Clinical negligence

Extract from the July 2017 Fiscal risks report

6.109 The uncertain future costs of settling successful clinical negligence claims against public sector health care providers are another material source of fiscal risk. Future costs reflect the number and value of claims brought forward, the proportion that result in damages, how big those awards are, and the timing with which they are paid. The number of claims is ultimately driven by the number of medical treatments that take place, the proportion of them resulting in an incident, and the proportion of incidents that result in a claim.

6.110 In primary care (e.g. GPs and dentists), practitioners are required to obtain personal medical indemnity insurance. This is provided by medical defence organisations (MDOs) – non-profit institutions owned by their members – and private sector insurers.

6.111 In secondary care in England, NHS Resolution (the operating name of the NHS Litigation Authority from April 2017) manages clinical negligence claims on behalf of the NHS through a number of schemes. These cover:

- **Historical liabilities**: claims for incidents that occurred on or before 31 March 1995 ('Existing Liabilities Scheme'), claims brought against the former Regional Health Authorities ('Ex-RHA Scheme') and dissolved bodies where there is no successor ('Department of Health Clinical Liabilities Scheme'). These schemes are all funded by the Department of Health.

- **Current liabilities**: incidents that have occurred since 1 April 1995, managed through the 'Clinical Negligence Scheme for Trusts' (CNST). This scheme is funded through participating members' contributions, largely from within the public sector.[1] In terms of cost, it is by far the largest scheme.

6.112 These schemes account for known claims that have already been submitted plus an estimate for claims 'incurred but not reported'. That is informed by past and current experience of the cost of claims arising from incidents that are expected to have occurred, but have not been reported at the end of the financial year covered by the accounts.

6.113 NHSR's accounts record provisions and contingent liabilities in respect of future costs of past events. Provisions relate to claims judged more likely than not to succeed. They are calculated by applying a probability to the estimated value of the claim, then discounting future cash flows into a present cost. Contingent liabilities are calculated as the remaining

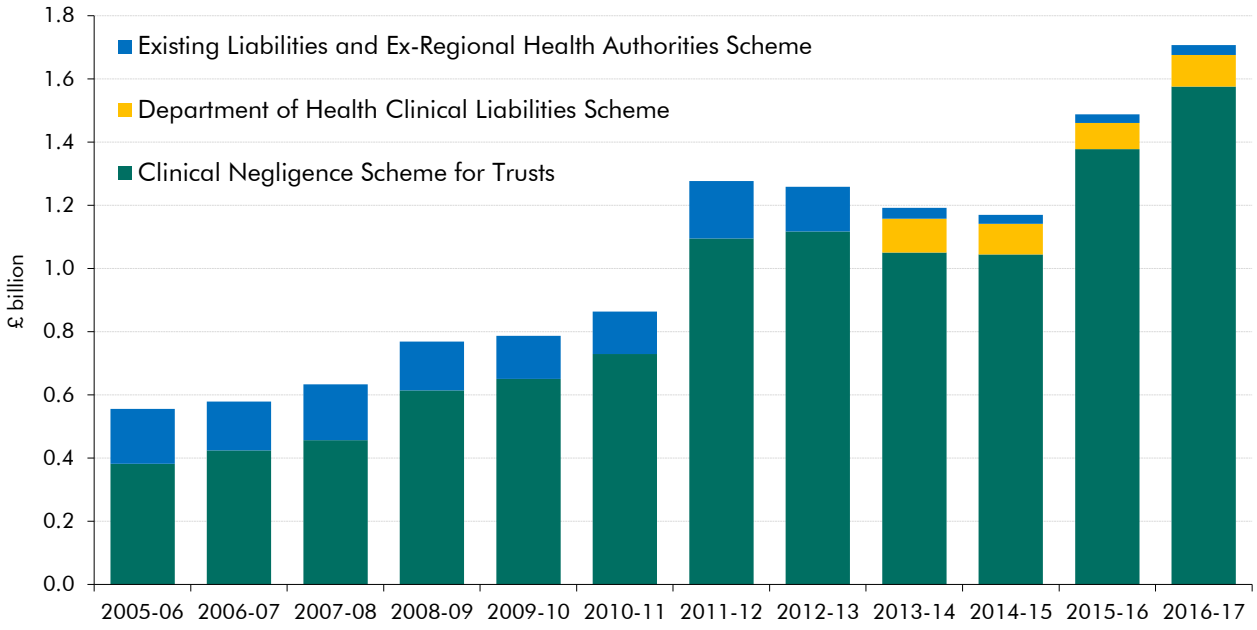
[1] In 2016, NHS Resolution provided indemnity cover to 530 members, including 209 clinical commissioning groups and 81 independent sector providers. CNST opened to the independent sector from 1 April 2013.

value of claims after the amount covered by provisions. These provisions and contingent liabilities are among the largest recorded in the WGA. Future costs in relation to primary care are not recorded in the WGA since the MDOs and other insurers are in the private sector. But the cost of the insurance cover is paid by practitioners, so a rise in contribution rates might require an increase in government spending indirectly via provider costs.

Trends in NHS Resolution spending, provisions and contingent liabilities

6.114 As Chart 6.28 shows, NHSR spending on clinical negligence claims has doubled in cash terms over the past six years and has risen by almost half over the past two. All the growth relates to current liabilities managed through the CNST. Spending on clinical negligence has risen from 0.9 per cent of DH's RDEL in 2010-11 to 1.5 per cent in 2016-17.

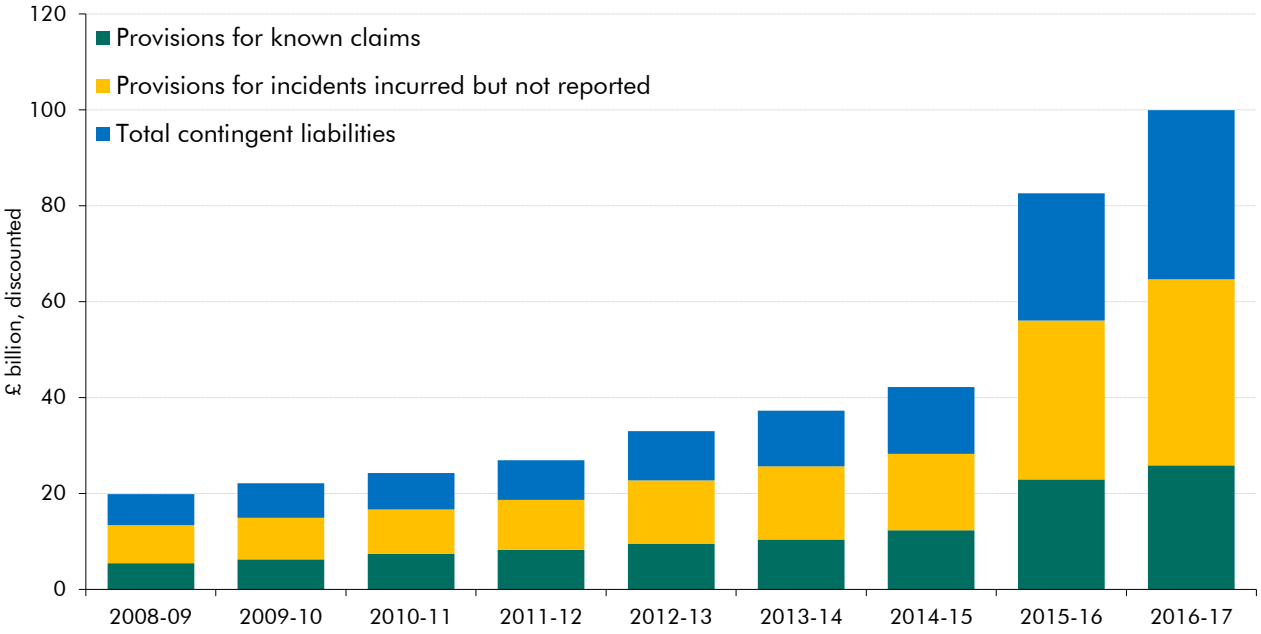
Chart 6.1: Annual expenditure on clinical negligence by scheme



Source: NHS Resolution, OBR

6.115 A similar upward trend can be seen in the provisions and contingent liabilities reported in NHSR's annual reports. These are discounted values, so were greatly affected in 2015-16 by the drop in the Treasury's long-term discount rate described in paragraph **Error! Reference source not found.** in relation to its effect on the nuclear decommissioning provision. The effect on the clinical negligence provision in 2015-16 was £25.4 billion. But even abstracting from that jump, the provision has increased by around 13 per cent a year on average over the past eight years – far faster than the 3.0 per cent a year average growth in nominal GDP.

Chart 6.2: Clinical negligence provisions and contingent liabilities



Source: NHS Resolution, OBR

6.116 Many factors have driven the higher spending and provisions:

- **Growth in the number of claims**: population growth and ageing have led to a higher number of patients and medical treatments, which increases the number of incidents potentially leading to claims. The number of new claims reported was rising until 2013-14, but has since fallen slightly each year. From available data, it is not clear whether the underlying drivers relate to the proportion of medical treatments resulting in an incident or the proportion of incidents that result in a new claim.

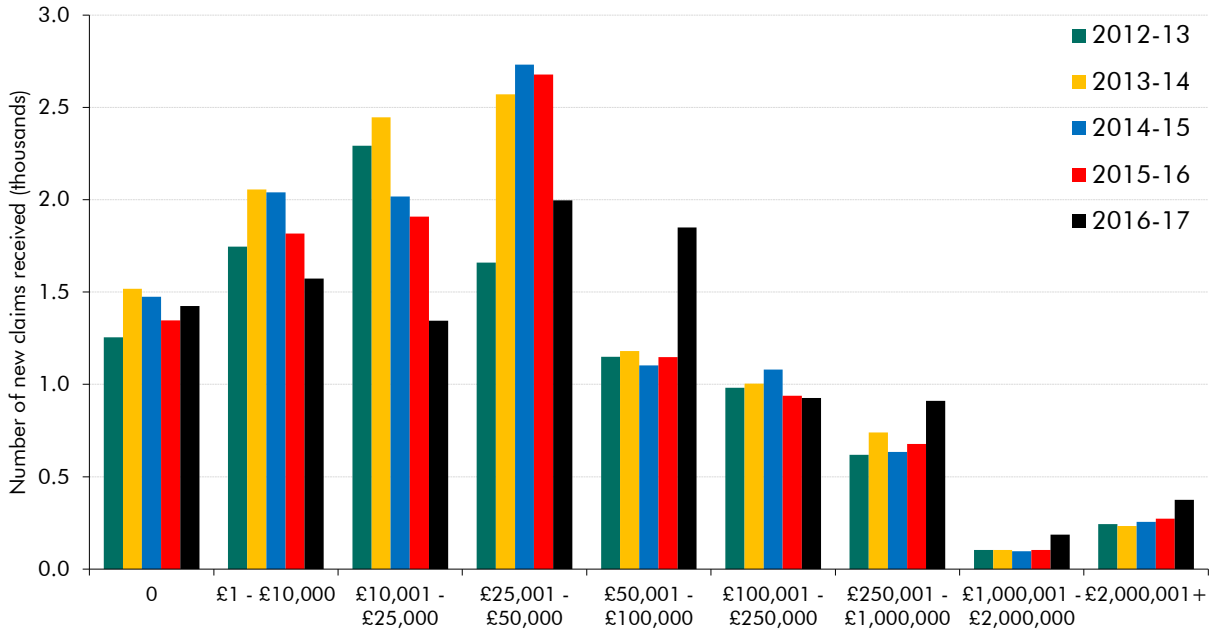
- **Growth in average damages per successful claim**: this is affected by the composition of awards by type and changes in the average awards for specific types. Both have raised average claims. Average awards are dominated by maternity incidents because of the very high value of claims arising from brain injuries at birth.[2] The value of an average claim received in this category has risen from £4.1 million in 2010-11 to £8.3 million in 2016-17. Factors driving this include increasing life expectancy, which means care is required for more years, and advances in medical treatment, which are often more costly.[3] Chart 6.30 shows the distribution of CNST cases received by size over recent years, illustrating that, although the total number of claims has fallen, the number of very large claims has increased. In 2016-17, the number of claims below £1 million was 6 per cent lower than the average of the preceding four years whereas the number of claims over £1 million was 59 per cent higher.

[2] NHSR reports that in 2016-17, 10 per cent of claims by number but 50 per cent by value related to the obstetrics speciality.
[3] Department of Health, *GP Indemnity Review*, July 2016.

- **Personal injury discount rate** (PIDR): this is the rate used to calculate lump sum awards in respect of personal injury, including clinical negligence. Unlike the Treasury discount rate used to convert future flows into a present cost, the PIDR actually affects the underlying flows themselves. It was held constant from 2001 to 2017, so has not contributed to growth in average damages per claim to date. But in February 2017 the Government lowered it from 2.5 to *minus* 0.75 per cent, effective from the following month. This was responsible for £4.7 billion of the £8.6 billion increase in the 2016-17 provision and will affect spending from 2017-18. NHSR notes that the lower PIDR could push the cost of claims arising from brain injuries at birth to more than £20 million per child. The Government recognised the potential cost of this change in Spring Budget 2017, adding £1.2 billion a year to the Treasury's central reserve.[4] It also launched a consultation on how the rate should be set in future. It closed in May 2017 and the Government is now considering responses.

- **Growth in average legal costs per claim**: some legal costs for successful claims are recovered from NHSR, raising overall costs.[5] In 2016-17, legal costs made up more than a third of the total payments. There has been a marked increase in claimant fees for lower value claims, with average fees for awards of up to £100,000 up from 32 per cent of the claim in 2004-05 to 53 per cent in 2016-17. In some cases, legal costs exceed the value of the claim itself. Rising legal costs may also be a factor driving the growing prevalence of no-win-no-fee arrangements.[6]

Chart 6.3: Clinical negligence claims received by size



Source: NHS Resolution

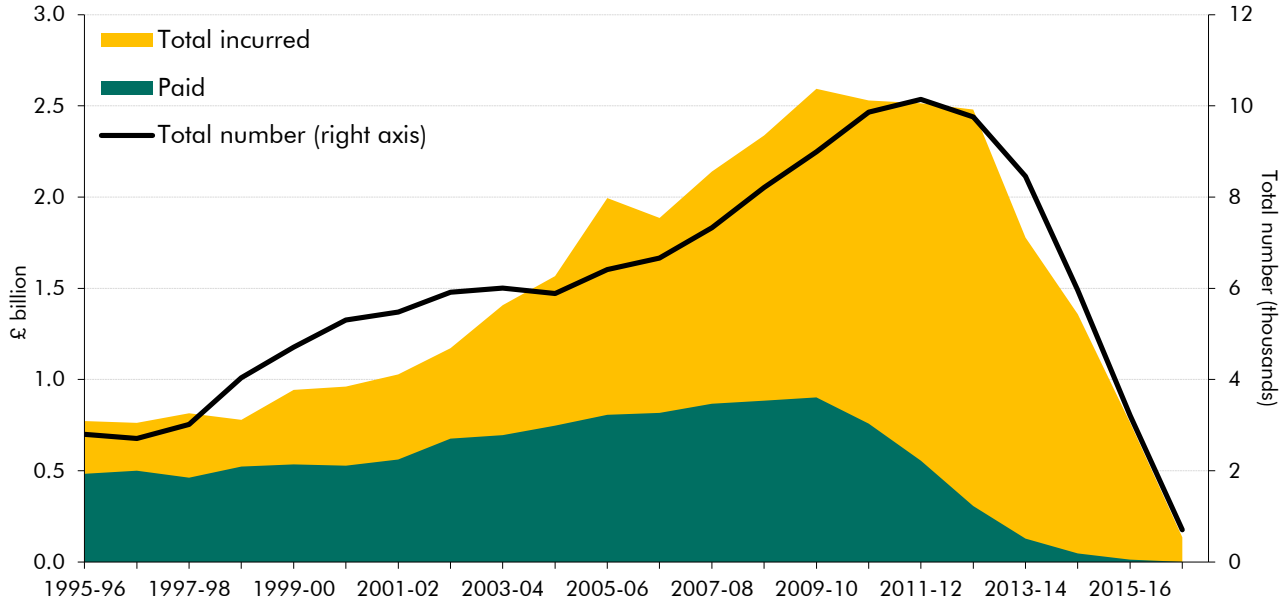
[4] The rate is set in relation to the yield on index-linked gilts. See Box 4.2 of our March 2017 *Economic and fiscal outlook* for more on how the PIDR change is expected to affect the public finances.
[5] Legal costs for successful cases covered by legal aid are recovered from NHSR. Since April 2013, lawyers' premiums for successful cases covered by no-win no-fee arrangements are paid from the damages of successful claimants.
[6] Since the lawyers bear some financial risk in these cases, their fees will include a premium to compensate and they will seek cases with the greatest probability of success. See Nuffield Trust, *Funding clinical negligence cases Access to justice at reasonable cost?*, 2016

Medium-term forecast risks

6.117 NHSR's 2016-17 accounts imply spending averaging around £2.9 billion a year over the next five years. That is up from £2.6 billion a year in the 2015-16 accounts, thanks to the effect of a lower PIDR and the rising cost of claims. Provisions and contingent liabilities reported by NHSR relate to incidents that are already known – including both those against which a claim has been made and those incurred but not reported. They do not include a forecast of the cost of claims on future incidents that can be expected on the flow of new medical treatments. While NHSR estimates the cost of these potential future claims for the purposes of setting DH DEL budgets and the addition to the Treasury's central reserve in Spring Budget 2017 following the PIDR announcement, there is nevertheless a risk that spending rises faster than anticipated.

6.118 The upward pressure on spending is further illustrated by Chart 6.31, which shows that the number and value of cases outstanding and resolved for incidents occurring in particular years have been rising over time. The numbers fall sharply in the most recent years because claims are made with a lag, so only a small fraction of the eventual total will have been received to date.

Chart 6.4: Clinical negligence cases and value by year of incident



Note: This chart shows known clinical negligence cases as at 31 March 2017
Source: NHS Resolution

6.119 Risks associated with clinical negligence claims in primary care are more difficult to analyse because they are not collated in the same way as NHSR collates those for secondary care. Most indemnity cover is provided by MDOs, which cover more than 95 per cent of GPs. Following last year's GP indemnity review the Government provided funding to GPs via the 'GP contract' to cover rising costs of indemnity. When the Government announced the PIDR reduction earlier this year, it stated that DH would work closely with GPs and MDOs "*to*

ensure that appropriate funding is available to meet additional costs to GPs, recognising the crucial role they play in the delivery of NHS care."[7]

6.120 Medium-term risks from clinical negligence costs could be related to the pressures on health spending described earlier in this chapter. The Medical Protection Society has argued that with clinical negligence costs absorbing a rising share of NHS spending – and the Spending Review settlement requiring significant efficiency savings relative to historical average rates of growth – there is a risk that greater pressures on medical professionals lead to higher numbers of incidents and future claims.[8] This type of adverse feedback seems plausible.

Long-term risks to fiscal sustainability

6.121 The majority of the NHSR provision and contingent liability relates to future claims beyond our five-year forecast horizon. But, as already noted, they do not factor in future claims from future medical activity. The question for fiscal sustainability is whether the cost of clinical negligence claims is likely to continue growing faster than GDP. This is not an issue that we have been able to explore for this report, but to the extent that the cost of clinical negligence is correlated with health spending more generally, our long-term spending projections would suggest it is an additional risk to fiscal sustainability.

Mitigating actions

6.122 NHSR has introduced a range of initiatives over recent years to manage claims more efficiently and to limit the rising cost of clinical negligence. For example, it helps trusts to share experience and manage costs better at a local level. To limit the increase in legal costs, it is also making greater efforts to resolve disputes via alternative mechanisms, such as mediation. Its 2017-18 business plan details these and other propositions.[9] In spring 2017, DH consulted on introducing fixed recoverable costs for lower value clinical negligence claims,[10] to reduce both the processing time and the cost of these claims. It also consulted on a voluntary alternative compensation scheme for severe birth injury that aims to reduce harmful events through earlier investigation and learning and provide compensation to eligible families without the need to bring a claim through the courts. And one possible outcome of the PIDR consultation could be a rise in the rate, which would offset some of the expected increase in the cost of lump-sum payments.

Conclusions

6.123 In terms of the characteristics set out in Chapter 1, the fiscal risks from clinical negligence are continuous and generally isolated from other risks – although they may be correlated with the those from wider pressures on health spending. They are largely endogenous to government action, in the sense that governments choose what clinical services to provide and are responsible for many of the factors that affect the incidence of negligence. On the other hand, governments have little choice over providing these services, which are

[7] Ministry of Justice, *Written Ministerial statement - HCWS503,* 2017.
[8] Medical Protection Society, *The Rising Cost Of Clinical Negligence: Who Pays The Price?*, 2017.
[9] NHS Resolution, *Business Plan 2017-18*, 2017.
[10] Department of Health, *Fixed recoverable costs for clinical negligence claims, consultation*, 2017.

expected in advanced economies. Risks from clinical negligence have been rising due to the combined effects of growing demand for medical services, developments in the legal market and rising costs per successful claim – both damages and legal costs. Lowering the PIDR has added to these pressures.

6.124 In terms of the 'four Ts', the Government *tolerates* the risk of the payments managed by NHS Resolution, by absorbing the cost of claims that are awarded compensation, but it also takes steps to *treat* it by taking action to mitigate costs, including legal costs, and trying to reduce the number of claims that occur via health service improvement programmes to reduce incidents and by looking at ways to address drivers in the legal environment.

6.125 We consider there to be a high likelihood of further increases in spending on clinical negligence beyond the amount currently provisioned over the medium term, largely because the provision relates only to past activity. Whether the flow of future claims not covered by the provision will be higher than has been factored into DH spending plans, plus the addition to the reserve associated with PIDR costs, is more difficult to judge. History suggests at least a medium likelihood that it will. Risks around the other assumptions underpinning the provision seem relatively balanced. We also see a high risk of clinical negligence costs putting upward pressure on spending over the long term, but the impact of this would be small relative to the wider risk from health spending described earlier in the chapter.