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Original Article

Urological litigation trends in the UK National Health Service: an analysis of claims over 20 years

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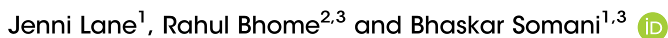
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Objective

To look into the urology litigation trends and successful claims in the National Health Service (NHS) over the last 20 years.

Methods

We requested data from NHS Resolutions to investigate current litigation numbers, costs and causes for claims. Data collected included the number of claims dating from 1996 to 2019, the total sum of damages paid out each year for urology and the causes for the claims dating from 2009 to 2019. Data from NHS Resolutions were analysed, stratified and categorized by the authors from this information, which was provided as two separate documents.

Results

The total cost of damages between 1997 and 2017 was £74.5m (range: £241 325–£7.8m per year). While the number of successful claims was 1653 (range 7–168 per year), the total number of claims was 3341 (range 31–347 per year) and, over time, this has increased almost sevenfold. The cost of damages has increased roughly in line with the number of claims. Over the last 10 years, non-operative-related claims accounted for 984 claims, of which the largest subset was for ‘the failure to diagnose and/or treat’ (n = 639, 65%), with 88 (9%) successful consent-related claims. There were 226 intra-operative-related claims. Of these, wrong-site surgery, a never-event, accounted for eight claims and there were six successful claims for failing to supervise juniors. A total of 1129 claims were postoperative claims, with retained foreign body or instrument accounting for 71 (6%) of these.

Conclusions

The number and cost of litigation claims have increased year on year. There is a need for continual improvement in patient care, surgical training, counselling, informed consent and early management of complications. The evidence reviewed in this paper suggests that the best approach to this is the combination of rigid adherence to and re-enforcement of common surgical guidelines and implementation of the national ‘Getting it right first time’ initiative.

Keywords

NHS resolutions, litigation, urology, claim, complication, compensation, consent, medico-legal, GIRFT, #Urology

Introduction

Surgical specialities accrue some of the highest litigation claims and costs due to their invasive nature [1]. Although urology continues to be linked to some of the fewest claims, the associated costs are still rising. The NHS cannot afford the increasing cost of clinical negligence claims. To tackle this, they have created a dedicated litigation department, ‘NHS Resolutions’, to help manage claims, carry out early liability investigations and support local systems with their responses. In this paper, we procured, analysed and presented data from NHS Resolutions to look into the urology litigation trends and successful claims in the NHS over the last 20 years.

Methods

To investigate current litigation numbers, costs and causes for claims, we requested data from NHS Resolutions under the Freedom of Information Act. NHS Resolutions is a dedicated litigation department to help manage claims and collaborate with associated services. It facilitates learning from clinical negligence claims by supporting local systems with their responses, sharing, learning and carrying out early liability investigations.

The data collected from NHS Resolutions included the number of claims dating from 1996 to 2019, the total sum of

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damages paid out each year for urology 1997 to 2017 and the causes for our claims dating from 2009 to 2019. The information was provided as two separate documents. The first covered the years 1996–2017 and outlined the number and cost of claims and was correct as of 31 December 2017. The second document contained the causes for claims from 2009 to 2019. Causes with under five claims were masked with a '#' symbol in accordance with data protection guidelines. The second document was correct as of 31 August 2020. Data from NHS Resolutions were analysed, stratified and categorized by the authors.

Results

The total cost of damages between 1997 and 2017 was £74.5m (range £241 325–£7.8m per year). While the number of successful claims was 1653 (range 7–168 per year), the total number of claims was 3341 (range 31–347 per year) and, over time, this has increased almost sevenfold. The cost of damages has increased roughly in line with the number of claims.

Trends in Claims and Cost of Damages

Figure 1A shows the rising number of claims coded as urology over the last 20 years. In total, urology received 2585 claims in 20 years. Claim numbers remained relatively stable until 2007/2008 when they rose sharply. The largest increase was between 2010/2011 and 2013/2014 when claims numbers rose by 48 and 50, respectively, over two consecutive financial years. Over the course of 20 years, the number of claims has increased almost sevenfold. Figure 1B shows the amount paid in damages. As illustrated, the cost of damages has increased roughly in line with the number of claims. An anomaly year was 2007/2008; whilst there were only 81 successful claims in urology, a staggering £7 801 400 was claimed. One can assume that, because this sum is not in line with an increase in the number of claims, it is attributable to one or several costly successful claims.

NHS Resolutions also provided data regarding the different causes of claims and the injuries incurred over the last 10 years (Table 1). Causes and injuries which account for less than five claims over this period have not been included in analysis due both to the difficulty in quantifying them and their lack of relevance because of their rarity over this time.

Non-operative Claims

Non-operative-related claims account for 984 claims, which was the majority of successful claims. The largest subset of these claims was for 'the failure to diagnose and/or treat' (*n* = 639, 65%). This is understandably a common cause for litigation, as delays in diagnoses can have detrimental effects on outcomes and are more likely to lead to a claim [2,3]. Patients who received unnecessary treatment accounted for 346 claims (35%). Additionally, there have been 88 (9%) successful consent-related claims over the last 10 years.

Intra-operative Claims

There were 226 intra-operative-related claims received over the last 10 years. We do not have full details of the majority of these claims, with NHS Resolutions recording the majority of them (61%) as 'intra-operative problems'. Wrong-site surgery, a never-event, accounted for eight claims. Of interest, six successful claims have been made against urologists for failing to supervise juniors.

Postoperative Claims

The majority of the injuries that occurred were postoperative injuries, a total of 1129 during the last 10 years. Of these, 370 claims (33%) were attributable to damage of structures, for example, bladder, bowel and nerve damage. Retained foreign body or instrument accounted for 71 claims (6%). NHS Resolutions have coded 104 claims related to cancer; however, the data received did not elaborate further on this.

Discussion

This paper supports other evidence that litigation costs in surgery have increased every year [1,4]. A study undertaken by the Kings Fund analysed the possible causes of this increase [5] and concluded that there were a number of reasons for this linear change. The first is a change in the doctor–patient relationship, moving away from the paternalistic relationship where the doctor dictates a treatment course. Patients have a right to be involved in decision making and those who consequently feel misinformed could be more likely to make a claim. Secondly, more patients research their symptoms prior to attending clinics or outpatient appointments, making them more informed about their choices. These are both positive changes and encourage patients to feel autonomous about decision making with regard to their health. Therefore, clinicians should continue to appreciate that communication is vital in supporting patients during treatment considerations. Finally, in recent years, many solicitors have offered Conditional Funding Arrangements, most commonly associated with the phrase 'no-win, no-fee', leading to patients having increased access to litigation and legal representation [6]. The results provided by the Kings Fund concur with this analysis, as depicted in Fig 1, with a notable increase in litigation claims from 2007/2008.

Over the last 3 years, the number of claims has begun to stabilize. This could be in part attributable to the implementation of the national 'Getting it right first time' initiative [7]. This initiative was formed based on a national

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Fig. 1 Number of claims and cost of damages over the time period (1997–2019). (a) Total number of claims made under 'urology' between financial years 1996/1997 and 2018/2019. (b) Total costs of damages vs number of successful claims.

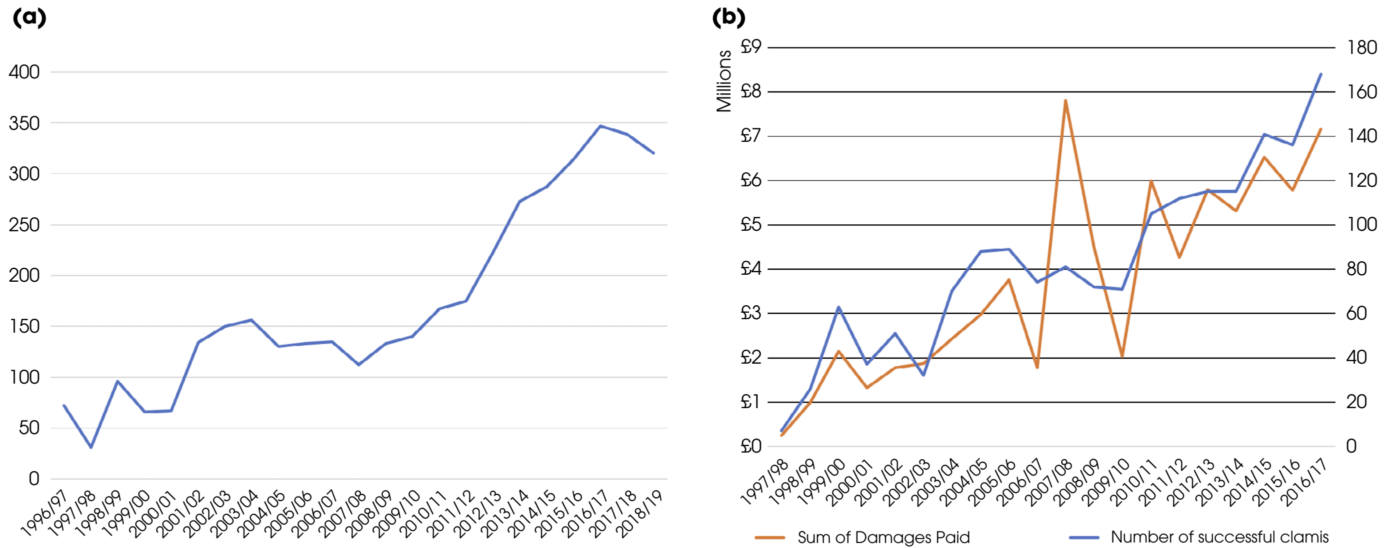

Table 1 Cause of claims and injuries occurred over the last 10 years (2009–2019).

Non-operative-related claims		**Intra-operative-related claims**	
Consent-related	88	Intra-operative problems	138
Failure to follow up	47	Operator error	57
Medication error	25	Equipment malfunction	9
Nursing-related	65	Wrong-site surgery	8
Unnecessary treatment	120	Failure to supervise	6
Failure to diagnose/treat	639	Inadequate monitoring intra-operatively	8
Postoperative-related claims			
Quality of life-related claims		**Damage**	
Incontinence	35	Bladder	107
Psychiatric/psychological damage	35	Bowel	36
Loss of sexual function	17	Testicle	68
Infertility	12	Loss of kidney	31
Impotence	10	Renal damage/failure	39
		Perforation	22
Cancer-related claims		Fracture	26
Advanced stage cancer	34	Nerve damage	19
Cancer	70	Pressure sores	17
		Tissue damage	5
Others			
Retained foreign body/Instrument	71	Bruising/extravasation	5
Unnecessary pain	259	Compartment syndrome	5
Postoperative infection	35	Multiple injuries	5
Burn(s)	11	Inappropriate discharge	7
Thrombosis/embolism	9	Failed sterilization	5
Anaphylactic: shock/allergy	8	Fatality	105
Scarring	8	Unspecified	13

review of urology services, starting in 2017. It models aspects of excelling centres and works with others to implement national recommendations into local practices, thus improving standards of care. Examples from the 2019 programme included focusing on improving subspecialist services and increasing the effectiveness of resources and procurement of equipment.

The breakdown of the causes of litigation provides an insight into the areas of our practice which carry the most risk and,

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therefore, where improvement in services is needed. It is important to note that NHS Resolutions collects information primarily as a claims management tool, rather than for risk management or research purposes. Therefore, some of the information provided is limited.

Non-operative claims accounted for the highest number of urological claims, and failure to diagnose or treat encompasses nearly half of these. This is not unique to urology and is reflected in many other surgical specialities. Ford et al. [1] stated that 19.7% of all successful claims during the years 2004–2014 across 11 surgical specialities related to a failure or delay in treatment. Oncological targets set out by the government could protect trusts from litigation if patients were treated within the 62 definitive treatment window [8]. However, arguably it is the more insidious symptoms or patients who are labelled 'failure to follow up' due to an administration error who come to harm.

There have been 88 successful claims related to consent over the last 10 years. This is despite the importance of informed consent and assessing patient capacity, something taught extensively throughout medical training. A study by Veerman et al. [10] looked at the intricacies of the consent process and found a disparity between the expectations of the patient and the surgeon. While surgeons believed that patients desire more information on the cause, effect and prognosis of their disease, in fact, many patients wanted more information on the characteristics of the operation and risks or complications rates of that specific surgery [9,10]. Many hospitals now give patients a patient information leaflet prior to consenting for a procedure, which allows individuals time to process risks of procedures prior to being consented on the day of surgery [11]. Many trusts use the BAUS procedure-specific consent forms as an adjunct to the consent process. However, these are not without their own limitations; a recent analysis of the leaflets provided by BAUS highlighted their poor readability and therefore it is essential that provision of any leaflet is accompanied by a thorough discussion of risks and benefits [12]. Litigation claims for inadequate consent continue to make up a significant proportion of preoperative claims, which suggests that a more robust consent process, such as the distribution of improved patient information leaflets to complement a discussion or the introduction of a two-stage consent process prior to elective surgery, should be made a mandatory activity rather than simply be considered good practice.

Intra-operative-related claims represent a small proportion of the overall claims in surgery. However, arguably these could be some of the most avoidable through training and mandatory preoperative checks. Wrong-site surgery still accounted for eight claims despite being listed as a 'never-event' [13]. Correct implementation of preoperative marking and the WHO checklist should prevent wrong-site surgery; however, it is important to note that human factors play a considerable role in never-events [14,15]. This fact highlights the critical role of the entire theatre team to engage with surgical checklists and adherence to procedures to prevent these mistakes. It also brings into account the importance of non-technical skills as a part of the surgical training.

Whilst damage to structures during routine surgery is rare, the data show that incidents where this does occur account for a large proportion of the postoperative complications and subsequent claims. For example, BAUS suggest that in the consenting process for ureteroscopy the risk of damage to the ureter is quoted as <0.1%, but because of its severity, this should always be included on consent forms [16]. Medicolegal challenges can arise when a patient experiences an adverse outcome but there is no evidence to refute the claim that they were unaware of the risk, making documentation of informed consent vital. A study in the USA found a strong association between delayed ureteric repair and claim amount [17], making early identification of complications essential. Furthermore, the same study identified that, if the cause of damage was due to failing to supervise a trainee, the claim amount increased significantly [17].

Inadvertent damage to structures in some operations could be classed as 'unavoidable'. For example, in surgery to remove bilateral goitre damage to the recurrent laryngeal nerve (RLN) injury is a permissible complication, yet bilateral RLN injury would be classed as negligence unless there was firm documentation to demonstrate that the nerve had been identified and spared [18]. A key takeaway for urologists from this is to ensure that operation notes are clear, and every precaution has been taken to minimize damage to structures.

Retained foreign body or instrument accounted for 71 claims over the last 10 years. In urology, 'the forgotten stent' is a preventable and potentially lethal complication, with encrusted stents presenting an increased risk of infection and requiring operative management [19]. Many trusts have now implemented a stent registry, some of which automatically notify patients of the need for stent changes or removals [20,21].

Urology is no different from other surgical specialities, in that the number and cost of claims are generally increasing year on year. This paper has highlighted some of the key areas and categories into which these claims fall and analysed the micro-trends within the data.

In conclusion, the number and cost of litigation claims have increased year on year. There is a need for continual improvement to patient care, surgical training, counselling, informed consent and early management of complications. The evidence reviewed in this paper suggests that the best approach to this is the combination of rigid adherence to and re-enforcement of common surgical guidelines and

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implementation of the national 'Getting it right first time' initiative.

Acknowledgement

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Disclosure of Interests

None declared.

Code Availability

Not applicable.

Data Availability Statement

The datasets used and/or analysed during the present study are available from the corresponding author on reasonable request.

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Supporting Information

Additional Supporting Information may be found in the online version of this article:

Table S1. Number and Primary Cause of Claims Closed/Settled with damages paid under Urology speciality between financial years 2009/10 - 2018/19 and Number and Primary Injury of Claims Closed/Settled with damages paid under Urology speciality between financial years 2009/10 - 2018/19.

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