avma
action against medical accidents

The charity for patient safety and justice

Proposals for ensuring patient safety lessons are learnt from litigation

1. Introduction

1.1 Action against Medical Accidents (AvMA) is the independent charity which works for better patient safety and justice for patients when things go wrong in healthcare and cause harm. AvMA specialises in providing independent advice and support for patients and their families who have been affected by such lapses in patient safety through our helpline and also more intensive casework including our inquest support service. Since its inception in 1982 AvMA has provided advice and support to over 100,000 people. This gives us a unique insight into the kinds of things that go wrong and the experience of people following such incidents. AvMA also has extensive knowledge in the field of clinical negligence litigation. We accredit solicitors who meet the exacting standards for our specialist clinical negligence panel of solicitors, and provide training and other services to clinical negligence lawyers.

1.2 AvMA has long believed that much more could be done to learn lessons for the improvement of patient safety from cases that have been the subject of litigation. We believe there is very limited evidence of this happening systematically. Whilst only a small minority of the people who come to AvMA for help turn to litigation, invariably when they do so, the desire to ensure that lessons are learnt and safety improved to prevent the same thing happening to someone else is high on their agenda. The fact that the issues giving rise to failings in health care, including negligence claims repeat themselves indicates that not enough is being done to address the causes of these clinical failings or to learn lessons from them, this includes legal claims. The processes around failings including litigation should be a driver for change but the lessons learned from these processes must be fed back in a consistent way. This short paper summarizes a potential framework for ensuring that this is done. We look forward to discussing this with the Department of Health and other stakeholders with a view to developing the detail of how this approach should work.

1.3 AvMA believes that the need to learn lessons exists in both the NHS and private health care organisations. The term "healthcare provider" is used in this paper to connote all providers of health care including: NHS trusts, Clinical commissioning groups, General Practitioners and dentists as well as private health care services.

1.4 For the purposes of this paper, the expression "clinical failings" has been used to describe any failings in patient safety which have been identified as part of considering issues connected to a clinical negligence claim. We believe that it is important to capture the learning from these failings whether or not they constitute a breach of the duty of care owed. to the patient.

2. Our Core Proposals

2.1 Care providers should be obliged to demonstrate that they have recognised and acted on the lessons learned from litigation. We recommend that a simple but uniform and compulsory process should be followed by the legal representatives or Responsible Person (see definition), once a breach of duty or clinical failing has been identified, in particular once a clinical negligence claim has concluded.

2.2 The main tenets of this paper are that where any breach of duty or clinical failing has occurred, even if it does not result in an admission of liability or settlement, a Responsible Person must be obliged to prepare a reporting document which sets out all of the breaches of duty and clinical failings identified. Additionally, we recommend a requirement that the breach and/or the clinical failing is published, this is similar to the system currently used in coronial law where the Chief Coroner (CC) publishes all the Prevention of Future Death (PFD) reports and replies on the Ministry of Justice (MoJ) website.

2.3 We suggest that the reporting document should be referred to as a Patient Safety Letter.

2.4 The suggestions made assume that care providers will be obliged to nominate a person within their organisation to be responsible for the handling of patient safety letters and disseminating the learning. This person is referred to in this paper as the Nominated Person (see definitions).

2.5 The patient safety letter should have three functions. First to set out the breaches of duty or clinical failings identified so these can be addressed by the care provider.

Secondly, to challenge how robust the care provider's internal procedures have been in investigating the breaches and clinical failings and whether they should have been identified earlier. In particular it should review:

(i) The care provider's investigation and management of patient safety incidents, especially the quality of any Serious Incident Reports (SIR) or similar process followed

(ii) The care provider's handling of the complaint process (where appropriate)

(iii) Consideration of the Letter of Claim and Letter of Response

(iv) Confirm and identify the learning from the incident for improving patient safety, and actions taken or planned as a result

(v) Compliance with the Duty of Candour at each stage since becoming aware of a clinical failing or an incident that gives rise to a claim

Thirdly, the patient safety letter should be published by the care provider. This will ensure a greater degree of public accountability. The Francis Report into Mid Staffordshire noted that the public should have "access to open, honest and transparent information to assess compliance with appropriate standards".

2.6 The patient safety letter should be sent to the Patient and their representative (see definition) for approval and comment within a given period of time. Once the letter is agreed, the care provider's Responsible Person must then send a copy to the care provider's Nominated Person. If it is not possible to agree on the letter then the care provider's version should be adopted but the patient's alternative suggestions published alongside as an appendix.

2.7 The patient safety letter and the Nominated Person's response should be published on the care provider's website, so the public is aware of them. If the breaches of duty/clinical failings involve individuals then the letters should be anonymised.

2.8 Relevant external organisations such as the Care Quality Commission, the relevant commissioner of the service and NHS Improvement should be provided with a copy of each patient safety letter and consider them as part of their monitoring/regulation of the care provider.

List of Definitions:

Care Provider: Throughout this paper we have referred to care providers to encompass all organisations delivering health care. This includes NHS trusts who are part of the NHS LAs Clinical Negligence Scheme for Trusts (CNST), those NHS trusts which fall outside of the CNST, private hospitals and individuals offering private care, as well as Clinical Commissioning Groups and primary care providers.

Clinical Failings: Refers to any care or treatment provided by a care provider which is considered a lapse in patient safety. . The definition encompasses:

- Care that falls within the definition of a notifiable safety incident as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulation 20 2014 (the Regulations)
- Care that triggers or ought to trigger investigations being carried out as identified in the Serious Incident Framework (SIF) prepared by NHS England and published in March 2015
- Failings in care that are or ought to be identifiable from investigations carried out by the care providers complaints procedure
- Any failings in care that are identified through the litigation process, regardless of whether the failings resulted in proceedings being issued and/or a claim being brought.

Nominated Person: The person nominated by a care provider to be responsible for ensuring that arrangements are in place to review the clinical failings communicated to the care provider through the patient safety letter. They are also responsible for responding to patient safety letters and disseminating the learning derived from the process to the relevant clinicians and care provider departments. They will also be responsible for working with relevant personnel to put in place strategies to address the cause of the clinical failing and for publishing the patient safety letter and care providers response on the care provider's website.

Patient/Representatives: This refers to the patient or where the patient has died, their personal representatives. It may also refer to the where a patient has issued proceedings and is recognised as a claimant in proceedings. It also covers the situation where the patient

or personal representatives have nominated a lawyer or third party such as a voluntary sector advice provider to act on their behalf.

Relevant External Organisation: Any regulatory, statutory and advisory bodies such as the CQC, Monitor, National Reporting Learning Systems (NRLS) or the NHS Trust Development Authority.

Responsible Person: Responsible Person is used in this context to connote the relevant person, whether that is a risk manager, senior complaints officer, NHS LA case handler or lawyer responsible for writing the patient safety letter.

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Action against Medical Accidents

Freedman House
Christopher Wren Yard
117 High Street
Croydon CR0 1QG

020 8688 9555

www.avma.org.uk

www.facebook.com/AvMAuk

@AvMAuk