

National Health Service Litigation Authority: 10 years on

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ABSTRACT – This paper outlines the circumstances leading to the formation of the National Health Service Litigation Authority (NHSLA) and describes how the authority has developed in its first 10 years. It also offers a few pointers to the future.

KEY WORDS: claims management, clinical negligence, liability, risk management

The National Health Service Litigation Authority (NHSLA) came into being just over 10 years ago, so this is an opportune moment to review its history and achievements and to speculate on what the future might bring.

Creation

Two separate developments led to the formation of the authority. The first occurred on 1 January 1990, when National Health Service (NHS) indemnity was introduced. Hitherto, individual clinicians and health authorities had been accountable for their own claims. So, if a physician treating an NHS patient in an NHS hospital negligently misdiagnosed a condition and the patient suffered additional pain as a consequence, then the physician was personally liable and would have sought assistance from his or her medical defence organisation. Henceforward, the NHS agreed to take over all such past and future liabilities, with the exception of claims against general practitioners.

Second, the early 1990s saw the creation of NHS trusts, in various waves, ending on 1 April 1995. These bodies did not inherit any clinical liabilities from their predecessors but immediately incurred liabilities of their own.

A highly fragmented picture therefore developed. Scores of health authorities and hundreds of trusts began to handle clinical negligence claims in different ways and with varying degrees of capability. It became clear that a national framework was required and, following a consultation process, a scheme was established under Section 21 of the NHS and Community Care Act 1990 to cover clinical negligence claims. This became effective from 1 April 1995 as the Clinical Negligence Scheme for Trusts

(CNST), covering incidents occurring on or after that date.

The government decided to create a special health authority to administer the scheme, and thus NHSLA was born on 21 November 1995.

Early days

Initially, because the authority was literally starting from nothing, claims-handling was contracted to the Medical Protection Society. From 1 April 1998, however, this function was taken in house, where it has remained since.

It soon became apparent that a scheme was also needed to cater for older claims. The Existing Liabilities Scheme (ELS) was created to cover clinical negligence claims against both health authorities and trusts where the alleged negligence occurred before 1 April 1995. The ELS began on 1 April 1996 and was also administered by NHSLA. Whereas funding of CNST was by the trusts, funding for ELS came from the Secretary of State. The ELS covers liabilities dating back to the formation of the NHS in 1948, and claims in respect of incidents in the late 1940s and early 1950s have been received, invariably in respect of alleged obstetric negligence leading to the birth of a brain-damaged baby. There is no limitation period in the most serious of these cases because of the claimant's lack of mental capacity.

Another development on 1 April 1996 was the abolition of regional health authorities. Some of these had direct responsibility for patient care, chiefly arising from the London teaching hospitals. Consequently, another scheme was devised (Ex-RHA) to cater for clinical liabilities but, uniquely, these liabilities were transferred to NHSLA itself, which inherited several hundred claims as a consequence.

New schemes

On 1 April 1999, NHSLA launched two further initiatives at the request of the Secretary of State: the Property Expenses Scheme (PES) and the Liabilities to Third Parties Scheme (LTPS). The PES covers damage to buildings and contents owned by the NHS, plus business interruption costs. The LTPS is a wide-ranging scheme incorporating liability to

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members of the public, injury to NHS employees, professional indemnity, personal accident and defamation. Previously, unlike the case with clinical liabilities, NHS bodies had been permitted to insure against these contingencies. Substantial financial savings to the service were achieved immediately when these risks were brought in house.

Consolidation

As created, both ELS and CNST included provision for excesses. In other words, NHS bodies were directly financially responsible for particular amounts on each claim. This meant, in practice, that it was very difficult to gain a complete national picture. Moreover, organisations ploughed their own furrows on smaller claims, with varying degrees of success. To rationalise the position, therefore, the ELS excesses were abolished on 1 April 2000 and those for the CNST on 1 April 2002. For the first time, from the latter date NHSLA was able to control all clinical negligence claims against NHS trusts and health authorities in England, to commence the compilation of national statistics and to assess trends.

The authority

What is NHSLA? It is not an insurance company but rather a special health authority, and thus it is part of the NHS. It covers England only, there being separate arrangements for Wales, Scotland and Northern Ireland. The advantage of not being an insurer is immense because there is no need for huge financial reserves to be maintained, which would divert money away from patient care. The direct funding mechanisms (from central government and scheme members) mean that no intermediaries such as brokers have to be paid, again preserving money for the service.

The authority's framework document details its functions, including the following:

- to minimise the overall costs of clinical negligence in the NHS and thus maximise the resources available for patient care, by defending unjustified actions robustly, settling justified actions efficiently, and creating incentives to reduce the number of negligent incidents
- to minimise the risk that patient care in a particular community is jeopardised by a large settlement against its principal provider unit
- to improve the quality of patient care by providing an incentive for provider units to improve cost-effective clinical risk management, and by disseminating relevant information on clinical risks
- to maximise the incentive for provider units to improve claims management.

It will be immediately apparent that these functions include risk management as well as claims handling. Indeed, there is a specific injunction to improve the quality of patient care through risk management and other means.

Claims management

On the claims front, NHSLA inherited what can best be described as a nightmare. There had been a general lack of urgency, and many cases were allowed to drift unnecessarily into litigation. An adversarial attitude existed, whereby opposing parties mistrusted each other. There was failure to grasp key issues promptly or at all and the unnecessary incurring of huge legal bills. Claims were not reported promptly by members, and in about 20% of cases the defence solicitors failed to give any advice on liability, quantum or tactics. Moreover, there was an unhealthy tendency to commence costly litigation against other NHS bodies.

The authority decided that it was critical to take firm control of the litigation process and, after carrying out suitable research and analysis, appointed a panel of only 18 expert defence solicitors to handle cases across England. That contrasted with almost 100 separate firms that had been appointed by NHS bodies nationwide, ranging from the excellent to the abysmal. This panel in 2005 consists of only 12 firms.

A key role in developing and implementing the Pre-Action Protocol for the Resolution of Clinical Disputes, introduced in April 1999, was played by NHSLA. This encourages both sides to adopt a constructive 'cards-on-the-table' approach so as to facilitate early decisions and reduce legal fees.

Claims reporting guidelines were devised in order to assist members to notify claims and potential claims promptly and to undertake a preliminary analysis of the risks. Training seminars were provided to launch this initiative.

NHSLA has been at the forefront of the use of structured settlements (referred to since 1 April 2005 as 'periodical payments'), whereby seriously injured patients receive their damages regularly throughout their lives, at a guaranteed level adjusted by the retail prices index, rather than by way of a lump sum. This greatly benefits claimants and their carers because the income is assured. Lump sums, by contrast, can easily be frittered away or dry up in the event of the claimant living longer than expected. There is also a benefit to the NHS because more money can be retained for patient care since the initial outlay is diminished.

The authority has pioneered the use of alternative dispute resolution, in other words settling cases through such means as mediation or round-table negotiations, in clinical negligence cases. Its achievements were marked by the authority being named Public Sector Mediator of the Year in June 2004.

With its national overview, NHSLA can select cases to take to appeal and, it is hoped, to obtain beneficial precedents for the NHS. There is no scope in this short article to detail all the leading decisions over the past 10 years in which the authority has been involved, but the most recent include the 2005 judgment of the House of Lords in *JD and Others v E Berkshire Community Health NHS Trust and Others*, in which the House confirmed the authority's view that to impose a duty of care on doctors towards the parents of children suspected of having been abused would place clinicians in an impossible position; and *Cooke v UBHT NHS Trust*, an October 2003 ruling of the

Court of Appeal that rejected the claimant’s attempt to increase the basis of quantifying damages for future loss, a result that saved the NHS in England alone some £700 million per annum.

Risk management

Risk management is a key element of NHSLA’s activities. Various standards have been produced, attainment of which not only reduces the likelihood of claims but also qualifies for a discount on a trust’s contributions to CNST. These standards have been regularly refined, and there are now separate provisions for maternity services, ambulance trusts, mental health and learning disabilities, primary care trusts and acute trusts.

Objective assessment of compliance with the standards is achieved by an independent inspectorate. More than 500 visits were performed in 2004–5, and the number of trusts failing to achieve even level 1 (the lowest) fell significantly. For example, in 2004–5, attainment against the maternity standards was as shown in Table 1. Against the ambulance standards, which had been introduced only that year, attainment was as shown in Table 2.

NHSLA works closely with the Healthcare Commission under a concordat to ensure that the burden of inspections on the NHS is reduced to the minimum consistent with improving service to the public. Risk-management workshops and other forms of training are provided regularly to the service.

Table 1. Attainment against CNST maternity standards, 2004–5.

Level	Trusts (n)
0	0
1	102
2	46
3	5

Table 2. Attainment against CNST ambulance standards, 2004–5.

Level	Trusts (n)
0	4
1	16
2	8
3	2

Table 3. Numbers of new claims received per financial year, by scheme.

Year	CNST	ELS	Ex-RHA
2002–03	5614	467	4
2003–04	4168	334	2
2004–05	4316	296	7

Human rights information

In January 2003, NHSLA launched a totally new initiative at the request of the Department of Health (DH). This is the Human Rights Act Information Service, provided free of charge to the whole NHS. It consists of a quarterly newsletter, answers to individual queries and a database on the authority’s website (www.nhsla.com). This has been a major success and has received numerous plaudits.

Recent developments

Like all so-called ‘arms-length bodies’, NHSLA was subjected to a rigorous review in 2003–4, which resulted in a drastic reduction in the overall number of such organisations. Fortunately, the achievements of the authority were recognised and NHSLA emerged from the process strengthened by acquiring the Family Health Services Appeal Authority (Special Health Authority), with effect from 1 April 2005. This body is based in Harrogate and deals with appeals on varying subjects, eg in respect of the provision of pharmaceutical services.

Making amends,¹ the Chief Medical Officer’s report on the future of clinical negligence claims, was published in June 2003. It is envisaged that NHSLA will be charged with managing a small claims scheme, one of Professor Donaldson’s key recommendations. The authority is well qualified to do so, having piloted such a scheme successfully in 2002.

In August 2005, NHSLA was asked to manage equal-pay claims against trusts and health authorities. Such claims are growing rapidly in number, and the DH realised that a strategic view was required. Employment litigation constitutes a new avenue for the authority and an exciting challenge.

So, over the past 10 years, the authority’s achievements have been both considerable and wide-ranging. In particular, it has been able to rationalise the handling of clinical negligence claims in England by concentrating expertise, increasing efficiency and adopting a national overview. As a result, the time taken to settle claims has reduced significantly, and defence legal costs are controlled firmly. A much more constructive attitude to negotiations on the part of both claimants and defendants now exists.

Statistics

It is frequently maintained that a compensation culture exists, but NHSLA’s figures for clinical negligence claims do not bear this out. Comparative numbers of new claims per scheme demonstrate this

Table 4. Numbers of new claims received under LTPS, by financial year.

Year	Claim numbers
2002–03	7094
2003–04	7918
2004–05	7796

Table 5. Amounts paid in claims, by financial year.

Year	Clinical (£ million)	LTPS (£ million)
2002–03	446.2	14.5
2003–04	422.5	7.4
2004–05	502.9	21.3

(Table 3). The figures for the LTPS (chiefly public and employers’ liability) show a variable trend (Table 4). Damages paid, however, demonstrate a distinct upward trajectory (Table 5). The LTPS figure for 2003–4, showing an ostensible significant drop, reflects a change in accounting policy.

So, expenditure is escalating, but this is due in the main to higher awards by the courts, something over which NHSLA has no control.

The present and the future

At present, NHSLA has approximately 200 staff, split between offices in London, Croydon and Harrogate. It boasts a notable record of achievement, having started from scratch only 10 years ago. It is often consulted by the DH and has much contact with other arms of government, such as the Department for Constitutional Affairs. It has built a significant reputation in a short period of time.

However, no successful organisation can stand still, and there are undoubtedly challenges ahead. One of the greatest of these is the way in which the provision of NHS treatment is being diver-

sified, for example by the use of independent sector treatment centres, which creates a number of intricate legal problems. NHSLA is working with the DH to help solve these, and one of the first fruits of that dialogue is an arrangement whereby cover is being provided under CNST to independent sector treatment centres (ISTCs), currently via the primary care trust that refers the relevant NHS patient.

The Lyons Review has decreed that NHSLA must relocate 72 posts out of London by 2010 at the latest, which understandably has caused anxiety among the staff.

Another challenge, as yet uncompleted, is to persuade the courts to reduce the level of costs recovered by claimants’ solicitors. At present, under CNST, claimants’ costs are 50% higher than those of defence solicitors. Hourly rates allowed by the courts are significantly greater than those paid by NHSLA to its own panel. The Authority has had some success in achieving costs ‘caps’ in group actions, but it is seeking to develop this concept further.

Overall, therefore, the Authority has travelled a very long way in 10 years. Who can predict what the next 10 years will bring? Whatever the obstacles, NHSLA is well equipped to overcome them with confidence.

Reference

- 1 Department of Health. *Making amends*. London: DH, 2003.