

**APPG on Patient Safety**  
**Meeting report 24<sup>th</sup> October 2005**  
***Patient Safety: Limiting Litigation in the NHS***

Chair: Dr Howard Stoate MP

Speakers: Peter Walsh, Chief Executive, Action Against Medical Accidents  
Steve Walker, Chief Executive, NHS Litigation Authority  
Dr. Gerard Panting, Communications and Policy Director, Medical Protection Society

Howard Stoate, Chairman of the All Party Group on Patient Safety, opened the meeting by saying that Doctors didn't want litigation, but rather swift redress and that he hoped the NHS Redress Bill would reduce the need for cases to go to law.

Dr Stoate also pointed out that innocent doctors careers can often be damaged for years due the lengthy litigation process and that it was hope by all that the Clinical Redress Bill would result in incidents being dealt with in a swifter, fairer and more accountable way.

**Peter Walsh**

Peter Walsh started from the premise that it is a myth that we are living in a litigious society. He argued that, in fact, we live in an 'anti-litigation culture' in which people frown on suing doctors and the NHS. He referred the meeting to the NPSA annual report which, he pointed out, 'unequivocally' stated that there was not a litigation culture in the NHS.

He pointed out that in relative terms claims against the NHS had actually diminished during its 43 year history. To support this, he pointed out that 1 million patient safety incidents in the NHS over the past year had only resulted in 5,500 claims.

Peter Walsh said that most patients wanted three things. Top of the list was the truth, encompassing reasons and an explanation for the incident. The second was an apology and the third, reassurance that lessons had been learnt from their experience. He said that bottom of most patients list was a desire for compensation, except where it was needed for the patient to lead the standard of life they had previously been accustomed to.

He went on to say that litigation should be used as a safety net and detracted from the task of prevention and that not enough action was taken to prevent a reoccurrence.

Walsh said that he was disappointed with the NHS Redress Bill because the NHS remained the investigator, judge and jury in patient safety incidents.

He said that human error was inevitable and that it was also inevitable that people would fail to spot errors. He argued that the Bolam test was only intended for a court based system and that the NHS should have an 'avoidability test' which asked what went wrong and what should be put right as well as whether compensation should be granted or not.

He also argued that artificial caps on payments were shortchanging people and represented a step away from restorative justice which should aim to help people to be as near to as they were before the incident occurred.

Walsh said that any investigation should be required to include answers regarding future prevention and whether there should be a redress package. To this extent he said that he hoped that amendments are made during the passage of the bill and that he was especially keen for an independent body to make decisions on responsibility.

### **Steve Walker**

Steve Walker started by pointing out that the Clinical Redress Bill was only an enabling bill and not about litigation but a change in the philosophy in relation to adverse events in the NHS.

He pointed out that the NHS interfaces with a million patients a day and argued that the relatively small number of claims against the NHS suggested that there was not a compensation culture, but rather, a culture of candor amongst clinicians. But he said that human nature meant that openness would take time, with trust growing between Trusts and clinicians. He said that people should know rights and how to exercise them.

In response to Peter Walsh's comments on capping of payments, he clarified that the cap was on legal fees, but that there was no cap on payouts to patients.

He emphasized that the Clinical Redress schemes would be voluntary and that no one would be forced to seek compensation through redress. He said, however, that what redress would guarantee was an apology and explanation for the patient.

In terms of risk management, Walker stressed that to implement a 'no fault' system in the NHS was too expensive and that there would be no political mandate. He pointed out that most of the Clinical Redress Bill was in statutory instruments and that there would be a cap on the threshold of probably around £20,000.

Walker pointed out that under the new legislation, if an NHS employee agrees that they made a mistake, then there would be no need for independent analysis.

He also pointed out that the patient would still be free to go to litigation after redress.

To this extent he disagreed with Peter Walsh's assertion that it was important to have an independent body investigating incidents.

He conceded that patient safety elements should be built into redress.

## **Gerard Panting**

Gerard Panting pointed out that media references to NHS blunders outnumbered references to NHS miracles by three-to-one. He suggested this reflected the 'screwed' impression of what is going on in the health services.

Panting pointed out that doctors are devastated when things go wrong, but that most patients receive good, safe treatment.

He said that the 2000 deaths caused by adverse incidents in England and Wales had a profound and lasting effect on doctors. Of respondents, 11% said that the incident had had long lasting effects on their professional lives.

Asked who they turned to for support when things went wrong, 65% of respondents sited friends and family, while only 24% sited their employing trust.

Panting suggested that before being candid, clinicians had to understand what has gone wrong. He said that he hoped that the Redress Bill would bring about a culture of candor.

He pointed out that when things go wrong it is important to be able to ask another expert and that therefore independent analysis would be difficult. However, he supported a period of review.

Panting also pointed out that accidents were as frequent 10 or 20 years ago as they are today. He said that they could generally be broken down into three causes. These were communication errors such as consent issues, lack of expertise or system failures.

Panting said he was not a subscriber to the view that systems error is the majority cause of accidents.

**End**

## **Q&A**

Following the meeting there were a number of questions and comments from the delegates, the main points are listed below:

- **John Wilkinson, ABHI** commented that it comes as no surprise that failures in diagnosis top the litigation hit list and that diagnosis is, in modern times, a combination of the clinicians skills and the use of available diagnostic tools. He asked to what extent does the NHS Redress Bill address this interaction especially where certain diagnostic tools may not be available to a clinician? John also asked to what extent has the potential for increased referrals or litigation due to emerging perverse fiscal incentives been taken into consideration. He referred specifically to Payment-by-Results and GP Commissioning where the incentives

to keep case costs down might encourage clinicians to reduce the utilisation of diagnostic tools.

- **The General Optical Council** questioned whether independents working outside of the NHS would be covered by insurance under the NHS Redress Bill, warning that if not this would pose a risk to the public.
- **Julie Stone, Deputy Director, Council for Healthcare Regulatory Excellence** suggested that one single forum is needed for all those involved in patient safety incidents to come together and discuss the issue.
- **Helen Glenister, NPSA** highlighted the fact that there has been significant improvement in terms of the processes involved but that there is more to be done to improve the situation.
- **Jason Maude, Isabel Healthcare** emphasised that misdiagnosis as a cause of patient safety incidents is a major concern.
- **Baroness Neuberger** stressed the importance of reporting and learning when it comes to patient safety.
- **John Barron MP** suggested that patients need to be empowered in the process of redress.