MARSH

Department of Health

NHS Litigation Authority Industry Report

April 2011

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Section One
Executive Summary

Scope and Purpose of Review

This report presents the findings of a study commissioned by the Department of Health (DH) to review the role and remit of the National Health Service Litigation Authority (NHSLA). The key aim of the review is to establish the following:

- Whether the NHSLA achieves optimum performance in delivery of its risk pooling functions.
- Whether any sub-optimal performance by the NHSLA is responsible for the upward trends in scheme liabilities that have been experienced in recent years.
- Whether there may be opportunities to introduce greater commercial management and practice to improve the efficiency of the services.

The approach adopted within the 8 week project to address these questions included eliciting feedback from stakeholders, a review of the claims processes, documentation reviews and quantitative analysis.

Whilst a wide breadth of stakeholders' views have been taken into account both in person and by electronic means, feedback has not been obtained from every member or relevant stakeholder and as such their opinions may be different from those expressed in this report.

Overall Findings

Marsh has found that in general, the NHS risk pooling scheme is a valid concept which is widely accepted and endorsed, and its stewardship and administration by the NHSLA has been effective. Marsh therefore recommends that the scheme should remain with the NHSLA in the future. However, there are some areas where the NHSLA does not achieve optimum performance and there are a number of practices that are commonly applied by commercial insurance organisations that would lead to better performance in these areas.

Marsh high level findings and recommendations as to how these commercial principles could be applied to the NHSLA's operations are given below.

Claims Management, Legal and IT

The feedback highlighted mixed views on the claims handling approach, with some Trusts perceiving the NHSLA approach as a 'soft touch' and settling claims quickly rather than defending cases; whilst alternative views expressed that the NHSLA was too adversarial. It is not possible to establish a definitive link between any sub-optimal performance of the NHSLA and the rise in clinical negligence claims, with a large number of factors contributing to the rise in claims number and associated costs.

Significant delays in Trusts reporting claims to the NHSLA may be impacting on the ability to manage claims effectively, and the lack of alignment between incident reporting and claims reporting may lead to lost opportunities for early intervention. The legal panel is an effective way to maximise leverage in negotiation of fees and ensures greater consistency of approach, however the panel is used quicker than expected in some cases. In part, this may be due to under-resourcing issues whereby claims handlers in the NHSLA have a higher number of claims than expected.

Marsh recommends:

- Adopting a tougher stance on non-conforming Trusts with financial penalties for non-compliance with claims reporting.
- Adjustment of KPI's for legal panel and claims settlement to introduce 'quality' metrics, with less focus on speed of settlement, to ensure NHSLA are not seen as 'soft touch' for claimant solicitors.
- Detailed review of claims causation codes and greater use of data to improve risk management.
- Address resourcing issues to ensure maximum use of claims handlers, and effective use of legal panel.

Risk Management and Incentivisation

Marsh has found that the risk management standards are, in general, highly regarded and have introduced a consistent framework for risk management and have helped to elevate clinical risk management to a board level agenda.

However, there are opportunities to increase incentives for Trusts to improve their risk management standards and claims experience. There is also a lack of leverage for the NHSLA to impose penalties on poorly performing Trusts. In addition, Marsh have found that the current risk management system does not utilise the large and unique data set that the NHSLA holds in order provide wider analysis of claims over a greater range of clinical specialities.

Marsh recommends:

- Develop the current risk management standards to reflect more risk specific specialities such as A&E and General Surgery so that contributions more accurately reflect the risk profile of the Trust, with greater use of the data and more feedback to Trusts to ensure lessons are learnt.
- Greater use/application of discounts and penalties to reflect claims experience, and compliance with claims reporting protocols and incentivise best practice within Trusts.

- Increase the number of risk management standards to 4 (or perhaps 5 over time) in line with more general commercial risk maturity models, with a removal of the contribution discounts for the basic level of risk management (Level 1).
- Development of an on-line premium allocation tool to increase transparency and allow Trusts to see how changes in risk management criteria and procedures will affect their contribution levels.
- There should be greater alignment between the NHSLA standards and the approaches adopted by other bodies, in particular Monitor and Care Quality Commission (CQC).
- Risk assessments should be more regular and proportional to the size of the Trust.

Strategic and Cultural

The wider role of the NHSLA in handling complex claims, delivering education, risk management and collaborating with other medical and regulatory bodies is recognised as delivering value to the NHS. However, a third party administrator approach rather than a customer service driven culture is perceived by some members. The contribution of the NHSLA is sometimes wider than its original remit with additional responsibilities assumed. There is tight control at the top of the organisation with significant key person dependencies.

The current scheme does not allocate the full cost of clinical negligence claims, as contribution levels are based purely on claims to be paid (pay as you go). There are significant time lags in reporting and settlement of claims and therefore the reserves, which remain with the Department of Health, are significant (£15bn). Any alternative insurance solution will not remove these historical liabilities without significant cost for the ‘retro-active’ cover. However, exit barriers could be reduced to allow greater commercial competition.

Marsh recommends:

- The pooling arrangement is an appropriate structure. However consideration should be given to a ‘claims made’ scheme. Exit barriers should be reviewed to allow greater competition from commercial insurers.
- The NHSLA role in relation to improving patient safety could be increased, with the NHSLA assuming responsibility for incident reporting from the NPSA or greater alignment between claims and incident reporting.
- A broader review of governance and the constitution of the existing NHSLA board should be reviewed and clear succession plans for key staff established.

Summary and Acknowledgements

Marsh would like to extend special thanks to the National Health Service Litigation Authority, for their openness and co-operation throughout this project. Marsh would also like to thank the Department of Health (DH) for their support, and all interviewees and interested stakeholders for their input and feedback.

Marsh recognises that if these recommendations are adopted, this will require significant work and planning to turn the NHSLA into a more proactive and customer focussed organisation that actively engages in setting the risk management agenda for the NHS.

In summary Marsh believes that whilst the NHSLA does not achieve optimum performance in every aspect of risk pooling, the concept of risk pooling is valid and the stewardship and administration of the scheme has been effective and should remain with the NHSLA without wholesale change. Greater openness and transparency towards the scheme members (customer centric approach) and a tougher stance on the definition of 'clinical negligence' and non-conforming Trusts coupled with greater collaboration with other clinical bodies will position the NHSLA well for the future reforms. Marsh does not envisage any significant commercial involvement in the CNST at the moment but would suggest exploring the potential for involvement in the handling of non clinical arrangements.

Marsh

1 April 2011

Section Two
Introduction

The NHS Litigation Authority ('NHSLA') is a Special Health Authority, set up in 1995, to administer schemes under which NHS bodies can pool the costs of any 'liabilities to third parties for loss, damage or injury arising out of the carrying out of their functions'. The majority of these liabilities relate to clinical negligence claims. However, there are two separate pools within the NHSLA for property, and liabilities to third parties (largely public and employers' liability). 62% of the claims received in 2009-2010 by the NHSLA were for clinical negligence with payments on clinical negligence claims of £787 million.

The overall aim for the NHSLA, when it was established, was to 'promote the highest possible standards of patient care and to minimise the suffering resulting from any adverse incidents, which do nevertheless occur'. The published objectives of the NHSLA include:

- efficient, effective and impartial administration of the Schemes.
- minimising the overall costs of clinical negligence, third party liabilities and property expenses to the NHS, by defending unjustified actions robustly, settling justified actions efficiently, and contributing to incentives for reducing the number of negligent or preventable incidents.

Given the focus on maximising the resources available for patient care, there is a need to review the performance of the NHSLA against these objectives and to highlight areas for improvement.

2.1 Terms of Reference

Marsh has been appointed to undertake a review of the NHSLA following the Invitation to Tender from the Department of Health dated 24th December 2010. Within the scope of this project, Marsh has been appointed to establish:

- Whether the NHSLA achieves optimum performance in delivery of its risk pooling functions.
- Whether any sub-optimal performance by the NHSLA is responsible for the upward trends in scheme liabilities that have been experienced in recent years.
- Whether there may be opportunities to introduce greater commercial management and practice to improve the efficiency of the services.

In order to address these three key questions, the following aspects of the NHSLA have been reviewed:

- Claims management - handling process, incident reporting, including IT and legal aspects, history, culture and philosophy of the schemes.
- Risk management (RM) & incentivisation - RM framework including the methodology for calculating members' contributions and incentives.
- Strategic and cultural aspects of the NHSLA's operations.

Marsh would like to extend special thanks to the National Health Service Litigation Authority, for their openness and co-operation throughout this project. Marsh would also like to thank the Department of Health (DH) for their support, and all interviewees for their input.

Section Three
Context

The National Health Service is legally liable for any acts of clinical negligence committed by its employees arising in the course of their duty. This liability applies across the full spectrum of NHS services, whether in an acute hospital, ambulance, mental health, or primary care Trust.

In the UK the Medical Defence Union, Medical Protection Society and the Medical and Dental Defence Union of Scotland, indemnify their members, while the NHSLA covers all negligent acts committed within the scope of the NHS. It is not a compulsory requirement that Trusts are members of the scheme, but as of March 2011 all NHS Trusts, Foundation Trusts and Primary Care Trusts (PCTs) in England belong to the Clinical Negligence Scheme for Trusts (CNST).

The NHSLA's objectives are to:

- Ensure claims are dealt with consistently and with due regard to the proper interests of the NHS and its patients.
- Manage the financial consequences of such claims and to advise the Department of Health on both specific and general issues arising out of claims against the NHS.
- Manage and raise the standards of risk management throughout the NHS.
- Assist NHS bodies to comply with the Human Rights Act by providing a central source of information on relevant case-law development.
- Provide mechanisms for the proper, prompt and cost-effective resolution of disputes between the NHS primary care organisations and those providing, or seeking to provide, service for patients.
- Provide advice about, and assist with, litigation concerning equal pay claims involving NHS bodies in England.

The NHSLA is accountable through its Chairperson to the Secretary of State for Health, who is accountable to Parliament. Broad policy objectives and the financial framework within which the NHSLA operates are determined by the Secretary of State, whilst the Board has responsibility for operational effectiveness.

The initial task of the NHSLA was to administer schemes under which NHS organisations could pool their clinical negligence liabilities. From the 1st of April 1999, the scope of the NHSLA's work was extended to include two non-clinical risk-pooling schemes covering property, and liabilities to third parties.

3.1 Reform of the NHS

The Government has guaranteed that spending on health will increase in real terms in every year of this Parliament and is committed to increasing the proportion of resource available for front-line services to meet the current financial challenges and the future costs of demographic and technological changes. Over the next four years the Government is committed to reducing NHS administrative costs, and to radically reduce and simplify the number of NHS bodies, including the DH's arms-length bodies.

Greater choice and competition are the underlying drivers to changes in the procurement model for Primary Care Trusts (PCTs), with the introduction of GP Consortia to control the majority of the local healthcare budget. Patient safety and outcomes are central to current and future healthcare reform. Any Willing Provider (AWP) is a recently introduced procurement model that PCTs can use to develop a register of providers accredited to deliver a range of specified services within a community setting. The model aims to reduce bureaucracy and barriers to entry for any potential provider, and so improve patient choice, access, and deliver value for money. The NHSLA is working with the DH on appropriate indemnity models for this proposed model of healthcare reform in England, and will need to adapt to support these proposed changes.

Section Four

Methodology & Approach

The approach adopted to meet the project objectives is both qualitative and quantitative. Findings and observations are based on feedback and opinion elicited from a range of stakeholders, substantiated through quantitative analysis of relevant data sets. Analysis and proposed recommendations draw reference from a wide breadth of stakeholder views and from quantitative findings. The methodology incorporates the following:

1. Documentation review to develop a thorough understanding of the NHSLA framework, targets and objectives (a full reference list is provided in the appendices).
2. Structured interviews with a broad range of interested stakeholders including:
    - A cross-section of key individuals at the NHSLA, including the Board members, heads of clinical and non-clinical claims, Risk Management director, Technical Claims Unit and Director of Human Resources.
    - A sample of scheme members to elicit views on the NHSLA from the perspective of Trusts.
    - Solicitors - both panel defence and claimant solicitors.
    - Key stakeholders from the DH.
    - Commercial insurers and private sector claims administrators.

A full list of people interviewed is included within the appendices.

3. Feedback from Trusts and other stakeholders based upon an open letter of invitation for feedback placed on DH's website.
4. Analysis of the operational aspects of the NHSLA covering the following areas:
    - Review of the claims history of the Schemes to identify key trends, including benchmarking where appropriate.
    - Review of the methodology for calculating members' premiums, including the links with risk management and incentivisation.
    - Appraisal of the incident reporting, and claims handling process, including IT and legal aspects.
5. A claims audit of a sample of files to provide observations and recommendations on the claims management processes.

4.1 Report structure

The remainder of this report follows the structure outlined below and presents findings and recommendations in the following areas:

- Claims management including IT and legal structures.
- Risk management framework, including incentivisation and contribution allocations.
- Strategic and cultural observations.
- Overall summary and next steps.
- Supporting appendices.

Section Five

Claims Management

5. Claims Management key findings

- Some members perceived that in its desire to reduce costs associated with a claim, the NHSLA may be inclined to settle rather than defend cases. In doing so the NHSLA may have influenced the increase in claims as potential claimants anticipate a favourable outcome. However, alternative views were expressed that the approach of the NHSLA was too adversarial.

- A large number of factors have lead to an increase in claims costs, many of which are not within the control of the NHSLA. Claimant legal costs have increased significantly, whilst defence costs have remained relatively static, with legal costs representing about one third of the total costs.

- For non clinical claims the NHSLA performs worse than the corresponding benchmarks for settling claims and the number of open claims.

- There are significant delays in the reporting of claims to the NHSLA, by Trusts. Adopting a tougher stance on non –conforming Trusts with financial penalties for non-compliance with claims reporting could help to address this issue.

- The clinical claims handlers have a greater workload than expected, and the legal panel is sometimes used too early to conduct claims handling and processing, rather than provision of legal services.

- The wider role of the NHSLA in handling complex claims, delivering education, lessons learned, risk management and collaborating with other medical and regulatory bodies is recognised as delivering value to the NHS.

- The database of clinical negligence claims should be leveraged further to understand the drivers of clinical negligence and to guide strategy.

5.1 Overview

The NHSLA is responsible for managing claims for the following schemes:

- Clinical Negligence Scheme for Trusts (CNST) – the scheme is a ‘pay as you go’ pooling arrangement, which is funded by contributions, collected from member Trusts and covers clinically negligent claims arising from 1st April 1995 onwards. Contributions are collected annually, to pay for claims which are paid in the forthcoming year. No tangible reserves or provisions are held by the NHSLA for claims which will not be paid within the year, however the DH does account for such losses.

- Existing Liabilities Scheme (ELS) – this scheme is centrally funded by the DH and covers clinical claims against NHS organisations where the incident occurred before 1st April 1995.

- Ex-RHA scheme – this is a relatively small scheme covering clinical claims made against former Regional health Authorities, which were abolished in 1996. It is centrally funded by the Department of Health.

In addition to the above clinical schemes, since 1st April 1999, there have been two further schemes for non – clinical risks, covering:

- Property Expenses Scheme (PES) – this is a pooling arrangement, funded by members on a 'pay as you go' basis covering the property damage and business interruption losses. The cover is limited to £1m each for property damage and business interruption, with an excess level, whereby the first proportion of the loss (usually the first £20,000) is paid by the member Trust.
- Liabilities to Third Parties (LTPS) – this, again is a risk pooling arrangement paid for by members, and it covers the liabilities for claims arising from the Trusts' duty as an employer (Employers Liability) and duty to the public (Public Liability). Within this scheme, cover is also provided for Professional Indemnity, Directors and Officers liability and claims due to Personal Accidents.

These two non – clinical schemes are collectively known as the Risk Pooling Scheme for Trusts (RPST).

When the NHSLA was established in 1995, claims-handling was originally contracted to the Medical Protection Society, however from 1st April 1998 all claims have been managed in-house within the NHSLA.

5.2 Key Figures

- In 2009/10, 6,652 claims of clinical negligence and 4,074 claims of non-clinical negligence against NHS bodies were received by the Authority.
- £787 million was paid in connection with clinical negligence claims during 2009/10, up from £769 million in 2008/09.
- A total of £827 million was paid in 2009/10 in respect of all five schemes offered by the NHSLA.
- Legal costs incurred in respect of claims closed in 2009/10 were £164m, with 74% of this being in respect of claimant costs.
- 40% of clinical claims are abandoned by the claimant, whilst 4% are settled or approved within court [1].
- 34% of non clinical claims are abandoned by the claimant, whilst 0.3% are settled or approved in court.
- A total of £925 million will be collected in 2010/11 for spend across the following areas:-

Area	£ m
CNST Scheme	729
LTPS Scheme	33
PES Scheme	5
ELS Scheme	140
Ex-RHA Scheme	3
Administration	15
Total	**925**

- Over 500 claims have been settled with Periodical Payment Orders, with almost £1bn paid, and a further £1.7bn reserved for future payments under these order.
- Obstetrics claims are responsible for 12% of the number of clinical negligence claims, and 25% of the value paid, excluding Periodical Payment Orders. Over half of the contribution collected is in respect of maternity services.

[1] This includes the claims where court approval of a negotiated settlement is required

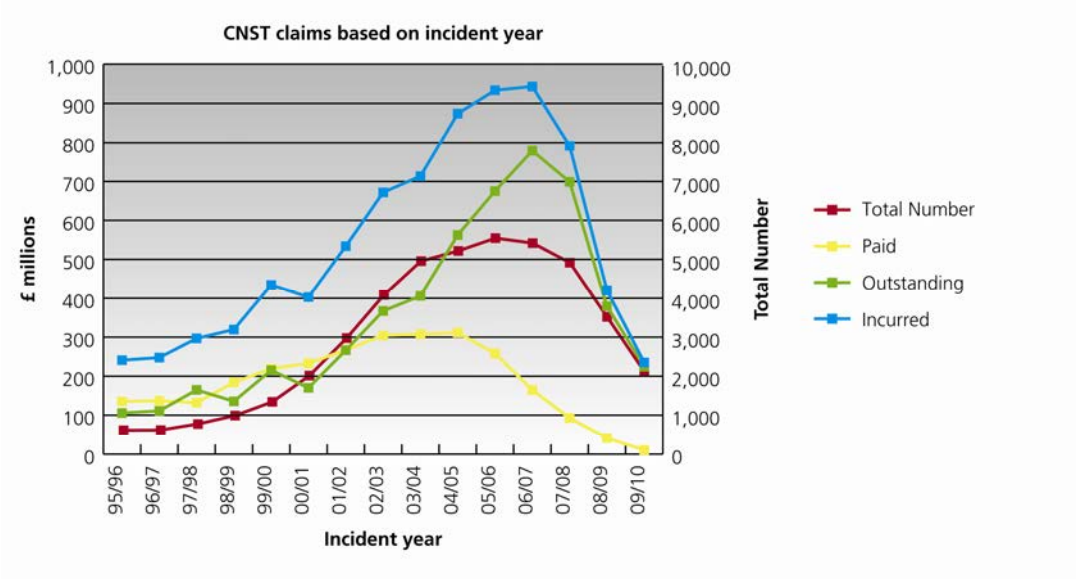
- For CNST, the average time delay from the incident occurring to the trust receiving a letter of claim is 1.8 years, with a maximum of 14 years for the CNST. There is a further average delay of 0.5 years before the NHSLA is notified and an average of 1.4 years before the claim is then settled.
- The costs of the NHSLA in respect of authority and claims administration was £14.1m in 2009/10.
- The annual overall cost of the NHSLA is less than 1% of the overall NHS budget of £80bn. However current reserve levels are £15bn.

5.3 Claims Trends

5.3.1 Claims maturity profile

In order to provide a clear overview of the claims experienced by the NHSLA, the claims data has been summarised in different ways, highlighting different aspects of the claims profile. Losses can be grouped according to when the incident occurred, irrespective of when the claim was reported or settled. This is contrasted with how the CNST data is often viewed, based on when the claims were received or payment made. The graph below shows the number, paid and total value of claims.

Figure 5.1 CNST claims: Paid, Total, and Number

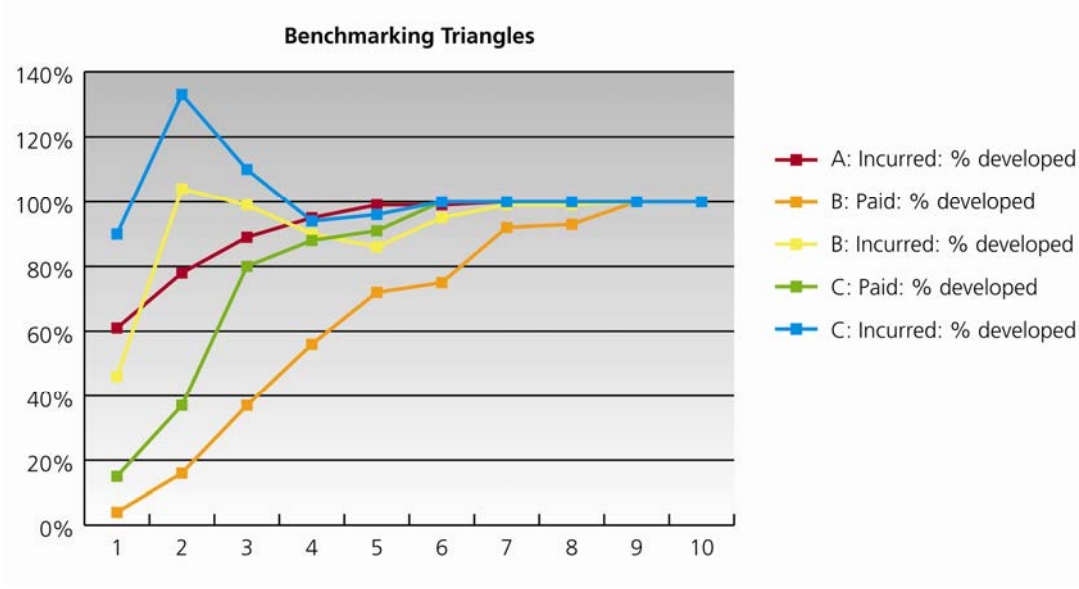


It is important to note that for more recent years, further movement and development of the claims is expected as more claims are reported and settled. There is a very clear increasing trend within the data up to 2006/07, and it is expected that that more recent years will also increase. Therefore when losses are grouped according to when the incident occurred, the increasing trend has been evident since the CNST was established in 1995.

From a commercial insurance perspective, it is important to track claims according to the date received, and the date paid which is a key focus for the CNST which is a 'claims paid' or 'pay as you go' scheme. However, it is also important to assess trends based on the incident dates, as shown in the above chart.

In order to monitor trends and to allow forecasting of future claims, insurers will often use 'triangulations'. These show the overall pattern of how the claims mature over time, from the incident date through to ultimate conclusion, in terms of the paid values, and the incurred (paid and outstanding) amounts. These amounts are expressed as a percentage of the ultimate aggregate cost of claims and can be applied to the latest claims statistics to develop forecasts of ultimate liabilities, when all claims have been settled. Example development patterns for Clinical Negligence are shown in Figure 5.2.

Figure 5.2 – Benchmarking Triangles



It can be seen from these benchmarks that losses finally settle after 10 years, with significant movement in the losses (both paid and incurred amounts) up until this time. For example, only a small proportion of claims are paid, within the first year after a clinically negligent act has occurred, with this rising to 100% (i.e. all claims paid) after ten years. The incurred development pattern includes the case reserves for each claim, in addition to the paid values. For the benchmarks B and C above, there is a degree of over-reserving, whereby the claims reserves are set too high and the final settlement of the claim is below the expectation (as illustrated by the blue and yellow line which go above 100%). Overall, this chart illustrates the maturity profile whereby significant delays are evident in reporting and settlement of claims

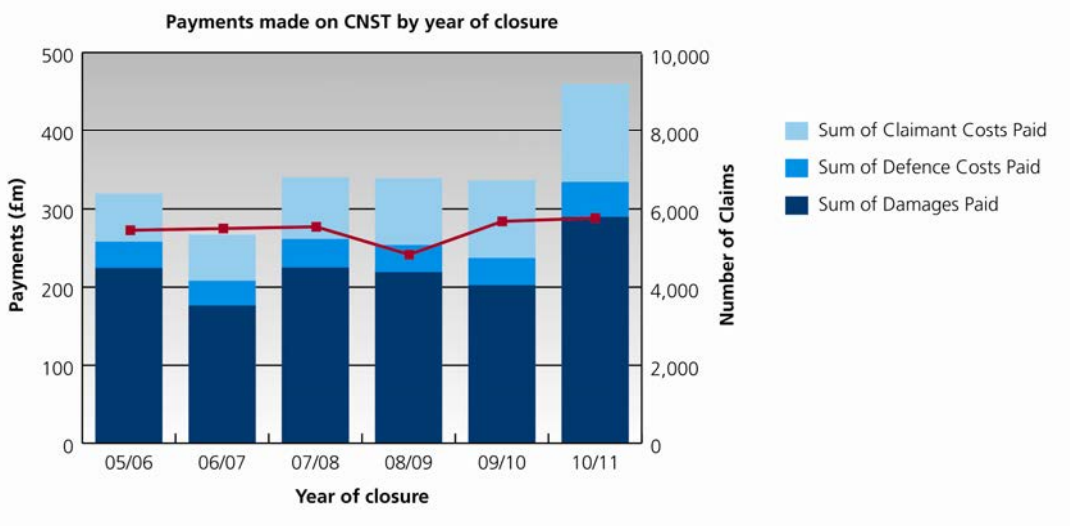
Clinical negligence is a very ‘long tail’ exposure, meaning there can be significant delays before reporting of the claim and further delays before the claims are settled. The CNST scheme is a ‘pay as you go’ basis and therefore does not monitor triangulation and development patterns, as this long tail effect is not relevant for the contributions. However, this delay between the incident occurring and the claim ultimately being settled does have implications in terms of the reserves held by the Department of Health.

It should be noted that these development patterns are strongly driven by the nature of the work conducted. As the NHSLA covers the vast majority of England in terms of clinical negligence, it is difficult to find applicable benchmarks from which meaningful comparisons can be derived. However, it is important to be cognisant of such trends due to the impact it can have on funding levels which will be required for future claims.

5.3.2 Increasing claims costs

Figure 5.3 below shows the payments made on clinical claims, by year of closure.

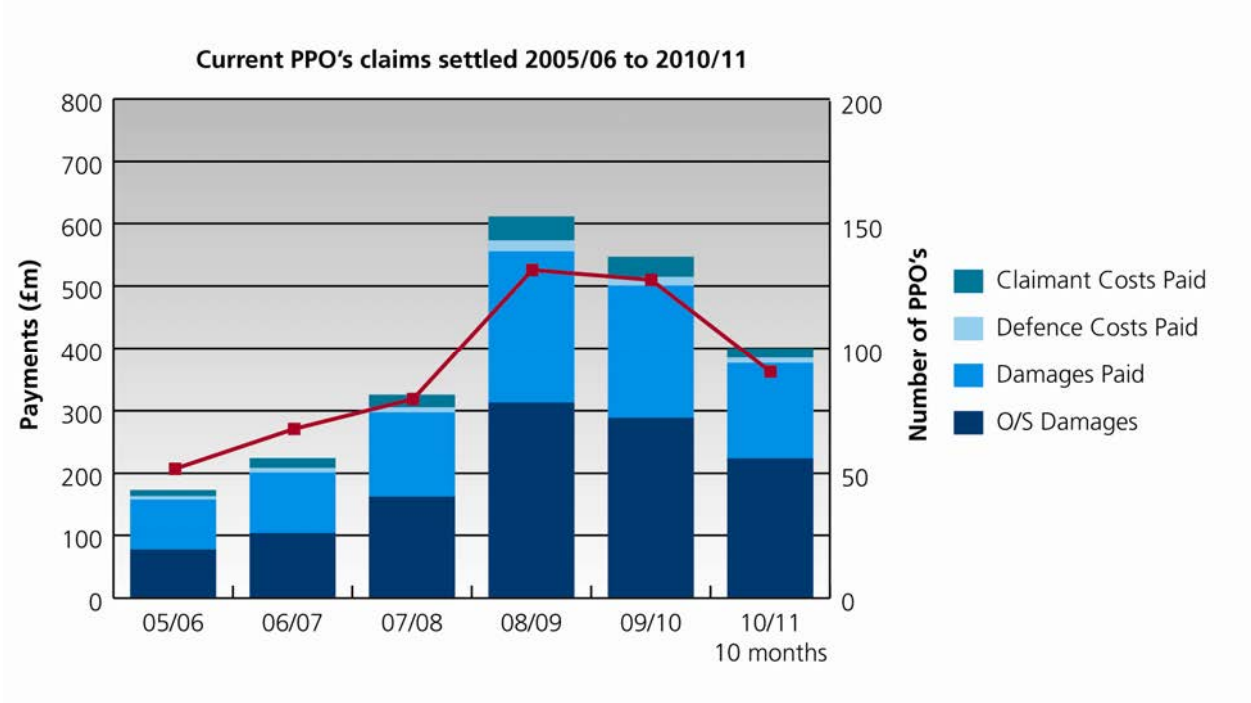
Figure 5.3 Payments of CNST



The total value paid has risen from 2006/07 onwards. There are still a significant number of open claims for CNST, with a total estimated reserve of £5.3 billion for known claims on the CNST scheme, as at 31st January 2011. In respect of the ELS scheme, a further £820m is currently estimated for the 486 known clinical negligence claims. In addition, actuarial analysis is used to estimate the value of unknown losses, whereby the clinically negligent act has occurred, but the claim has not been reported. These are known as ‘incurred but not reported’ (IBNR) losses.

For the CNST, there are a further 365 claims with a current 'periodical payment order' (PPO) settlement, with 551 total current PPO's including the Ex RHA and ELS. This reflects a settlement whereby, rather than the damages being paid in full as a lump-sum, an agreement is reached to provide payment for each year of the claimant's life. This can be beneficial from the claimants' perspective as it allows for a structured payment to reflect the costs of care over their lifetime; there are also benefits for the NHSLA from a cash flow perspective. Given the structure of the scheme in terms of funding, these cash flow benefits are significant. These have increased significantly over time, with a small drop in 2009/10, and likely further movement in terms of the numbers and values for 2010/11, as shown in Figure 5.4 below. However, it should be noted that this reflects PPO's settled in the year, with payments on PPO's settled in the previous years still being made and there is a total provision of £1.75bn for PPO's in respect of future payments. Overall, the value of PPO's is increasing significantly.

Figure 5.4 Current PPO's



The value of the current provisions for these PPO's is £1.75bn.

As highlighted in the above charts, the costs of clinical negligence claims have increased significantly over recent years, and forecasts suggest that these costs will continue to increase.

Identifying specific reasons behind the rise in claims experienced over the past few years is difficult to establish using quantitative techniques and causation analysis, due to the wide number of variables that need to be taken into account. However, key drivers behind the rise in claims are considered to include the following:

1. The litigious culture in England is widely commented as a reason behind the recent growth in claims. This broad generalisation is difficult to prove or disprove, and is arguably correlated to the prevalence of CFAs, the recoverability of success fess, the 'After the Event' premiums, and the promotion of 'no win no fee' arrangements in close proximity to, and even within, hospitals. Anecdotally, this factor is widely acknowledged as a contributory reason behind the increase in claims against the NHS, although other factors also affect claims trends.

2. The numbers of patients treated by the NHS has increased. For example, there has been a 27% increase in the Accident and Emergency attendances between 2007-08 and 2009-10; other specialities have seen similar increases.

3. Medical science and healthcare is constantly evolving and developing as clinicians strive for better patient care and outcomes. Changes and innovations to clinical procedures are ongoing and the corollary to this progression in healthcare is a corresponding risk of unintended consequences or mistakes. In the view of a number of scheme members and solicitors, claims are an unavoidable by-product of this continuous advancement in medical science.

4. Another reason offered as a contributing factor behind the rise in claims recently experienced, or at least a factor that hinders the reduction in claims, is the ongoing relatively high level of structural and organisational change experienced in the NHS. Changes to governance structures, procedures, regulatory bodies, inspection regimes, organisational hierarchies, provider models, staff composition, and any other broad category of influence, all contribute to an environment where process and procedure undergoes significant change. Whilst this generalisation is also difficult to prove or disprove, it is broadly recognised as a material driver for the claims experienced by the NHSLA.

5. Feedback from some Trusts indicated a perception that some claims are settled on a short term cost basis, rather than a pure clinical negligence basis, whereby individual claims are settled because the cost of settlement is more cost efficient that the costs of defending the case. This can lead to an increased number of claims based on the reputational effect of case management on an individual cost basis.

6. The increasing prevalence of claims using CFAs is broadly acknowledged to be a key driver in driving up the cost of claims. The following factors are attributed to CFAs:

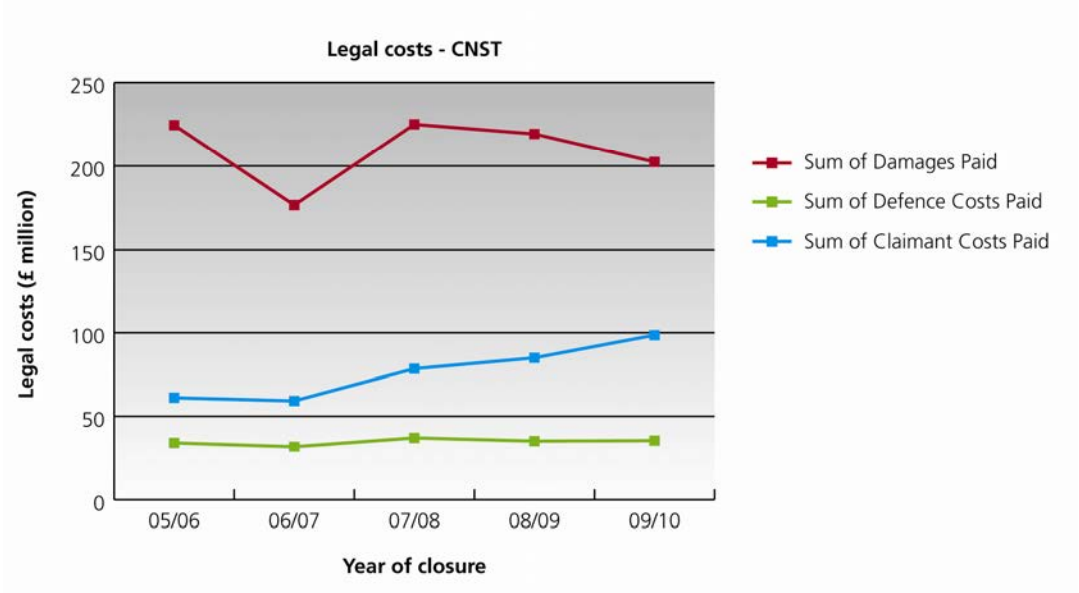
    - CFAs have opened the marketplace to non-specialists. Practitioners with a limited history in clinical negligence are becoming more commonplace, attracted to the perception of a potentially lucrative business. This has in turn stimulated potential claimants to seek

damages against the NHS due to increased promotion and awareness raising to NHS patients by legal firms.

- Success fees of 100% charged by the claimant solicitors are intended to cover legal costs for the cases lost. Anecdotal evidence points to this fee levy as perhaps the single most important factor in driving up the overall cost of claims. In this regard the presence of CFAs is, to quote a solicitor 'a nightmare scenario' for low value claims, whereby a £5,000 settlement can end up with an overall cost of £100,000. As at the end of March 2011, the Justice Secretary has announced plans to overhaul these rules.
- There is no financial incentive for claimant lawyers acting under a CFA to hasten a speedy resolution and settlement. The more time a claimant lawyer can charge to the case, the greater the fees earned in the eventuality of a successful outcome.
- It has also created an attractive market for 'claims farmers' who attract claimants and increase costs.

7. The use of experts in cases is also acknowledged to materially drive up the cost of claims. Fees charged by experts are unregulated, and a proportion of costs for settled cases can be attributed to fees charged by experts. For CNST claims, closed from 01/04/2005 to 31/01/2011, the costs of legal advice and representation were greater than the damages awarded in 38% of cases, with legal costs (claimant and defence) representing 35% of the total costs. The legal costs as a proportion of overall costs appear to have been rising, as shown in the table below:

Figure 5.5 Legal Costs



8. Furthermore, experts can be few in number, especially experts in specific fields of medicine. Consequently, cases take extended times to settle partly on account of waiting for times when experts are available. Drawing out the length of time it takes for resolution contributes to the cost of the claim, in administration related tasks.

    - Claims are, in general, contingent upon significant volumes of documentation. Case notes, testimonies, expert evidence, solicitors' reports et al all contribute to claims being documentation heavy. Feedback from claimant and defendant solicitors points to the time lags sometimes experienced in obtaining the necessary documentation from scheme members to progress with a claim. Such time delays in extracting copies of required documents from Trusts contribute to the overall length and cost of a claim.
    - Court fees have increased over the past 2 years.
    - Claimant solicitors' hourly rates have increased steadily over recent years.
    - For cases that involve a child, an incident may be acknowledged by a scheme member – i.e. a breach of duty established at the time of the alleged incident; but it may take years before the extent of the consequential condition can be accurately assessed and damages awarded.
    - A large proportion of claims are attributed to childbirth/ obstetrics, with an increasing number of these claims settled as PPOs. Figure 5.6 shows the number and value of PPOs paid within the CNST scheme for Obstetrics and Midwifery, based on claims settled from 2005/06 to 31/01/11. These clinical specialties are responsible for over half of all PPOs, with two thirds of the provisions for PPOs being due to these specialties.

Figure 5.6 Number, paid values and provisions for Periodical Payment Order's from Obstetrics 2005/06 – 31/01/11:

		As % of all PPO s
Number of PPO's	203	56%
Paid on PPO's	450,655,483	64%
Provision for PPO's	732,788,491	67%

In addition to the PPOs, the number of obstetric related claims is 12% of the total number of CNST claims closed between 2005/06 and 2010/11, representing 30% of the total damages paid, and 25% of the overall costs throughout this period.

- Feedback elicited from claimant solicitors also suggest that there are instances when the NHSLA may be responsible for the extended length of time it takes to settle a claim. Feedback highlighted that for some claims considered to be apparently meritorious, there are cases when the NHSLA is deemed to refuse to accept liability, thereby delaying the settlement of the case.
- Anecdotal evidence suggests a correlation between length of time taken to settle a claim and the overall cost of the claim. The data analysis generally appears to support this assertion, as demonstrated in section 5.6.2.

5.4 Claims Benchmarking

Benchmarking is a tool which is often used to compare an organisation with an appropriate peer group to highlight areas of strong performance and areas for improvement. The NHSLA currently provides an indemnity for clinical claims to every NHS Trust in England, and is therefore responsible for almost all clinical claims within England. It is not possible to benchmark the clinical negligence profile against a similar organisation, as the NHSLA is unique in its size, its provision of cover and its organisational and funding structure. Marsh has provided benchmark indications by drilling down to compare clinical specialties, and reviewing key statistics for the claims profiles. However, these benchmarks provide an indication of areas to consider, rather than definitive answers.

For the non clinical schemes, Marsh has benchmarked key indicators from the RPST, which provides indemnity in respect of Employers liability and Public liability claims. Marsh has a large database of such claims and has used this to provide observations on the claims profile of RPST.

5.4.1 Clinical Negligence Benchmarks - UK

In order to provide a benchmark of the key statistics from the CNST, Marsh has benchmarked the damages, legal costs, reporting delays, and settlement delays against another UK provider. The table below, which has been split into relevant clinical specialties gives an indication of some key benchmark figures. The data refers to large closed claims only (greater than £300,000) and all figures express the values for the CNST as a percentage of the benchmarked entity.

Figure 5.7 Clinical Negligence benchmarks

Clinical speciality	Average NHSLA damages as % of benchmark	NHS legal costs as % of benchmark	Average NHSLA reporting delay as % of benchmark	NHSLA settlement delay as % of benchmark
Anaesthesia	122%	350%	717%	53%
Cardio surgery	21%	323%	51%	31%
Cardiology	224%	90%	133%	69%
General Surgery	100%	478%	221%	58%
Neurology	42%	286%	249%	39%
Neurosurgery	43%	123%	218%	47%
Obstetrics	57%	300%	118%	81%
Obstetrics / Gynaecology	548%	219%	1337%	134%
Opthalmology	68%	499%	399%	84%
Orthopaedic Surgery	84%	455%	158%	57%
Plastic Surgery	74%	306%	1115%	31%
Psychiatry/ Mental Health	113%	86%	64%	46%
Radiology	188%	1035%	111%	90%
Radiotherapy	122%	347%	0%	62%
Rheumatology	22%	156%	1001%	100%
Urology	122%	85%	232%	18%
Vascular Surgery	120%	127%	279%	97%

Observations

- There are no discernable trends in terms of average damages paid out – this is likely to be because of case specific factors, and different nature of the providers.
- For legal costs, which show the combined sum of claimant and defence legal costs it can be seen that the legal costs for the NHSLA are significantly higher than the peer group, for almost all clinical specialties. However, may be due to the nature of the claims and the indemnity provided by the NHSLA.

- The reporting delays, for the majority of clinical specialties, are longer within the NHSLA, often substantially so. For the NHSLA there are two stages of delay in reporting, with delay between incident and reporting to the Trust and then further potential delay before reporting to the NHSLA.
- The only strong consistent trend is that, with the exception of obstetrics / gynaecology, the settlement delay (from reporting date to settlement date) is lower for the NHSLA than for the benchmark. This may suggest that the NHSLA has a quicker settlement approach. Again, however this may be due to the unique factors of the NHSLA and the indemnity it provides.

5.4.2 Clinical Negligence Benchmarks - other

As outlined above, it is difficult to provide meaningful benchmarking for the NHSLA as it represents the majority of the UK exposure for clinical negligence. In order to provide an indication of claims profiles from other jurisdictions, Marsh has reviewed the claims profile of the CNST against the US.

- The average length of time from date reported to date closed for paid claims in the US is 1200 days (40 months). For the NHSLA, this figure is approx. 17 months from date reported to NHSLA to settlement (for CNST closed claims).
- For claims with no indemnity payment the average time from report date to date closed was 960 days (32 months). For the NHSLA, this figure (from reported to NHSLA to settlement for closed CNST closed claims) is 14 months.
- If closed within 12 months of being reported, average defense expense in US is $2,331; whereas the corresponding figure for the CNST is £1,330.
- If the claim is still open after 48 months of being reported, in the US defence costs increase to $34,665; whilst the corresponding figure for the CNST is £33,000. Average defence costs do rise if the claim is open longer.
- Paid claims reported within 0-12 months of the incident have the lowest average indemnity, $167,559. The NHSLA equivalent is £4,000.
- Claims reported more than 48 months after the incident average the highest average indemnity of $221,605. The NHSLA equivalent is £48,000.

The generally held view within the interviews, and also within other jurisdictions (as shown above) is that the longer the time delay in reporting, and the longer the time delay in settlement, the greater the cost. Marsh has completed analysis to review the impact that time delays have on costs, which is presented in section 5.6.2.

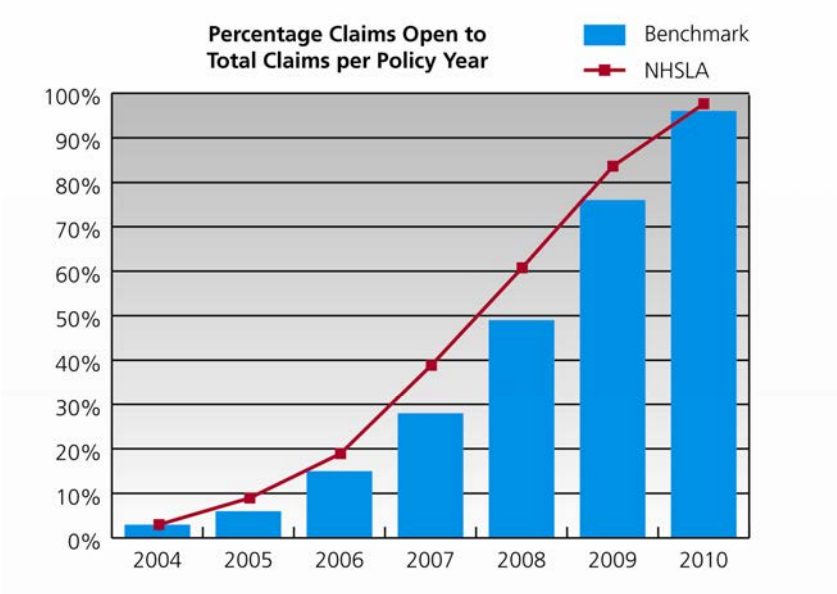
5.4.3 Employers Liability and Public Liability Claims Benchmarking – UK

The LTPS provides an indemnity to member Trusts for claims arising due to Employers Liability and Public Liability. The scheme also covers Professional Indemnity, Directors and Officers Losses, and Personal Accident losses. The indemnity received from scheme membership provided largely mirrors that provided within the commercial insurance sector.

Marsh has benchmarked the Employers Liability and Public Liability claims profiles against a substantial database of claims. The benchmark data reflects the claims profiles of UK companies for Employers Liability, and UK and European companies for Public Liability (with the majority being UK based). The peer group reflects all organisations across a range of industry types and therefore should be used to highlight overall trends rather than to provide definitive answers.

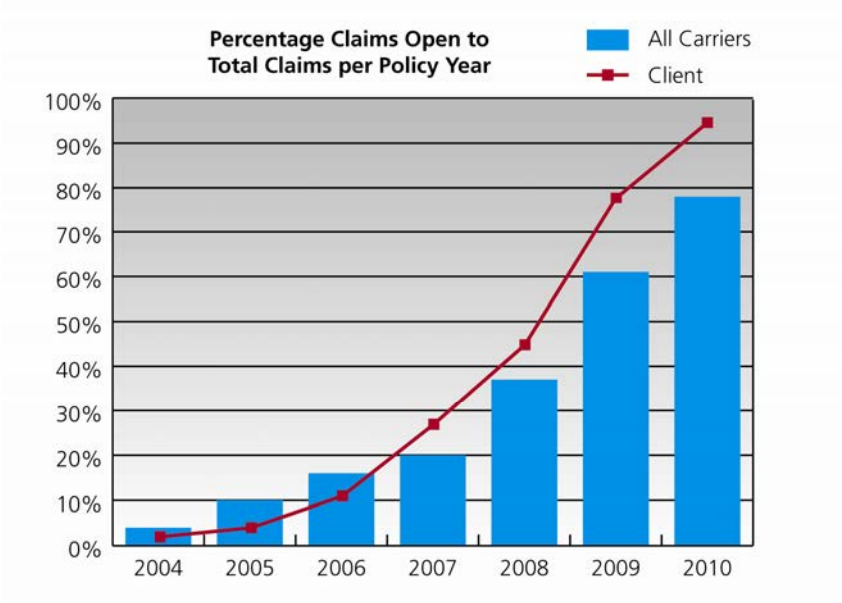
For claims of this nature, the definition of notification and incident dates varies considerably and may therefore impact on the analysis, with the potential for slight differences in the timing of the comparison. Marsh has benchmarked the percentage of open claims, for Employers Liability and Public Liability, for various years. Losses have been grouped according to year of incident. This is to allow comparison with most commercial insurance policies covering these risk areas, which are based on a 'claims incurred' basis.

Figure 5.8 Percentage of Open Claims - Employers Liability



The above chart shows that, other than for 2004, the NHSLA has a greater percentage of claims open than the benchmark. For example, for incidents that happened in 2007, the benchmark indicates that 28% of claims would typically still be open in 2011. For the NHSLA, 39% of claims are still open, meaning that fewer claims have been concluded, compared to the benchmark. There are a number of potential reasons for this, including the time delay in incidents being reported to Trusts, and the time delay in reports reaching the NHSLA. It may also be driven by the delay between claims being notified and reaching settlement.

Figure 5.9 Percentage of Open Claims - Public Liability

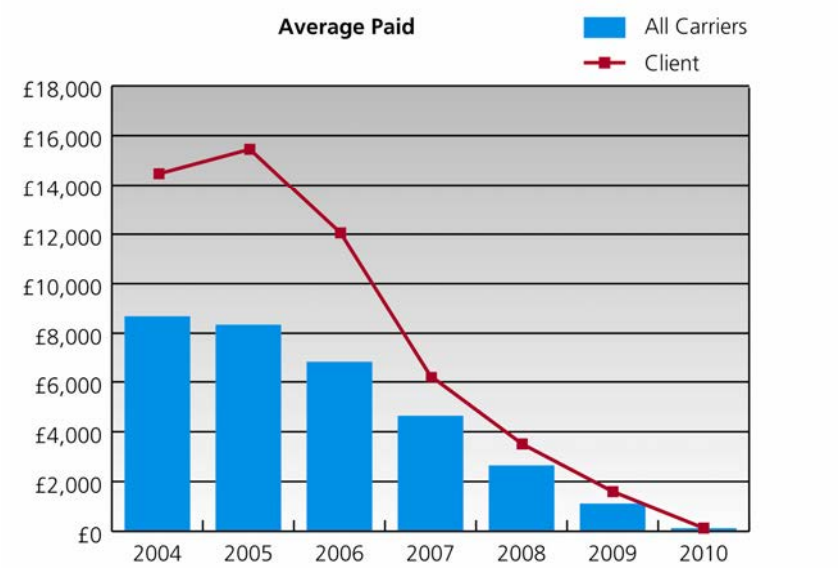


For years 2004, 2005 and 2006, the NHSLA has a lower percentage of Public Liability claims open, compared to the benchmark. However, this trend reverses in more recent years.

The percentage of open Employers Liability and Public Liability claims is consistently slightly above benchmark suggesting that claims are not being closed as quickly as the benchmark. There is the potential that this may have a negative impact on claims costs overall if claims are not being investigated quickly and claims driven to an appropriate speedy conclusion. However, this pattern can also be seen in the corporate market whereby the focus is on brand and relationship protection, rather than cost reduction, with greater importance sometimes placed on ensuring clients receive a quality service even if this results in higher incurred costs.

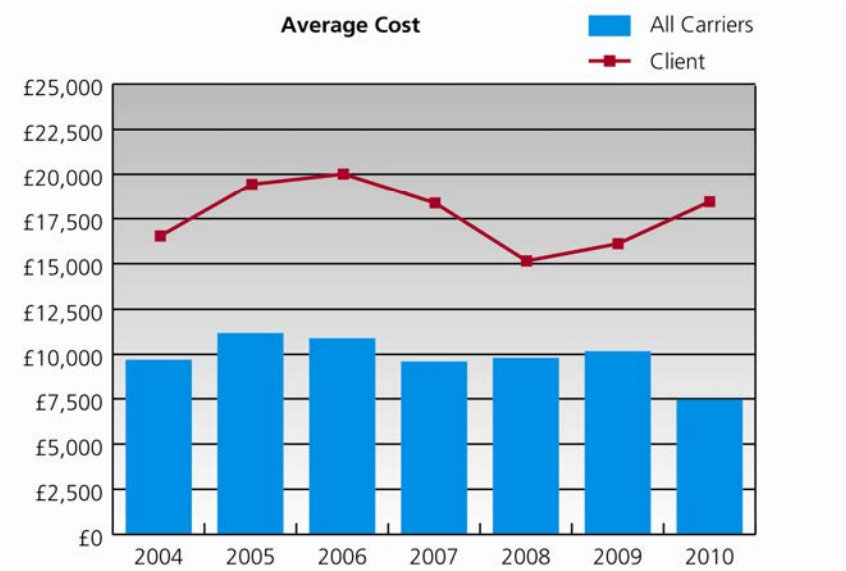
The average paid value per claim, including legal costs, and the total cost (based on the paid plus the reserved amount) have been benchmarked, with losses grouped according to the year in which the incident occurred.

Figure 5.10 Average paid values - Employers Liability



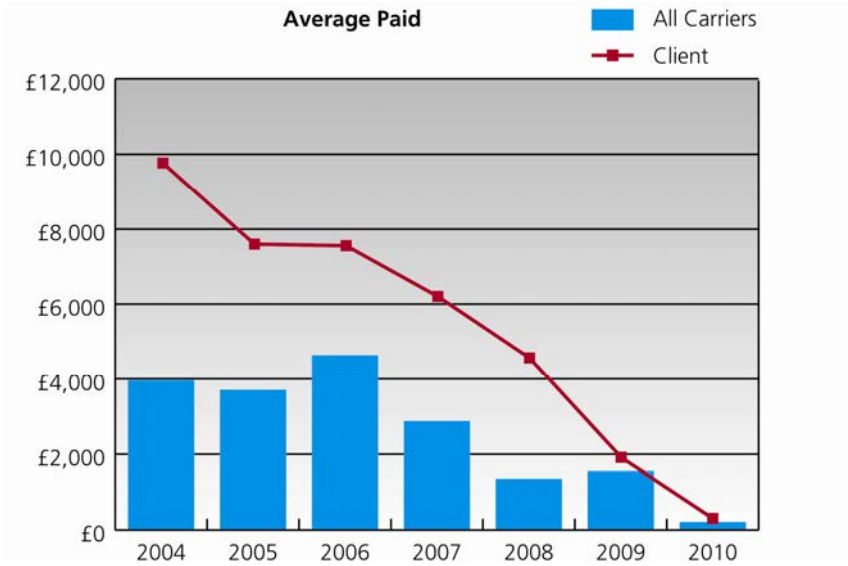
The lower values in more recent years reflects the claims maturity profile whereby less has been paid, on average for each claim.

Figure 5.11 Average cost (paid plus reserve) - Employers Liability



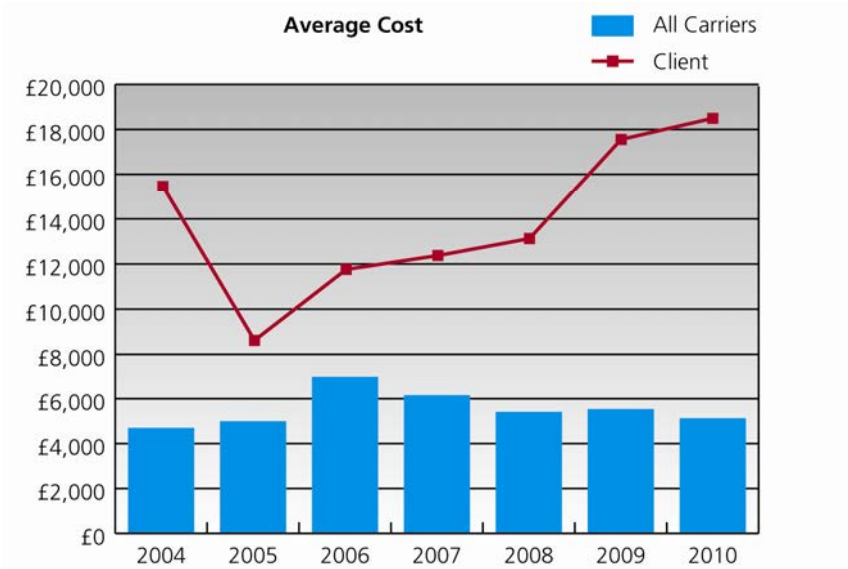
The average cost of paid claims and the average total cost (including reserves) is higher than the benchmark for the NHSLA for all years.

Figure 5.12 Average paid values – Public Liability



The lower values in more recent years reflects the claims maturity profile whereby less has been paid, on average for each claim.

Figure 5.13 Average cost (paid plus reserve) - Public Liability



As for the Employers Liability, the Public Liability claims, both in terms of average paid values, and average total costs are considerably higher than the benchmark.

5.5 Comparison with Commercial Insurers pricing strategies

An insurers' approach to pricing, and premium setting will be different to the approach of the NHSLA for a number of reasons:

- The NHSLA determines the overall contribution level, before allocating this to members. Insurers would calculate the premium based on the individual Trust and therefore the pricing would be specific to the risk drivers of the entity.
- Insurers would also levy a 'capital charge', based on the costs of exposing the capital to risk and uncertainty. Commercial insurers are required to maintain reserves for losses which are forecast under the policy, and there is an opportunity cost on this capital base. Due to the large value of risks within the clinical negligence scheme and the significant delays before settlement, this capital charge could be significant.
- Insurers would charge for the administration of the underwriting and claims management process; this is aligned to the administrative costs of the NHSLA.
- Insurers would also levy a charge for the profit margin.
- Deductibles, or excesses are applied within most commercial insurance policies ranging from £10,000 for each claim up to £5m. This is not generally the case for Medical Defence organisations. This leads to lower levels of premiums, although it increases the costs for the insured entity as they are responsible for the first proportion of any loss and the resource to manage claims below the level of the excess.
- Financial limits of cover are usually applied on commercial insurance policies. This would reduce the cost of the premium, however it leaves the insured with the responsibility for paying losses above the financial limit. Given the development of clinical negligence claims whereby settlement values are increasing, the significant time delays between incidents occurring and subsequent reporting and settlement of cases ('long tail'), along with the greater prevalence of PPOs with high settlement values, Marsh is aware of cases where the current limits on clinical negligence have proved inadequate.
- Marsh has not sought commercial insurers pricing indications within the scope of this project, however based on the Impact Assessment conducted in February 2008 in respect of the extension of NHS Indemnity for non NHS providers on clinical care it was estimated, for an Independent Sector Treatment Centre, that the commercial premium was ten times the level of the NHSLA premium.
- Insurers, however, **may** be able to reduce the level of claims payments via greater defensibility which in turn could lead to lower premium levels. Whilst defending unjustified claims is appropriate for both financial and moral reasons, this needs to be balanced against the overall objectives of the NHS whereby patients should not have valid claims rejected due to insurance policy conditions.

- Insurance premium tax, currently at 6% of premium paid. This would obviously flow back to the Government as taxation revenue, however there would be cash flow implications.

Within the NHSLA scheme, as a pooling arrangement, there is the potential for a rebate of contributions should the level of claims paid fall below the forecasts. Such a rebate of contribution occurred for the 2006/07 contribution to a value of 15% of the initial contribution. This is a benefit of a pooling arrangement. Commercial insurers may consider a premium rebate arrangement within the policy contract, but claims would need to fall significantly below the premium level.

5.6 Claims processing

The NHSLA is underpinned by an objective of 'Providing the highest possible standard of patient care' by its 'efficient effective impartial administration of the scheme', and to:

- minimise costs.
- make appropriate payments.
- minimise risk that large settlement will effect patient care.
- evenly spread out settlements.

This philosophy contrasts with the approach within the corporate environment where the focus is usually on cost effectiveness, speed of response, reduced cost impact to business, profit, and providing sufficient information for business decisions. Those corporate businesses that apply a similar approach to that of the NHSLA are those where brand protection and awareness are a high priority.

5.6.1 Team Structure, Reporting and Caseload

Risk Pooling Scheme for Trusts (RPST)

There are 18 case managers in two teams, each with team leaders, and 4 home based external claims inspectors who focus on Employers Liability claims. The average case load is 291 claims per handler.

Based on Marsh's experience, the typical caseload for Employers Liability and Public Liability cases for insurers and other claims service providers (loss adjusters, solicitors) is in the region of 350 cases per claim handler. Therefore the current resource would normally be sufficient to provide claims handling services for the RPST.

Clinical Negligence

There are 4 teams of case managers with 9 or 10 claims handlers in each team. There are approximately 30% less case managers than there were in 2007, whilst claims have increased by over 30% over the same period. Each claims handler is responsible for 262 claims, on average, although there are variations within this figure. Marsh would expect this figure to be lower with a maximum of 250 cases per handler.

Technical Claims Unit

In addition there is a Technical Claims Unit (TCU) with 6 individuals, who provide high level technical assistance to the clinical negligence and RSPT teams. These individuals also have case management responsibilities with 90% of their time in respect of clinical negligence claims. This team provides significant support in terms of training and mentoring, in addition to providing technical advice and working with other medical and government organisations to draft standards. The role of the TCU, outside of its claims handling responsibilities is reviewed in section 7.2.1 of the report.

5.6.2 Reporting delays and claims management protocols

There are three opportunities for delay within the claims management process:

- From when the incident takes place to when it is reported to the Trust
- Between reporting to the Trust and the Trust notifying the NHSLA
- Settlement delay – the time delay between notification to the NHSLA and ultimate conclusion.

The table below shows the average, and the maximum time delays for the CNST scheme, based on closed claims from 01/04/2005 to 31/01/2011. The time delays are shown in years, with on average 3.7 years elapsing between the incident occurring, and the claim being closed. It should be noted that there are significant variations in the time lags, according largely to the clinical specialty, and also by Trust:

Figure 5.14 Reporting and Settlement delays, in years

	Delay from incident to reporting to trust		Delay from reporting to Trust to reporting to NHSLA		Settlement lag: Report to NHSLA to settlement	
	Average	Maximum	Average	Maximum	Average	Maximum
CNST	1.79	14.13	0.54	13.99	1.38	13.92

A notable consequence of the overall length of time taken for claims to reach settlement is the strain put on the affected clinicians and patients. This pressure and stress experienced by clinicians and patients involved in a claim, is difficult to measure and evaluate, yet nonetheless is considered an important and significant consequence of the claims process that needs to be acknowledged. This strain faced by clinicians and patients alike together with the consequential implications and impacts, is recognised by a broad cross section of NHSLA stakeholders.

Under Civil Procedure Rules (CPR) for clinical negligence claims, there is a requirement to acknowledge receipt of a letter of claims within 21 days, and to investigate and respond to the claim within 4 months.

The table below shows the time delays between Trust notification and NHSLA notification, grouped into a delay of less than 21 days, which would allow a letter of acknowledgement to be sent by the NHSLA according to the CPR protocol, and greater than 21 days. 25% of claims are reported to the NHSLA within 21 days of the Trust being notified.

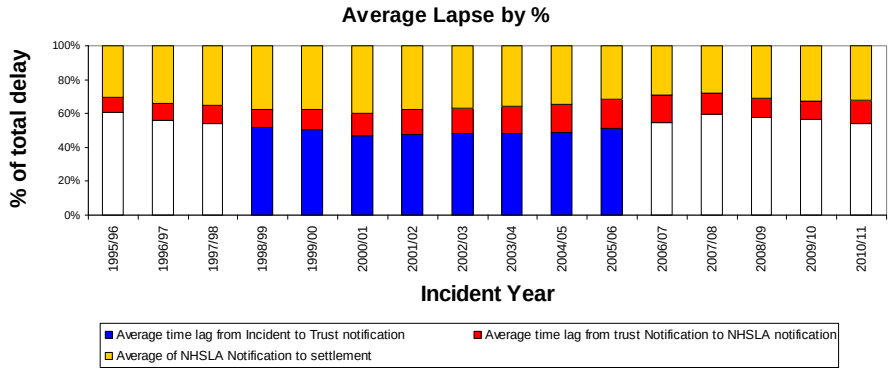
Figure 5.15 Time lags between Trust notification and NHSLA notification

Time lag between Trust notification and NHSLA notification	No. Claims	Average Cost
a) 0-21 days	12470	£176,332
b) 22 days & Over	35816	£205,491
z) Unknown	253	£674,814

The average cost of claims increases with a longer reporting delay, which is consistent with the trends typically observed.

Figure 5.16 below shows how the overall delay between incident and ultimate conclusion of the claims is comprised, showing the average time delay between incident and the claim being reported to the Trust (blue bar), the average time delay between the Trust receiving a letter of claim and notification to the NHSLA (the red bar) and the settlement delay showing the time elapsed between the claim being reported to the NHSLA and ultimate settlement, or conclusion of the claim.

Figure 5.16: Average delays



It can be seen that the delay before the claim is reported to the Trust is the largest component of the delay, with the settlement delay also being significant. This would suggest that if the NHSLA was more actively involved in incident reporting and incident management, the biggest contributor to time delays could be reduced, for some claims. It is recognised that due to the complexities involved and the time taken for the injuries to manifest themselves that the time delays for reporting some claims cannot be reduced.

Financial penalties to the Trusts for non-compliance with reporting criteria should be considered to attempt to reduce reporting delays, for example by use of excesses for non–conformance with reporting protocols, or the removal of the risk management discounts if there is consistent non-conformance with claims reporting protocols. This would need to include a requirement for the quality of the data provided, and not just the speed.

5.6.3 Claims Procedure Documents

There are a large number of procedure documents and internal claims handling / reporting documents. These appear comprehensive for the day to day management of claims but it is unclear whether there is consistency and synergy between the documents and link to the membership requirements of the scheme. This may lead to difficulties for the Trusts, and may contribute to late reporting or inadequate reporting. Marsh recommends that feedback is obtained from the Trusts with a view to issuing one procedure document with specific procedures for Clinical Negligence and RPST, and shared items such as:

- Notification procedures.
- Payments/Scheme indemnity procedures.
- Clarity on liaison between NHSLA and Trusts.
- NHSLA responsibilities agreement.
- Medical Report Summaries.

5.6.4 Delegated Authority Scheme

All claims are reported to the NHSLA excluding the 10 Trusts who have taken up the Delegated Authority Scheme (DAS). This scheme allows the Trusts concerned to manage the claims in-house up to a pre agreed limit of £25,000. The scheme is tightly managed with all Delegated Authority approved by the Chief Executive, who has full financial responsibility as Accounting Officer for the NHSLA.

The 10 trusts that have Delegated Authority and a summary of their claims, are:

Figure 5.17 DAS Trusts

Trust	Average cost for claims up to £25,000
Oxford City PCT	0
Cherwell Vale PCT	0
Nuffield Orthopaedic	1,396
Royal Devon and Exeter	2,748
Royal Berkshire and Battle	2,284
South Tees Hospitals	2,677
Northern Devon Healthcare	2,942
Oxford Radcliffe Hospitals	2,806
Gloucestershire Hospitals NHSFT	2,964
South Central Ambulance NHS Trust	3,812
Average value for claims under £25,000 for Trusts with DA	2,725
Average value for claims under £25,000 for Trusts without DA	2,926

For claims up to the level of the delegated authority, the average costs of claims for trusts under the **DAS are 7% lower than the overall average**. It is unclear without further investigation whether this reflects different clinical specialties, different case mixes, or number of patients, or whether the delegated authority scheme does lead to tighter management of claims with lower costs. Generally, Delegated Authority is often seen to lead to more cost effective working practices. At present no premium reduction is offered for assuming responsibility under the delegated authority scheme, although Trusts are likely to incur additional costs associated with the claims management. Marsh recommends that if delegated authority does lead to reduced claim values, and allows individual Trusts to manage the claims aligned to protecting their own reputation and that of its clinicians, that a contribution discount could be offered to incentivise Trusts to accept Delegated Authority. However, effective measures need to be in place to ensure Trusts have resource and expertise to handle the claims in an efficient manner, with the NHSLA currently auditing such delegations.

5.6.5 File Audit and Claims Review

Marsh audited 20 files selected at random, comprising 1 Public Liability claim, 6 Employers Liability claims and 13 Clinical Negligence claims. The earliest file selected was from 2009, as the NHSLA advised that for older claims, complete information was not consistently available on the electronic system.

Overall the results of the file audits and discussion with service teams showed some inconsistencies, with some benefits and some weaknesses of the current approach:

Benefits

- Good level of technical service.
- Good use of legal cost draftsmen.
- Good investigation and repudiation.
- Some well structured files and easy to use IT system.

Weaknesses

- Evidence of unclear cause of delay in acknowledging the claim, leading to the timeframes for CPR being missed.
- Some incomplete files on the electronic system and insufficient information.
- Evidence of the legal panel being engaged too early, for example NHSLA are paying legal costs to the legal panel to obtain medical reports from the Trust.
- Little evidence of proactivity in reporting by trusts.
- Small number of KPI's, focus on speed rather than quality.
- Caseloads for RPST lower than expected compared to insurers and claims service providers; whilst caseloads for Clinical Negligence claims are higher.

NHSLA confirmed that there are no policy indemnity refusals. This approach differs to the one adopted by insurers and external service providers who will look to deal with claims on a legal liability basis and consider the claims on the basis of documentation available.

The level of clinical negligence expertise in the NHSLA is very high, and this represents the majority of the claims costs. The management of such claims is politically sensitive. From the evidence to date it appears that it would be very difficult to mirror the level of knowledge and expertise at NHSLA elsewhere.

For the RPST, the case loads are below expected, and there is less NHS specialist knowledge required. Typical outsource costs, based on 'underwriter industry norms' for claims handling would be £300 per file. This figure should be contrasted with the £200 currently charged to Trusts for the management of the sub excess claims, although Marsh has not reviewed whether this fee covers the cost of providing the service. This area should be explored further to assess whether efficiencies could be gained through the outsourcing of the claims handling function for the RPST.

5.6.6 Interview Findings on Claims Processes

Benefits

In general, qualitative findings indicate a broadly positive view on the efficiency of claims handling by the NHSLA. Feedback on balance, from the majority of stakeholders interviewed included the following comments on the current process and approach:

- Claims are in general approached with a sense of urgency and professionalism.
- Scheme members find communication with the NHSLA to be straightforward and open, although some strong exceptions to this were reported; areas were highlighted where improvements could be made.
- Dealing with the NHSLA is considered to be smooth and generally effective.
- It is acknowledged that timescales can be constrained by the legal framework and due process.

A benefit considered critical is the role the NHSLA plays in setting precedents in case law. The NHSLA is recognised as anticipating the potential consequences of settling a new claim, which may in turn give rise to further additional claims of the same nature. The legal expertise and knowledge of clinical negligence that resides within the NHSLA - developed over the past 15 years, is considered to be critical in allowing the NHSLA to deliver this widely acknowledged benefit. In this regard, the Technical Claims Unit is generally viewed very favourably.

Weaknesses

Feedback was also provided that indicates a number of areas where the NHSLA could improve the manner in which it handles claims on behalf of members:

- The NHSLA is considered to lack consistency in its approach to admitting liability – anecdotally the NHSLA settles some cases immediately, while contesting other claims despite the evidence being the same.
- There are times when the NHSLA is thought, based on interview feedback, to settle cases too quickly, in spite of members' views that cases could be defended. Equally views were expressed by members that the NHSLA does not always facilitate prompt resolution of claims, especially for those claims where negligence is felt to be apparent and settlement the obvious course of action. In this regard the approach adopted by the NHSLA is regarded as inflexible and lacking pragmatism.
- Some members conveyed a frustration with the poor level of communication exhibited by the NHSLA, with difficulties experienced in discussing specific cases with NHSLA staff, and long delays encountered in dealing with routine correspondence. To substantiate this view, some members felt that staff at the NHSLA are over-worked / under resourced and case handlers consequently variable with regard to accessibility and level of dialogue.
- It is perceived by some members that there is a lack of senior staff members at the NHSLA.
- This experience of sub-optimal communication manifests in the perception by some members of the NHSLA being detached and the view that staff members find it difficult to relate to the working environment in a large NHS Trust.
- Further transparency over the premium allocation methodology is desired by members.

5.7 Other aspects of claims handling

5.7.1 Legal Panel

The NHSLA currently uses a legal panel, where legal representation is required on claims. The panel comprises 10 firms, with pre agreed fees ranging from £80 to £205 an hour depending on the activity to be undertaken.

Benefits

- NHSLA has reduced the number of panel firms to a lower number, which helps to maximise leverage in negotiation of fees and ensures greater consistency of approach.
- Claims handling will evolve and develop as per the specific case, with processes and procedures to be shared amongst Panel members.
- The Panel is benchmarked with monthly statistics on KPIs including average settlement time and average costs of claims. However, it is imperative that the KPIs also measure quality and not just the time to settle. For example, targets for mediation could be considered.
- PPOs are an efficient way of paying claimants and the NHSLA has an advantage in issuing annuities as a Government entity.

Weaknesses

- Examples were provided of a Trust using non-panel solicitor to do preliminary work, with the NHSLA then using a panel solicitor to defend the claim, leading to duplication of work.
- There is evidence that the legal Panel is employed too early, and are used to conduct claims handling and processing, rather than provision of legal services.

From early 2011, the NHSLA has introduced a fixed fee of £5,000 for all activity, for all claims with proceedings issued and served, up to a value of £50,000. Hourly rates apply for cases outside these criteria.

A fixed fee structure is appropriate and is often used, in preference to an hourly rate which does not encourage efficiencies. Based on Marsh's experience, the fee structure in the market varies considerably but for standard injury liability claims a fee structure of circa £1500 for claims up to £100,000 can be agreed. Clinical negligence claims are generally of a more complex nature, and it is therefore unlikely the fixed fees could be reduced to this level, although savings could be achieved by reducing the rate below the £5,000. Marsh recommends negotiations to reduce the level of this fixed fee.

5.7.2 Information Technology Framework and Data

The current IT system is an in house system, with all claims held on the NHSLA Claims database, referred to as CMS (Claims Management System). All data are put onto the CMS centrally by an administrative assistant, based on information provided by the Trust. There are four basic categories within the CMS database – Cause; Injury, Location and Specialty. For each of these categories up to three causes can be entered into the system. The CMS is primarily a claims reporting system and was not designed with data extraction tools.

Data Observations

There are a large number of causation codes which are used within the claims recording process, and they are not always used in a consistent way. This makes data interrogation difficult, and means that trends are not highlighted appropriately. There is the potential for clinical specialties to be miscoded or inconsistently used as no root-cause analysis is undertaken. Trusts sometimes determine the codes, rather than the NHSLA and the codes are not always updated within the system if further information reveals the cause of the incident is not accurately recorded (for example obstetrics claims can be reported under accident and emergency due to where the patient presented at the hospital). This has implications in terms of data analysis, but perhaps more significantly it leads to potential inaccuracies in how the contribution is allocated.

Based on the three causation codes available, Marsh understands that entries are sorted alphabetically and not in order of precedence. As for the incorrect causation codes identified above, this has the potential to skew the data analysis, and also affect the integrity of the contribution allocation calculations.

The current data system is not flexible enough to allow sufficient data extraction. For example, multiple data searches would be required to identify all claims relating to surgery through searching the free text information for relevant key words – surgery, theatre, surgeon, etc.

The provision of appropriate information and data to the Trusts is not consistent. For example some criticisms were expressed over the lack of sharing of Trusts own claims data. These barriers should be removed to allow more sharing of data, and structured information.

Structured Data Capture

The NHSLA are in possession of a highly powerful tool, in respect of the database of 15 years of clinical negligence claims. There is the potential to leverage this resource with greater analysis to understand the drivers of clinical negligence and to use this to guide strategy in terms of improvements to patient safety, and to target resource in priority areas. This feedback loop needs to be enhanced in terms of utilising and sharing the data and enhanced analysis with Trusts, Royal colleges, and public bodies with a patient focus.

Marsh believes that there are opportunities to significantly improve the data recorded to assist with greater analysis. The causation codes and classification of the data should be revisited, and guidance provided to ensure consistency of recording. Marsh recommends that clinicians are involved in devising appropriate data and causation codes.

The quality and structure of the information will influence the NHSLA's ability to indentify complex claims early. Information recorded in unstructured text fields e.g. "Claim Description", "Cause Description" or contained in word or PDF attachments, is very difficult for computer systems to analyse and therefore it can cause an unnecessary delay in the intervention process.

The NPSA capture Incident Data in a very structured format however it is not clear whether this data is transferred to the NHSLA in a format whereby it can be used effectively to identify potentially complex claims. Currently, the NHSLA do not record detailed or complete data on incidents. Trusts are generally discouraged from reporting incidents until a letter of claim has been received, other than major clinical incidents e.g. major obstetric incident, graded as red/serious and investigated under the healthcare governance arrangements. A best practice approach, which is supported by anecdotal evidence from other agencies who manage clinical risks, highlights that an integrated incident and claims system allows early intervention which can help to resolve the situation in a more effective manner. Evidence suggests that apologies, greater communication, explanations or alternative resolutions may help to reduce the number of incidents which give rise to a claim. Given the changes imminent for the NPSA, it may be appropriate to review the incident recording framework and to integrate it with the NHSLA claims recording system.

Greater links need to be built into the system between claims handling and risk management to allow the powerful tool of data analysis to be leveraged effectively.

IT Observations

The IT system used by the NHS is beneficial as an in house system can reflect the specific needs of the organisation. However, investment in IT is needed to allow greater efficiencies, leveraging the power of the data and to streamline the approach.

The ability to share an IT platform with the Trusts and solicitors could assist in saving resources and speed up the claims reporting and management process. Enhancing the Claims Administration Systems could help to automate further and streamline claim workflow, increase accuracy and efficiency of certain tasks, facilitate collaboration, and improve data management.

Enhancing the IT platform to a greater level of sophistication could assist the NHSLA's ability to identify which claims are likely to be the most complex is fundamental. This will allow intervention to focus on the most appropriate claims handler and appropriate resource. This will assist in managing the claim as efficiently as possible. IT can be used to assist this process by using filters to identify complex claims as they are entered into the system. In addition, it is possible to use IT to automatically identify occurring trends within the claims system. Obviously this depends on the system being established in such a way as to identify trends but could assist with managing claims, and identifying risks as early as possible.

Marsh recommends a systems review and an analysis of the software tools available commercially which may highlight enhancements that could be made to the current system.

Section Six

Risk Management Framework

6. Risk Management Framework Findings

- The risk management standards are generally well regarded, with significant value derived from the external assessment process. However the focus on documentation rather than outcomes could be improved.

- Commercial best practice would suggest a move to 4, and ultimately 5 levels of risk management standards, with no discount for low levels of risk management.

- The risk management discounts are appropriate incentives for the larger trusts, however the discounts available for good claims experience are awarded in only a small number of cases. This should be reviewed to ensure greater incentivisation to reduce claims.

- The calculation of the contribution sizes is a risk based approach taking into account clinical specialties, the number of employees in each specialty and risk management levels. This mirrors the approach within the commercial market, and whilst the risk measure could be broken down further (e.g. using the type of birth, rather than number of births for obstetrics), an appropriate balance needs to be struck to ensure the calculation is equitable and transparent.

- Many commercial insurance policies would have excess levels whereby the first portion of any claim is paid by the Trusts, to align interests and to provide motivation to manage claims down. However these were removed from the CNST following feedback from the DH to ensure standardisation of claims handling approach and completeness of data.

- There should be greater alignment between incident reporting and claims reporting to allow maximise use of data to highlight and address trends, and to allow early intervention and management.

6.1 Risk Management (RM) Standards

Background

A key function of the NHSLA is to provide incentives for scheme members to reduce the number of negligent or preventable incidents. The NHSLA aims to achieve this through its risk management standards and assessments.

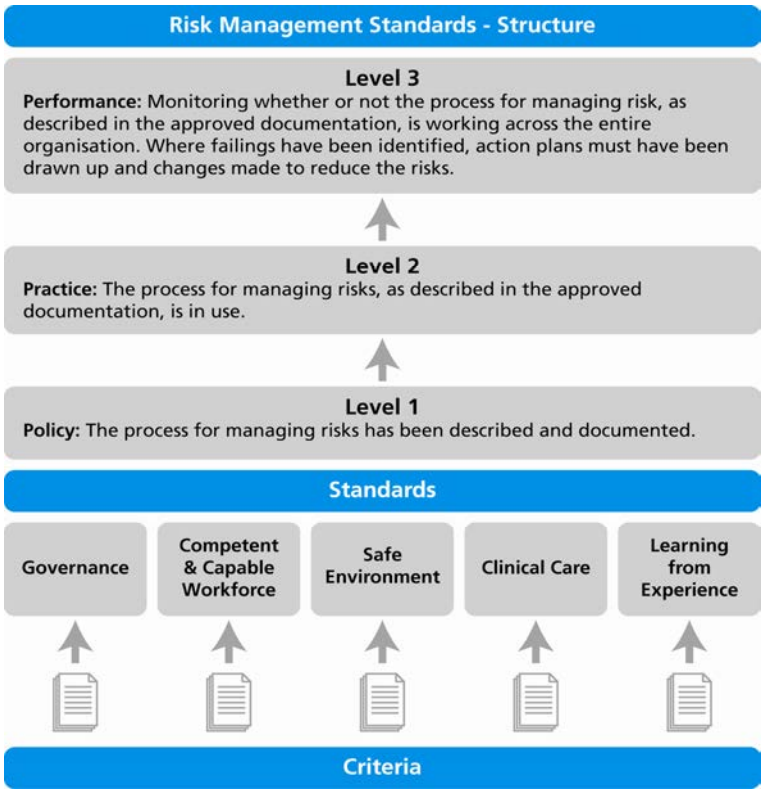
There are comprehensive sets of risk management standards for each type of healthcare organisation (acute, mental health and learning disabilities, PCT / Independent sector and ambulance standards). These standards incorporate organisational, clinical, and health & safety risks. There is also a separate set of clinical risk management standards for NHS maternity services.

Organisations' compliance with the standards is assessed at three levels, and assessed at least every 3 years by an external organisation, Det Norske Veritas Ltd, on behalf of NHSLA. Organisations that achieve 'Level 1' receive a 10% discount on their CNST and RPST contributions. Those organisations that achieve Level 2 and Level 3 receive a 20% and 30% discount respectively. The CNST Maternity Standards are also divided into three levels and organisations successful at assessment receive a discount of 10%, 20% or 30% from the maternity portion of their CNST contribution.

With approval from the Department of Health, providers of independent sector treatments are no longer subject to mandatory assessment, although they may request to be assessed.

The risk management standards are intended to provide a framework for risk management and each standard is referenced to a variety of sources. The NHSLA itself does not advocate or provide an opinion on clinical and non-clinical guidance; the standards have been developed to reflect the legal framework and current best practice.

Figure 6.1 Risk Management Framework



6.2 Benefits

There are a number of benefits to the risk management standards that are consistently espoused by a broad cross section of stakeholders.

1. The standards are widely believed to provide a degree of consistency to governance, process and procedure across the NHS. This consistency is strongly advocated by scheme members for the contingent benefits it provides in terms of efficiency in working practices at a general level within the NHS.

2. The standards provide a level of rigour to working practices, especially with regard to audit and documentation. The degree of rigour increases markedly with the achievement of L2 and L3 compliance.

3. For larger Trusts that pay relatively large contributions to the CNST, the discounts on the contribution paid to the NHSLA for achieving L1, L2 and L3 compliance are considered to be an effective financial incentive for members to strive to attain higher levels of risk management.

4. The financial incentive has raised the profile of the risk management standards to the roles of the Chief Executive and Finance Director / CFO. Top down interest in the risk management standards is widely believed to be a key factor in helping to embed risk management throughout an organisation.

5. The standards consolidate best practice from a wealth of sources and translate this into practical guidelines. In this regard the standards focus on process and are therefore considered to be pragmatic, helpful and easy to understand and follow.

6. From a non-executive perspective there is significant value and assurance gained from the assessment process. Assessment of an organisation against the standards from an external body provides independent assurance, considered particularly important to non-executives.

7. The majority of opinion solicited believed the attainment of L3 enhanced the reputation of an organisation. As a generalisation, Trusts that are L3 are regarded as well run, leading organisations.

8. The standards are continuously developed to reflect changes in best practice. This evolution in the standards reduces the risk of obsolescence.

6.3 Weaknesses

Notwithstanding the benefits of the risk management standards, which are by and large strongly supported by a broad stakeholder cross-section, there are a number of areas where improvement is considered necessary.

1. The value provided by the standards is not apparent to all members beyond the financial value realised through the discount achieved on the contributions made to the schemes. In particular there is no conclusive correlation between improved patient safety and adoption of risk management. For members that pay relatively small contributions to the schemes, a clear cut financial incentive gained from achieving up to 30% discount is absent. As the bureaucratic burden for achieving compliance with the standards is not inconsiderable, Trusts that have no financial incentive are not always motivated to seek assessment at Levels 2 or 3.

2. The premise underlying the approach adopted by the assessors is one that is evidence based. This approach has drawn criticism from some scheme members, who question the efficacy of the assessment, as focus is placed on reviewing documentary evidence which may not be fully representative or reflective of a Trust's overall approach to managing risk. The standards are considered to be too narrow in their focus and overly prescriptive, whilst failing to take into account other initiatives in Trusts that manage risks, as well as the wider behavioural and cultural factors present in a Trust.

3. The timing of assessments is not universally agreed to be effective in allowing assessors to accurately evaluate Trusts' adherence to the risk management standards. The assessment visits take place over two days, regardless of the size of the organisation. No additional time, for example, is allocated to evaluating a large Trust against L2 or L3 standards; and the degree to which a true, accurate and comprehensive assessment can be provided for a large Trust against L2 (embedding risk management) in two days is also questioned (Marsh understands that this 'proportionality' question is under review by the NHLSA RM team)

4. There is wide agreement that the assessment process requires improved levels of consistency. Views on the efficacy of the assessors are divergent – some assessors are regarded very highly, whilst some are regarded poorly. Anecdotal evidence also indicates that the advice provided by the assessors varies. For compliance with L1 in particular, the experience of some scheme members has led them to conclude that the assessors are overly bureaucratic in the feedback and advice provided.

5. There is a degree of overlap and duplication between the scope of reference covered by the risk management standards and areas focused on by other regulators / accreditation agencies – in particular the Care Quality Commission (CQC) and Monitor. Whilst the level of duplicative requests to Trusts is acknowledged to have decreased in recent years, further streamlining and collaboration between the bodies is deemed warranted, in order to reduce inefficiencies and risk of conflicting advice and/ or evaluation of Trusts.

6.4 Incentivisation

Contribution Methodology

The current approach to allocating contributions determines the total value of payments for the CNST for the forthcoming year, and allocates this amount to each member in proportion to their risk, based on the following methodology:

1. The risk of each specialty

Based on the historical claims data, adjusted for the number of whole time equivalent (WTE) staff employed, and the number of registered births, each clinical specialty is allocated into 13 risk groups, by grouping specialisms which show similar levels of risk.

This analysis is reviewed annually to determine whether the risk categories and their relative weightings have changed and to incorporate trends.

2. A relative risk weighting for each risk group

This is based on the value of claims per WTE for each risk group. Nurse specialists are included within each risk group, but with a lower weighting than doctors. For obstetrics claims, the number of births is used instead of WTE.

3. The total risk value for each member

This is calculated by multiplying the number of WTE for each specialty by its relative risk weight, for each Trust.

4. Allocate the total contribution required

The overall contribution required is allocated to members in proportion to their total risk value. There are two further adjustments to the contribution paid:

- A claims discount
    - An adjustment of either 5% or 10% discount, or 5% or 10% loading can be applied (or no adjustment) based on whether the claims number and value are higher or lower than expected.
- The risk management discount
    - An adjustment of 10%, 20% or 30% discount is applied based on achievement of Levels 1, 2 and 3 risk management standards respectively. These discounts are applied separately for general and maternity care for the relevant portion of the contribution.

The intention is to allocate the contributions in as ‘fair and equitable way as possible whilst keeping the process reasonably simple’.

For Trusts which use independent treatment centres, extended choice network providers and free choice network providers, an adjustment is made in proportion to the usage made, as measured by the Finished Consultant Episodes referred.

For the non clinical schemes (RPST), the contributions are allocated using income, whole time equivalents and wageroll for the LTPS, and buildings value, contents value and total income for the PES allocation. A discount is then applied based on the risk management level of the Trust.

6.4.1 Industry Practice

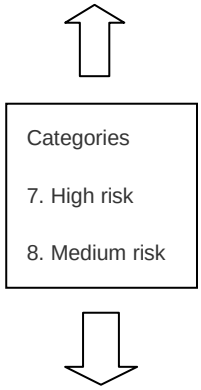
The allocation of the contribution amongst the members, is not dissimilar to how large multinational or multi-divisional organisations allocate a global insurance premium amongst divisions or territories (notwithstanding that the NHSLA is a 'pay as you go' scheme). Within the insurance sector, a typical premium allocation model is based on allocating the premium in a transparent and equitable manner. Each division should also understand the factors affecting premium allocation, and what action can be taken to drive down premium costs. The following aspects would typically be taken into account in the allocation:

- The underlying risk of the division. This compares to the clinical specialty used within the NHSLA contribution allocation.
- The exposure base, for example, the more employees a division has, the greater the allocation for employers liability premium. This is the equivalent to the number of WTE, and number of births.
- Claims experience, for example, a good claims experience would receive a lower allocation
- Large loss adjustment factor, to avoid over penalising a particular division for 'bad luck' as opposed to poor risk management, claims are often capped at a maximum level with any surplus shared between the other divisions on a risk weighted basis.

In terms of grouping each of the clinical specialties (claims are recorded against 69 clinical specialties which are then grouped into 13 different categories as highlighted above, according to the risk characteristics), Figure 6.1 below shows the risk categories used by a UK medical defence union matched against those of the NHSLA:

Figure 6.1 Clinical Specialties

	NHSLA	Other Provider
Group 1	Obstetrics	1. Obstetrics
Group 1A	Neurosurgery; spinal surgery	2. Neurosurgery
Group 2A	Gynaecology	
	Non spinal trauma; Orthopaedic surgery; Bariatric surgery	3. Trauma and orthopaedics
Group 2	Cardiac Surgery; Cardiothoracic surgery; Colorectal Surgery; Thoracic Surgery; General surgery; Urology; Vascular surgery	6. General surgery
Group3A	Ophthalmology; Otorhimolaryngology; Cardiology; Paediatric surgery	
Group 4A	Neurology; Radiology; Accident and emergency; Sports and exercise medicine; Forensic medical examiner	4. Accident and emergency; 5. Neurology
Group 4B	Anaesthetics	9. Anaesthetics
Group 4	Allergy; Alternative medicine; Audiological medicine; Community health; Dermatology; Endocrinology; Gastroenterology; General medicine; Genetics; Genitourinary medicine; Geriatric medicine; Health screening; Intensive care; Internal medicine; Neonatology; Nephrology; Nuclear medicine; Occupational health; Oncology; Pathology; Paediatrics (excluding surgery); Psychiatry; Radiotherapy; Rehabilitation' Medicine; Respiratory medicine; Rheumatology	10. Psychiatry and mental health 11. Low risk
		12. Ambulance 13. Nursing and other



The main observation is that risk grading is comparable for the two organisations, with the exception of General Surgery which is seen as riskier for the medical defence organisation than for the NHSLA.

In terms of applying discounts for risk management standards, most corporate approaches would not offer divisional discounts, due to a lack of consistent assessment processes. The Medical Defence Union does not adjust the 'premiums' based on previous claims, or risk management standards, nor does the Medical Protection Society. There is a clinical negligence insurance policy offered within the commercial sector, where an effective discount of 10-15% is offered based on certain risk management criteria; however this is relatively new to the insurance market place.

6.5 Contribution Amounts

In 2010/11, the total allocation of contribution, prior to the risk management discounts being applied was £958m, with the largest proportion of this (£516m) being the allocation for maternity services. Figures 6.2 and 6.3 below shows the range of the contributions collected from the members, both for maternity, and general.

Figure 6.2 Contribution amounts

		Less than £0.5m	£0.5 £1m	£1m £2.5m	More than £2.5m
	Number	223	18	88	62
	Value	26,316,504	13,321,088	147,319,953	255,176,577
%	Number	57%	5%	23%	16%
%	Value	6%	3%	33%	58%

It can be seen that there are 223 members who paid less than £0.5m (with 98 members paying less than £50,000 in 2010/11); whilst there were 62 members with contribution greater than £2.5m – these Trusts represented 16% of the number of Trusts but paid 58% of the total contributions. The largest contribution paid (before risk management discount) was £9m.

Figure 6.3 Contribution amounts maternity

		Less than £2.5m	£2.5m £5m	£5m £7.5m	More than £7.5m
	Number	42	91	11	6
	Value	71,692,741	328,285,685	66,735,092	49,576,093
%	Number	28%	61%	7%	4%
%	Value	14%	64%	13%	10%

There were only 42 members who had contribution levels of less than £2.5m (7 of whom contributed less than £1m) for maternity, with 91 members paying between £2.5m and £5m. The largest maternity contribution paid was £8.5m.

On a combined basis, the largest total contribution was £16.6m. It is worthy of note that this Trust received no risk management discount on either maternity, or acute; neither did it receive an adjustment to its contribution on the basis of its claims.

Claims Discounts

The contribution calculation is adjusted by either -10%, -5%, 0 or +5%, +10% according to whether the claims are better than expected for the given risk profile, or worse than expected. The criteria for the discounts or penalties are:

10% discount:	Actual claims are less than 50% of that expected, both by number of values.
5% discount:	Actual claims are less than 50% of that expected by number and less than 75% of that expected by value; or actual claims are less than 75% of that expected by number and less than 50% of that expected by value.
5% loading	Actual claims are more than 50% greater than expected by number and more than 25% greater than expected by value.
10% loading	Actual claims are more than 50% greater than expected both by number and value.

Claims discounts are not frequently awarded, as shown in Figures 6.4 and 6.5:

Figure 6.4 Claims discounts 2010/11

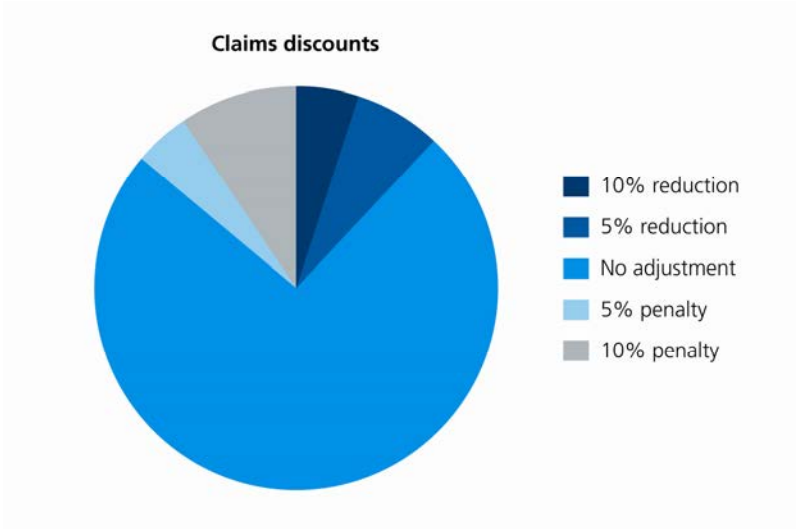


Figure 6.5: Maternity Claims discounts 2010/11

A small number of Trusts receive an adjustment based on a claims discount or experience rating. This would suggest that the criteria for the adjustments are quite restrictive and difficult to achieve. Alternatively, this could be interpreted as the contribution calculations accurately reflecting the underlying risk and therefore claims, per Trust, do not deviate significantly from the expected. Marsh recommends reviewing the claims discount criteria to allow a greater number of Trusts, with lower claims profiles compared to expected, to receive discounts.

6.6 Use of Excesses / Deductibles

Prior to 2002, most Trusts had an excess on the CNST programme, whereby the first proportion of the claims was handled, and paid by the Trust. These deductibles ranged from relatively low levels up to £250,000. Deductibles, or excess levels, are generally seen to have an incentive effect as it aligns the financial interest of the Trust to reduce risk and claims with the interest of the NHSLA, or the commercial insurer. Most commercial clinical negligence insurance policies would have an excess level imposed, although organisations such as Medical Defence Union (MDU) and Medical Protection Society (MPS) do not generally impose deductibles.

In 2002, following feedback from the Department of Health, the NHSLA removed the deductible levels and 'called in' the claims from each Trust. The reasons for this included the desire to standardise the approach to claims handling, and to ensure completeness of data. At the time a number of drawbacks were identified with Trusts handling their own claims below the excess:

- There were significant inconsistencies in how claims were managed.
- Inefficiencies were considered prevalent with duplication of resources.
- Claims initially thought to be within the excess were managed locally at Trust level, but if the costs rose above the deductible level, the claim would become the responsibility of the NHSLA. This meant that there could be significant delays before the NHSLA became involved, which had the potential to prejudice claims or lead to higher claim payouts.
- Data sets and financial reports were incomplete.

Generally, few respondents within the interviews saw the lack of an excess as a significant issue, and many Trusts do not have the suitable resource available at a local level to manage claims. Several Trusts did refer to the misalignment of interest between the way the NHSLA manages claims, and how the hospital would wish resolutions to be found, specifically where the interests of the clinician is involved. This was referred to as an issue both in terms of whether financial offers are made to patients, and also in terms of the speed of resolution – although the feedback was not always consistent, with some Trusts wishing claims to be paid quicker, and other Trusts believing that the NHSLA settled too quickly.

However, Trusts currently have the option of participating in a delegated authority scheme whereby they handle their own claims up to a limit of £25,000. Very few Trusts have chosen to participate in the delegated authority scheme, which maybe be due to satisfaction with the current scheme, or because there is inadequate resource at a local level. However, it should be noted that there is no reduction in the contribution level for those Trusts which take part in the delegated authority scheme, which is likely to have a strong impact on the willingness of Trusts to participate.

On the non clinical schemes, there is an excess currently imposed: on the PES, the excess is generally £20,000, whilst for the LTPS, the level of excess varies from £0 (for Directors and Officers' liability and Personal Accident claims) to £10,000 for Employers' Liability claims. This means that Trusts are responsible for paying and managing claims which settle within the excess level, and paying the first proportion of claims which are settled by the NHSLA above the excess level.

The majority of Trusts currently pay the NHSLA £200 per claim to provide claims handling services for claims which are below the excess. Based on benchmarking in the commercial sector, this figure could be increased to nearer £300 to provide a more commercial rate for the NHSLA. Consideration should also be given to imposing excess levels on the CNST but introducing the option of paying the NHSLA a claims handling fee for the claims below the excess. This would be similar to the approach on the RPST. There are disadvantages of having an excess, but provision of a claims handling service, at a cost just below the market rate, could allow the NHSLA to retain the benefits of control, consistency and data and the financial incentive could help to align interest (although the cost of recovering the money and the resource required for reconciliation would need to be taken into account). Marsh recommend that further consultation is sought on this option, to allow the benefits and disadvantages to be balanced.

6.7 Risk Management and Links to Claims

It is difficult to present evidence to prove a positive correlation between the implementation of risk management standards and a reduction in incidents and claims. Reasons presented for the absence of an empirical link include: the multiple drivers responsible for the recent increase in claims and associated costs; the time lag between an incident occurring and a claim being made against the NHS; the fact that most L3 organisations (and hence most advanced with regard to risk management) are large Trusts incorporating many high risk specialities, the corollary of which is a high number of incidents; and the assertion that Trusts with L2 and L3 attainment are more open and transparent with an increased likelihood of incidents being reported.

Furthermore, medical treatments have increased, both in number and complexity, and therefore trends over time in claims do not necessarily reflect improvements in risk management.

The complexities of having a number of different specialties, and different complexities of procedure within each of these specialties, in addition to the other issues highlighted above, means that it can be difficult to sanitise data in order to provide appropriate comparisons purely of the impact of risk management standards (i.e. in order to truly assess the impact of risk management standards, it would be necessary to standardise the data to remove all other variables which can impact on claims).

There are several research papers which have attempted to explore the link between risk management standards, incentivisation and claims, or patient safety. ‘Enterprise Liability, risk pooling and diagnostic care’, dated February 15th, 2011 reviews the impact of incentives on patient care. This link is analysed through exploring the link between the deductibles, risk management discounts from the NHSLA, and the use of diagnostic imaging tests – one type of diagnostic activity that can be helpful in reducing error and improving patient safety, and hence being a proxy for risk management. Overall the research indicates no strong links between incentives and diagnostic tests.

A further paper, ‘The Impact of risk management standards on the frequency of MRSA infections in NHS Hospitals’ investigates further links between the NHSLA’s risk management standards and patient care, by reviewing the number of MRSA infections against the risk management standards achieved by the Trusts. Overall, the findings are ‘consistent with the exercise of greater infection control measure by hospitals with higher assessed risk management standards’, which is consistent with the premise that ‘hospitals react to the incentives provided by discounts applied to their liability risk-pooling contributions’. This, perhaps, supports the notion that discounts do not affect individual clinicians’ decisions, but are more effective at impacting on the strategy and perhaps culture of the Trust.

Contribution Levels and Claims

The contribution level is currently based on the risk categories of the clinical specialties, and the whole time equivalents, as outlined in section 6.4. Therefore the contribution level is already adjusted for the risks of clinical specialty, to some extent, and the exposure levels within these specialties.

For each year from 2006/07 onwards, the contribution paid has been reviewed against the claims paid[2], for each member of the CNST. It should be noted that we have used the contribution levels prior to the risk management discounts being applied in order to explore the impact of the risk management standards. Closed claims only have been used, as the system is a 'pay as you go' scheme. The value of claims paid is then expressed as a percentage of contribution: a value of 100% indicates that, in that year, the value of the contribution was equal to the claims paid; greater than 100% indicates that the Trust received more in indemnity payments, than it paid in contributions, whilst less than 100% indicates a contribution level higher than claims paid.

For each Trust, this figure is matched against the risk management standard received. These figures are then plotted on the graph in Figure 6.6. The Trusts above the 100% line, this indicates that in that year, they received more in claims, than they paid in contribution. Whilst for Trusts below the 100% line, they received less in claims than the contribution paid. There is a clustering effect whereby it is not possible to see each individual trust for each year, however the distribution and spread can be seen on the diagram.

[2] Excludes PPO's

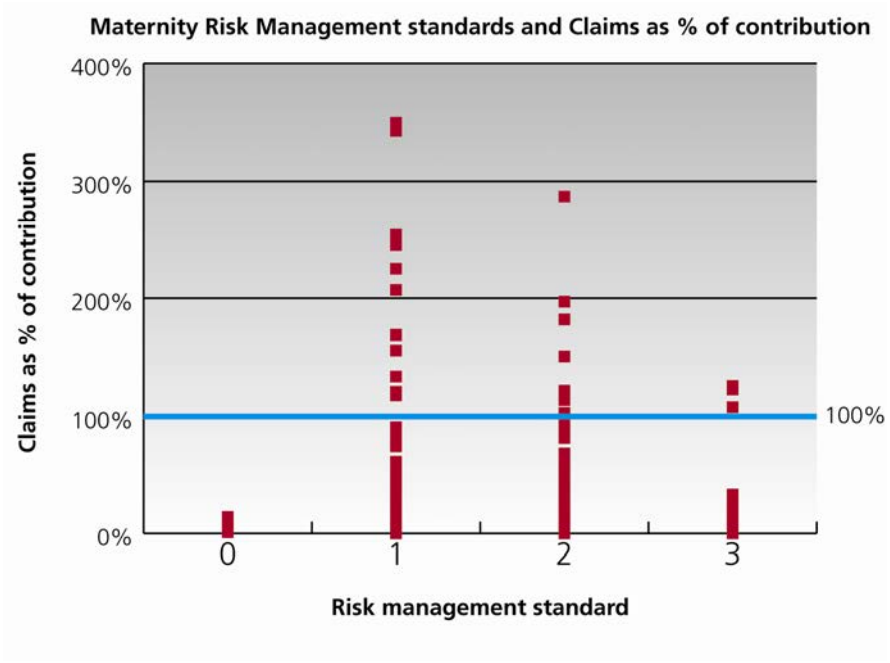
Figure 6.6 Risk Management standards and Claims

This chart shows that the majority of Trusts with lower risk management standards receive significantly more in claims payments than paid in, as contributions. This analysis is before application of the risk management discounts, and therefore reinforces that discounts are appropriate at the higher levels of achievement.

The same analysis has been completed separately for the Maternity standards and contributions, using the same approach, as shown in Figure 6.7:

The range of percentages is less wide than for the general risk management standards, however there does appear to be a similar trend.

Figure 6.7 Maternity Risk Management standards and Maternity claims



This analysis, whilst not definitive, does appear to show signs of a link between risk management standards and claims. Further work would be needed to refine the analysis further and ensure that changes in clinical specialties, in achievements of risk management standards and in claims profiles are fully taken into account within the analysis.

Based on this indicative link, this implies that the risk management discounts offered are important to address the balance between claims and contribution. It is possible that if the CNST was opened up to additional competition from commercial organisations that those Trusts which pay more in contribution than received in claims are potentially more likely to have efficient quotations from the commercial sector and may therefore leave the pooling arrangement first. This could leave an adverse selection effect whereby the pool will retain the entities which represent a risk greater than that implied by the clinical specialties and number of whole time equivalents.

Table 6.8 below shows the number of members receiving each level of standard, as at 2010/11, split according to the size of the contribution in order to help identify any trends in terms of size of Trust and risk management sophistication, whilst table 6.9 shows the maternity contributions and maternity risk management standards:

Figure 6.8 Contribution levels and Risk Management standards

	Contribution less than £1m	Medium Contribution £1m £2.5M	Contribution > £2.5m	Total
Risk Management Rating				
0	1	0	0	1
1	122	31	26	179
2	29	45	26	100
3	3	10	8	21
Total:	155	86	60	301

Figure 6.9 Maternity contribution levels and Maternity Risk Management Standards

	Contribution less than £1m	Contribution £1m £2.5M	Contribution > £2.5m	Total
Risk Management Rating				
0	0	0	1	1
1	2	17	38	57
2	1	8	38	47
3	0	3	11	14
Total:	3	28	88	119

It can be seen that the majority of Trusts are a Level 1 or 2, with only a small number reaching Level 3. There does appear to be some link between the two standards with a greater percentage of Level 3 Trusts, also obtaining a higher rating on the maternity standards.

6.8 Incident Reporting

Within the current framework, Trusts are required to report patient safety incidents to the NPSA, where such incidents are defined as ‘any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving NHS-funded healthcare’. There is no current requirement to report incidents to the NHSLA, with claims only being reported once a letter of claim has been received, or certain serious adverse events. In the 2010 review of Arms Length Bodies review reference, it was decided that the NPSA would cease to exist. It is not currently clear whether an alternative organisation will be required to facilitate the central reporting of incidents.

In terms of best practice, it would be appropriate for the NHSLA to be involved within incident reporting, as this would allow incidents to be analysed and tracked to identify trends, allowing early possible intervention to either minimise the proportion of incidents becoming claims, or to prevent further incidents occurring. It is clear that a very small proportion of incidents become claims - between April 2009 and March 2010, 1,190,475 reports of patient safety incidents were received; whilst 6,652 clinical negligence claims were received by the NHSLA over the time period.

Figure 6.10 summarises incidents currently recorded by the NHSLA for the CNST, as at 31st January 2011, showing the top 10 clinical specialties individually, and the remaining reported incidents grouped into ‘other’:

Figure 6.10 – CNST incident reporting summaries

				Reporting delays average (days)		Reporting delays maximum (days)	
Clinical specialty	Number of incidents	Outstanding estimate	Defence costs paid	Delay from incident to notification to Trust	Delay from Trust notification to NHSLA notification	Delay from incident to notification to Trust	Delay from Trust notification to NHSLA notification
Casualty / A & E	83	27,686,999	51,051	558	91	1,976	768
General Medicine	69	9,767,686	29,564	757	90	4,081	474
General Surgery	65	11,599,455	8,295	619	111	3,427	818
Gynaecology	36	8,250,532	42,968	1,196	68	3,736	439
Obstetrics	131	384,929,705	522,215	995	191	4,754	2,007
Obstetrics / Gynaecology	79	172,348,278	133,722	873	126	4,006	1,050
Orthopaedic Surgery	110	21,046,116	39,384	782	118	2,526	2,753
Paediatrics	26	37,559,180	29,820	989	151	4,385	869
Psychiatry/ Mental Health	24	3,574,767	2,234	758	43	4,260	263
Unknown							

An additional 95 incidents are currently recorded against the ELS scheme.

Figure 6.11 ELS incident reporting summaries

	68	24,308,430	4,570	1,247	100	5,550	979
OTHER	264	112,179,077	152,873				
Total	955	813,250,224	1,016,696	794	99	5,550	2,753

As would be expected, it can be seen that gynaecology and obstetrics have the largest number of incidents reported. There are significant time lags within the data with an average of 794 days (i.e. just over two years) in the delay between incident and reporting to the Trust, with a further 99 days delay, on average, in reporting to the NHSLA. (The maximum delay is considerably longer with 15 years maximum before reporting to the Trust, and 8 years delay between the Trusts reporting the incident to the NHSLA).

Analysis to highlight whether certain Trusts showed higher levels of incident reporting suggests there is no bias in terms of incident reporting from certain Trusts. There are a number of Trusts which appear to have significant delays in reporting known incidents to the NHSLA, with 8 Trusts showing average reporting delays of more than 1 year between being notified themselves, and reporting this to the NHSLA.

A best practice approach to risk management would recommend that incident data, as well as claims data is recorded and analysed. Evidence from other providers of clinical negligence indemnity has identified the monitoring of incidents as a key factor in allowing early intervention and management of claims to an appropriate resolution.

The NPSA has historically been responsible for recording incidents within the NHS. From 1 April 2010 it became mandatory for NHS trusts in England to report all serious patient safety incidents to the CQC. A best practice approach to risk management would allow this significant bank of data to be linked to the data held by the NHSLA, and analysis completed on a timely basis to review the trends emerging from the incident data and the claims data, and corrective strategies and revised guidance implemented.

6.9 Conclusions and Recommendations for Improvement

Notwithstanding the difficulties associated with proving a definitive link between risk management and claims, there are a number of areas where additional endeavour would help improve the feedback loop. It is acknowledged that there are occasions where lessons learned from claims made are incorporated into the standards (for example within the maternity standards) and that current initiatives are striving to make this feedback loop more systematic. However, in general there is limited learning from claims against the NHS which is then incorporated into the risk management standards.

The NHSLA has an extremely powerful set of data representing claims made against the NHS over the past 16 years. The application of this data is limited with regard to analysing claims trends and claims history – either geographically; by clinical speciality; or by Trust etc. Consistent views from scheme members indicates a general lack of feedback from the NHSLA on claims, and the potential improvement in risk management processes that such feedback could support is therefore lacking. Scheme members have the potential to receive between a 10% reduction and a 10% increase on the contribution paid to the CNST.

Difficulties in establishing proactive links between claims management and risk management at the NHSLA include issues with claims coding, which presents problems with interpretation of the causes of incidents; confidentiality which prevents risk management staff at the NHSLA accessing claims data; and internal silos within the NHSLA where communication could be improved and where there is a strong culture of finance, claims and law – less of a risk management culture. Also noted as a hindrance to ensuring lessons are learned from incidents and claims is the governance structures present in some Trusts, whereby claims and risk management functions are not always in close proximity.

This finding is broadly recognised by the NHSLA and initiatives are underway to formalise lessons learned.

- The recently piloted scheme to write to scheme members following a claim to ascertain if action had been taken to prevent the incident reoccurring. At the time of the review ten letters had been sent to Trusts with responses indicating that five Trusts implemented action plans only after having been prompted by the NHSLA.
- Another initiative recently commenced is the 'Solicitors' Risk Management Reports on Claims' whereby panel solicitors provide short and succinct summaries of claims to the NHSLA and Trusts articulating the causes of the incident and links to the risk management standards are made through error codes. Over 1,600 reports have been submitted since 2010.
- Through analysis of claims the NHSLA has identified that Diagnostics was the largest root cause of claims and standards relating specifically to diagnostics are planned to be included within the RM standards for 2012.
- A maternity claims data project reviewed 10 years worth of claims (over 5,600 claims) and four broad themes have been identified for further analysis.

Whilst these initiatives are considered to be relevant and worthwhile examples of proactively learning from incidents, there is significantly more learning that could be gleaned from the claims data which in turn could be translated into improving patient care and reducing clinical negligence. It is important to take into account the current resource level at the NHSLA. At time of review there were three staff working in risk management.

Section Seven

Strategic & Cultural Aspects of the NHSLA

7. Strategic and Cultural aspects Key Findings

- The wider role of the NHSLA in handling complex claims, delivering education, lessons learned, risk management and collaborating with other medical and regulatory bodies is recognised as delivering value to the NHS.
- The NHSLA should move from being a claims administrator to become more proactive in incident reporting, claims, risk management and education.
- The scheme framework is a pay as you go scheme, with no tangible reserves or provisions held for claims which will not be paid within the year although the DH does account for such losses. This could be changed to a claims made basis to increase transparency of costs and incentivisation (as claims management discounts will be applied to a larger contribution level) and to allow increased competition through removal of exit barriers.
- There is tight control at the top of the organisation with control vested in a few hands.
- Dashboard and performance metrics need to be enhanced to include reputation metrics, technical excellence and performance metrics with Trust members.
- There should be greater alignment and integration between the NHSLA and other public bodies with a patient safety remit.

Strategic & Cultural aspects of the NHSLA

7.1 Introduction

In the context of the objectives of the NHSLA as highlighted in Section 2, the current decentralisation within the NHS, the focus on maximising the resources available for patient care and the need to allow for ‘any willing provider’, the strategic and cultural aspects of the NHSLA’s role need to be examined and adapted to reflect the ‘new world of the NHS’.

7.2 Remit and value of the NHSLA

The NHSLA has to manage both the commercial and political aspects of defending clinical negligence claims (and others) against the NHS. The scheme is voluntary (although currently has a 100% uptake from NHS Trusts) and needs to balance the requirements of the NHS and the needs of patients and the wider government system and achieve efficiency for taxpayers.

The current remit of the NHSLA is substantially around the key broad themes of claims management, risk management, technical advice and other areas e.g. handling Freedom of Information (FOI) requests, equal pay etc.

7.2.1 Technical Claims Unit (TCU)

The TCU is respected amongst key stakeholders and external parties and adds to the value and wider delivery role of the NHSLA. The TCU provides: technical advice, training, education, involvement in cases which can lead to legal precedent setting and helps to draft standards by working with other bodies such as the Civil Justice Council, the British Medical Association (BMA), Medical Defence Organisations, the General Medical Council and the Royal Colleges e.g. the TCU recently worked with the Royal College of Radiologists to give guidance to their members on how best to engage 'expert advice'.

The work of the TCU is where Marsh believes the NHSLA should concentrate future activity i.e. high value added technical and precedent setting advice as well as driving collaboration between clinical and related bodies in the areas of claims management.

7.2.2 Alternative Dispute Resolution

The NHSLA's use of Alternative Dispute Resolution (ADR) for defending complex group claims and streamlining processes is a good example of value to the NHS that is not necessarily captured in the KPIs or dashboard of the organisation. The protocols established in a number of group cases have delivered a number of benefits:

- Removed the need for After The Event (ATE) insurance - the Claimants do not require ATE insurance as they are not at risk of any adverse cost orders for the purposes of their involvement in the protocol. Therefore, the savings to the NHSLA in more complex cases will be significant.
- Removed the basis for success fees to be claimed- the Claimant solicitors are at no risk of not recovering their costs and, therefore, cannot claim a success fee. Typically claimant solicitors intend to sign up Claimants on CFAs with 100% success fees.
- Established a clear cost-effective process for dealing with cases, removing opportunities for claimant costs building over time
- Confirmed the agreement for the use of single joint experts. - it is necessary to obtain expert evidence in the vast majority of complex cases. An obligation to utilise joint experts immediately halves the associated costs and also means costs involved in meetings between opposing experts, a fundamental part of the standard litigation process, are also avoided.
- Established a structure in relation to interim payments on account of costs and set recoverable hourly rates in advance - the collaborative approach towards these cases will manifest as a significant saving in relation to base costs on each case, because the amount of work that the Claimant solicitors will need to undertake is significantly reduced.

- Other costs e.g. proceeding costs per case and counsel cost savings can also be mitigated using this more streamlined approach.

This results in efficiencies and real value being added to the NHSLA and the wider NHS funded system (the taxpayer).

Significant value to the system is delivered by the NHSLA (through the TCU) in complex group cases. This value is not captured in the performance metrics of the organisation. Marsh proposes that the lessons learned in these group cases be applied where possible to the less complex cases that the NHSLA handles – particularly in terms of streamlining claims handling processes and the greater use of ADR e.g. mediation. Marsh is aware that the NHSLA comment that they will often seek the use of mediation but that claimant and defence solicitors are not always supportive. The barriers to its use should be identified and explored. Some of the pending legal reforms following the Lord Justice Jackson review and Justice Ministers March 2011 announcement on CFAs / smaller claims scheme settlements may assist in removing some of these barriers.

Intangible Benefits of Alternative Dispute Resolution – (lessons learned based on real cases)

- Reputation is enhanced and an element of the mission statement is delivered '…minimise the suffering resulting from any adverse incidents'.
- Trust staff and experts were not diverted from their NHS duties to provide evidence thereby delivering on the 'more resources to doctors and nurses' requirement.
- The clinicians themselves who may be implicated by association are protected and vindicated
- In some cases the crisis management and communications (media inquiries, press statements) have been led by the NHSLA enabling the Trust to concentrate on operational improvements
- Significant changes to practice have occurred through shared learning channelled through senior members of the relevant profession.

This approach should be used more widely across the NHSLA developing more responsive and streamlined, flexible processes with targets set and monitored for the use of ADR (including legal panel targets where appropriate).

7.3 Culture and Modus Operandi of the NHSLA

Whilst it is difficult to be precise about an organisation's culture in a short space of time, Marsh is of the view (based on observation and feedback), that the culture and modus operandi of the NHSLA includes the following:

- Tight control at the top of the organisation. There is a small management team and Governance board. There are key person dependencies within the organisation, for example; Financial Director and CEO. It is important that succession planning for key individuals is considered.
- Different views were expressed about the NHSLA's claims resolution philosophy. Some interviewees expressed the view that the NHSLA often refuses liability initially, even when settlement is the only real course of action. This has to be balanced against the existing remit of the NHSLA to 'defend unjustified actions robustly'. However, contrasting views received suggest that the NHSLA settle too quickly when claims should be defended. There was a wide disparity of views on the approach to claims defensibility.

'The culture is one of PI insurance and while that is OK for EL and PL claims it is not appropriate for clinical negligence claims'. **– NHS Trust**

'*In short, insurance expediency has taken precedence over legal principle and until and unless the balance is re-struck, more claims will be pursued and settled, irrespective of merit, with an associated upsurge in adverse costs for the NHSLA'* **– NHS Trust**

'Clinical negligence is unlike any other form of fault based civil litigation. There are legal rules which are subject specific, the most basic of which are the Bolam / Bolitho tests for breach of duty. They separate out the no-fault unwanted outcomes (of which there are huge numbers) from the fault based unwanted outcomes (of which there should be very many fewer') **- NHS Trust**

- The NHSLA can be seen, by some, as a 'soft touch'. With 98% of claims settling out of court there is sometimes a belief that a well timed letter of claim and well positioned offer will probably be accepted. However, contrasting feedback was also received. This suggests that delicate balance needs to be struck within the NHSLA – between meeting KPIs around quicker settlements and ensuring that they are not seen as a 'soft touch' for claimant solicitors.

'There is a huge tension between the Trust being named as the defendant in claims and yet the NHSLA making decisions about when to instruct counsel etc. The NHSLA is seen as a "soft touch" by defendants and we are certain that recession effect aside, this has undoubtedly led to an increase in the number of claims' **– NHS Trust**

- Adopting a tougher stance on non-conforming Trusts should be institutionalised at the NHSLA, for example; imposing excesses, limiting coverage, downgrading RM assessment standards if claims reporting protocols are not observed.

- Strong technical capability for more complex cases. The TCU is well respected and adds significantly to the value and wider role of the NHSLA, for example; training, education, creating legal precedents. This team is well qualified and delivers real value to the NHSLA in the area of drafting standards, working with other bodies. This work is one area which Marsh believes the NHSLA should focus on i.e. high value added technical advice, involvement in legal precedent setting and driving collaboration between clinical and related bodies.
- Very heavy workload. In general case managers on the clinical negligence side have on average 262 cases per manager. This can result in a significant reliance on the legal panel to deliver on the NHSLA remit and therefore a rise in costs.
- Inconsistent quality and delivery. This in part is linked to a heavy workload but nonetheless there is anecdotal evidence of inconsistencies and service quality concerns in the lower value claims area.

'There is too much variability from case manager to case manager in terms of how they manage claims i.e. agreeing extensions to limitation; they often do things that we completely disagree with'.- **NHS Trust**

- A third party administrator approach rather that a 'customer service' driven culture towards members. A number of Trusts have commented that the only real contact with the NHSLA is at the time of invoicing for that year's contribution. More open communication and service level agreements with Trusts should be adopted moving forward. The NHSLA should be working for the members to administer the members scheme. Interestingly the NHSLA does not appear to see CNST member Trusts as a key partnership (listing them only joint 4th in a recent presentation – March 2011). It should be noted that not all Trusts have expressed the same concern.

'*In a recent claim the NHSLA's claims inspector wrote a report upon which the NHSLA decided to admit liability without the Trust's prior approval, when we asked to see a copy of the report we were told that the Trust was not entitled to see it and that liability could be admitted without the Trust's approval'* – NHS Trust

'Any executive body administering a membership scheme which does not give due regard to the wishes and intentions of its members is in danger of losing its credibility'.- NHS Trust

- Trying to deliver on a broad remit beyond claims handling and taking on additional responsibilities, including requests for the Department of Health. This includes risk management, education / training, producing 'lessons learned', delivering on Freedom of Information (FOI) requests, selecting legal precedents to pursue whilst maintaining costs and headcount.
- Delivering increased Periodic payment orders. As more periodic payment orders are created (the number of PPOs the Authority is paying rose by 20% in the year to March 2009 and by 22%

in the year to March 2010). It is worth nothing that on a technical point the NHSLA has a comparative advantage over any commercial provider in issuing annuities as the government's calculations are not based on investment and ignore interest rates.

Marsh supports the re-branding of the NHSLA from a 'claims administrator' to a more pro-active incident reporting, claims, risk management and educational body. In this context a name change could even be considered, for example; NHS Claims and Risk Management Authority. The strategy and culture would need to be aligned with the new mission and values to avoid being seen as a purely cosmetic exercise.

7.4 Scheme Framework

The current approach as outlined in Section 5, is a pay-as-you go scheme whereby claims are forecast for the current year by the scheme actuaries and this amount is shared amongst the Pool members based on the risk weighted allocation in section 5.

Membership of the schemes is voluntary, and the membership rules state that if members do cease to be a member, then claims not settled within 30 days of the date of termination of membership would no longer be paid by the Scheme. Due to the complex nature of the claims involved there can be significant delay before payment of claims, which could potentially leave any Members who chose to leave the scheme having to settle the claims without the support (financial or administrative) from the NHSLA.

This scheme works well if there are no substantial changes to the membership base in terms of risk profile, size and membership. However, because the scheme is on a cash flow basis (i.e. contributions are collected purely to pay claims in the forthcoming year), this leaves an additional exposure, which is not currently funded for those claims which have been reported but are not settled within the year, and also 'Incurred but not reported' (IBNR) claims whereby the clinically negligent act has taken place, but the claim has not been reported, as it can take significant time for the injury or damage to become apparent. As a result, the provisions for these additional liabilities are on the Department of Health balance sheet with a value of £15 billion. These claims will need to be paid in the future, and therefore if the membership base changes this may impact on the ability to collect sufficient contributions to pay claims.

7.4.1 Alternative Scheme Approaches

A number of scheme alternatives are available:

- Move to a 'claims made' basis, rather than a 'claims paid' approach. This would allow Trusts to exit more easily as claims made and reported during the currency of the policy would be covered. This would lead to increased contributions for members but would afford greater flexibility. The additional cost could be addressed via the tariff mechanism as the increase in contributions would be offset by a reduction in the reserves for Department of Health.
- The contributions could be calculated to cover the incurred losses, based on the paid and outstanding reserves. This would limit the amount of 'new' liabilities for the Department of Health and the additional costs to members of the increased contributions could be addressed through the tariff setting mechanism. Marsh recommends a more detailed government accounting review of this option, but in principle this is an option which would allow greater transparency of the costs of clinical negligence claims, and would mean the incentives offered via the risk management scheme of 10%, 20% and 30% would have greater financial significance as they would be applied to a larger contribution.

Commercial Insurance

The main driver for Trusts to consider commercial insurance is likely to be cost based with dissatisfaction with the current level of the contributions, and the rises seen in contributions. There may be dissatisfaction from individual Trusts in terms of the service received but this is unlikely to be the main driver to leave the Trust, unless premium levels are more efficient from a commercial insurer.

A commercial insurer may be able manage claims more aggressively leading to lower claims and ultimately lower premiums. However, this needs to be balanced against the reputation of the Trust, the clinician and the objective of patient care.

Most insurers are likely to impose excesses whereby the first proportion of any claim is borne by the Trust; coverage may be limited with restrictions on certain risk areas; warranties and conditions imposed, whereby claims may not be paid unless certain conditions are not complied with, for example delays in reporting may lead to claims not being paid. Insurers would also have the option of refusing cover to certain Trusts, and possibly even certain clinical areas or individual clinicians, leaving a gap in the coverage provided. The NHSLA could potentially end with an 'adverse selection' issue with the high risk areas remaining in the pool and the lower risk areas leaving. Whilst the allocation methodology is risk based and does take into account many drivers of risk, it is likely that some Trusts and some clinical areas, for example Obstetrics, may be uninsurable at an economic price.

Any new insurance offering will not remove the existing Department of Health liabilities. The most realistic commercial insurance opportunity would be to allow Trusts to exit more easily from the NHSLA via removal of the exit barriers, to allow increased competition. This would require consideration of changing the basis of the current scheme (for example to claims made, or to include reserves within the pricing methodology) and to ensure that appropriate data was available to allow commercial insurers to provide quotations. Insurers could then provide a 'claims made' coverage going forward and write a 'retro-active' policy to cover all prior years for 'incurred but not reported; losses (i.e. losses where the incident has taken place, but the claims have not yet been reported) since the CNST was established in 1995. However, there would be a substantial cost for this 'retro-active' cover. Consideration would also need to be given to the links between any such retro-active cover and the £15bn of liabilities for clinical negligence within the Department of Health.

Whilst Marsh thinks that this alternative should be explored in more detail, the long term secutiry and the economic and wider role of the NHSLA cannot be replicated by a commercial insurer, driven by a profit motive and commercial underwriting principles.

7.5 Benefits

There are a number of benefits to the current strategy and culture within the NHSLA.

1. The management team can make quick decisions relating to individual cases based upon their knowledge and experience.
2. From a governance perspective there is independent, non-executive director input into assuring that the NHSLA is delivering on its required remit
3. Technical excellence is delivered through a small specialised team.
4. The broad remit of the NHSLA reduces the need for other Arms Length Bodies or organisations to deliver in these areas thereby potentially reducing duplication
5. The knowledge and experience of the staff in terms of claims handling for the NHS and related advice.

7.6 Weaknesses

The weaknesses of the existing approach are:

1. Control is vested in a few hands therefore the danger is that decisions are not shared widely and may not have taken into account a wide group of affected stakeholders.

2. The governance structure does not include a non-executive director with a 'patient agenda'. There is an available position on the board and the NHSLA has expressed a willingness to fill this role with a suitable candidate, pending the outcome of this study.

3. A denial approach to liability can result in bad feeling and inefficiencies caused by delays in the system. A 'softer touch' approach to claims may reflect the delicate political and legal balance that the NHSLA is attempting to deliver. There were opposing views on whether the NHSLA settle claims too quickly, or deny liability and defend claims when settlement would be a more appropriate solution.

4. In addition the Risk Management resource is under resourced and operating independently from the claims teams (systems issues, patient confidentiality etc)

5. The heavy workload results in an inconsistent quality of service to Trusts and the potential over reliance on the legal panel for outsourced claims work.

6. The contribution of the NHSLA is sometimes wider than its original remit, with additional responsibilities assumed at the request of the Department of Health. The broad remit is also impacted by a lack of resourcing.

7.6 Recommendations for Improvements

- Strategy, remit & governance – 'Re-brand' the NHSLA's role and mission to incorporate a learning based open and transparent organisation that delivers high value added claims advice, technical guidance, risk management, training / education, incident reporting and drives collaboration between clinical and related bodies. Consideration should be given to changing the name of the NHSLA to NHS Claims & Risk Management or similar and aligning the culture to an organisation with a more structured approach to accepting liability, notwithstanding the 'soft touch' comments above. Consideration should be given to adding a 'patient interest' non-executive on the NHSLA's governance board. The current scheme actuaries have been appointed since 1995 and as such this contract should be tendered for governance reasons. These changes should drive a more service driven organisation in the future.

- Human Capital / personnel – Consideration should be given to succession planning for the CEO recognising the need for strong governance with the management and executive

team. A list of key NHSLA personnel should be created and all appropriate staff should have suitable performance appraisals, mentoring support and incentives to remain at the NHSLA for example, opportunities for further study, long-term financial incentives linked to appropriate performance. There is a need to recruit additional staff in the technical, claims handling and Risk Management area within the NHSLA.

- Dashboard / performance metrics – re-work the NHSLA dashboard to include reputation metrics, technical excellence and performance metrics with Trust members, for example, delivering data analysis and trends, response times, customer satisfaction, training courses, incident reporting and lessons learned papers.
- Incident reporting and Integrated approach to Clinical Risk - NHSLA to assume the incident reporting and incident analysis role of the NPSA, with appropriate structure and resource to ensure maximum benefit is derived from incident reporting in terms of enhancing patient care and reducing risk. NHSLA's Risk Management standards should be reviewed in conjunction with other bodies, for example NICE, Monitor and CQQ to review their standards to create greater alignment. It would be beneficial to have one body to oversee a drive for consistency in clinical governance, quality, management and risk management within the NHS with the NHSLA playing a key role.
- Communications and transparency

  Scheme members - communications booklets on service standards and coverage produced for members including scheme rules, coverage, rights of appeal, exit rules etc. Marsh suggests the NHSLA develop a set of Service Level Agreements (SLAs) for Trusts, and are monitored against these. An on-line premium allocation tool should be developed so that members can see how their contribution is calculated and what variables will influence their allocation portion. On-line tool to identify the areas of focus for Risk Management should also be considered. This should be placed on the NHSLA website. Consideration should be given to having more, relevant members forums (e.g. Acute RM forum), an annual Trust conference and a Trust representative on the governance board of the NHSLA.

  Department of Health - an appropriate representative from the Department of Health should attend regular monthly steering group and one-to-one meetings with NHSLA and review revised dashboard metrics.

  Internal communications – There should be stronger link between the risk management team and the claims handling team, for example with more sharing of data. This may require greater investment of IT to allow sharing of data, and re-coding of the claims.
- Efficient working practices - Aligned to our calculations the NHSLA should reduce the number of cases per case manager for clinical negligence claims and be allowed to recruit

additional staff to fill the gap. This will avoid inconsistency in service levels and the unnecessary passing of work to panel solicitors.

- Claims settlement culture - a delicate balance needs to be struck within the NHSLA between meeting KPIs around quicker cost based settlements and ensuring that they are not seen as a ‘soft touch’ for claimant solicitors. Adopting a tougher stance on non-conforming Trusts, for example; around improvement actions, reporting deadlines, and auditing should be institutionalised at the NHSLA, by imposing excesses, limiting coverage, downgrading Trusts if there is non – compliance with reporting of claims, and provision of information. Appropriate KPI’s need to be used to measure not just the speed of settlement, nor the proportion of claims settling out of court, but quality metrics based on reaching appropriate resolutions, and increasing the use of mediation.
- Alternative scheme structures – on an aggregated basis, the pooling arrangement is an appropriate structure. However, Marsh recommends that further consideration is given to a claims made scheme and to increasing the contribution levels to include outstanding losses in addition to paid losses. This would require an adjustment to the tariff mechanism. Exit barriers should be reviewed to allow greater competition from commercial insurers.
- Marsh recommends that insurers are invited to comment on the insurability of the CNST scheme as part of an ‘open invitation to comment’ as part of the implementation phase of our recommendations.

Section Eight

Summary & Next Steps

Greater choice and competition are the underlying drivers to changes in the procurement model for Primary Care Trusts (PCTs), with the introduction of GP Consortia to control the majority of the local healthcare budget. Patient safety and outcomes are central to current and future healthcare reform. Any Willing Provider (AWP) (or Any Qualified Provider) is a recently introduced procurement model that PCTs (and other commissioning groups) can use to develop a register of providers accredited to deliver a range of specified services within a community setting. The model aims to reduce bureaucracy and barriers to entry for any potential provider, and so improve patient choice, access, and deliver value for money. The NHSLA will need to adapt to this proposed model of healthcare reform in England.

In summary Marsh believes that whilst the NHSLA does not achieve optimum performance in every aspect of risk pooling, the concept of risk pooling is valid and the stewardship and administration of the scheme has been effective and should remain with the NHSLA without wholesale changes. Greater openness and transparency towards the scheme members (customer centric approach) and a tougher stance on the definition of 'clinical negligence' and non-conforming Trusts coupled with greater collaboration with other clinical bodies will position the NHSLA well for the future reforms. Marsh does not envisage any wholesale commercial involvement in the clinical negligence scheme (CNST) at the moment but would suggest exploring the potential for involvement in the handling of non clinical arrangements.

Marsh believe the recommendations outlined in our report will support the wider NHS healthcare reforms.

Marsh

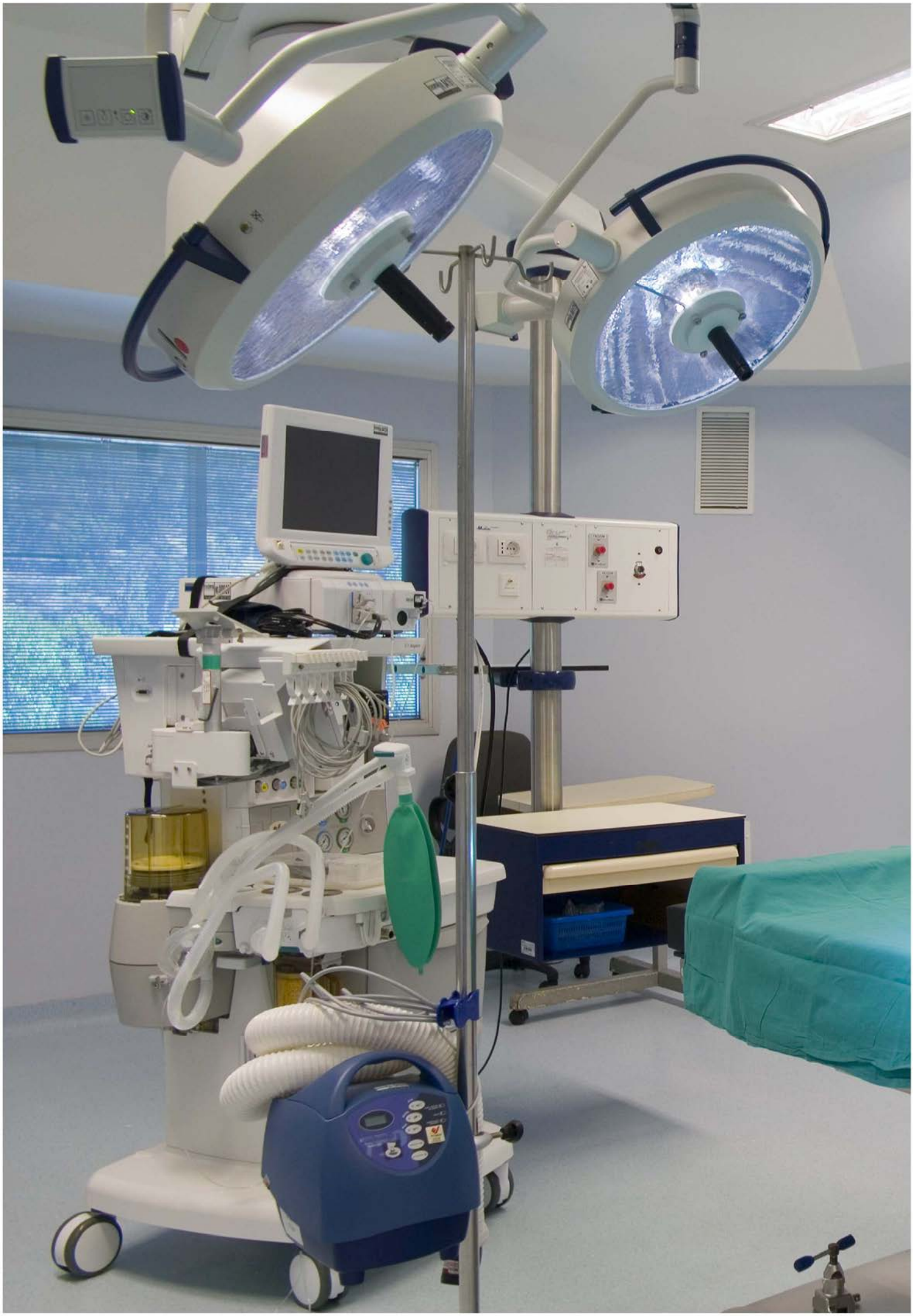
5 April 2011

Appendix A
Data List

- Solicitors' Risk Management Reports on Claims, Letter to Members, *Feb 2010*
- Proposal for a review of the NHSLA Risk Management Standards and Assessments *Sep 2010*
- Terms of Reference Solicitors' Risk Management Reports on Claims Steering Group
- NHSLA Low Value Claims Scheme
- The Future of the CNST
- Mid Staffordshire NHS Foundation Trust Claims, *16 Nov 2010*
- Complaints and Litigation (from John Meads, Technical Claims Unit)
- Referrals to the TCU (from John Meads, Technical Claims Unit)
- NHSLA – Past, Present and Future Challenges (from John Meads, Technical Claims Unit)
- NHS Workforce practices and NHS Standards
- Accommodation Claims An Update (Sally Chapman, 28th April 2010)
- Accommodation claims and the challenge to *Roberts v Johnstone* 18th Dec 2008)
- The Murderous Patient Is there a Duty of Care? (Sally Chapman, 28th May 2009)
- Questioning the Expert, Aug 2007
- Press Statement, Claims Against Mid Staff NHS FT, 24th Feb 2010
- Report to the NHSLA Board, Claims Involving George Rowland, 5th Jan 2011
- DNV Case Studies
- Maternity Claims, Chris King, 11th and 18th March 2009
- Press Release on Behalf of NHS Respondents JD vs East Berks
- Email from TCU to Clinical Panel Firms re Discount Rate on 15th Dec 2010
- Study of Stillbirth Claims
- PPO Example – Grace Eves v Harrogate & District et al

- Clinical Negligence Apportionment Protocol
- Report to the NHSLA Board, Healthcare Associated Infections, 7th Jan 2011
- Hospital Acquired Infections TCU CMS Advisory Note – Feb 2007
- TCU Advisory Note C Diff, Staphylococcus Aureus – The Science – Feb 2007
- TCU Advisory Note, Infection Control Initiatives – Feb 2007
- TCU Advisory Note, The Legal Basis of Claims Arising out…of an HAI
- Leicester Epilepsy Litigation, Chris King, 10.12.08
- Report to the NHSLA Board, Dr Andrew Holton, Jan 10 2011
- Mugweni vs NHS London Judgment, 23/02/11
- Email – HRA Guidance following Savage and Rathbone, 12 Oct 2010
- 09-09 complete dataset with NHSLA levels (version 2)
- Ambulance pilot data for 3.9 for the SMS
- Claims data meeting notes – 24th Sept 2010
- Claims related to Medical Devices and Equipment
- Data Analysis – case studies – anonymous – Case studies from DNV
- Report by Frontline Consulting: evaluation of the links between clinical negligence indemnity premiums and good practice in clinical governance (DE0240 – 00 – Department of Health – Insurance – Draft Final Report - Confidential
- DNV KPIs 2010 – 2011
- Draft 4 – Solicitors Risk Management Reports on Claims Steering Group Action Points January
- NHSLA Overall level and HSMR (Hospital Standardised Mortality Rates) for 2005: Paper outlining relationship between NHSLA scores and measures of quality of care, commissioned by the NHSLA.
- Post Assessment Questionnaire – General all Feb 11
- Report template Updated Format example level 1 (Assessment report template)
- Review of NHSLA Infection Control Assessment Outcomes 03-04 and 04-05_final: Paper: A Review and Comparison of the NHSLA Infection Control Standards Assessment Outcomes

- SRMP Follow Up Letters Summary Final : Paper showing follow up to the Solicitors Risk Management reports
- The Telegraph Hospital Guide v NHSLA Assessment Outcomes – statistical output from analysis
- Balanced Scorecard template
- KPI Paper
- Correlation between assessment levels and claims experience – paper outlining why no clear correlation
- Paper: impact of RM standards on frequency of MRSA infections (Research paper by Paul Fenn)
- CQC – DNV data and research
- Healthcare data update – current work
- Data analysis – case studies
- Brief analysis of NHSLA data with Doctor Foster and CQC data
- 2008 Staff Survey report
- Rowland - Savings
- Ledward - Savings
- Mid Staff Savings
- Maidstone – Tunbridge Wells HCAI Savings
- Holton Savings
- RCR Advice



Appendix B
Interview List

NHSLA		
1	Steve Walker	NHSLA
2	Tom Fothergill	NHSLA
3	Alison Bartholomew	NHSLA
4	Joan Higgins	NHSLA
5	Steve Chahla	NHSLA
6	Scott Henning	NHSLA
7	David Bell	NHSLA
8	John Mead	NHSLA
9	Non Executives: Keith Ford, Rory Shaw, Nina Wrightson	NHSLA
10	Technical Claims Unit	NHSLA
11	Rob Oldham	DH
12	Carl Vincent	DH
13	Mike Vickers	DH
14	David Flory	DH

MEMBERS		
15	David Pillsbury	Deputy Governance Director
16	Andrew Maloney	Director of HR and Governance, Greater Manchester West Mental Health NHS FT
17	John Saxby	CEO, Pennine Acute Trust
18	Mike O'Daly	Nottingham University Hospitals NHS Trust (Trust Secretary)
19	Jane Collins	CEO, Great Ormond Street Hospital
20	Tim Smart	CEO, Kings College NHS Foundation Trust

21	Tony Bell	CEO, Royal Liverpool and Broadgreen University Hospitals
22	Jayne Downey	Associate Director of Governance and Quality, Salford Royal NHS Foundation Trust
23	David Astley	CEO St George's Healthcare Trust
24	Shanti Kelly	Claims Manager, St George's Healthcare Trust
25	Neil Riley	Trust Secretary, Sheffield Teaching Hospital Trust
26	Lynn Wissett	Deputy CEO, East Lancashire Hospitals NHS Trust
27	Helen Thompson	Deputy CEO and Head of Nursing, Calderdale and Huddersfield NHSFT
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