a much less attractive field for lawyers and those who stay in it will be much more discerning about the cases they take on. Lawyers will cherry pick “sure-fire winners” and those with 50-50 cases will find lawyers reluctant to act for them, he maintains.

“It is very much a backward step for access to justice. We would also argue that it’s bad news for patient safety in the NHS. The NHS will learn fewer lessons and there will be less of an incentive to up their game.” He also believes an unintended consequence of the changes is that the less qualified general personal injury lawyers will “have a go” at the more specialised field of clinical negligence. Legal aid will fund only acknowledged experts to handle cases.

Legal aid, Walsh argues, is “by far the most cost-effective and fairest way to settle clinical negligence cases” and what the government should have done if it wanted to save taxpayers’ money was make legal aid freely available without a means test. Lord Justice Jackson and the NHS Litigation Authority both recommended that legal aid should be retained for clinical negligence cases. The definition of children who will still qualify for legal aid to sue over birth injuries has been drawn so tightly, says Walsh, that some will be excluded in an arbitrary way.

Stephen Walker, who retired last year after 16 years as chief executive of the NHS Litigation Authority, takes issue with the Medical Defence Union’s assertion that the current system is unsustainable. “There ought to be proper debate about compensation in the round, but simply to say it is unsustainable isn’t a sufficient basis even to get the debate off the ground,” he says. “The reverse of the argument is if you stopped getting things wrong so consistently then you wouldn’t have to pay in the first place. I think defendants are always on the back foot when they attack the level of compensation, which is paid after all only to a minority of patients who are being harmed because at the end of the day their man did it. The patient who’s being compensated is the victim. In the big cases they’re usually the victim of a very real tragedy and they wouldn’t have been paid unless the MDU, the NHSLA or whoever pays actually thought that there was a liability, that their man had been negligent or in breach of his duty.

“I think it’s a weak argument to say it’s unsustainable because it’s not. The money will be found. Having said that, I think there’s a big debate to be had about how the care of significantly damaged people should be funded, whether they’re NHS patients, private healthcare patients, or road traffic accident victims. But I don’t sense there’s a political will to take that one on at the moment.”

He adds: “I think it’s really important that defendants also take into account the claimant’s side of the debate because I can guarantee you that I never paid a penny to a victim who wasn’t desperately in need of the funds. Whether it was subsequently applied to all the issues it was claimed for I don’t know because I have no right to know.”

Robert Francis’s hard hitting report this month, on lessons for the NHS from failings at the Mid Staffordshire NHS Foundation Trust, had little to say about litigation over clinical errors. But as a barrister with more than 30 years’ experience of clinical negligence claims, Francis told MPs on the House of Commons Health Committee that unless the NHS adopted a new culture of openness and candour the £1bn a year litigation bill would continue to grow.

“If wrong has been done to a patient, if a public service has done wrong to them and injured them, they deserve compensation. They deserve first of all to be told that has

happened, and they deserve that that wrong has been put right," he said.

"If we aren't honest about it I'm afraid the litigation bill will just get bigger and bigger, because people will go on these days until they receive justice and receive satisfaction and many would say quite rightly. If you want to put me and my colleagues out of business, then settle all these things at the earliest possible time. Just as importantly, if the health service is to learn lessons, it's no use trying to learn lessons from an obstetric disaster eight years down the line after it's been settled for millions of pounds in court."⁵

An obvious question is whether the NHS can afford not to take whatever steps are needed to reduce the number of birth injury cases which result in such huge payouts, human tragedies, and continuing costs to society. Some 70% of the £3.1bn paid out on maternity claims between 2000 and 2010 related to shortcomings in the management of labour and cardiotocography interpretation, and cases where a baby was left with cerebral palsy. Compensation totalling more than £1.26bn was paid in 542 cerebral palsy cases.

In the majority of cardiotocography interpretation claims, the care was provided either by a midwife alone or by a midwife with a junior doctor. Suzanne White, a clinical negligence partner at the London law firm Leigh Day and Co, which has one of the biggest practices in the field, sees the same picture recurring in the cases she handles: "Poor midwifery care, inadequately trained junior doctors, failures by staff to interpret

the cardiotocograph accurately, and simply not enough senior obstetricians to deal with difficult labours." Having more consultants available on maternity units would be expensive, but the cost might be outweighed by savings on compensation payments and care further down the line. The Royal College of Obstetricians and Gynaecologists has called for fully trained doctors to be on site, day and night.

The NHSLA report on 10 years of maternity claims predicts that claims will continue to rise and the overall costs to the NHS, both in compensation and treatment costs, will "almost certainly" increase. It warns: "This financial cost to the NHS, along with the costs that cannot be quantified, can only be reduced through improved risk management."

Competing interests: I have read and understood the BMJ Group policy on declaration of interests and have no relevant interests to declare.

Provenance and peer review: Commissioned, not externally peer reviewed

- 1 NHS Litigation Authority. Ten years of maternity claims: an analysis of NHS Litigation Authority Data. October 2012.
- 2 NHS Litigation Authority. Report and accounts 2011-12. June 2012.
- 3 Dyer C. NHS compensation fund gets £185m bailout as claims rise by 30% in a year. *BMJ* 2012;344:e411.
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Figures

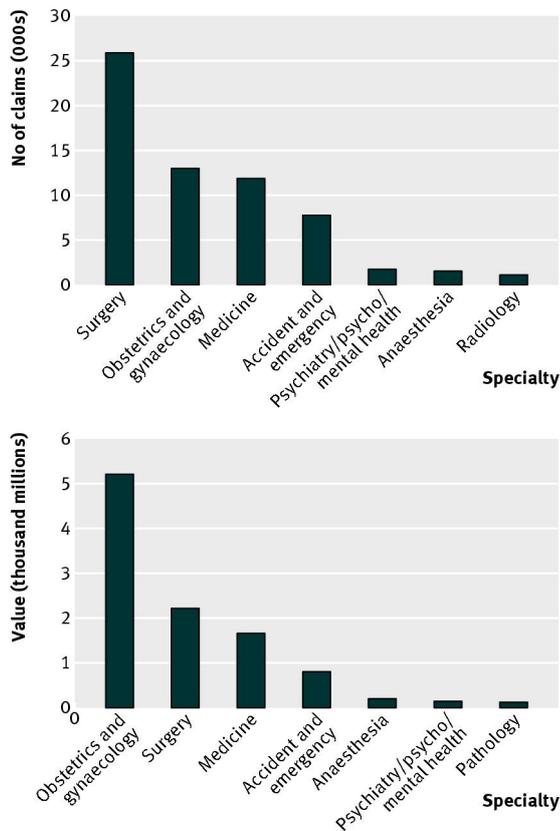


Fig 1 Number (top) and value (bottom) of reported Clinical Negligence Scheme for Trusts claims for selected specialties, 1 April 1995 to 31 March 2011¹ (excludes below excess claims handled by trusts before 1 April 2002)

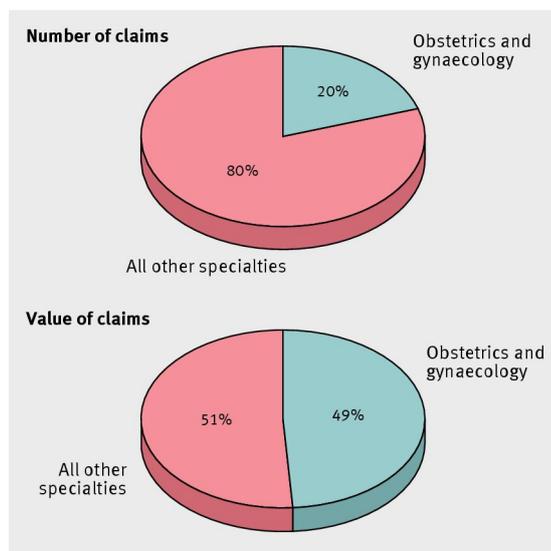


Fig 2 Total number and value of reported Clinical Negligence Scheme for Trusts claims, showing birth errors as proportion of total, 1 April 1995 to 31 March 2011¹ (excludes below excess claims handled by trusts before 1 April 2002)