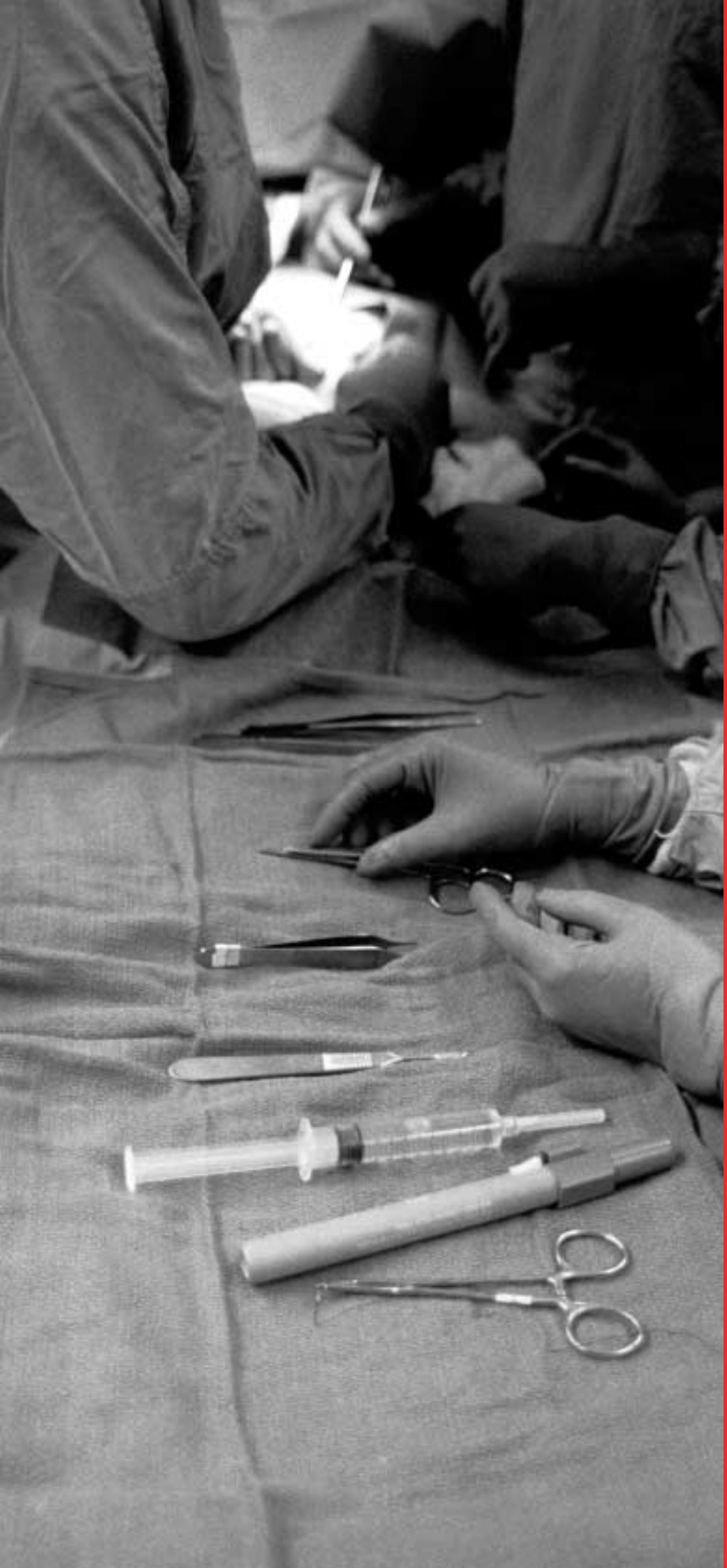
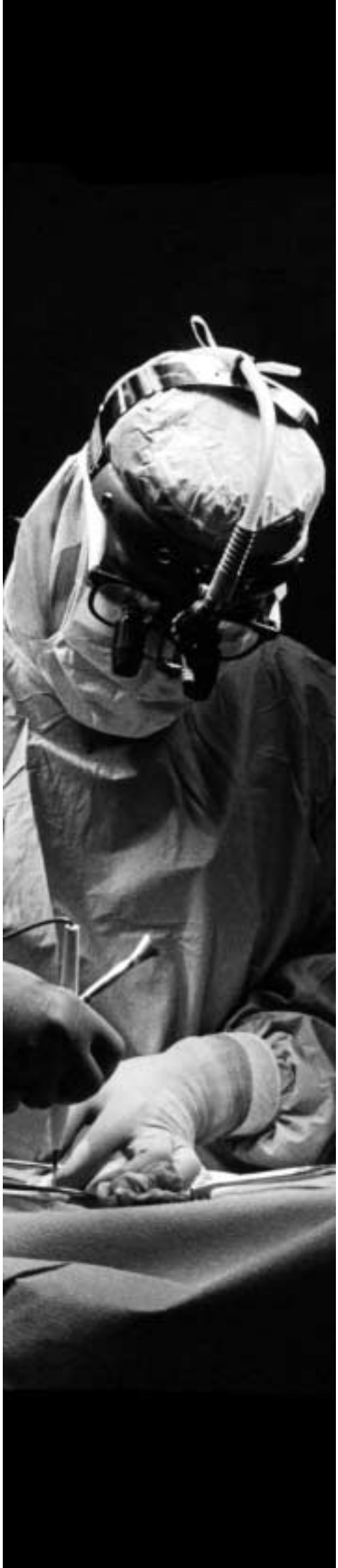


Archwilydd Cyffredinol Cymru
Auditor General for Wales

Clinical Negligence in the NHS in Wales

Report by the National Audit Office on behalf of the Auditor General for Wales



Clinical Negligence in the NHS in Wales

Report by the Auditor General for Wales,

presented to the National Assembly on

23 February 2001

This report has been prepared for presentation to the National Assembly under the Government of Wales Act 1998.

John Bourn
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6 February 2001

The Auditor General for Wales is totally independent of the National Assembly. He certifies the accounts of the Assembly and its associated sponsored public bodies; and he has statutory authority to report to the Assembly on the economy, efficiency and effectiveness with which the Assembly and its sponsored public bodies have used their resources in discharging their functions.

This report was prepared for the Auditor General for Wales by the National Audit Office Wales.

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EXECUTIVE SUMMARY

1 The National Health Service (NHS) has a duty of care to those it treats. People who consider they have suffered harm from a breach of this duty can make a claim for compensation and damages against the NHS. In 1999-2000, over 700 patients or relatives of patients made claims against Welsh trusts and health authorities for alleged clinical negligence. The compensation payable in respect of successful claims varies in size but can be considerable, with claims ranging from below £1,000 to over £3 million.

2 This report sets out the results of work carried out by the National Audit Office Wales to:

- identify the costs of clinical negligence to NHS Wales (Part 2);
- examine the management processes in place to handle claims promptly and cost effectively (Part 3); and
- review whether trusts are proactive in taking appropriate steps to reduce the incidents that give rise to claims for clinical negligence, and the scope for alternative ways of resolving potential claims (Part 4).

3 Healthcare providers (the 15 NHS trusts for the purposes of this study, which was restricted to claims against NHS Wales) are responsible for the costs of negligence cases in respect of the clinical actions of their employees. Claims arising from incidents prior to the formation of the trusts remain the responsibility of the health authorities or their predecessors which directly managed the hospitals at the time. Under the Assembly's new ten-year Plan for the NHS in Wales, announced in February 2001, health authorities are to be abolished by April 2003, with the National Assembly taking more direct control of its health responsibilities

4 Legal advice is provided to all trusts and health authorities for all new claims by Welsh Health Legal Services, part of Conwy and Denbighshire NHS Trust. Trusts and health authorities have an arrangement to share the cost of large awards through the Welsh Risk Pool, now also administered by Conwy and Denbighshire NHS Trust.

Summary of findings and conclusions

5 The annual cost of clinical negligence to the NHS in Wales is considerable and rising, reducing the funds available for patient care. However, until recently there has been little effort made to tackle the problem in a robust, co-ordinated manner. The absence of management information, at both trusts and centrally in the Assembly, is striking; we had to generate the majority of information in the report ourselves. Although the reasons behind incidents of negligence are often complex and difficult to determine, National Audit Office Wales analysis of a sample of cases suggested that errors arising from a breakdown in administrative, rather than clinical, procedures were at least contributory factors beneath a good proportion of cases of negligence. Some recent initiatives to reduce the risk of clinical negligence arising in the first place and to collect better information on its incidence are welcome. But there remains considerable progress to be made by the NHS Wales in tackling clinical negligence.

Cost of clinical negligence

6 At March 2000 there were over 1,600 open (unresolved) claims for clinical negligence against the NHS Wales, with a total potential value of over £400 million. However, claims may take a number of years to resolve, and many will not result in compensation to the claimant. We reviewed the information available on the current and future costs of clinical negligence - primarily within the annual NHS (Wales) Summarised Accounts - and found that:

- the precise costs attributable to clinical negligence in the NHS (Wales) Summarised Accounts are difficult to establish and interpret. This is not a criticism of the accounts, but rather reflects the judgements and technicalities involved in accounting correctly for costs whose eventual size and period of payment can remain uncertain for some time after the original liability has arisen;

- based on information held by Welsh Health Legal Services, the National Audit Office Wales assessed the likely liability for claims open at March 2000 to be in the range £60 - 154 million;

- in terms of annual costs, in 1999-2000 cash payments made by the NHS Wales on clinical negligence cases totalled £26.9 million. Expenditure reported in the NHS (Wales) Summarised Accounts, which attempts to recognise the cost when the liability is incurred rather than when claims are settled, was £40.9 million. Both sums represent significant increases over the previous year, although annual charges, however calculated, can be distorted by single, large settlements; and

- in recent years the trend of clinical negligence costs is upwards. Reasons for this rise are not clear and lie outside the scope of this study. Legal changes are likely to mean, however, that clinical negligence costs will continue to rise at least in the short term.

How claims are managed

7 The management of clinical negligence claims is an expensive, lengthy and complex process. For example, from our analysis of a sample of claims we found claims to take on average over four years to resolve from date of incident to date of settlement. It takes on average nearly 2 years for patients to make a claim against the health body after the incident of negligence has occurred, and 2½ years for trusts to settle those claims that they receive.

8 We looked at a number of aspects of claims management, including the main parties involved, the underlying causes of negligence, the factors contributing to the lengthy time taken to resolve claims, and the availability of management information. We found that:

- Welsh Health Legal Services is generally viewed by trusts as a good provider of legal services in clinical negligence claims. However, since their costs are not passed on to health bodies who use their services, there is no incentive for trusts and health authorities to seek alternative suppliers to test the value and quality of services provided. There has been no assessment of whether Welsh Health Legal Services continue to provide value for money since 1994; that they are in the process of implementing a system of independent review is therefore welcome;

- the impact on trusts of the likely rise in clinical negligence claims in recent years is being exacerbated by the effect of NHS reconfiguration in Wales and the Woolf reforms' aim to speed up the progress of cases. With enforced deadlines and penalties for mismanagement of claims, this higher workload is likely to put an increased demand on claims managers within trusts who are already under pressure;

- in our case study analysis, potentially avoidable errors by clinicians and others, associated with administrative, communications, or wider systems issues, as opposed to strictly clinical judgement or technical errors - termed "non-clinical" errors in this report - were either the main cause of negligence or the main reason why the case could not be defended in 16 per cent of claims. Based on our sample, the total cost to the NHS in Wales of such cases in 1999-2000 might have been some £4.2 million. If the NHS Wales were to reduce the incidence of such errors by, say, a third, this might save some £1.4 million each year;

- questionnaire responses showed that trusts believed that difficulties in agreeing compensation with the claimant were the principal cause of delay in settling a claim. They also considered the management of a claim by a claimant's solicitor to be another main cause of delay. Pro-active investigation of an incident and better co-operation of clinicians were thought by trusts to be the most effective ways to reduce the time taken to resolve claims; and

- although steps have been taken to computerise information on clinical negligence, the almost complete absence of even basic management information, at both trusts and centrally, on cases is striking and seriously hinders case load analysis and management. The National Assembly's Losses and Special Payments Register represents a potentially useful source of basic information on claims, provided issues concerning its ownership and management can be resolved.

Reducing the incidence of clinical negligence

9 While there remains scope for improving the management of clinical negligence claims, the best way of reducing costs is to reduce the number of clinically negligent incidents. This would also clearly have significant benefits for patients. The National Audit Office Wales looked at measures that have been taken in Wales to improve clinical care - and thus potentially reduce negligent incidents - through learning from experience. We also considered briefly the scope for resolving adverse incidents to the full satisfaction of affected patients without recourse to lengthy and costly legal processes.

10 Our findings were as follows:

- the introduction of risk management standards by the Welsh Risk Pool, together with incentives for trusts to comply with them (through reduced excess payments), is a useful mechanism for trusts to tighten procedures and so minimise the potential for negligent incidents;

- the results of independent assessments of trusts' compliance with the risk management standards in 2000 show that there remains considerable scope for further improvement. Only five of the 15 trusts achieved the benchmark of at least 75 per cent compliance. The three standards where compliance across Wales was the lowest correspond to the non-clinical errors the National Audit Office Wales found can contribute significantly to incidents of clinical negligence;

- one of the most important risk management standards is that trusts should have adverse incident reporting systems. Such systems are key to gathering evidence on clinical error, in such a way that causes can be tackled. Progress by trusts in implementing adverse clinical incident reporting systems has been slow, and there is no standardised system as yet; and

- research has established that patients take legal action against healthcare providers for several reasons, with financial recompense often considered less important than the need for recognition of error and an apology. Trusts rarely use alternative remedies, such as mediation and ex gratia payments, to resolve problems arising from clinical negligence, although they can offer benefits for both healthcare provider and patient. Although alternative remedies are not suitable in every case, there is considerable scope for greater use of them.

Final concluding comment

11 The NHS Wales now recognises that more needs to be done to prevent clinical negligence costs continuing to rise. There have been a number of recent initiatives to tackle this issue; the Welsh Risk Pool, in particular, has been proactive in expanding its cost-sharing role into improving risk management and spreading good practice. However, it is important that the NHS Wales accords a higher priority to tackling clinical negligence; the sooner inroads are made, the sooner resources will be released for patient care.

PART 1: INTRODUCTION

Clinical negligence

1.1 The National Health Service (NHS) has a duty of care towards those it treats. People who consider they have suffered harm from a breach of this duty can make a claim for compensation and damages against the NHS. In 1999-2000, over 700 patients or relatives of patients made claims against Welsh trusts and health authorities concerning a perceived lack of care they received from the NHS. As at March 2000, there were over 1,600 open (unresolved) claims.

1.2 In order for a claim to succeed the claimant must prove four things:

- that they were owed a duty of care (a relatively straightforward matter for most patients under the care of clinical staff);
- that the duty was breached (whether the clinician acted with the ordinary skill of an ordinary clinician exercising that particular art - known as the Bolam test). Broadly this means that the clinician must have acted in a way that a reputable, reasonable clinician would regard as incompetent, that is, that the mistake was one that no responsible clinician would have made;
- that the breach of duty caused, or contributed materially to, the damage in question; and
- the consequences and effect of the damage.

1.3 The Limitations Act 1980 requires that claims are made within three years of the date of incident or three years from the date the patient became aware that they had suffered from negligence. With minors, the three-year limitation period begins once they have reached the age of 18. (There are no time limits for people under a disability who cannot manage their own affairs.)

The cost of clinical negligence

1.4 Claims are made concerning a wide range of clinical work. The compensation payable is highly variable and can range from below £1,000 to over £3 million. The damages payable in compensation comprise a number of elements:

- general damages, awarded for pain, suffering and the loss of amenity (the inability of a ballroom dancer to dance as a result of an ankle injury, for example);
- past losses, such as loss of earnings, cost of drugs and paid carers; and
- future losses, such as future loss of earnings, cost of future care, the purchase of a suitable house and equipment.

Certain specialities, particularly orthopaedics and those which are birth-related such as obstetrics, are more likely to generate claims with higher values. Examples of claims are illustrated below.

Examples of clinical negligence claims

Case 1

In 1994, doctors failed to perform a cervical examination on a patient who had just given birth, although her medical notes indicated she was showing signs of cervical cancer and required an examination. The cancer was only diagnosed one year later when the patient returned to hospital. The patient died shortly afterwards. The trust admitted liability and the claim was settled for £130,000 with claimant legal costs at £10,600 and defence costs at £2,200.

Case 2

In 1995, a patient was given medication for back pain. The consultant failed to warn the patient that the medication would reduce the effectiveness of the contraceptive pill. The patient became pregnant and sued for damages for raising the child and for increase of pain to her back. She was awarded £72,600.

Case 3

In 1994, a patient underwent an operation to correct a dislocated shoulder. The operation was unsuccessful but this went unnoticed by the medical staff. The patient now suffers from permanent disability to the shoulder. The trust admitted liability and settled the case for £100,000 in 1999. Claimant and defence legal costs totalled £8,300.

1.5 The National Assembly for Wales is concerned over the rising cost to the NHS of both new and existing claims. The issues involved in quantifying the cost are considered in Part 2 of this report, but, as an illustration, provisions for future liabilities relating to clinical negligence made by health bodies in Wales increased from £70 million at March 1997 to £93.7 million at March 2000.

Stages of a claim

1.6 After a potential negligent incident has occurred, the patient may file a formal complaint or a request for their medical records. Depending on the information obtained, the patient may then make a formal claim against the NHS. The process of resolving claims is similar in most instances. Key stages are:

- research into liability and causation (to establish if physical or psychological damage had occurred due to negligence);
- assessment of quantum (the amount owed to the patient due to the alleged negligence); and
- resolution through settlement in or out of court, abandonment, or other means, such as mediation (alternative dispute resolution).

Who administers clinical negligence claims?

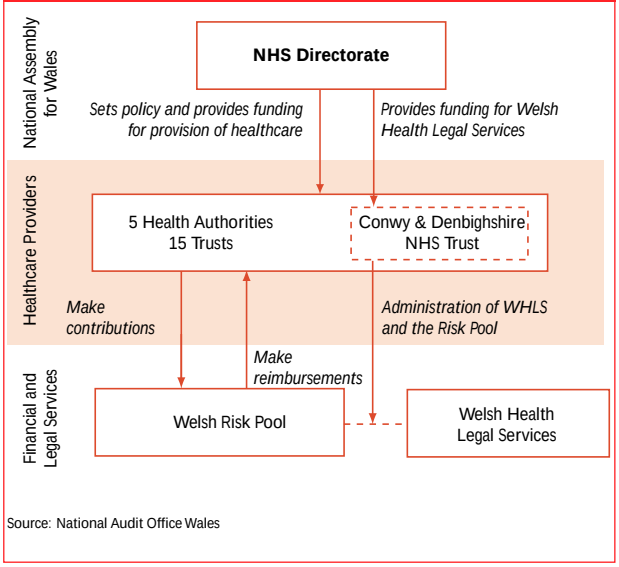
1.7 Healthcare providers are liable for the costs of negligence cases brought by patients against them in respect of the clinical actions of their employees. In Wales the providers are the 15 NHS trusts. Claims arising from incidents prior to the formation of trusts remain the responsibility of the five health authorities, where they or their predecessors had directly managed the hospitals at the time the incidents took place. On 2 February 2001, the Assembly Health Minister and First Minister announced the Assembly's ten-year plan for the NHS in Wales, *Improving Health in Wales - A Plan for the NHS with its Partners*. Under the Plan, health authorities are to be abolished by April 2003, with the National Assembly taking more direct control of its health responsibilities.

1.8 Welsh Health Legal Services provide legal services to all Welsh trusts and health authorities for all new clinical negligence cases. Some five per cent of claims currently being pursued are being defended with advice from private firms. Welsh Health Legal Services are funded directly by the National Assembly through North Wales Health Authority and, although based in Cardiff, are part of and administered by Conwy and Denbighshire NHS Trust.

1.9 The trusts and health authorities have an arrangement to share the costs of large awards through the Welsh Risk Pool, now also administered by Conwy and Denbighshire NHS Trust (until 31 March 1999 the Risk Pool was managed by the Welsh Health Common Services Authority, which was abolished at that date). Each trust and health authority makes a contribution to the Risk Pool based on its turnover and claims history. The contributions are set so that they cover the estimated full cost of claims for the following year. The Risk Pool then reimburses the costs incurred by providers on all claims above an excess level. Until September 2000 - therefore covering the period of fieldwork for this report - the excess was £30,000 in each case. Since then, the level of excess has varied. The Risk Pool has recently expanded its role from cost sharing arrangements into improving risk management and spreading good practice – this is considered in Part 4.

1.10 Figure 1.1 below illustrates the relationships between these bodies.

Figure 1.1 Relationships between Welsh health bodies dealing with clinical negligence



Source: National Audit Office Wales

1.11 The current configuration of the NHS in Wales is the product of a substantial programme of mergers. In April 1996, eight district health authorities and eight family health authorities were merged to form five new health authorities. Successive mergers have also reduced what were 30 trusts to the 15 now in operation. These mergers affected all but four trusts in Wales. This reconfiguration affects the availability of comparative prior year data on clinical negligence.

Policy and legal changes

1.12 The 1998 White Paper *Putting Patients First* launched a number of initiatives to improve standards of clinical governance in the NHS across the United Kingdom. As part of this process, two new bodies have been established. The National Institute for Clinical Excellence has been set up to promote faster access to treatments that work best for patients, to help remove unproven and out of date treatments and to help tackle the problems of "postcode prescribing". And the Commission for Health Improvement now provides an independent check that local systems to monitor and improve the quality of healthcare are working.

1.13 A significant change in the legal framework took place in April 1999, when the Woolf reforms of the civil justice system introduced radical changes in court rules and procedures for county and high courts, including the Pre-action Protocol for the Resolution of Clinical Disputes. The protocol aims to encourage a climate of openness when something is perceived to have gone wrong with a patient's treatment, or the patient is dissatisfied with that treatment and/or the outcome. It also aims to increase the prospect that disputes can be resolved without resort to legal action. It provides general guidance on how a more open culture might be achieved when disputes arise. And it recommends a timed sequence of steps for claimants and healthcare providers (and their advisers) to follow. If proceedings are issued, it will be for the court to decide whether non-compliance with the protocol merits sanctions.

The scope of the study

1.14 The Comptroller and Auditor General's annual reports on the NHS (Wales) Summarised Accounts have highlighted the rising costs of clinical negligence in each year since 1995-96, and commented on improvements in the accounting arrangements and measures taken by the NHS in Wales to manage the risks of clinical negligence. The Assembly Audit Committee report on the NHS (Wales) Summarised Accounts for 1998-99, presented to the National Assembly in July 2000, concluded that there were two main areas of focus in controlling the growing incidence and cost of clinical negligence in Wales: the prompt and cost-effective handling of clinical negligence claims, and the effective use of risk management standards to reduce the number of accidents occurring. The Committee considered that the Assembly's NHS Directorate had made insufficient progress in both areas.

1.15 This report focuses on the measures to reduce the costs of clinical negligence to the NHS in Wales. The objectives of the study are to identify:

- the full extent of negligence claims against health bodies in Wales; and
- whether there is more that health bodies and the Assembly can do to manage claims better and to reduce the number of clinical negligence claims that arise.

1.16 Part 2 of the report examines the cost of clinical negligence to the NHS in Wales. Part 3 focuses on the management processes in place for handling claims promptly and cost-effectively. Part 4 looks at the wider issues of whether trusts are proactively taking the appropriate steps to reduce the number of incidents that give rise to clinical negligence claims, and the scope for alternative ways of managing potential claims.

1.17 While the focus of the study is the scope for reducing the rising cost of clinical negligence, this is very much within the context that patients who may have received poor treatment should have access to fair redress. The report does not advocate reducing costs by preventing claimants from receiving due compensation when they have suffered from negligent treatment. Rather, it encourages trusts to reduce the incidence of future negligence by learning from the mistakes of the past. Part 4 focuses primarily on stopping

negligence from occurring in the first instance, and, where negligence has occurred, ensuring that trusts handle complaints and claims in such a way that satisfies the needs of the patient.

1.18 The study was restricted to claims against NHS Wales. We did not examine claims against primary healthcare providers, such as general medical and dental practitioners, opticians and community pharmacists, as they are self employed and claims are made against the individual practitioner and not against the NHS.

Study methodology

1.19 Evidence of clinical negligence in Wales was gathered by:

a) a survey by questionnaire of all trusts and the health authorities that continue to deal with negligence claims;

b) visits to five trusts where we interviewed the claims manager and others involved in handling complaints and risk management;

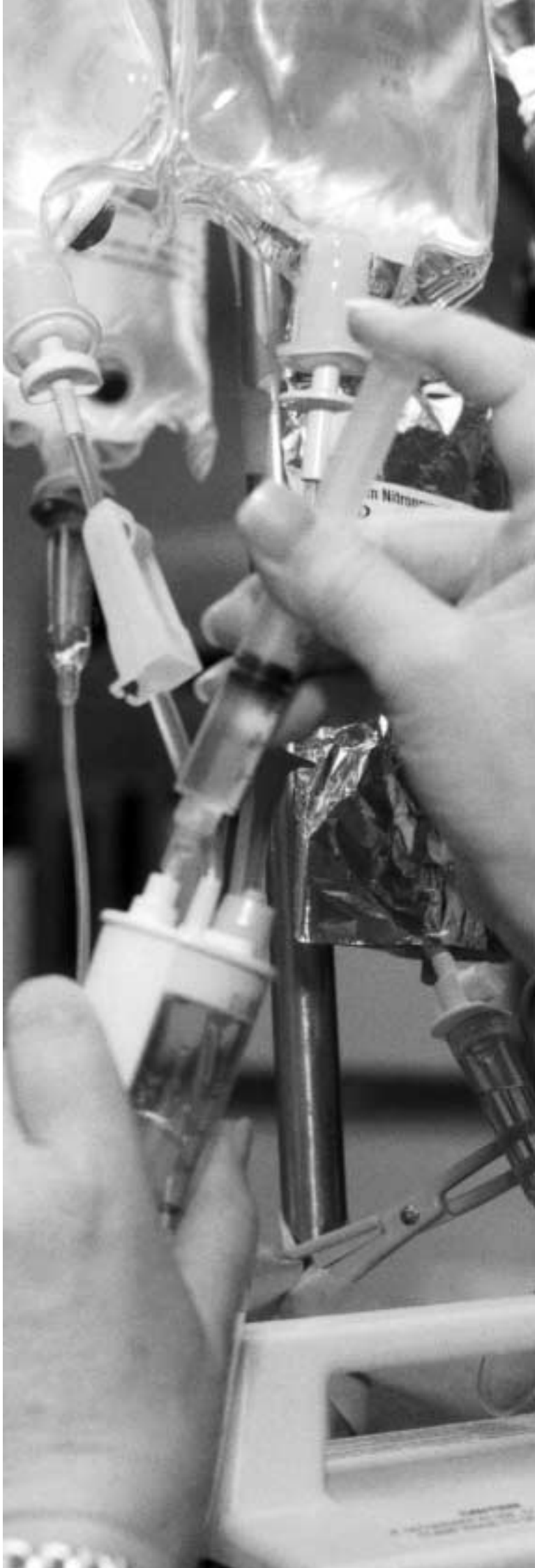
c) analysis of a sample of 94 claims made against the five trusts visited;

d) review of the NHS (Wales) Summarised Accounts and data held by the bodies responsible for administering claims; and

e) review of the existing body of research into complaints and adverse incidents.

Further details of the methodology are set out at Appendix 1.

1.20 The study ran in parallel with a similar National Audit Office study undertaken for the Comptroller and Auditor General, on *Handling Clinical Negligence Claims* in England. The Comptroller and Auditor General report reflects the different administrative framework that operates in England for managing claims, set out in Appendix 2.



PART 2: THE COST OF CLINICAL NEGLIGENCE

Introduction – determining the cost of clinical negligence

2.1 At March 2000 there were over 1,600 open (unresolved) claims against the NHS in Wales, with a total potential value of over £400 million. However, claims may take a number of years to be resolved and many will not result in compensation to the claimant. This figure of £400 million does not, therefore, represent the likely future cost of these clinical negligence cases to the NHS in Wales. This section of the report seeks to establish:

- the annual cost of clinical negligence to the NHS in Wales;
- the likely future cost; and
- whether the figures point to an increasing trend in costs.

Annual cost of clinical negligence

2.2 The primary source of publicly available information on the cost of clinical negligence is the NHS (Wales) Summarised Accounts, the Assembly's aggregations of the individual accounts of NHS trusts and health authorities (there is a Summarised Account for each type of health body).

2.3 The Summarised Accounts are prepared on an accruals basis, as are almost all commercial and government accounts (including the NHS Summarised Accounts in England). This means that expenditure is recorded when a liability is incurred or when management assess it as prudent to assume that a liability will arise, rather than when the resultant cash payment is made. This standard accounting treatment results in the anticipated future costs of negligence being charged as expenditure in the accounts when they are relatively, though not absolutely, certain, even though the payment of cash may not follow for some time. As a consequence, however, the reported expenditure charged in year represents an accounting estimate rather than the in-year cash cost of clinical negligence. Some technical differences in the way that clinical negligence costs are treated in the NHS Summarised Accounts in England - outlined in Appendix 3 - militate against direct comparisons.

2.4 Total NHS expenditure on clinical negligence in 1999-2000 included in the NHS (Wales) Summarised Accounts is £40.9 million (at the time of preparing this report the Auditor General for Wales' audit of the Summarised Accounts had not been completed; all references to figures within them are therefore provisional). This sum comprises two elements: health authorities and trusts, as shown in Figure 2.1 below. These costs are included in the £63.9 million expenditure recorded against *Provisions for losses, special payments and recoverable debts* shown in notes to the two sets of accounts. (Appendix 3 shows extracts from the Summarised Accounts, with the relevant figures highlighted and explained).

Figure 2.1 Expenditure on clinical negligence in the 1999-2000 summarised accounts

	£m[1]
Health Authorities	28.0
Trusts	12.9
Total	**40.9**

[1] Costs exclude legal and other administrative costs.

Source: NHS (Wales) Summarised Accounts (unaudited)

2.5 Another measure of the annual cost of clinical negligence is the actual cash paid out each year by health bodies in settlement of claims. The National Audit Office Wales obtained from the Assembly the cash costs of settlements made in recent years by trusts and health authorities in relation to NHS hospitals. The cash costs incurred by trusts and health authorities on clinical negligence in 1999-2000 were £26.9 million, an increase of 42 per cent over the previous year.

2.6 The annual cash costs given above exclude the claims administration costs of both Welsh Health Legal Services and health bodies. The relevant costs of Welsh Health Legal Services are some £1 million a year. Our questionnaire sought to determine health bodies' annual administrative costs. Gaps in responses make it difficult to establish these costs but, on the basis of the information available, they are likely to be in the order of £500,000. However, these additional sums are insignificant when compared with the costs of the additional medical care needed to rectify the results of clinical negligence. It is not possible to estimate these costs on the basis of the information currently available within the NHS.

Future costs of clinical negligence

2.7 The total potential future costs of clinical negligence to the NHS in Wales (including cases where it is by no means certain that a liability exists) are considerably greater than the annual cash costs. Information on possible future costs is included in the NHS (Wales) Summarised Accounts in three categories (see also Appendix 3), depending on the likelihood of payments having to be made, as shown in Figure 2.2.

Figure 2.2 The estimated future costs of clinical negligence: at 31 March 2000

	Probability of payment[1]	Trusts £m	Health Authorities £m	TOTAL £m
Creditors	Over 95%	5.1	12.2	17.3
Provisions[2]	50 – 95%	43.4	50.3	93.7
Contingent liabilities[3]	5 – 49%	130.8	66.5	197.3
Total		**179.3**	**129.0**	**308.3**

[1]Categories determined in the Assembly guidance to health bodies on accounts preparation. [2]Does not include associated defence legal fees and other administrative costs. [3]Includes personal injury claims.
Source: NHS (Wales) Summarised Accounts (unaudited), and National Audit Office Wales

2.8 Until this year, information on creditors relating to clinical negligence was not separately disclosed in the Summarised Accounts but was included within the overall totals for all creditors of trusts and health authorities. For the 1999-2000 Summarised Accounts, Assembly officials have worked in conjunction with staff of the National Audit Office Wales to identify separately the creditors attributable to clinical negligence. At 31 March 2000, these totalled £17.3 million.

Welsh Health Legal Services' quantum lists

2.9 The primary source of evidence for the costs of clinical negligence reported in the financial statements of trusts and health authorities is the quantum lists prepared by solicitors at Welsh Health Legal Services[1]. As well as estimates for each open case of damages, defence and claimant legal costs, the quantum lists include an estimate of the probability of each claim being settled, with cases categorised within four bands. Figure 2.3 gives the position across the NHS in Wales at March 2000.

Figure 2.3 Estimated costs for all outstanding claims defended by Welsh Health Legal Services by probability of settlement as at March 2000

Probability of Loss	Number of open cases	Estimated value of all costs £m
Probability 1 (above 95%)	282	72
Probability 2 (50% - 95%)	166	40
Probability 3 (5% - 49%)	860	236
Probability 4 (4% or below)	246	54
Unspecified	51	12
Total	**1,605**	**414**

Source: Welsh Health Legal Services quantum lists

2.10 The figure shows that the total value of open claims assessed by Welsh Health Legal Services at 31 March 2000, irrespective of the likelihood of settlement, was £414 million. Of the £414 million, the value of claims assessed as having a greater than 50 per cent probability of payment was some £112 million.

2.11 It is not possible to reconcile the estimated cost of open claims shown in the quantum lists to the total liabilities for future costs reported in health bodies' annual accounts. The accounting guidance issued by the Assembly categorises future clinical negligence costs in terms of the percentage probabilities of payment reported in the quantum lists (Figure 2.2). However, within this framework, trusts and health authorities are legitimately able, within reason, to make their own interpretations of future liabilities likely to arise from clinical negligence claims. Moreover, not all open claims are handled by Welsh Health Legal Services. Thus the total end of year provision in the Summarised Accounts at March 2000 was £93.7 million. The directly comparable figure in the quantum lists - for those claims assessed as having a probability of settlement of between 50 per cent and 95 per cent - is £40 million.

2.12 Included within the quantum lists are Welsh Health Legal Services' estimate of the expected year of settlement of claims. They estimate that 68 per cent (by number, with a value of £78 million) of claims assessed as having at least a 50 per cent probability of settlement will be settled during 2000-01, with the remainder of such claims all settled by April 2006.

[1]Although all trusts now use Welsh Health Legal Services for legal advice, this has not always been the case and there remain some claims in the system being handled by private solicitors; the potential cost of these claims is not known and they have been ignored in the following analysis.

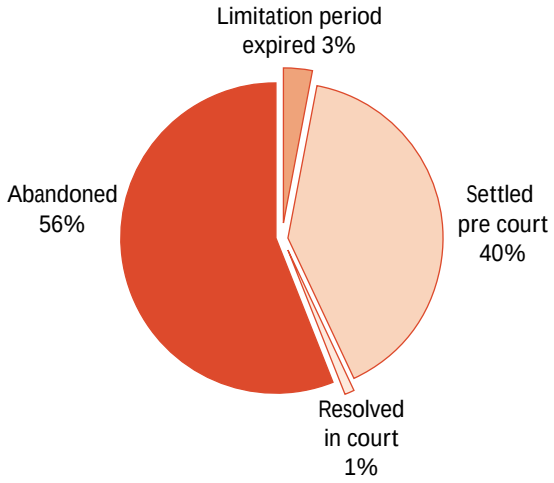
2.13 Although the predicted costs reported in the quantum lists are the best source of information on likely costs, the nature of clinical negligence cases means that it is not possible for Welsh Health Legal Services or individual trusts and health authorities to forecast each claim with complete accuracy. The probability of settlement and likely costs cannot be estimated until the incident has been investigated and the circumstances of the claimant are known. In several instances, particularly where claims had been made only recently, there was insufficient evidence to determine costs and record them in the quantum lists. Even at a later stage in the case, elements of the damages payable to claimants may be impossible to assess until both sides have obtained expert opinions. As claims progress and more evidence is gathered, estimates on costs may be refined.

2.14 The National Audit Office Wales carried out its own exercise to assess the likely future cost of clinical negligence to the NHS in Wales at March 2000, based on the quantum lists. Two factors were taken into account: the likelihood of payment and the accuracy of Welsh Health Legal Services' estimates of claim settlement value. In both instances, the lack of available statistics within the NHS meant that the National Audit Office Wales gathered information from health bodies through its questionnaire and its sample of cases.

Likelihood of payment

2.15 Responses by health bodies to our questionnaire show that 409 claims were closed (resolved) during 1999-2000 (two trusts were unable to provide us with this information). Of these closed claims, 40 per cent were settled with compensation without going to court - Figure 2.4. The remaining claims were either abandoned by the claimant, resolved in court, failed to be issued within the three-year limitation period. Figures in Wales are comparable with those in England where the National Audit Office found that, in 1999-2000, 38 per cent of claims were settled with compensation to the claimant, with the remainder abandoned by the claimant or otherwise resolved without financial outcome.

Figure 2.4 Numbers of claims resolved in Wales in 1999-2000



	Number resolved
Abandoned	230
Settled pre court	163
Limitation period expired	13
Resolved (struck out or settled) in court	3
Total	**409**

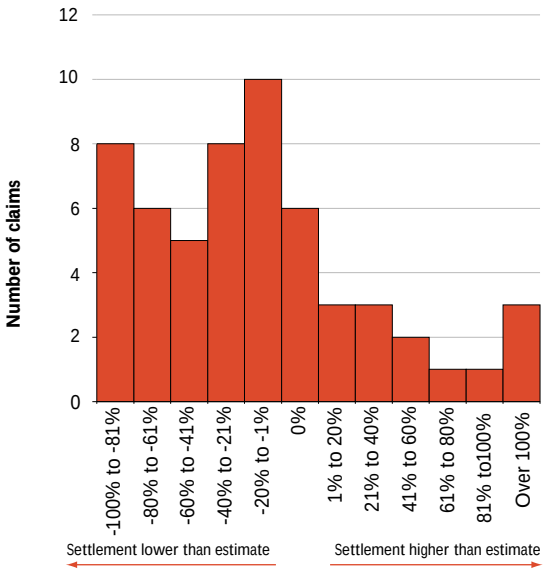
Source: National Audit Office Wales questionnaire responses

Estimate of claim settlement

2.16 Welsh Health Legal Services' policy is to be prudent and estimate the maximum damages that might be paid; claimants may be prepared to accept lower sums in settlement. The consequence is that the quantum list figures represent worst case scenarios for trusts and health authorities.

2.17 In our case study sample we were able to examine 56 closed claims which had information on actual and estimated settlement costs. Comparisons between estimates of damages in these claims and actual settlement revealed that in 37 cases (66 per cent) the eventual settlement was lower than the estimate. Figure 2.5 shows the degree to which estimate varied from settlement for the sample. The average settlement was £44,100 - 26 per cent lower than the estimate of £59,800. (Some of these estimates may have been made at a very early stage of a case, when it is hard to forecast with accuracy - see paragraph 2.13.)

Figure 2.5 Comparisons between estimate of damages and actual settlements



Source: National Audit Office Wales analysis of a sample of 56 closed claims

National Audit Office Wales assessment of future costs

2.18 We applied our findings on the likelihood of payment and accuracy of estimate to the total potential value of claims in the quantum lists. At the 95 per cent confidence level we forecast that the cost to the NHS in Wales of settling the clinical negligence claims open at March 2000 will be between £60 million and £154 million with the mid-point in this range being £107 million. This is broadly in line with both the value of claims assessed as having a greater than 50 per cent chance of settlement according to the Welsh Health Legal Services' quantum lists, £112 million, and the total provisions and creditors recorded at 31 March 2000 in the NHS (Wales) Summarised Accounts of £111 million.

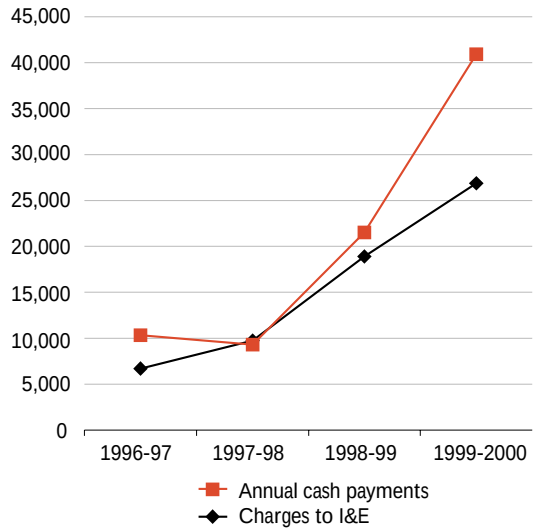
Is the cost of clinical negligence rising?

2.19 In view of the mounting concern over the costs of clinical negligence, and the perception that they were rising, the National Audit Office Wales sought to establish whether the existing information pointed to a rising trend.

Annual costs

2.20 Figure 2.6 below shows the cost of clinical negligence over the past four years in terms of both the actual cash costs of settlements provided by the Assembly, and the annual expenditure charged in the Summarised Accounts (the difference between the two methods is set out at paragraphs 2.3-2.5).

Figure 2.6 Annual Cash Payments and Charges to Income & Expenditure Account



Source: National Assembly and NHS Summarised Accounts (1999-2000 unaudited)

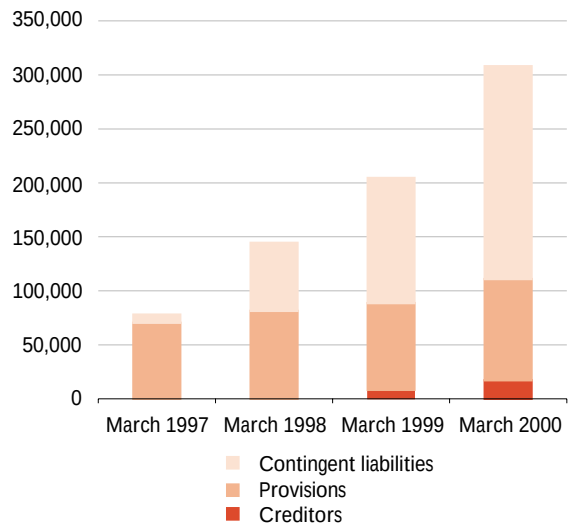
2.21 Both measures of the annual costs of clinical negligence in Figure 2.6 exhibit a clear upward trend – and the cash costs increased four fold between 1996-97 and 1999-2000 (developments in accounting practice account for some of the increase in income and expenditure charges over this period). However, the unpredictability of clinical negligence, in terms of both numbers of claims settled and their value, means that annual charges, however calculated, will tend to fluctuate. A single large settlement in any one year might distort the overall picture.

Future costs

2.22 A better indicator of trends is the estimated cost of future settlements, based on open claims. It is not possible to compare the total potential value of outstanding claims at March 2000 from the quantum lists with earlier figures as Welsh Health Legal Services' records were held manually until January 2000. Figure 2.7, therefore, shows the total estimated future costs reported each year in the NHS (Wales) Summarised Accounts.

2.23 Figure 2.7 shows that estimates of the total potential future costs have quadrupled over the past four years to March 2000.

Figure 2.7 Creditors, Provisions and Contingent Liabilities reported at 31 March



Source: NHS (Wales) Summarised Accounts (1999-2000 unaudited)

Note: Health authority creditors reported separately for the first time in the restated 1998-1999 accounts - paragraph 2.8

Most of this increase is attributable to contingent liabilities which have risen from £7.5 million to nearly £200 million over this period. This is largely due to a clarification and tightening of the accounting requirements concerning the reporting of contingent liabilities. However, there has also been a significant rise in provisions, from £70 million at March 1997 to £93.7 million at March 2000, an increase of 33 per cent. This, together with the upward trend of annual payments above, is the most reliable indicator of a rise in clinical negligence costs. The limitations of the information available, however, mean that it is not possible to establish the extent to which this might have been caused by either a rise in the number of claims or the average settlement cost.

Possible reasons for a rising trend

2.24 The wider reasons for this rising trend lie outside the scope of this study. In giving evidence to the Audit Committee on the Auditor General for Wales' report on the 1998-99 NHS (Wales) Summarised Accounts, the then Accounting Officer attributed the rise to two major factors: the increasing likelihood of individuals to seek legal redress; and the rising levels of compensation payable in such cases. Other reasons suggested to us include:

- the media has had a profound influence on people's perceptions of the NHS and doctors in general; and
- people have come to question the care they receive at hospital.

The rise is thus not necessarily a reflection of the incidence of clinical negligence.

2.25 Irrespective of possible social reasons underlying a rise in clinical negligence, changes in the legal framework point to a continued rise in the cost of claims, at least for the next few years:

- the Woolf reforms referred to at paragraph 1.13 mean that cases are likely to be settled more rapidly. This may lead to an initial "bunching" of claim settlements. (The ability of trusts to manage the likely rise in workload is considered at paragraph 3.40); and
- the Court of Appeal, on 23 March 2000, awarded an increase in damages payable for pain, suffering and loss of amenity. They recommended that the increases were tapered so that cases under £10,000 were unaffected and only damages at the highest level (over £135,000) would be increased by the full amount of 30 per cent.

The nature of clinical negligence claims and the difficulty of estimating future costs make it impossible to quantify the impact of these changes.

KEY POINTS

The precise costs attributable to clinical negligence reported in the NHS (Wales) Summarised Accounts are difficult to establish and interpret.

In 1999-2000 total cash payments made by the NHS in Wales on clinical negligence cases were £26.9 million, an increase of 42 per cent compared with the previous year. Total creditors and provisions increased by four per cent over the same period.

The total value of open (unresolved) claims at March 2000 was over £400 million, but the National Audit Office Wales assessed the likely liability to be in the range £60 - 154 million. This is in line with the total creditors and provisions in the NHS (Wales) Summarised Accounts of £111 million and the data held by Welsh Health Legal Services.

In recent years the trend of clinical negligence costs is upwards. Reasons for this rise are not clear, but legal changes are likely to mean that clinical negligence costs will continue to rise at least in the short term.

Money spent on clinical negligence settlements reduces the funds that could otherwise be used for patient care in Wales.

PART 3: HOW CLAIMS ARE MANAGED

Introduction

3.1 The management of claims is an expensive, lengthy and complex process. It requires well-trained staff and a professional defence team to ensure that costs are kept to a minimum and patients given just compensation.

3.2 This section looks at:

- who manages claims;
- issues involved in managing claims; and
- how they are managed.

Who manages claims?

The role of the claims manager

3.3 The key post for handling clinical negligence claims in trusts and health authorities is that of claims manager. The primary function of a claims manager in respect of clinical negligence is to work alongside Welsh Health Legal Services to reach a resolution where the patient is given a satisfactory explanation of what happened and just compensation where appropriate.

3.4 Around 30 staff are involved in managing clinical negligence claims in trusts in Wales, five of them on a full time basis. The role and responsibility of the claims manager varies from trust to trust, depending on its size, claims workload and the number of staff in the team. In the smaller trusts, claims managers tend to work on a part time basis and rely on Welsh Health Legal Services to manage their claims. In the larger trusts, there are more staff involved in handling claims, and the trust tends to rely on the experience and expertise of the claims manager. Claims managers in the smaller trusts are more likely to report directly to the Chief Executive, whereas claims managers in the larger trusts typically report to heads of departments, such as Risk Management, Nursing and Quality, and Corporate Services.

3.5 Claims managers are not lawyers. Although roles and responsibilities may vary, their main function is to organise the day-to-day administration of files and correspondence between Welsh Health Legal Services, clinicians, financial departments, and claimant solicitors. All claims managers follow a series of steps that must be taken before a claim can properly be resolved - Figure 3.1below.

Figure 3.1 Elements of claims handling

Prompt investigation of alleged negligent episode and evidence gathering	A proper evaluation of the claim will only be possible once all facts about the incident have been identified and properly recorded. Claims will turn on the available evidence and can sometimes succeed where there is insufficient information available to allow a complete defence of the claim. This is a particular problem for birth-related claims where the time limit for bringing claims is effectively 21 years after birth. Many clinicians involved may have moved or retired, so adequate witness statements on adverse incidents should be taken as soon as the trust believes a claim may arise from an incident.
Working with clinicians	Claims handlers need to enjoy the confidence of clinicians to facilitate the collection of witness statements, establish facts and identify key issues. Clinicians have no contractual duty to assist with claims handling, although the General Medical Council has issued professional guidance that they should apologise for adverse outcomes and offer explanations. This may not be the same as an admission of liability.
Disclosure of records	This is the legal requirement to provide copies of all relevant medical records to the patient or their legal representative. The Pre-action Protocol requires disclosure within 40 days of the request.
Arrange for evaluation of causation, liability and likely quantum	This is the core of claims handling. Although 60-70 per cent of all claims are abandoned by the claimant, this will usually only occur when the trust, through disclosure of records and the exchange of expert evidence, has shown that there was no breach of duty of care causing the adverse outcome.
Liaising with lawyers	A claim alleging clinical negligence is a legal action. It will require either rebuttal through disclosure of records showing that there was no causation or through a legal defence that shows there was no legal liability. Both courses have legal implications and may require expert legal advice. No trusts have in-house solicitors with such expertise.

Source: National Audit Office

3.6 From our visits to the trusts and through survey responses, we found two factors which potentially militate against the effective performance of claims managers: the lack of appropriate training, and, more significantly, the absence of local management information.

Lack of appropriate training

3.7 At the time of our fieldwork, trusts had provided little in the way of formal training to those handling claims. Only one claims manager in Wales had gained any qualifications in claims management. Only two people (from the same trust) had received formal in-house training on claims management from the trust itself and no one had received any training from the NHS Staff College. Ten staff from five different trusts had received training through seminars held by external firms of solicitors or through seminars held by the Association of Litigation and Risk Management. One trust commented that it had recognised the need for updating training standards and was currently considering ways of improving its training for staff dealing with claims management. A potentially useful source of training is the recent Risk Management Development Programme, commissioned by the Welsh Risk Pool and delivered by the NHS Staff College. This programme contains a module on claims management.

Absence of local management information

3.8 Trusts have been slow to modernise their methods of managing claims and the related information. Two of the five trusts we visited had only just begun to set up computerised claims databases. Most trusts continue to hold only paper records of correspondence without any computerised record of dates, costs, and other information about claims. This seriously hinders them from undertaking any analysis of their negligence caseloads. Some trusts argued that, since each clinical negligence case is different, any analysis would be likely to produce meaningless data. We consider, however, that as a minimum by determining trends on time scales and costs, trust managers would be better informed and able to make decisions on how to progress claims in general. Without such information it will be difficult for trusts to learn lessons from clinical negligence cases and to take appropriate action to prevent recurrence of claims management problems.

3.9 There is also no scope currently for comparing one trust's performance against another. Questionnaire responses confirm that none of the trusts compare their performance against others in Wales or England, mainly because there are no mechanisms to enable them to do so. There is little chance for disseminating best practice, although many claims managers expressed the opinion that the Risk Managers Network is a useful forum for disseminating best practice (paragraph 4.17). The Welsh Risk Pool commented that it recognised the need to begin benchmarking; some of its members meet officials from the NHS Litigation Authority (Appendix 2) annually to compare practice.

The work of Welsh Health Legal Services

3.10 Management of claims rests with the health bodies, primarily trusts, against which the negligence is alleged. The main body that represents the NHS in Wales in clinical negligence disputes is Welsh Health Legal Services (paragraph 1.8) who play a central role in the day-to-day management of the claims in ten of the 15 trusts. In the remaining five trusts, the claims managers assume responsibility for managing the claims but continue to receive advice from Welsh Health Legal Services. All but three trusts in our questionnaire considered that Welsh Health Legal Services always or usually took the lead in determining strategy when defending claims.

3.11 Since Welsh Health Legal Services is funded (through the North Wales Health Authority and Conwy and Denbighshire Trust) by the National Assembly, trusts do not pay directly for their services. The decision to promote Welsh Health Legal Services as the primary supplier of advice was based on a 1994 NHS study which showed that they provided better value for money than private firms. Under current arrangements there is no incentive for trusts to engage alternative solicitors. However, this means that:

- although trusts are responsible for managing claims, the full costs of defending claims are hidden from them; and
- trusts cannot compare the performance of Welsh Health Legal Services against any alternatives.

3.12 In England, where the administrative structure for defending claims is different (Appendix 2), the NHS Litigation Authority has taken major steps to monitor the work and quality of legal advisers. In Wales, there has been no similar analysis since 1994: the National Assembly does not monitor whether Welsh Health Legal Services continue to offer value for money. However, following a recommendation from the Management Board of the Welsh Risk Pool that it be independently reviewed, Welsh Health Legal Services has gone out to tender for a system of self-assessment or accreditation.

3.13 All the trusts that expressed an opinion to us reported in our questionnaire that they were usually or always satisfied with the quality of service provided by Welsh Health Legal Services. Interviewees confirmed that Welsh Health Legal Services was generally viewed as a professional organisation, which over the years had gained much valuable expertise in defending clinical negligence claims.

KEY POINTS

Claims managers are the focal point for handling clinical negligence claims within trusts. In most trusts, in view of the demands made of them, claims managers would benefit from more focused training.

Although some trusts are now starting to computerise their information on clinical negligence, the almost complete absence of even basic management information on clinical negligence cases is striking and seriously hinders case load analysis and management.

Welsh Health Legal Services provide legal advice to all trusts and health authorities. They are instrumental in the day-to-day management of claims in 10 of the 15 trusts. Since their costs are not passed on to health bodies who use their services, their status as monopoly supplier to trusts is guaranteed.

There are no mechanisms for monitoring whether Welsh Health Legal Services continue to offer value for money. However, Welsh Health Legal Services is in the process of implementing a system of independent review.

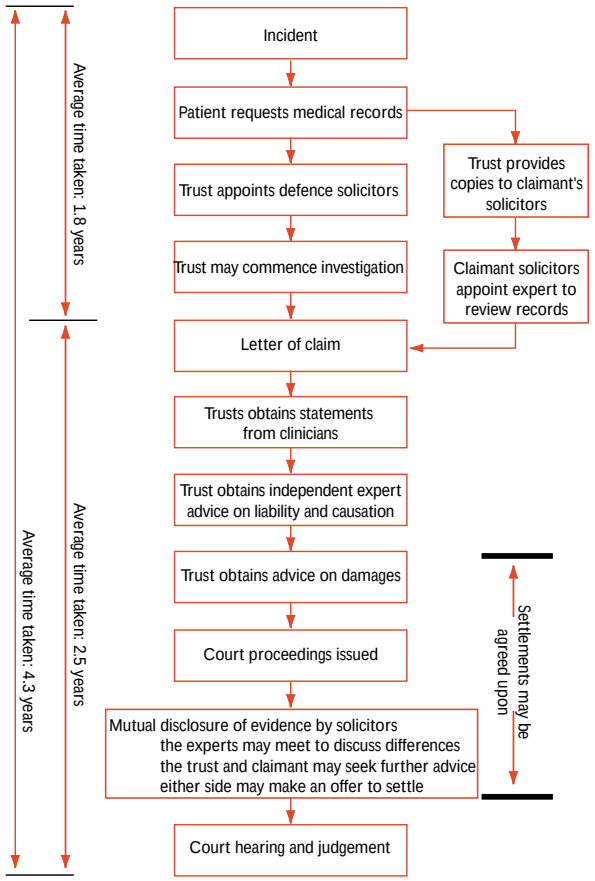
Welsh Health Legal Services is generally viewed by trusts as a good provider of legal services in clinical negligence claims.

The claims process

3.14 In 1999-2000 there were a total of 870,000 in-patient and day cases treated in hospitals in Wales. The National Audit Office Wales questionnaire to trusts found that a total of 3,430 complaints were received, of which 94 related to reported adverse clinical incidents (not all trusts were able to provide information on these topics); and 705 new clinical negligence claims were received (including 80 claims made against health authorities before the establishment of the trusts).

3.15 Each claim will pass through a set of stages before a conclusion can be reached. Figure 3.2 over, shows the main stages of a claim, with the time taken for the main stages based on our sample analysis of claims settled in 1999-2000.

Figure 3.2 Stages of a claim, from incident to settlement



Source: National Audit Office Wales

3.16 Trusts normally learn of forthcoming claims in one of three ways:

- internal reporting systems may alert the trust to the possibility of an "adverse incident" (paragraph 4.12);
- a complaint about a clinical matter may indicate that negligence may have occurred, and the complainant may resort to litigation if he/she is not satisfied, or if investigation of the complaint indicates that the trust may be at fault; or
- they may receive a request for a patient's medical records from the patient or from their representing solicitors. The trust is legally obliged to disclose patients' records under the Data Protection Act. The request may or may not provide sufficient information to allow the trust to begin investigations into the circumstances of the potential claim.

3.17 A formal claim may be made after a suspected negligent incident has occurred. The recent introduction of the Pre-action Protocol (paragraph 1.13) means that trusts now must respond to a claim within three months, confirming whether they are to contest the case, denying liability, or settle. Within this time, the trust must gather statements from the clinicians and others previously involved with the care of the patient. In accordance with the Pre-action Protocol, the trust, usually through its solicitors, will provide its own explanation of the events and outcomes, within three months of the letter of claim.

3.18 In all cases, causation must be identified and if clinical negligence has occurred the quantum - financial compensation - agreed. This can be a lengthy process, particularly in more complex claims where several medical reports are required, or when negligence is not easily determined. And the level of quantum in each case, since it reflects factors such as potential loss of earnings, depends on the circumstances of the claimant. Since the circumstances of each case tend to vary, a feature of clinical negligence cases is that every claim is different, making it difficult to establish benchmarks. For example, loss of a leg can be more costly in terms of clinical negligence compensation for a professional athlete than for someone who is already bedridden.

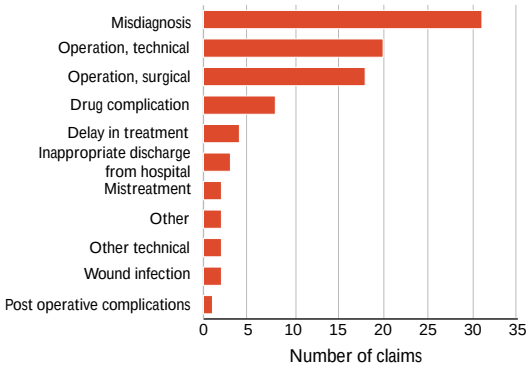
3.19 If the patient has not abandoned the claim and if the trust has admitted liability, at this stage the claimant and defence solicitors begin to negotiate settlement costs (paragraph 1.4).

Causes of negligence

3.20 The National Audit Office Wales looked at: the causes of negligence; why cases are settled; the length of time taken to resolve cases; and the rising workload. With the lack of trend information on clinical negligence available at the time of our fieldwork, the National Audit Office Wales analysed its sample of 94 claims in order to establish the underlying causes of negligence, admitted or alleged.

3.21 The most frequent cause of clinical negligence was negligence due to misdiagnosis, which often leads to either a delay in treatment or inappropriate treatment. Negligence was also often caused due to technical or surgical mistakes made before, during, or after the operation. Figure 3.3 shows the type of alleged or admitted negligence found in our case study sample.

Figure 3.3 Frequency of negligence found



Source: National Audit Office Wales analysis of 94 cases

Non-clinical errors

3.22 The precise cause(s) underlying negligence can be difficult to determine and may be the result of a complex series of events. Nevertheless, National Audit Office Wales analysis found that a significant contributor to alleged negligence, or the reason why trusts were advised to settle, was the

Main Cause of Negligence	Events contributing to main cause of negligence
Misdiagnosis	Doctor fails to take an x-ray Doctor underestimates patient's concerns Failure to recognise signs of illness X-rays not being read properly, or being difficult to read Poor communication between clinicians
Operation, technical	Failure to listen to the patients requests Failure to perform pre-operative checks Failure to provide pre- or post- operative explanations Inadequate supervision of instruments – dislodged or not removed. Unnecessary or inappropriate operation – in some cases due to inadequate supervision of clinicians Wrong or faulty use of anaesthetic Poor communication between clinicians
Operation, surgical	Damage to organs, muscles, or nerves Failure to administer appropriate drugs during operation Incomplete operation Poor post operative care – pain and suffering Miscommunication between patient and doctor – patient never consented to operation or failure to alert patient to risks involved
Drug complication	Drugs administered to person with known allergies or person on known other medication Drugs administered inappropriately – intravenously, orally etc. No information provided to patient on side effects of medication Failure to listen to patient concerns
Delay in treatment	Administrative error Lack of continuity of care – changing of doctors and nurses
Other, technical	Doctor/nurse misreading medical notes No correct instruments available
Wound infection	Inadequate cleansing of wound
Other	Potential accident in the waiting room
Inappropriate discharge from hospital	Poor communication between clinicians

Source: National Audit Office Wales

incidence of potentially avoidable errors by clinicians and others, associated with administrative, communications, or wider systems issues, as opposed to strictly clinical judgement or technical error. We have referred to these errors as "non-clinical". Such errors ranged from breakdowns in communication - between clinicians, patients and non-clinicians - to straightforward administrative failings such as losing patient records.

3.23 We found evidence in 39 of the 94 claims examined where non-clinical errors contributed to the negligence admitted or alleged. In some cases, non-clinical errors occurred more than once. Figure 3.4 outlines the criteria we were looking for and the number of instances that were recorded in these 39 claims.

Figure 3.4

Type of non-clinical error	No. of instances
Poor documentation of clinical procedures undertaken	15
Poor communication between clinicians	12
Poor communication between clinician and patient	11
Poor documentation of communications with patient	8
Inappropriate person giving advice to patient	3
Inadequate supervision of clinicians	2
Inappropriate person undertaking clinical procedure	1

Source: National Audit Office Wales analysis of 94 cases

3.24 These 39 claims include cases that remained open and where non-clinical error was a contributory, rather than the main, factor behind the alleged negligence. It is not always straightforward to distinguish between clinical and non-clinical errors. Nevertheless, the National Audit Office Wales analysis suggested that within these 39 claims there were 15 cases where the claim had been settled and non-clinical errors were either the direct cause of the negligence or they were the sole reason for settlement. The settlements for these claims ranged from £1,200 to £1.35 million and resulted in over £2.4 million in settlement and legal costs to the NHS in Wales for claims settled in 1999-2000.

Example of claims where non-clinical errors resulted in negligence or in settlement of claim

Case 4

In 1997, a patient had his arm in a plaster due to a fracture. The plaster was scheduled to be removed 9 weeks after it was applied but was removed after only 9 days. The consultant had misread the patient's notes. The claim was settled for £7,500.

Case 5

In 1994, the patient suffered from a bilary leak during or shortly after operation, which is common but went undetected by the doctor. Medical staff therefore failed to treat it sooner, which caused a long, slow period of deterioration. The corrective operation did not take place until nearly two months after the initial operation. The claim was indefensible because the patient records were poor, making it impossible for the consultant to determine if negligence had occurred. The claimant received £50,000 in damages.

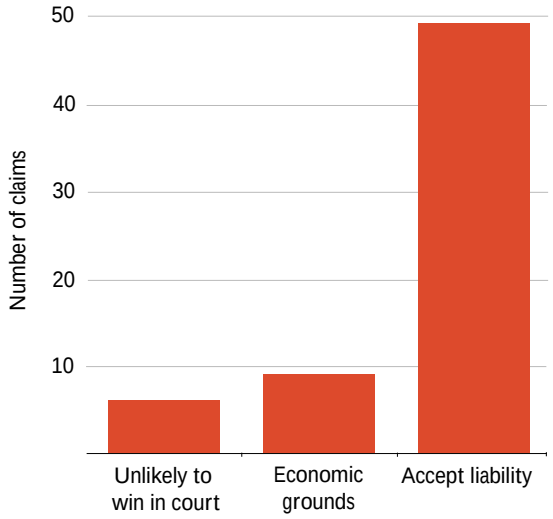
3.25 Improving procedures - record keeping, communicating with medical staff and with patients, and supervising clinical procedures - could therefore significantly reduce the instances of negligence occurring and hence their cost. The proportion of cases in our sample where non-clinical error was the direct cause of negligence or the sole reason for settlement was 16 per cent. The average cost (including settlement and legal fees) of these cases, excluding one exceptionally large claim of £1.35 million which would otherwise distort the overall picture, was £78,000. If these findings on proportion and average cost were applied to all cases reported in our questionnaire responses as settled in 1999-2000, then the total cost of such cases would have been some £4.2 million. On the assumption that the 1999-2000 pattern of settlements and costs were repeated in future years, if the NHS Wales were to reduce the incidence of such non-clinical errors by, say, a third, this might save some £1.4 million each year in clinical negligence settlements and legal fees. This estimate does not take into account the rising trend in costs identified in Part 2. However, it is also the case that where health bodies settled cases owing to inadequate record-keeping, robust records might have served only to confirm the alleged negligence.

3.26 The Welsh Risk Pool has included procedures on record keeping, communicating with medical staff and with patients, and supervising junior staff in the Risk Management Standards it has been promulgating. Trusts' relatively low compliance with these particular standards, and Risk Management Standards more generally, are discussed in Part 4.

Why cases are settled

3.27 The National Audit Office Wales analysed in detail a sample of 64 closed cases to determine why the NHS settled cases. The most common reason was admission of liability to negligence. In 49 of the 64 claims the trust recognised and admitted to negligence and settled on those grounds. In the remaining 15 claims, the trusts had settled either because legal costs were likely to exceed the cost of settlement, or because the claim was likely to be won by the claimant if it went to court. Figure 3.5 shows the rationale for settling claims.

Figure 3.5 Rationale for settling



Source: National Audit Office Wales analysis of 64 closed claims from 1999-2000

3.28 In six cases, the trust settled on the grounds that, although it did not acknowledge liability, nonetheless the case would be unlikely to be successfully defended if tested in court. These claims were all the result of non-clinical errors, as discussed above; reasons why, in the trust's view, the case was at risk included doubts over the quality of defence witnesses or the documentary evidence to support the case. These six claims accounted for some £225,000 in settlement costs.

KEY POINTS:

In a third of our sample analysis, non-clinical errors were either the main cause of negligence or the main reason why the claim could not be defended. Based on our sample, the total cost to the NHS in Wales of such cases in 1999-2000 might have been some £4.2 million.

If the NHS Wales were to reduce the incidence of such errors by, say, a third, this might save some £1.4 million each year.

The National Audit Office Wales detailed analysis of a sample of closed claims found that the majority of claims were settled because the trust had admitted liability.

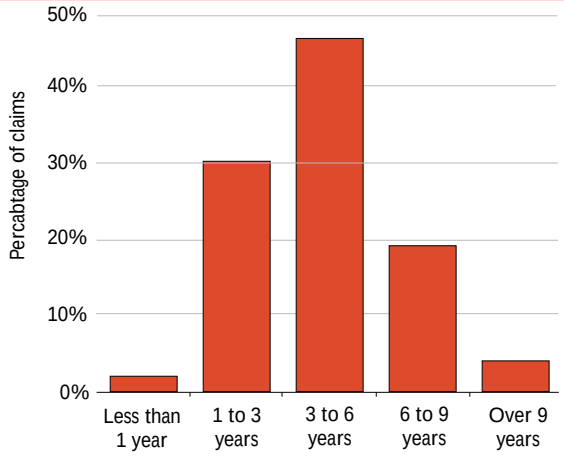
Trusts settled cases without admitting liability on economic grounds, or if the claim was likely to succeed in court.

The length of time taken to settle a claim

3.29 Patients making claims of clinical negligence may have to wait years to receive due compensation for the suffering caused by the care they received. A main concern over the handling of clinical negligence claims is thus the length of time taken to reach a settlement. Delays complicate procedures for the NHS as relevant medical staff may have moved on and it becomes more difficult to recollect events.

3.30 Trusts hold very limited information on the time taken to settle cases. The National Audit Office Wales therefore analysed the elapsed time in its sample of 64 closed claims. This showed that it took on average $4^{1}/_{3}$ years from the alleged negligent incident to the date when compensation was paid (Figure 3.2). The range of time taken from incident to settlement is highlighted in Figure 3.6.

Figure 3.6 The range of time taken from incident to settlement



Source: National Audit Office Wales analysis of its sample of closed claims

3.31 The two main components of the time period from incident to settlement were:

- an average of nearly 2 years for patients to make a claim against the trust after the incident had occurred; and
- an average of 2½ years from the date of the formal claim to the date when a settlement was paid.

3.32 Although lengthy delays in the progress of clinical negligence claims are unwelcome to all parties, we found that, in statistical terms, the correlation between length of time taken to settle cases and subsequent settlement costs to be weak. Other factors, such as the nature of the alleged negligence and the circumstances of the claimant, are more significant in terms of settlement costs.

Example of a lengthy claim with low costs

Case 6

In 1989, the patient was admitted to Accident and Emergency with a fractured arm. Doctors had observed and treated a fracture in the elbow but failed to diagnose a fracture in the patient's wrist. The claimant's solicitors requested medical records in 1990 but received various notes and x-rays only two years later because the records and x-rays held by the trust had been lost. In 1994, the trust acknowledged that it could have been negligent. In 1997, 7½ years after the incident had occurred, the claimant and trust agreed on a settlement of £2,500.

Causes of delay

3.33 From analysis of the case files and visits to the trusts, we found that there are four principal factors that can influence the length of time taken to resolve a claim:

i) the degree of complexity of the claim - particularly where special damages must be measured over a period of time, or when causation and quantum are not easily determined;

ii) poor co-operation between the parties - particularly when agreeing settlement costs;

iii) the quality of record keeping, which may range from illegible note taking or missing records and x-rays to delays in transferring files from the health authority to trust or from old trust to new trust; and

iv) lack of communication between the departments within the trusts that deal with incidents, complaints and claims.

3.34 The National Audit Office Wales' questionnaire to trusts asked for more details on their perceptions of the causes of delay in resolving claims. They responded that difficulties in agreeing quantum with the claimant and the way in which claimants' solicitors manage claims were the two main causes in delaying the settlement of a claim. Difficulties in establishing causation and the time taken to obtain external expert reports (point i) above) were also identified as important factors. The full range of responses is illustrated in Figure 3.7 opposite, in order of significance.

Figure 3.7

Questionnaire responses on the principal causes in delaying the settlement of a claim	Percentage responses[1]
Difficulties in agreeing quantum with claimant	20%
Management of claim by claimant's solicitor	18%
Difficulties in establishing causation	16%
Time taken to obtain external expert reports	14%
Delay in making claims	12%
Degree of co-operation from clinicians	6%
Difficulties in obtaining documentation on treatment	4%
Involvement of WHLS	4%
Time taken to obtain internal reports	4%
Management of claim by defendant's solicitor	2%

[1]Trusts were asked to select their top five causes.

Source: National Audit Office Wales Questionnaire results

3.35 Our analysis of the case study files confirmed that all of the above points often contributed to delays in resolving a claim. There was almost always difficulty in agreeing settlement with the claimant. Trusts also experienced delays in obtaining expert medical reports, particularly for complex claims; in these particular cases, more than one expert medical report might be needed to determine the extent of damages caused, further adding to delays. Sometimes it was difficult to obtain the doctor's account of the event in question. Before responding to the claims manager's request, doctors would have to refer to the medical records, which could take time to locate and send. We found examples where doctors had been relocated to another hospital, or had moved abroad; in some cases it seemed that the doctor had simply not received the letter from the claims manager requesting a response.

3.36 As is shown in Figure 3.7 delays are not always created through fault of the trust. Patients often delay making a formal claim after the alleged negligent incident, sometimes through unawareness of negligence caused (for example, a failed sterilisation may be detected only when the patient becomes pregnant). Of the 59 claims in our case study sample where we were able to locate relevant dates (information on dates was not always available from the case files), 24 patients had taken over two years in which to lodge a formal claim against the trust (see Figure 3.8, over). There were some instances where delays were attributable to the slow progress made by claimants' solicitors (in some cases claimants who were dissatisfied with the services they were receiving changed their solicitors during the process, creating further delays).

Examples of claims that took a long time to settle

Case 7

In 1985, a mentally ill patient suffered a cerebro vascular attack because the anaesthetist had failed properly to monitor her during what proved to be an unnecessary operation. In 1990, the Health Authority received a summons. Eight months later the patient died. In 1991 the Welsh Office advised on settling but not before causation was resolved. From 1991 to 1995 the Health Authority received medical advice and a schedule of damages, during which time an interim payment of £2,000 was made. In 1995, those representing the patient had changed solicitors. In 1996 the Trust, who had taken over the claim from the Health Authority, received a new schedule of damages with further medical advice. By the end of 1997, Welsh Health Legal Services advised the Trust to settle up to £30,000 and two months later, Counsel recommended damages of £15,000 in addition to payments already made. Settlement was made the following year, and the claim was finally closed by the Trust in 2000.

Case 8

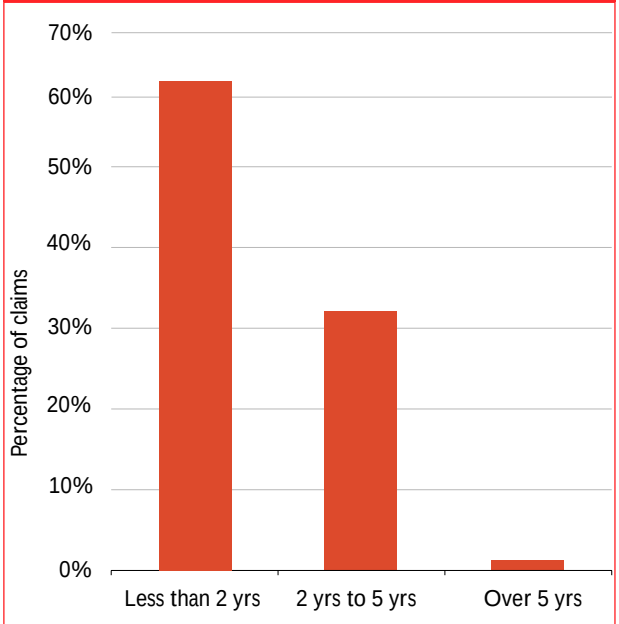
In 1993, a patient underwent an operation for laryngitis. It was only later realised, when the patient was referred by the GP for a second opinion, that he was suffering from tuberculosis and not laryngitis. A formal claim was lodged two months later. Solicitors were sent the medical records the following month. Two years later, proceedings were issued against the Health Authority and a defence was filed two months later. It took one year to exchange witness statements. In February 1997 Counsel advised that the Health Authority would lose the case if it went to court. They set quantum at a maximum of £100,000. In March, the Health Authority admitted liability to failing to x-ray the patient, but the Health Authority could not agree on causation. Evidence was collected on causation throughout 1997. In December, it was noted that, because the date of incident fell after the creation of the trusts, the Trust was responsible for handling the claim. It took a further 10 months for the claim to be transferred from the Health Authority to the Trust and another 3 months for the solicitors to issue a new claim. In March 1999 the Trust was advised to settle for £60,000 and final settlement of £88,000 was agreed in July 1999, 6 years and 3 months after the incident occurred.

Case 9

In 1995, a patient's colon was allegedly damaged during a hysterectomy. Doctors had also failed to diagnose a subsequent ileus, which was then treated in February the following year. Treatment of the ileus was successful. The initial allegation was that the patient's bowel had "been stapled" during the operation, but the consultant's opinion stated that there were adhesions to the small bowel, which is common after major surgery. Although the Trust found the case defensible, they had difficulty finding the notes and there was poor communication between the clinicians who had undertaken the operations. Furthermore, witness statements were difficult to obtain as one of the consultants had moved to Malaysia. The Trust was advised to settle although they did not believe they were negligent. They lacked evidence to support the case because of poor documentation of the patient's stay at hospital. The claim was settled for £5,000 in 1999.

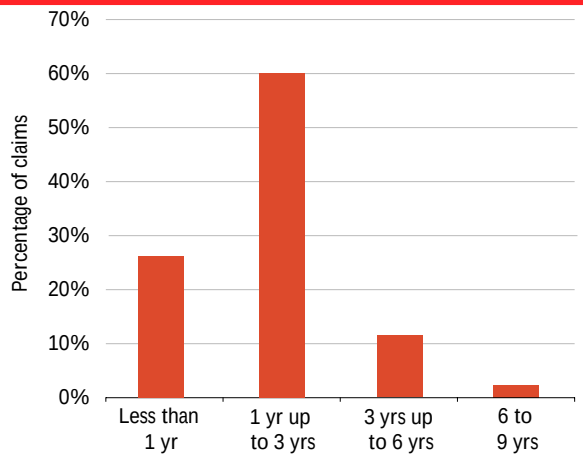
3.37 Even after the trust has admitted liability, the difficulties involved in agreeing the level of settlement mean that it can take some time to resolve a claim. In 49 of the 64 cases we examined, the trust had admitted liability and settled on those grounds. Analysis of the 35 claims in which we were able to identify dates shows that it took on average 23 months from the trust having admitted liability to a settlement being paid - Figure 3.9.

Figure 3.8 Range of time taken for claims from date of incident to date of formal claim



Source: National Audit Office Wales analysis of its sample of closed claims

Figure 3.9 Range of time taken for claims from date of admitting liability to date of settlement



Source: National Audit Office Wales analysis of its sample of closed claims

Measures taken to accelerate the progress of a claim

3.38 Our questionnaire asked claims managers for their views of the most effective measures used by the trusts to reduce delays. Responses indicate that both pro-active investigation into a claim and the co-operation of the relevant clinicians are seen as vital measures. Figure 3.10 shows trusts' assessments of the effectiveness of mechanisms available for reducing the time taken to close a case.

Figure 3.10

Measure that may reduce time taken to resolve claims	Percentage of respondents assessing the measure as very effective[1]
Pro-active investigation of incidents	81%
Co-operation from clinicians	75%
Early involvement of defence solicitors	56%
Automatic full disclosure of full documentation	56%
Early admission of fault	50%
Early discussion with claimant's solicitors	38%
Use of internal expertise as much as possible	25%
Speaking directly to patients[2]	10%

[1]Trusts were asked to rank each measure on a 1-5 scale, where 1 was very effective and 5 not effective. [2] Trusts explained that, once a claim is made, there is little if any contact with the patient.
Source: National Audit Office Wales questionnaire responses

Examples of claims experiencing delays in settling, after liability was admitted

Case 10

In 1993, the trust had admitted liability where the patient had undergone an operation 2 years after its scheduled date. In 1991 the patient was due to be treated for traction but through "slipped through the net". The patient had suffered a considerable amount of pain whilst waiting for his operation. The medical advisor's report stated in 1993 that the hospital was liable; however, he advised that the causation and quantum be given careful consideration because it was important to identify whether or not the patient would have endured the same pain and suffering had he had the operation earlier. In addition to the delay in determining causation and quantum, the trust had not heard from the claimant's solicitors from 1994 to 1995. The case was finally settled in 1998, exactly five years after the trust had admitted liability.

Case 11

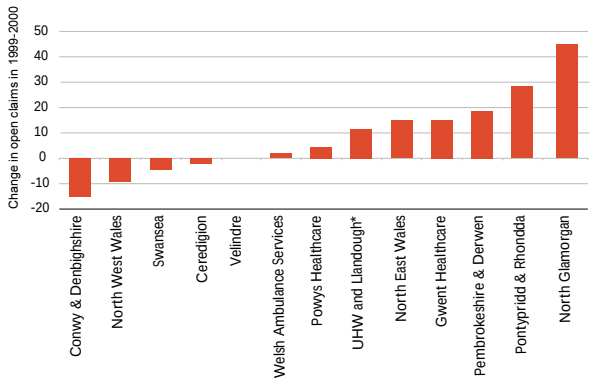
In January 1995, the trust admitted to negligence in a case where a man suffering from multiple sclerosis was given an inappropriate hip operation and where the repair operation performed 6 months later was considered to be poorly performed. In 1996, after the trust had obtained numerous reports on quantum, the patient did not agree to the settlement offered by the trust. In 1998 the trust received scheduled damages from the claimant's solicitors, but contested them on the grounds that the patient had been suffering from multiple sclerosis and not due to the negligence caused. Counsel advised the trust to settle the claim for £135,000 and finally in September 1999 the case was settled for £161,000, four years after the trust had admitted liability.

The rising workload

3.39 The evidence from Part 2 pointed to a rise in the number, as well as value, of claims in recent years. Reconfiguration of the trusts appears to have only added to the claims management workload. In several of the larger trusts, fewer staff are now available to work on the additional claims acquired from precursor trusts. In addition, during the time of our fieldwork, several trusts were still managing with a temporary management structure, and unclear lines of accountability, particularly at senior level. For example, at one trust which is the product of a merger, it was unclear if the claims manager would report to the Acting Chief Executive the yet to be appointed Chief Executive, or the Medical Director who had been made responsible for clinical governance in the interim.

3.40 There is evidence that trusts are already finding difficulties in coping with the clinical negligence workload. Only four trusts were able to resolve more claims than they had received during 1999-2000; the remainder faced an increase in the number of open claims against them (Figure 3.11). For the three trusts with the largest rise in number of open claims, the increase was more than 50 per cent.

Figure 3.11 Increase or decrease in number of open claims, 1999-2000



Source: National Audit Office Wales questionnaire

* Now part of Cardiff and Vale NHS Trust

Three trusts were unable to provide us with the data on either closed claims or new claims received.

3.41 The Woolf Reforms that came into effect in April 1999 include set timetables for certain stages of claims (paragraphs 1.13 and 3.17). These timetables represent substantial improvements over the average times taken to deal with claims made after this date. Failure to adhere to the timetable may carry a financial penalty in terms of costs awarded against the non-compliant party. In order to cope with the Woolf reforms and avoid penalties for causing delay, trusts need to ensure that all possible negligence cases are promptly investigated and defences prepared for, even though many of these cases may not give rise to claims.

3.42 It is too early to assess the impact of Woolf reforms on trusts' ability to manage their workload. In the National Audit Office Wales sample analysis, there were 11 cases where claims had been made after January 1999; of these, five claims had been settled by June 2000 (and one abandoned). For these more recent claims the average time taken to reach a settlement from date of claim was under a year, compared with the overall average of two and a half years for the sample as a whole (paragraph 3.31). A sample size of 11 is too small to draw statistically-valid conclusions. But if the Woolf reforms succeed in imposing reductions on the time taken to deal with clinical negligence claims, and given the increasing backlog of open claims referred to above, trusts will come under increasing pressure to manage claims more promptly.

How claims are managed - the availability of information

3.43 Paragraph 3.8 referred to the absence of management information at the local, trust level. This was highlighted by trusts' apparent inability to provide responses to elements of the National Audit Office Wales questionnaire. For example, various trusts could not provide us with information on the number and value of outstanding claims against them, nor the outcome of claims closed in 1999-2000. Just as we found minimal management information on clinical negligence claims within trusts, neither is there a body of data held centrally on claims across Wales.

3.44 Driving through improvements in performance requires the availability of robust information for managers. Managers need a base level of information for them to assess current levels of performance, to make judgements about strengths and weaknesses, and to focus on areas for improvement, with measurable targets, where appropriate. Further information is also needed to monitor progress, to assess whether performance is improving and whether corrective action is necessary. In the absence of accessible, usable data on clinical negligence - such as location of alleged incidents, number of claims, initial estimate of quantum, cost of settlement, time taken to process - managers in the NHS in Wales, in health bodies and the Assembly, do not have the basic tools needed for them to make informed decisions on reducing the considerable cost of clinical negligence.

KEY POINTS

Managing clinical negligence claims is often a lengthy and complex process. Each claim is treated individually and for all claims the cause of negligence and the cost of damages caused to the patient must be determined.

From our case study we found claims to take on average 4 1/3 years to resolve from date of incident to date of settlement. It takes on average 2 years for patients to make a claim against the trust after the incident of negligence has occurred and it takes an average 2½ years for trusts to settle those claims that they receive.

Trusts believe that difficulties in agreeing quantum with the claimant are the principal cause of delay in settling a claim. They also consider the management of a claim by claimant's solicitors to be another main cause of delay.

Pro-active investigation of an incident and better co-operation of clinicians are considered by trusts to be the most effective ways to reduce the time taken to resolve claims.

The impact on trusts of the likely rise in clinical negligence claims in recent years is being exacerbated by the effect of NHS reconfiguration in Wales and the Woolf reforms' aims further to speed up the progress of cases. With enforced deadlines and penalties for mismanagement of claims, claims managers must investigate all potential claims promptly and thoroughly.

This higher workload is likely to put an increased demand on claims managers who are already under pressure.

3.45 There are, however, initiatives at the early stages of implementation which might improve knowledge management within Wales. These are considered in the following paragraphs.

National Assembly's Losses and Special Payments Register

3.46 The National Assembly has been developing a Losses and Special Payments Register database system (LaSPaR) to replace existing procedures with a national standardised format for actioning write-offs or special payments approval. The trial run of LaSPaR began in January 2000 with the intention of the system going fully live by April 2000. Its main purpose was to:

- ensure that health bodies monitor all aspects of losses and special payments, from initial registration to final outcome, on a case by case basis;

- allow health bodies and the National Assembly to identify settlement/claiment costs, provisions, and defence or other administration costs provisions, and to action any subsequent adjustments; and

- ensure that all payments and income recoveries are identified separately and that analyses can be performed on these transactions.

3.47 However, LaSPaR has expanded and, in addition to its original function, can now hold further details regarding specific non-financial information on clinical negligence cases, such as any legal advice, details on the patient and doctor/s involved, and further notes on the nature of the negligence which occurred. Now LaSPaR no longer has a purely financial function, health bodies have expressed concern at management of the project, questioning whether greater risk management expertise is needed. There have also been major concerns over the confidentiality of patient records (the NHS has a legal duty to keep information on patients confidential). As a result of these concerns, LaSPaR had not yet become fully operational.

3.48 LaSPaR could potentially become a useful tool for both monitoring the trends of claims and claims management and in analysing risk management issues. Since the database has now expanded beyond its original, purely financial function and can now hold sensitive information regarding patients and doctors, it is important that the National Assembly resolve stakeholders' concerns and establish appropriate management arrangements.

Welsh Risk Pool

3.49 The Welsh Risk Pool, in recognition of the need for a claims analysis covering the whole of Wales, intend to begin compiling data on approximately 20 claims every year. The Risk Pool intend that the review process will analyse the quality of management in three stages: incident reporting, complaints handling, and claims management. The review will focus on the lessons to be learned and the changes in practice made to reduce future risk; these messages will be shared with other health bodies through the Risk Managers Network.

3.50 This initiative, should it mature, would mark the first attempt at determining trends on a national scale and as such is welcome. A sample of 20 cases represents 22 per cent of the 89 cases closed by the Welsh Risk Pool in 1999-2000. However, it is a very small fraction (1.25 per cent) of the total number of claims open at March 2000. It is open to question, therefore, whether a sample of this size will be sufficient to inform the management of all clinical negligence claims, particularly in view of the apparent growth of claims in recent years.

Centralised databases

3.51 In January 2000, Welsh Health Legal Services implemented a claims database that holds information found in the quantum lists on all claims which they are defending. This means that data on a large number of claims (90 per cent) is now held centrally, although historic data is not available in a readily accessible form. The Welsh Risk Pool has also begun to computerise their filing system on claims above £30,000 this year. Again, historic data on claims above this level is therefore not readily available for management use.

KEY POINTS

There is no central monitoring of the incidence, cost and management of clinical negligence claims across the NHS in Wales.

The National Assembly's Losses and Special Payments Register represents a potentially useful source of basic information on claims, provided issues concerning its ownership and management can be resolved.

Over time, the recently established claims database of the Welsh Health Legal Services could also represent a useful source of local information.

PART 4: REDUCING THE INCIDENCE OF CLINICAL NEGLIGENCE

Introduction

4.1 There remains scope for improving the management of clinical negligence claims. The more fundamental issue, however, is whether it is possible to reduce the number of incidents which give rise to claims in the first place. This would clearly have significant benefits for patients, as well as reducing the costs of clinical negligence cases to the taxpayer. The Government has set in train various initiatives aimed at improving clinical governance, outlined briefly at paragraph 1.12. This section looks at measures that have been taken locally to improve clinical care - and thus potentially reduce negligent incidents - through learning from previous experience. It also considers briefly the scope for resolving adverse incidents to the full satisfaction of affected patients without recourse to lengthy and costly legal processes.

Welsh Risk Pool initiatives

4.2 The Welsh Risk Pool has been instrumental in introducing measures that may significantly control risk and therefore cut the cost of clinical negligence. It has expanded its role to improve risk management procedures within the trusts and to create avenues for spreading good practice.

Risk Management Standards

4.3 Since 1996, when the management of the Welsh Risk Pool moved from the Welsh Office to the Welsh Health Common Services Authority, the Risk Pool has broadened its role to become more proactive in seeking to reduce the risk of negligence occurring in hospitals throughout Wales. In 1997 the Welsh Risk Pool first developed Risk Management Standards, aimed at ensuring that robust procedures in areas of risk were in place. (Health authorities have developed their own separate standards as many standards do not apply to them, although steps are now being taken to include health authorities in the same framework for risk management.)

4.4 Most standards cover a specific area known to have high levels of risk where accidents and near misses are likely to occur, while others focus on improving risk awareness and ensuring that there are strategies in place to address risks. Underpinning each standard is a list of procedural areas for assessment. There were 16 risk management standards in place during the fieldwork for this report - 11 generic and 5 specialist (the latter relating to clinical specialist areas which carry their own specific risks that need to be separately identified and managed). Figure 4.1 below sets out the standards, and gives an example of the areas for assessment underpinning one of them (the standard relating to patient records).

Figure 4.1 Risk Management Standards

Generic Standards	Specialist Standards
Risk Profile	Maternity
Risk Management Strategy	Operating theatres
Adverse Incident Reporting	Accident & Emergency
Patient Records	Mental Health
Clinical Audit	Community
Complaints	
Policies and Procedures	
Communications	
Supervision of junior staff	
Assessing competence	
Health and Safety related issues	

RISK MANAGEMENT STANDARD NUMBER 4: Patient Records

Areas for assessment:

1. There is a patient records policy document approved by the Trust Board which addresses the issues of:
   - Compilation (for example, dating and timing of patient record entries)
   - Legibility (for example, clarity of writing and signing)
   - Completion (for example, discharge instructions)
   - Amalgamation of notes of different professionals (for example medical, nursing and other clinical notes)
   - Patient-held records
   - Computerised records
   - Binding
   - Linking with x-rays, test results, etc.
   - Storage
   - Security
   - Access for patient
   - Copying
   - Retrieval
   - Availability
   - Retention and destruction
   - Confidentiality.
2. There is a procedure in place which ensures that the policy is audited routinely
3. There is evidence that the monitoring process is in effective use.

Source: Welsh Risk Pool

4.5 The Risk Pool has sought to use external assessors in order to establish the compliance of individual trusts with the standards. Initial attempts at external assessment were only partially successful: there were difficulties in finding suitable assessors, and the major reconfiguration of the NHS trusts in 1999 disrupted the assessment process. In 2000, however, assessors employed directly by the Welsh Risk Pool completed an independent assessment of trusts' compliance for the six months ending 31 March 2000. The results of this assessment are considered below (paragraph 4.8).

4.6 There is now some incentive for trusts to implement the risk management standards as the Welsh Risk Pool has linked compliance with rates of excess payable on claims. Since September 2000 and the assessment process referred to above, the rate of excess payable on claims has varied depending on the total cost of the claim (see Figure 4.2). While claims of up to £100,000 still have an excess payable of £30,000, there are progressively higher excesses for higher claims. Moreover, trusts that have been assessed as achieving a benchmark of at least 75 per cent compliance with the risk management standards will benefit from a reduction in excess payments of £5,000 for each claim.

Figure 4.2 Variable excess payments

	Excess payable when total cost of claim is:		
	up to £100,000	£100,000 – £250,000	over £250,000
Under 75% compliance with risk standards (£)	30,000	40,000	50,000
75% or better compliance with risk standards (£)	25,000	35,000	45,000

Source: Welsh Risk Pool

The 2000 assessments

4.7 The assessors quantified compliance against each standard for each trust, based on how the trust performed against each area for assessment. Aggregation of performance against each standard then gave an overall score for each trust in percentage terms. In order to ensure that a consistent approach had been taken to the assessments, the Welsh Risk Pool carried out a validation exercise on the assessment process. This involved detailed review of the assessment of one high scoring trust and one low scoring trust for each standard. The validation exercise did not reveal any significant inconsistencies with regard to assessors, nor across the standards.

4.8 Following the validation exercise, assessment results showed that five trusts achieved over 75 per cent compliance: Pontypridd & Rhondda (achieving the highest level of compliance with 88 per cent); Ceredigion and Mid-Wales; Swansea; Cardiff and Vale; and Pembrokeshire & Derwen (see Figure 4.3). However, there remains some way to go before all NHS trusts in Wales reach satisfactory levels of compliance against the standards. The average score for all trusts was 71 per cent, and the five worst-performing trusts fell within the compliance range 55 per cent to 63 per cent.

Figure 4.3 Results of the 2000 assessment of trusts' compliance with the risk management standards

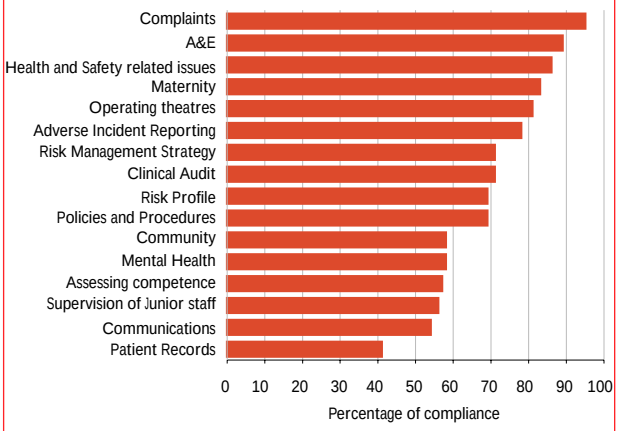
Trust	Specialist Score%	Generic Score%	Total Score%
Pontypridd & Rhondda	86.7	89	87.80
Ceredigion and Mid Wales	81	83	82.16
Swansea	87.5	76.5	82.00
Cardiff and Vale	81.6	75.8	80.90
Pembrokeshire & Derwen	73.5	83	78.25
Gwent Healthcare	79	68.5	73.50
North West Wales	64	79	71.50
Bro Morgannwg	83.5	56	69.75
North Glamorgan	67.8	69.5	68.70
Welsh Ambulance Services	76	57.5	67.70
North East Wales	69	55.5	62.25
Conwy & Denbighshire	62	60.5	61.25
Carmarthenshire	71	52.5	61.10
Powys Healthcare	63.1	59	60.80
Velindre	85.3	49.5	54.70
Average	**75.4**	**67.7**	**70.80**

Source: Welsh Risk Pool

4.9 Figure 4.4 opposite shows the overall performance of trusts against each standard. Scores range from 95 per cent compliance for the complaints standard, to 41 per cent against the patient records standard. The three areas that scored lowest compliance - the supervision of junior staff, communication between doctors and patients, and patient records - correspond to the non-clinical errors which, in our case study sample, were the direct cause of negligence or the sole reason for settlement (paragraph 3.25). The risk management standard assessment exercise therefore reinforces

our case study finding that there is considerable scope for improvement in these key areas of risk, which could significantly reduce the cost of clinical negligence to the NHS in Wales.

Figure 4.4 Compliance scores of all trusts with Risk Management Standards, 2000



Source: Welsh Risk Pool

4.10 We also looked to see whether there was a link between compliance with the risk management standards and the incidence of clinical negligence claims at trusts, the latter measured by open claims as a proportion of bed occupancy. Whilst in statistical terms, the correlation was not particularly strong we note that the four trusts that had the lowest incidence of negligence claims as measured in this way all achieved the 75 per cent benchmark compliance with the risk management standards.

4.11 The Welsh Risk Pool is making efforts to ensure that the Risk Management Standards take account of other initiatives. The NHS Executive in England has developed a control framework, comprising 18 controls assurance standards for health bodies to work towards (and health bodies are now required to include statements on compliance with these standards in their Annual Reports). Risks covered by the controls assurance standards - which include fire safety and waste management, for example - are wider than the Welsh Risk Pool's risk management standards. Some controls assurance standards, however, overlap with risk management standards, such as records management and risk management system. The Welsh Risk Pool has therefore worked with health bodies and the Assembly to merge its risk management standards with the controls assurance standards so that, with effect from January 2001, "NHS trusts in Wales have one comprehensive set of standards [now known as Welsh Risk Management Standards] at as early a stage as possible, thus reducing the amount of duplicated effort and potential confusion in assessing different standards"[2]. However, within the wider controls assurance standards, those that relate to clinical negligence risk will continue to be assessed by the Welsh Risk Pool and provide the basis for trusts to achieve excess discounts.

Adverse Clinical Incident Reporting Systems

4.12 Risk Management Standard number 3 requires that each trust implement a computerised adverse incident reporting system for the reporting of incidents, mistakes and near misses, so that if acted upon early they may be managed promptly and potential claims can immediately be identified. The Welsh Risk Pool have defined adverse clinical incidents as "any occurrence which is not consistent with the routine treatment or care of the patient/resident, or routine operation of the organisation". At their most serious, adverse incidents can amount to clinical negligence.

4.13 Basing their estimates on earlier research carried out in the United States of America and Australia, an expert group under the chairmanship of the Chief Medical Officer for England highlighted in their report *An Organisation with a Memory* that the best estimates available indicated that adverse incidents, in which harm is caused to patients, occur in ten per cent of hospital admissions. In Wales, this would amount to some 87,000 adverse incidents a year. Research has also attempted to quantify the links between adverse incidents and clinically negligent incidents. Two pieces of research in the United States of America concluded that between 22 and 33 per cent of adverse events were the result of negligence, although the number of instances in which claims were made or upheld was much smaller. The National Audit Office Wales questionnaire also sought to examine the extent of the link. Respondents to our questionnaire reported a total of 94 complaints relating to adverse clinical incidents; 13 (some 14 per cent) of these had developed into negligence claims.

[2] Welsh Risk Pool

4.14 In the United States of America, health bodies are required to report adverse incidents, or "sentinel events" in order to participate in the Medicare and Medicaid programmes. In the United Kingdom, notwithstanding that routine adverse incident reporting, including incidents that do not result in claims for negligence, is now becoming more common, there has been criticism of the failure of the NHS to learn from those events that are reported. The lack of an open culture in hospitals makes it increasingly difficult to discuss problems and solutions to these problems. Recent reports in the health field have highlighted the absence of consistent centralised reporting systems.

4.15 The first trust to introduce a computerised adverse incident reporting system was University Hospital Wales in 1994 (now part of Cardiff and Vale trust). Progress across Wales, however, has been slow: two trusts (Velindre and North East Wales) have not yet implemented a system, and five completed implementation only as recently as 2000 (Gwent Healthcare, North West Wales, Powys Healthcare, Welsh Ambulance Services and Carmarthenshire).

4.16 The NHS England intends to adopt a national incident reporting system and, at the time of preparing this report, the Assembly was considering how to take forward a standardised database in Wales. Standardisation has the benefit that it allows for consistent data collection for analysis purposes.

Risk Managers Network

4.17 The Welsh Risk Pool has established a Risk Managers Network that identifies and discusses key issues on Risk Management and disseminates examples of good practice. The group, which meets every six weeks, was in part established because of the issues considered in Part 3: the lack of comparative and historical data, and because of poor communication between trusts on risk issues. The Risk Managers Network includes representatives from trusts, health authorities and the Assembly and comprises a range of clinical, professional and managerial staff with broad risk management responsibilities. The Network receives expert risk management advice from a private firm of consultants.

4.18 Feedback from our questionnaire shows that several respondents believe the Risk Managers Network is a useful tool in disseminating information on adverse incidents and for benchmarking. Given the poverty of shared information, as discussed in Part 3, any arrangement to facilitate the discussion of issues of joint concern is an improvement.

4.19 Although human errors will always occur, there is clearly much more that can be done to reduce the incidence of clinical negligence. With only five of the 15 trusts achieving the benchmark of at least 75 per cent compliance with the promulgated risk management standards, and progress on learning from earlier mistakes by implementing adverse incident reporting systems being slow, there remains much to be done. Reducing the annual number of new cases of clinical error by ten per cent over the next three years might represent an achievable target by making urgent further progress on risk management and incident reporting systems. This might produce significant annual savings: as an illustration, saving ten per cent of the total compensation paid by NHS bodies in 1999-2000 (paragraph 2.5) would release some £2.7 million. Reducing the incidence of clinical negligence would help to counter-balance the likely additional costs that will arise from factors such as difficulty in achieving the Woolf Reform timetables, the Court of Appeal's recommendations on the levels of damages payable and the more questioning attitude of patients.

KEY POINTS

The best way of reducing the costs of clinical negligence is to reduce the number of clinically negligent incidents.

The introduction of risk management standards by the Welsh Risk Pool, together with incentives for trusts to comply with them (through reduced excess payments), is a useful mechanism for trusts to tighten procedures and so minimise the potential for negligent incidents.

The results of independent assessments of trusts' compliance with the risk management standards in 2000 show that there remains considerable scope for further improvement. Only five of the 15 trusts achieved the benchmark of at least 75 per cent compliance. The three standards where compliance across Wales was the lowest correspond to the non-clinical errors the National Audit Office Wales found can contribute significantly to incidents of clinical negligence.

One way of encouraging trusts to comply with risk management standards would be to increase the discounts given on the excess payments when claims are met from the Welsh Risk Pool.

To reduce error, it is essential to learn from earlier mistakes. Adverse incident reporting systems are key to gathering evidence on clinical error, in such a way that causes can be tackled. Progress by trusts in implementing such systems has been slow, and there is no standardised system as yet.

Reducing the annual numbers of new cases of clinical error by ten per cent over the next three years might represent an achievable target by making urgent further progress on risk management and incident reporting systems.

This might produce significant annual savings which would help to counter-balance likely additional costs arising from other factors.

Preventing claims arising from incidents and complaints

4.20 Although there is much that can be done to reduce the incidence of clinical negligence, it will not be possible to eradicate clinical negligence completely. Trusts, however, may be able to reduce the costs associated with clinical negligence, to the mutual satisfaction of both healthcare provider and patient, by preventing such cases escalating into the legal sphere. The Woolf Report advocates that alternative - non-litigious - dispute resolutions be explored before considering litigation. And research into the subject has found that many patients feel they must take legal action in order to receive an apology for, or an explanation of, what went wrong. In some cases, financial payout can be poor compensation for the time taken for clinical negligence claims to be settled.

Why patients sue the NHS

4.21 The norm in cases of clinical negligence where liability is admitted is for legal proceedings to be put in train, leading to resolution by means of settlement. However, a report by the Public Law Project in 1999 on complaints in the NHS, concluded that most patients who feel sufficiently dissatisfied with the treatment they have received to make a complaint against a trust, have no intentions of suing; that they complain only to seek an apology and the assurance that action will be taken to prevent the incident from re-occurring. However, complainants who are either dissatisfied with the complaints procedure or with the trust's handling of the complaint, will often resort to legal means to seek an apology. Other research has also found that the main causes of litigation are usually other than the prospect of financial recompense - Figure 4.5.

Figure 4.5 Research into why patients sue

When patients were asked, "once the original incident had occurred could anything have been done which would have meant you did not feel the need to take legal action", 41 per cent responded with "yes". Actions taken that could have prevented claims from arising were:

	Respondents
Explanation and apology	37
Correction of mistake	25
Pay compensation	17
Correct treatment at the time	15
Admission of negligence	14
Investigation by hospital/drug company	3
Disciplinary action	4
If listened to and not treated as neurotic	5
Honesty	4

Source: Why do people sue doctors? A study of patients and relatives taking legal action, Charles Vincent, Magi Young, Angela Phillips, The Lancet, June 1994

Alternative Remedies – Mediation and Ex gratia payments

4.22 Key to preventing incidents turning unnecessarily into clinical negligence claims is the establishment of better relationships between trusts and their patients. At its most basic level, appropriate channels of communication need to be available. Our survey of trusts found that five trusts had never offered patients making claims the chance to meet clinicians to discuss their care, while a further seven had done so only rarely.

Case study

One trust is attempting to improve the level of communication between trust and patient as part of its Charter Mark commitment. The trust has employed a Patient Perceptions Officer under the Nursing Directorate who uses an interactive approach in understanding the needs and experience of the patients. The Patient Perceptions Officer makes regular visits to the different units and wards to gain the perspective of both patient and staff needs. He also keeps in regular contact with local voluntary organisations and with Community Health Councils, using their particular expertise with dealing with public concerns. The Patient Perceptions Officer is instrumental in disseminating the information gained and he is actively involved in training new staff on quality and complaint handling.

4.23 While better communication between trusts and patients would go some way to assuage patients' concerns and avoid costly and time-consuming legal action, there are other measures available to trusts to handle potential clinical negligence claims. Since the introduction of the Civil Procedure Rules, judges may penalise parties, where they consider it appropriate, who do not genuinely attempt to settle cases promptly. Greater use of alternative dispute resolution, such as mediation and ex gratia payments, might reduce delays in settlement.

4.24 Mediation, the process whereby a neutral third party intervenes to facilitate negotiation, has been proven to offer remedies not capable of being granted by the courts since it can provide a visible and open forum for the parties to discuss settlements and speed the claim along.

4.25 Mediation is not necessarily a cheap option: a pilot study indicated that costs were at least on a par with those for the normal litigation process. Nor are all claims are suitable for mediation. According to the same study, such cases fell into three categories:

- those lacking settlement potential - where there was a desire to set a precedent;
- those where the claim value was high and the protection of a vulnerable claimant is best afforded through the legal process – such as claims involving brain-damaged babies; and
- those where information was lacking on which to base settlement negotiations.

4.26 Responses to our survey show that trusts rarely offer mediation to patients who have suffered from the treatment they have received. Two trusts do usually offer mediation, but nine have never done so. In England, since June 2000 the NHS Litigation Authority has required its solicitors handling claims to offer mediation wherever appropriate and to provide details of cases they and claimants' solicitors recommend. Although mediation is not suitable for all claims, there is also scope for trusts in Wales to explore the potential for greater use of mediation in cases where it is sensible to do so.

4.27 Some trusts offer ex gratia payments to patients who do not want to use legal means to gain compensation and where the trust had recognised fault. Although questionnaire responses indicated that trusts found ex gratia payments the second most effective measure to reduce the cost involved in clinical negligence, it is rare that trusts make such payments. Ex gratia payments can ensure that costs are kept to a minimum, as there are no legal fees, and that the victim is compensated quickly. Although they do not rule out the possibility of future litigation, where ex gratia payments have been made, we have no evidence of the complainant resorting to further litigation. However, trusts should guard against the risk of using the weight of legal and medical expertise at their disposal to persuade people to give up their rights to legally-determined compensation.

Examples of Ex gratia payments

Case 12

In 1999, a patient underwent a successful ear operation but was left scarred from the bandage that had been wrapped too tightly around her forehead after the operation. The woman's husband contacted the consultant, who promptly recommended he contact the claims manager directly. The trust admitted liability immediately and made an offer of £2,000. After negotiations, the patient accepted £2,500.

Case 13

In 1998, a family contacted the trust to request an internal investigation into their son's death. The boy had died from multi-organ failure and enterocolitis. Results of the investigation showed that the doctors failed to rule out a rare disease when the child was admitted to hospital one year earlier, which resulted in the boy's death. Although it is procedure for the hospital to carry out further tests on a patient showing signs of the disease the doctors felt the child was recovering and should be spared the potentially dangerous tests. As the family preferred to settle out of court and as soon as possible, an ex gratia payment of over £8,500 was awarded as statutory payment for the death of a child and to cover additional costs. The payment was made six months after the family had initially contacted the trust.

KEY POINTS

Research has established that patients take legal action against healthcare providers for several reasons. Financial recompense is often considered less important than the need for recognition of error and an apology.

Trusts rarely use alternative remedies, such as mediation and ex gratia payments, to resolve problems arising from clinical negligence, although they can offer considerable benefits for both healthcare provider and patient. Although alternative remedies are not suitable in every case, there is scope for greater use of them.

APPENDIX 1

Methodology

1 We used a variety of methods to collect evidence for this study.

Survey of trusts and health authorities

2 We sent survey questionnaires to all NHS trusts and health authorities in Wales. The questionnaires were based on similar ones used as part of the National Audit Office study on clinical negligence in England, but modified to reflect circumstances particular to Wales following discussions with sector representatives.

3 The survey collected data on:

- the number of claims handled by the NHS body
- how the NHS body managed claims
- outcomes of claims against the NHS body
- the timeliness of settlements
- the costs of managing claims
- solicitors used in defending claims; and
- accountability

4 All trusts and two of the five health authorities returned the survey, the other health authorities stating that they were no longer involved in claims management. Not all bodies were able to answer all the questions.

5 Since health authorities only retain primary responsibility for claims arising in respect of incidents that occurred prior to the formation of trusts, our analysis focused on the way in which trusts approached the management of clinical negligence claims.

Visits to NHS trusts

6 We visited five of the 15 NHS trusts in Wales to discuss the issues in greater depth, identify good practice supported by case studies, validate the responses to the questionnaire, and examine samples of settled cases. The five trusts were selected to cover all health authorities and to be representative of a range of other factors, including volume of claims, organisational structures, and degree of impact of reconfiguration. They were:

- Bro Morgannwg NHS Trust
- Gwent Healthcare NHS Trust
- North East Wales NHS Trust
- Ceredigion and Mid-Wales NHS Trust
- Cardiff and Vale NHS Trust

Sample of cases

7 We analysed a sample of 94 negligence cases drawn at random from the five trusts visited; these included ex-health authority claims now being managed by those trusts. Of these 94 claims, 64 had been closed during 1999 -2000 with settlement. It was not possible to find all the information we were looking for - such as dates - in each case.

Other

8 We also obtained information on clinical negligence from a variety of other sources:

- the National Audit Office Wales' financial audit of the NHS (Wales) Summarised Accounts;
- analysis of sector-wide data held by the Welsh Risk Pool, Welsh Health Legal Services and the NHS Directorate of the Assembly;
- review of existing research on clinical negligence, including submissions to the House of Commons Health Select Committee for their examination of adverse clinical incidents; and
- the findings, where available, of the separate report by the Comptroller and Auditor General on clinical negligence in England.

APPENDIX 2

Management of claims for clinical negligence in England

Funding settlements for clinical negligence

1 The system of handling claims in England is more complex than the one used in Wales. In England, there are two main schemes running to help NHS bodies meet the costs of liabilities and both schemes are administered by the NHS Litigation Authority, a special health authority. From April 2000 the Existing Liabilities Scheme covers all clinical negligence liabilities for each clinical negligence claim for incidents that occurred before April 1995 (the Scheme was set up in 1996, but before April 2000 trusts and health authorities were responsible for managing many claims). The Clinical Negligence Scheme for Trusts is a pooling arrangement for member trusts for clinical negligence claims where the incident occurred after March 1995. Similar to the Welsh Risk Pool, trusts pay the equivalent of premiums and in return receive assistance with the costs of the case above a certain excess level. It differs from the Welsh Risk Pool arrangement in that the trusts set select their own excess level from a range offered by the NHS Litigation Authority. The size of excess selected will affect the level of contribution that is paid into the Scheme.

Handling claims

2 For claims below their selected Clinical Negligence Scheme for Trusts' excess level, trusts in England have full discretion as to how claims are handled. As a consequence there are a number of models for the way that claims are handled locally. The most prevalent models used are:

- Trust acquires in-house legal expertise and retains management of the claim;
- Trust contracts for specialist legal advice but retains management of the claim; and
- Trust appoints external solicitors to manage claims.

3 For claims above Clinical Negligence Scheme for Trust excess levels the NHS Litigation Authority assumes control of the claim.

Defending claims

4 Prior to 1996 and the establishment of the NHS Litigation Authority, there were around 90 different firms of solicitors representing the various health bodies; practice and the quality of work varied widely. To address these issues, the NHS Litigation Authority appointed "gatekeeper" solicitors whilst recruiting its own staff.

5 Gatekeepers were appointed to review proposed settlements and legal defence strategies on behalf of the Authority. They acted as contract/agency staff rather than second solicitors for the claim.

6 The NHS Litigation Authority also created a panel of legal advisers to provide advice on any claims requiring the appointment of solicitors under the Clinical Negligence Scheme for Trusts. It appointed 18 firms (named partners/fee earners from within each firm) from April 1998, initially for three years; from April 2001 the panel will reduce to 16. From 1999, the panel began to take on Existing Liabilities Scheme claims along with all claims above the excess under the Clinical Negligence Scheme for Trusts.

APPENDIX 3

Reporting the costs of clinical negligence in the Summarised Accounts

1 This appendix shows extracts from the 1999-2000 Summarised Accounts of NHS trusts in Wales to illustrate how transactions relating to the in-year and future costs of clinical negligence are reported. Note that the figures referred to in Part 2 of this Report are from the unaudited 1999-2000 accounts, and include clinical negligence costs reported by health authorities, as well as the trust figures shown below.

A. Current costs of clinical negligence: Income and Expenditure Account

Provision for losses, etc

5.2 Provisions for losses, special payments and irrecoverable debts: charges to operating expenses

	Premium for insurance arrange-ments £000	Payments not previously accrued £000	Increase/ decrease in provision for future payments £000	Total £000	1998-99 (Restated) £000
Clinical negligence		6,913	12,580	19,493	3,095
Personal injury		1,349	3,931	5,280	2,490
All other losses and special payments		795	-201	595	366
Defence legal fees and administrative costs		539	617	1,156	1,868
Insurance premiums (1998-99 figures include Welsh pool)	214			214	6,030
	214	9,596	16,927	26,737	13,849
Irrecoverable debts		132	1,600	1,732	967
Income received/due from Welsh Risk Pool	-	-	-	-	(1,023)
Total charged to expenditure	**214**	**9,728**	**18,527**	**28,469**	13,793

The charge to the Income and Expenditure Account includes two elements:

- Amounts payable in the year in respect of claims which had not been previously anticipated; and
- The movement (increase or decrease) in the provision for future settlements of compensation, contributing to a "fund" created to finance those future claims with a reasonable probability of payment.

(In Part 2 of this report, some £6.6 million is deducted from the £19.5 million total shown here (paragraph 2.4). This is the amount paid by the Risk Pool to health authorities in respect of claims, and is included within the health authorities summarised accounts.)

B. Future costs of clinical negligence: Balance Sheet

The future costs of clinical negligence comprise three elements: creditors, provisions and contingent liabilities (paragraph 2.7 refers).

Creditors

10.1 Amounts falling due within one year

	£000	31 March 1999 £000
Interest payable	198	1,419
Public dividend capital loan advance	850	500
Brokerage from health authorities	3,650	
Payments received on account	1,615	828
NHS creditors	14,232	12,352
Non-NHS trade creditors-revenue	37,701	36,173
Non-NHS trade creditors-capital	7,251	12,558
Non-NHS trade creditors-losses and special payments	5,631	
Tax and social security costs	22,446	22,021
Public dividend capital-dividend capital-dividend payable	2,226	1,898
Patient's money	2,145	2,409
Obligations under finance leases and hire purchase contracts	558	437
Pensions relating to former directors	172	611
Pensions relating to staff other than former directors	835	899
Superannuation	7,131	5,731
Other creditors	13,538	9,138
Accruals and deferred income	15,082	15,576
	135,261	122,550

Future payments in respect of cases where trusts consider they are certain to settle are reported within creditors.
These costs are included within the line "Non-NHS creditors - losses and special payments".

Provisions for liabilities and charges

11.1

	At 1 April (Restated) 1999 £000	Adjustment to provision set up in a previous year £000	Unwinding of discount £000	Arising during the year £000	Utilised during the year £000	At 31 March 2000 £000
Clinical negligence	36,436	(3,611)	-	16,191	(5,628)	43,388
Personal injury	7,701	(2,492)	-	6,423	2,259)	9,373
All other losses and special payments	426	(426)	-	225	-	225
Defence legal fees and other administrative costs	2,117	(643)	-	1,260	(653)	2,081
	46,680	(7,172)	-	24,099	(8,540)	55,067
Pensions relating to:						
former directors	252	-	-	418	(218)	452
other staff	4,747	(636)	164	1,862	(768)	5,369
	4,999	(636)	164	2,280	(986)	5,821
Other	1,842	(1,009)	-	5,025	(170)	5,688
	53,521	**(8,817)**	**164**	**31,404**	**(9,696)**	**66,576**

A provision is established for those claims where trusts consider a compensation settlement is probable. In calculating the provision for future settlements, the trusts will first re-assess the accuracy of the opening provision to establish if that is adequate for existing claims. Adjustments are then made to take account of new claims for future settlement identified during the year, and for any provision used in settlement of claims in the year.

Contingent liabilities

20 At 31 March 2000, claims with a potential value of £130,781,000 (31 March 1999: £87,270,00) had been made against NHS trusts in Wales. These claims are disputed and, until they are resolved, the trusts' financial liability, if any, cannot be determined. In accordance with the requirements of FRS12, no provision has been made in the 1999-2000 accounts for these items.
In addition, 5 trusts reported liabilities for major repairs to buildings arising from abestos contamination, fire prevention work and replacement of defective pipework with an approximate total value of £121,000,000. As above, no provision has been made in these accounts for these items.
Other litigation claims could arise in the future due to incidents incurred but not reported. The expenditure which may arise from such claims cannot be determined with reasonable accuracy and no provision has been made for them.

Those claims where the likelihood of settlement is considered by the trust to be only possible are not included within the financial statements, but instead are reported for information only in a separate note to the accounts.

Comparisons with England

2 The overall accounting treatment for clinical negligence within the NHS in England differs from that in Wales in two important respects. First, in Wales, trusts do not report the potential costs of claims yet to be made in respect of past incidents - incidents "incurred but not reported" - as these costs are unknown. In England, however, for the first time in the 1999-2000 NHS Summarised Accounts (unaudited at the time of preparing this report), health bodies have disclosed an estimate of the costs of incidents incurred but not reported as £1.9 billion. These values have been derived from actuarial assessments based on previous claims.

3 Secondly, unlike England, no adjustment is made in Wales to discount the values reported for the future costs of clinical negligence claims. Given the much smaller portfolio of live cases, the introduction of a further layer of complexity to the account figures is considered to be of limited value to users of the accounts, and analysis by Assembly staff has shown that it would not have a material effect on the total cost estimates. However, discounting is applied in a few specific Welsh cases where it is known that claims settlement will result in annual payments over a significant period of time.

4 Because of these two important differences in the accounting treatment for clinical negligence, no ready comparison between England and Wales of the reported costs can be made, and any cross-border analysis of this nature should be treated with caution.

APPENDIX 4

Risk Management Standard 3: Adverse Incident Reporting Systems

Main Priority: To ensure that an adverse incident reporting system is in use throughout the trust.

Areas for Assessment

1 The systems for reporting incidents are clearly identified.

2 Staff throughout the trust are knowledgeable about how to report.

3 Adverse incident reporting forms are available in all parts of the trust.

4 Staff know what to report (for example, there is a set of trust-wide indicators of those specific adverse incidents and "near misses" which should always be reported).

5 The risk management strategy makes clear that the adverse incident reporting system is in itself not part of the disciplinary process (It is recommended that some examples be given of what incidents would be unforgivable).

6 A system is in place for ensuring that all adverse incident reporting forms are assessed for appropriate action, within 2 working days.

7 There is a system for feeding back actions taken on a report, to the person reporting.

8 There is a policy for rapid follow-up of major clinical and other incidents.

9 There is a data collection process in use which creates meaningful management information of trends, etc.

10 Reports on the trends of the adverse incidents are submitted quarterly to the Chief Executive.

11 The adverse incident reporting arrangement will be integrated with the trust's claims management and complaints systems.

12 There are sets of indicators giving examples of adverse incidents and "near misses" specific to each department, ward or speciality.