Have We Won?

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A meeting of the Medico-Legal Society was held at the Royal Society of Medicine, 1 Wimpole Street, London W1, on Thursday, 8 March 2007. The President, Mr Bertie Leigh, was in the Chair.

**The President:** Welcome everybody. This is not the first time that Steve Walker has addressed this Society. Neither he nor I can remember when the last time was, but it is always a good idea to have people who have filled the same slot back from time to time. I remember when the Chief of Police from the Metropolis came and gave us a lecture: he said he had looked up a lecture given in 1922 by his predecessor in which he had reported that there had been 2,000 motor cars stolen from the streets of London in the preceding year, and what he had thought was remarkable about this was that every motor car had been left parked in the street. He said he had looked up the same statistic for the year preceding his own lecture and he found the number had expanded somewhat to some 10 or 20,000 cars and he thought that it was extraordinary that the owners had learnt nothing in the interval, because of all of these cars were also left parked in the street.

I dare say that Mr Walker will tell us that not much has changed about clinical negligence in the intervening years since he last addressed us. The title we have given him is *Have We Won?* – not because we anticipate any triumphalism from him, but it is remarkable that the volume of litigation against the NHS has fallen, and the only reason why the financial burden has gone up is because the cost of caring for cerebral palsy children has gone up, otherwise the net cost of litigation has gone down, which is presumably a tribute to the Authority which is charged with protecting the funds of the NHS, which has to fend off claims from those who say they have been damaged. At the same time Mr Walker is mindful of the fact that he is charged with maintaining a balance and that those who have been damaged have an interest in the service as well and he is not simply, as the Chief Executive of an insurance company would be, charged with limiting liabilities. It is a sign of the breadth of his skills that whilst holding this office he has done a Masters in Medical Law and Ethics; he has also been a Justice of the Peace throughout that time; and his achievements were recognised last year by the Queen when he was made a CBE. So he is a man of many parts and I am sure we will all be very interested to hear whether he thinks that the Authority has indeed won.

**Mr Walker:** Good evening, and thank you very much for coming tonight. *Are we winning?* The title was chosen by your enigmatic, possibly idiosyncratic some would say, President. I have worked on the assumption that it wouldn’t be appropriate to be triumphalist – and I will talk about that in a moment – and that we are possibly referring to a sporting metaphor rather than a military one, but I will come back to that shortly. I worked on the assumption that whenever I attend lectures here the overwhelming majority of the audience are doctors and that doctors might like to hear me talk about what is happening in risk management and the law. I am appalled to find that there are so many lawyers here this evening and, while I am happy to accept questions, I would rather not have too much heckling, thank you very much, especially from those who wish to remain on our panel. (Laughter.)

One of the things I always say – and I recollect that I did say this five or six years ago – and this is really important and people seem to lose track of it, is that the NHS Litigation Authority is part of the National Health Service; we are a special Health Authority; we are a creature of statute
or, more specifically, Regulations made under statute, and it is very important that everyone bears
that in mind at all stages; that is our litigation opponents, patients and everyone else; we exist to
serve the National Health Service. We have obligations to patients, and I will talk about that in a
moment, but it is really important to remember that basic point. We are what is called an “Arm’s
Length Body”, which implies and in practice means that we act with a certain degree of
autonomy, both from the Department of Health and the National Health Service, but we are
subject to the same constraints, and that means we are subject to financial constraints just like
every local Acute Trust, PCT, Mental Health Trust, Ambulance Trust, and the rest. We are
subject to the same political pressures, too, but because I want to keep the job at least until
retirement I won’t say anything more about that.

We perform two primary strands of work, and I want to say a little about each and how they
have developed since the last time I spoke to this organisation.

Those two strands are the management of claims and litigation, on the one hand, and the
management and supervision of risk management processes, on the other. They are both
performed solely and exclusively for members of our schemes and, by definition, members of our
schemes have to be NHS bodies. I mention that because there is some confusion about
Independent Sector Treatment Centres, for example. They are not members of our schemes. We
may be able to provide an indemnity vis-à-vis some of their work insofar as there may be a
liability on the PCT which commissions that work, but they are not members of our schemes.

I am saying some of these things only because they are frequently asked questions and I
thought this was a good opportunity perhaps to answer some of those questions without them
being asked from the floor later.

For this evening’s purposes I will talk primarily about clinical risk, although we do deal with
employers’ liability and public liability risks for the Service, too.

To put what we do into context, in risk management and claims management, it is also worth
remembering that we are talking about one of the most complex organisations in the world – that
is the National Health Service, not the Litigation Authority. We are a relatively simple
organisation in every sense. We are told that the NHS engages, in England alone, in about a
million processes or interfaces a day, everything from major surgery to minor diagnostics,
prescriptions, simple advice-giving, a whole raft of activities. One extreme example is sectioning
under the Mental Health Act. That many activities, that many interfaces with, almost by
definition, pre-existing vulnerable patients means that inevitably things will go wrong. It is
unacceptable that so many go wrong, but I would like to offer here a personal view about how
many there are.

Commentators talk about one patient in ten suffering an adverse event when they are in an
acute hospital, but I have seen no evidence for that and I find it impossible to believe that one in
ten suffers an adverse event of consequence. Other people talk about numbers like 80 to 100,000
incidents that happen in English hospitals every year. Most of the data I have seen is based on
extrapolations using formulae that were devised elsewhere and applied to small sampling
exercises in the UK. I don’t know the answer.

Unfortunately, the NPSA hasn’t been able to give the answer yet, although I believe that it
will. I think that the processes that are now in place at the NPSA through the National Reporting
and Learning System will shortly be delivering a lot of data, and it may well cause a lot of
rethinking of the priorities. But, whatever the number, it is generally accepted that a significant,
but debated, proportion even of those events are not preventable – “stuff happens” as they say.
That is not a great thing to say about healthcare, but things do happen; things happen unexpectedly, things happen which might have been anticipated but weren’t, things happen that it
was impossible to anticipate, and we then get into the blame game, which is formalised into the
tort system, and that is where the Litigation Authority comes into play.
There is a big question often asked about trivial events. If someone suffers a minor injury, something that may be painful for a few days and may be inconvenient, should they simply accept that? Should they bear it stoically and say “Hey, it’s one of the vicissitudes of life”? Should they do that because 95% of the population actually does that? It is an open question, but it is one that crops up increasingly now in debates about law reform. Can society in the round afford to be concerned about every minor injury, every minor adverse outcome, every minor inconvenience, and who does the cost benefit analysis that determines how much resource has to be applied (a) to compensate, but critically, (b) to try and prevent? The one thing that has changed very dramatically since the last time I talked to this Society is that now the fact that it is about money – and when I say “it” I mean nearly everything we do is about money – has become much more overt. It was probably always true, but now people are very frank about the fact that resources are not unlimited, cannot in any way, shape or form be made to stretch into infinity, and I think it is very healthy that people recognise and talk about this. I don’t like it. It would be lovely if resource was never an issue, but I think that that kind of honesty informing proper debate is much healthier than pretending that we are all living on some kind of a different planet where it is not an issue.

Having raised the subject of honesty and risk, let me pose this question. This evening’s Chairman, your President, has already talked about Chester v Afshar and I for one want an advance ticket to the next event here: it is certainly going to be a lot more interesting than this one, as you have already realised I guess, but it is a very interesting case. My personal view is it is probably fact and case specific, although it is beginning to crop up and be quoted and mentioned in other cases and I will follow the debate with great interest. However, there is no doubt that the risk assessment, which in turn informs the consent process, is becoming increasingly important. It is becoming more important than ever before in risk management, not just financial risk assessment but in assessing the whole risk, and increasingly I think professional people will be asked to what extent they understood all the risks before they could even begin to contemplate explaining all of those risks to a layman, because without explaining those risks in words of one syllable, quite frankly, how can they possibly say that they have taken consent from a patient who has come to them in total reliance? I think that Chester will certainly influence thinking in that respect. I think that as professionals, ladies and gentlemen, you need to think very, very carefully about that, because I think old assumptions have gone by the board and it is not enough to just say “Sign here”. I know everyone will say “Hey, we’d never do that”. Believe you me, I see a lot of evidence that people do and, even worse, they get someone else to say “Just sign here”, and that is probably the cardinal sin once something goes wrong.

But where should responsibility for risk management lie anyway? One of the drivers that is informing the Chief Medical Officer’s current and new initiative – “Safety First” – on patient safety is that historically too many people have notionally been responsible for managing risk, which has almost inevitably meant that the problem has fallen between too many stools. Should it be Trust Boards, should it be Trust Management, should it be professionals employed by the Trust, should it be the Royal Colleges, should it be risk managers? Well, the truth, of course, is it should be all of those people and all of those bodies, and maybe more. In practice, the big question-mark is who is accepting responsibility for risks that you as an individual are exposing your patients to? I really, really urge you, ladies and gentlemen, to think about that, because I think increasingly that is one of the questions that is going to be asked in almost every case of an adverse outcome.

Two suggestions – personal from me – this isn’t NHS, this isn’t Department of Health, this is Steve Walker speaking. You have all read about the compensation culture; is there one, isn’t there one? There isn’t one in the NHS. Claim numbers aren’t rising. Forget it, it just isn’t happening. We are not seeing fraudulent claims. It’s just not happening. I believe that, as does the Prime Minister – not that he has shared it with me personally, but he has made public statements – the
Better Regulation Task Force and the Lord Chancellor, I think they are all right when they say the big problem about the compensation culture is the perception of risk, that people will litigate, that people will act defensively, that volunteers won’t volunteer, etc. As a result of that perception, though, the idea of risk assessment, really analysing the risks that might arise from a particular event, has had a very bad press. The Health and Safety Executive, you just have to mention them for people to say “Yeah...” and start talking about conkers at school and slides in the playground. There are people in the audience laughing. You know it’s true. But the truth is that risk assessment is a valuable tool if it is carried out properly, not with a view to never taking risks but with a view to understanding what the risks are, how they are measured, how best to minimise them and how best to explain them to the people who are at risk so that they can make an informed decision about how to proceed. My suggestion, the one which led me to qualifying my statement and saying it is me personally, is this: why are all new initiatives, political, management, Trust wide, Departmental, why are they not properly risk assessed? I don’t just mean in financial terms, but if they were properly risk assessed, and risk assessment with costings became part of the process that informed the debate, part of the process that led to the decision being made, I think we would see some very dramatically different decisions being made at all of those levels. Now, I am quite happy to take flack from the floor or questions from the floor on that, but I think that we really should give some thought to it and, I come back to what I have said: I think Chester in its own little way is going to be a major factor that will influence thinking along those lines.

For the avoidance of doubt, I am not advocating defensive practice. We have all heard about defensive practice, particularly in medicine, in the United States. That is driven by money; that is driven by money/insurance; and I am not advocating that at all. That is the worst of all possible worlds. If we were thinking along those lines, if the Litigation Authority was a commercial insurer, I would certainly be saying “No obstetrics, thank you. I don’t care where they have their babies, but not in my hospitals”. That is never going to happen within the National Health Service. You know, in case there are any midwives in the audience, obstetric/maternity claims account for about 60% of our expenditure. If it wasn’t for those claims the Litigation Authority wouldn’t exist, but no-one is advocating that we give up delivering babies in National Health Service Hospitals. But I do think that better informed practice, as opposed to defensive medicine, is the way forward and I think we need to work to develop that as a mind-set going forward.

I said that the other main strand of what we do is litigation; implicit in the name of the Authority, obviously. In a sense it is misleading, because we don’t litigate; we hardly ever litigate. Counsel in the room who act for us will tell me we don’t litigate nearly enough to generate a reasonable livelihood for them. Is that correct, sir?

A member of the audience: Absolutely.

Mr Walker: I thought you would say that. In 2005/6 the Litigation Authority received under 6,000 new claims; that is from every NHS body treating patients in England, under 6,000. Remember what I said earlier about a million processes or procedures a day. It is miniscule. Any commercial organisation dealing with sharp end, risky procedures would think that was fantastic, and in many respects it is. Now, there are lots of reasons why it is that low and those of you who represent claimants I am sure would be very quick to say one of the problems is funding. I don’t disagree with that. I am certainly not saying that it is our attitude to claims and litigation over the last six or seven years since I spoke to you that has kept this figure level – although that is what I say when I have my annual appraisal, of course – but it has been fairly static now for two or three years. I think it is too early to say that it is on a plateau, maybe going to dive, that clinical negligence is a dying art, you can forget about pursuing a career in clinical negligence, any of those things, but the fact is that it hasn’t taken off the way it was predicted to do eight to ten years ago. It isn’t causing the problems to the National Health Service that people (like the front page of the Metro about four or five weeks ago) would have you believe. You know, we are talking
about a miniscule proportion of NHS budget. I think those numbers also reinforce what I have said by giving the lie to any suggestion of a burgeoning compensation culture; it really just isn’t happening in the National Health Service.

In the same year 2005/6 we spent £560 million, a lot of money, but in overall budgetary terms it is very small. Again, the Metro, trying to develop a good story, said that if we hadn’t paid any of that there would have been no deficit. Well, that is true, but some of us seem to think that if we have harmed a patient, then he or she might just be entitled to some compensation, and the rules we apply to pay that compensation, and to determine what the levels are, are pretty much those that are applied by the courts. One of the reasons that costs have plateaued also, is it only fair to say, is that structured settlements have become more common, or periodical payments regimes as they are now called. We don’t pay the huge lump sum today, we pay perhaps a third of that huge lump sum and we pay the balance year by year throughout the life of the patient who requires, typically, care over their lifetime. I think the last time I spoke here I predicted that periodical payments would become more common. We certainly campaigned for them and now the law has changed and the judiciary are allowed to impose them, even against the wishes of the patient, or indeed against our wishes should we oppose one. In practice they are not doing that. That is an interesting area that is currently being observed by many people, but I will talk a little bit more about periodical payments in a moment, because I want to talk about indexation.

I know that I said the last time I spoke that we were adhering very closely to what was effectively the script we had been given by Lord Woolf in Access to Justice. I know that your President and this evening’s Chairman feel very strongly about Access to Justice. We disagree on many aspects; in fact, we agree on many, many things, but we disagree very strongly about many aspects of Access to Justice. I said that we would take on board his criticisms, or many of them, vis-à-vis clinical negligence, and we have done. We aim to settle claims quickly, and by and large we do. We aim to settle them fairly, and the evidence for that is that we have very few cases going to litigation. Of those numbers we have about 50 going in front of a judge every year on a contested matter. Many more go before a judge to get approval to a settlement, but only about 50 are contests. That is very small beer and I am quite proud of that. We offer Alternative Dispute Resolution, which frankly very few people seem interested in. The academics talk it up, politicians talk it up; the people at the coal face do not want mediation by and large, or round table meetings, frankly. We are doing a lot of them but they are jolly expensive and I am not sure that ADR is quite the panacea that it was thought to be by many of the academics or, indeed, some of the senior judiciary five or six years ago. That is not just our experience, it is the experience of many. But by and large all our claims are settled one way or another by negotiation or correspondence; we just do not go in front of a judge.

One of the problems that we said we would address then, and I have to confess that we have made very little progress on, is legal costs, the so-called frictional costs of getting damages to people. I said that we spent £560 million last year. Of that about £150 million was paid to lawyers and, before there is any burst of protest from the floor, some part of that was VAT (which they will say never hit their bank accounts) and some part of that was disbursements which we pay to the medical profession for producing expert evidence for us, and some very small, minuscule, I am sure, part went to counsel for their part and their assistance. But £150m out of £560m is a very high proportion and we need to do something about that. I can make a cheap point, and I will, that defence costs are always very, very much lower than claimant costs, but I happen to know that there are some good reasons and excuses for that, apart from the fact that there is a huge differential in the hourly rates that they charge. Don’t anyone test me on that one because I will invoke Mr Leigh’s help on it as well. But the rate of disproportion between defence costs and claimant costs has remained fairly constant over time.

Why are these costs so high? Well, we have tried most things we know to reduce costs. People on our panel would tell you that we have battered them down into the ground, that they can
barely afford the cost of getting to work in the morning, but that hasn’t made a huge difference to the ratios. We argue with claimants’ lawyers about their costs. We go to assessment from time to time. We have an assessment beginning on Monday where I am ruthlessly, no doubt it will be said, suggesting that £450 an hour is an excessive rate for a Sheffield based lawyer to be charging. No shock from the audience! Maybe the audience thinks that is a very reasonable rate, I don’t know, but we have found it very difficult to reduce this burden and it is one of the few problems that Woolf addressed that hasn’t been solved. He referred to making costs more proportionate, but it just hasn’t happened.

So I propose putting a question to you, and I am very happy to take the feedback when I stop talking and give you a chance. How can we reduce these so-called frictional costs? Particularly, how can we do it without denying lay claimants, who are patients of the NHS and who feel they have a good shout and a right to be heard, the advice and the guidance they need so they know that we are not ripping them off when we make them an offer or when we tell them that there is no liability, because that is the dilemma. Those of you who followed the Redress Act as it was a Bill going through Parliament will know that legal costs were a big issue there. How do you reduce these costs? This isn’t a cheap attack on lawyers, it is a real problem. It is a problem for society; it is a problem that is cropping up now in the criminal courts as well as the Legal Services Commission reins in costs. How do we ensure that people get the advice they need, the guidance they need, the hand-holding they sometimes need, without paying £150 million a year? Answers on a postcard! I will give you the chance to make your suggestions in a moment.

The second question that we are regularly asked by the media and we are regularly asked by clinicians (so I have included the answer, just to pre-empt the questions tonight, because I thought there would be primarily medically based as opposed to legally based people here) is how can a claim ever be worth seven figures? The media ask us that almost every week. We get Freedom of Information questions about it. Those of you who saw that stuff in the Metro, which was not quite accurate, will recollect that they reported the fact that the numbers in there were derived from an answer to a parliamentary question that we provided, and that was true, but they still said “Well, is it true?” Did they think we had made it up to answer Parliament and make ourselves look bad by having paid out £12 million in a particular case? That’s journalists for you.

In very simple terms the answer is we get to seven figures – and the first digit is rarely a 1 nowadays, I should tell you – because we are paying for the cost of future care. We are not paying for skilled nursing, we are certainly not paying for medical care, we are paying by and large for physical labour, manual labour with a little bit of training. We are paying for the kind of people who lift people in and out of bed and put them in their wheelchair; they put them in the bath, they evacuate their bowels, they do the kind of things that the overwhelming majority of people with those needs have met by parents and loved ones, with a little help from the state, with a lot of help in some cases, but that is what we are paying for; we are paying for labour, and if I give you a quick breakdown I can illustrate the point.

I had a schedule on my desk when I put these notes together. It is a relatively short life expectancy, this case, very short, to age 40, and the child is about 5 or 6 at the moment. General damages, paid for pain, suffering & loss of amenity for this child who was damaged at birth and to whom we have admitted negligence are about £190,000. Now, obviously that child isn’t going to be going out spending that money and celebrating, but we will pay general damages of £190,000. Past costs of care up to the date when we were trying to settle were £40,000. We were being asked to pay half a million pounds under a legal formula that is used for improved housing. The family were moving to a bigger house, so they had a bigger ground floor, they had a wide drive so they could get a car in with a wheelchair; very common, very standard in these kind of cases. The formula case, if you doubt my word, is Roberts v Johnson, because I do remember some of these cases. Until the child was aged 11 it was estimated that this child was going to need about £57,000 worth of care per annum. That was for 24 hours of care during term time, 14 odd
hours during school holidays, and the multiplier was going to be 5.8. For years 11 to 19, the key education years, if you like, it went to £73,000 per annum, and the multiplier was just over 6. Age 19 to 40 the figure had risen to £115,000. The assumption was that this child would have achieved a degree of independence, would possibly be living in a flat somewhere else but would need a great deal of care and attention. These children, like most other children, get bigger, they get heavier and you start to need two people to lift them, turn them, carry them. You need people working overnight; you have to pay for these people to be trained. These people are entitled to holidays; they cannot work in excess of the Working Time Directive hours. If you do the maths that totals about £4 million, and that is not a high value claim in the current climate. I mention it only because we are frequently asked. I have been asked by Government Ministers, I have been asked by the Department for Constitutional Affairs how you get to seven figures. It is as easy as that. And I could have chosen a big case to try and impress you. That is not a big case by current standards.

I mentioned periodical payments. In that case, instead of paying £4 million today to settle the claim, we might pay £1.5 million and pay the rest in instalments for the rest of the child’s life – a big advantage to the NHS, of course, because it helps cash flow, the money is not going out today; no windfall to the estate if the child dies at a younger age than the predicted age 40; but no chance of the money running out, because the money will be paid for the rest of the child’s life however long he or she lives, and it is that certainty of payment, certainty of a flow of income, which has been attractive to many claimants.

Now, in the past, when it was up to the two parties to agree these settlements, we would only settle on the basis of those annual payments being indexed by reference to the Retail Price Index. When the law was being changed, in their wisdom Parliament said RPI would effectively be the default position but that a judge might listen to evidence about other indices and, if appropriate, use another index.

Over a period of time a number of cases have been prepared for trial but abandoned on the way in, but in two recent cases – Flora is one of them – the Court of Appeal expressly said RPI is not a default position which requires exceptional circumstances to be varied. RPI ceases to be appropriate if and when a judge has listened to the evidence and decided that another index is appropriate. No doubt whatsoever, the Average Earnings Index (AEI) has risen much faster than RPI, and that is what claimants argue for.

In the case that we took to trial and which will go to appeal later this year, a case called Thompstone, the judge elected for an alternative index, ASHE 6115, which was thought to be more appropriate. The problem with that one is that it doesn’t run like the average earnings index where you have two straight, more or less parallel lines one above the other. Its relationship to RPI has varied over time. So it may be the most appropriate, it may not, but if you are remotely interested in this area of work, you will hear a great deal about indexation over coming months, you will read a great deal about it in the Press and, come the autumn, you will read what the Court of Appeal has to say about it.

I have to say that, from our point of view and that of the insurance industry, who are also closely affected by this, of course, some certainty would be appreciated. We would obviously, rather have the lower index, because we are protecting money. The problem we have at the moment is that it is difficult to reserve and predict what a case will cost, because we don’t know which index is going to be appropriate, and it actually costs tens of thousands of pounds to test these indexation arguments on either side in every one of these cases and, with all due respect to counsel on either side of the room, that is a waste of money; it really is. We need some certainty.

Even more so, the other big issue of the day as far as we are concerned is the debate about public or private provision of care. It is costing claimants and defendants – and claimants in our world on these big claims are always, always publicly funded, so you are paying for all of this, because you pay for my people as well – tens of thousands of pounds per case to determine who
should bear the care costs – and it is not just care, it is education as well – where there is a statutory provision that someone else should pay, for example a local authority, an education authority, a PCT. They may even have a regime in place that is paying for this care that is needed, but, coincidentally almost, in a minority of cases there is also a tortfeasor, someone who can be sued.

Now, there is a very attractive principle that the tortfeasor, the person who did wrong, should pay for everything. But why should the tortfeasor pay if there is already a statutory obligation on a tax funded body to pay? We could debate that one all night. It is a genuine ethical dilemma. It is a genuine dilemma in the sense of two answers either of which can be defended, and I have to tell you that both have been defended in the courts and the courts have come down finding either way as well, but it is a dilemma that has to be resolved, because the waste of public money in resolving these issues is astronomical. The complexity and the ambiguity in the drafting of the legislation and the regulations flowing from the legislation is enormous. People who do this for a living and read this stuff for a living say “I don’t know what it means”, and I am talking about eminent Court of Appeal judges (see what Dyson LJ said recently); I am talking about eminent High Court judges, like Mumby J; I am talking about the Master of the Rolls’ Working Party on Structured Settlements. This area of the law needs to be resolved and, insofar as any of you have any influence in terms of law reform, I for one would be very grateful if you could get those who can address these issues to address them. I am a member of the Clinical Disputes Forum and we are working on this. I am also on one of the committees of the Civil Justice Council; a paper is being prepared there for taking forward on this subject; but it is a minefield, and it is an unfair minefield. We find it very frustrating, because I have dozens of these cases on the go at the moment. I have said earlier that we have obligations to patients, because we maintain that relationship by virtue of our being part of the National Service. Imagine what it is like for a patient who can’t have these issues, indexation, public or private provision, resolved. Can you imagine being the severely disabled patient who has their lawyers saying “Well, actually we don’t know the answer; we will probably have to get this in front of a judge, unless they come up with a good offer”? I am very conscious that I am managing a big account and we will probably have swings and roundabouts. For individual patients it is just incredible that we can allow such a situation to persist.

I said I would only talk for a relatively short while. I can see eyes are glazing over already and I am sure many of you want to get away to watch Newcastle United on television this evening as well, so I will stop very shortly.

The Litigation Authority isn’t an insurer. We operate in many respects like an insurer, but we are not; we have no shareholders. We are expressly charged, as I have said, with providing appropriate remedies where a liability is established. That is not true of any liability insurer, of course.

So I want to come back to this evening’s title, your President’s title. We don’t actually see ourselves as being in competition with claimants, because all our claimants are patients and we see ourselves as having, strange as it may seem, a similar relationship to them that the doctors, the nurses, the midwives and everyone else involved in the NHS has with them. We have obligations towards them. We don’t have an obligation to pay them all, of course, and we certainly don’t have an obligation to pay them whatever they ask, but we really do feel that we are not in competition or at war with them. We don’t actually even see ourselves in competition or at war with most of (I emphasise “most of”) their lawyers. If we are winning – and we have made some inroads, against the odds, over the last six or seven years since I last spoke to you – I think we are making progress in rationalising some of the systems. We have certainly (and forgive me using this word; it is good shorthand) embedded the concept of risk management in the National Health Service at an administrative level. We would like to see it driven down and down and getting closer to the sharp end. We are trying to rationalise systems vis-à-vis claims management. So
perhaps the winning or losing metaphor should be using the image not so much of a footballer or a cricketer winning or losing in the context of a team but maybe a long distance runner, who will always only ever measure his or her performance against their own personal previous best. In those terms, we are maybe on target; maybe we are at about the 20 mile mark in a marathon, but, as any marathon runner will tell you, at the 20 mile mark you are halfway round; the really painful bit is the last 6 miles.

So at that point I will shut up. I will be happy to take any questions or hear any comments, or if you have any suggestions as to how we resolve the difficult questions I have posed, even better.

(Applause.)

Discussion

The President: It is not surprising perhaps that a Newcastle United supporter thinks that winning is an ambiguous and complex term. (Laughter.) If anyone has got any questions could you identify yourselves for the shorthand writer, please?

Dr Josse: Eddie Josse, medical practitioner. I just wanted to ask you something about risk management and assessment. I gather that if I was in the railway industry I could put a lot more money into one braking system as compared to another braking system, and we know that this has been discussed. It costs a lot more and it would save more lives. The question then becomes is it worth the money for saving one extra life or preventing damage? As I understand it, Health Authorities work on the same lines, that they say “Is it worth putting £5m extra per year to save one situation?” and they say “No, we don’t have the money, and therefore we will risk assess and manage along those lines”. Now, if the authorities did spend more money, the cost would then fall less on your authority. So there is a tension there because, as far as you are concerned, you would wish the Health Authorities to spend more to reduce the risk and therefore save the damage to human beings. How do you get over that tension and how do you manage it within the Health Service, if that is a fairly simple way of explaining a dilemma?

Mr Walker: Good question. One of the ways we deal with it is by massively discounting the contributions that we call in from Trusts for their adherence to our risk management standards, which are independently assessed, unlike the Healthcare Commission standards, and by reference to their claims experience, both in terms of the numbers of claims and the value of claims. So we actually give cash discounts to those Trusts which we think are making informed efforts to manage risk. But you have raised a great example, the railway braking systems. You know, of course, that the railway companies elected not to go for the very expensive and allegedly fail-safe system, but at least they had the honest, open debate – I don’t think they could avoid it following the major accidents, especially Paddington and Hatfield, but they had the public debate, they talked about money, which is very unusual in this context, in public, they talked about accepting a certain amount of risk as opposed to spending so much money, and the very interesting dilemma will come (and heaven forbid that it should come, but when it does it will be very interesting) when a railway company which has publicly elected to go down the cheaper route having measured the risk has an accident that could have been prevented and has to account for its decision-making process.

Many years ago, I remember, when I was a law student – it is so long ago I couldn’t possibly put a date on it, but I would say in the 1970s probably – the Ford Motor Company introduced a car called something like the “Pinto”. They were alerted by their risk management processes to the fact that its petrol tank was in an exposed position. It is what the Americans call a “Compact”. They can’t give them away in America even now; they were even harder to sell then; but they delivered this small, compact car and they discovered that the petrol tank was in an exposed position at the rear end vulnerable to a rear-end shunt. They did some analysis work. They made (for them) the mistake of saving all of their analysis work, so it was available when the inevitable happened. I am pretty big on disclosure and it was a good thing that it was disclosed. They were
fined by the health and safety administration, whatever it was in the States in those days, many, many millions of dollars, even all that time ago, and the American courts awarded punitive damages amounting to many, many millions of dollars to the victim of the first accident that occurred, precisely because they had done that cost/benefit analysis and they had opted for cheap as opposed to safe.

So what I would say is that we are trying to address it by discounting against evidence that risk management is taking place, but I think that we should welcome a debate that introduces the cash element into all aspects of health care, I really do. You know, we have avoided talking about rationing; we avoid talking about all the things that we know are happening because of financial pressures. I think it is much healthier to have the debate, to get it out into the open, and then neither politicians nor managers can hide or be mealy-mouthed, they have to say “Look, you can have this, but if you have this you can’t have that”. It is not that hard. We do it ourselves, every day; we all do it in our lives, you know. I just think it is much healthier to get the money on the table and talk about it and not fudge your decisions and pretend you are making them for other reasons. But, yes, we would love to see lots of money spent on better management of risk, better assessment of risk, risk prevention, but I emphasise, as I said earlier, not on defensive practice; you know, one man’s risk management is another’s defensive practice; using a check-list, if you like, is risk management. Using the check-list and saying “This is too risky, I am not going to do it”, that is defensive. We are not advocating that at all.

Mr Sear: Richard Sear, a surgeon. You talk about risk management, and one can see why you would say that. In fact, the practise of surgery is about accepting risk. We often do not have a choice as to whether we operate or not. So the easy way to avoid it, of course, is for me to say to a patient, “Well, I am not going operate on you, it is just too risky.”

Mr Walker: Sure.

Mr Sear: We all know that.

Mr Walker: Well, we know it happens in other jurisdictions, as you know.

Mr Sear: But it may be that there is nothing you and your organisation can do. Maybe the answer lies in training your surgeons better, giving them better facilities, not expecting them to operate in the middle of the night when they are tired, closing all operating theatres; in other words, it may be that you have to increase the budget somewhere else, not in your organisation. I went to a very interesting seminar last year on risk management, at which we were invited to look at the oil industry, the aviation industry and I think it was the mining industry. I am told the aviation industry is superb at risk management. The trouble with patients is that, you know, you can make a choice as to whether you get on a plane and go to Athens or to America, but if you have an illness that requires surgery or other management you are stuck with it. So we are not operating in the same environment.

Mr Walker: I couldn’t agree with you more. I have had that debate with the Department of Health at every level over the last eleven years. The Department of Health loves the idea of the aviation industry as an event reporting industry; the oil industry, particularly the offshore oil industry, ditto; you know, you are dismissed if you don’t report an adverse incident, no matter how trivial, whatever. The point you make is perfectly valid, that when you have a patient who needs a procedure you can’t say “No, I am not going to”. I wouldn’t want you to do that and you wouldn’t want to do it. What I am urging there is honesty with the patient, because we do – and you will have to trust me on this – but we do see a lot of examples where there has been less than total frankness with patients about what the risks are. You have seen some of the cases which are reported in the media and in the legal press. I don’t disagree with a single word you have said, but I would urge frankness. I am sure you are frank with your patients, but not everyone is. The big difference that the aeronautics, aviation, petrochemical industries share as compared to health though, of course, is that everyone who is involved in the process is equally at risk if they don’t report. If you’re flying regularly in an aeroplane as a crew member, even if you are the most
junior stewardess or you are the most senior pilot in the fleet, it is in your interest, every bit as much as it is of any passenger on the aeroplane, to be alert to any risks and to report any shortcomings in the aeroplane, any problems you are experiencing, any dangers that you see at any particular airport, because if that aeroplane goes down you will go with it. If that oil platform goes up, you will go up with it. In our environment – forgive me assuming our environment – but in the clinical environment that is not quite the case, and therefore once the pressure is on sometimes I think there is a tendency to forget the risks because you know them. You have made a couple of statements about risk tonight. Everyone in the room, including me, was nodding when you were speaking. We all know that, but a junior doctor who is, as you say, working long shifts, working overnight when he is tired or she is tired increasingly these days, they don’t remember. I agree with you entirely, I think risk should be taught as part of the curriculum. I think people should be reminded. I know that the curricula now include things like communication skills. I think risk management, in a very sensible, constructive fashion, ought to be a compulsory part of all medical curricula now as well, and I think it ought it to be repeated, too, quite probably, not just at age 20 or 21.

Dr Gill: Good evening. David Gill, a psychiatrist. In my NHS practice we are increasingly keen on risk management, and in many cases it entails a sort of box-ticking exercise, and what risk management actually means is filling up the form that says you have done the risk management. What is the actual evidence that goes to prove that the risk management process actually does reduce the risk of an organisation, or to what extent is it just sort of like looking in the mirror when you are doing your driving test?

Mr Walker: Well, I would suggest that using tick boxes, which of course pilots do every time they start the engines on an aeroplane, and looking in the mirror, not just on your driving test but when you are on the road, are both very important risk management practices and self-evidently, I would say of both of those examples, do minimise the risk of an adverse event occurring. Interestingly though – and I wasn’t going to mention this because it sounds a bit conceited, but you have given me this great opening – he is not a plant, ladies and gentlemen, I don’t know this gentleman – there is academic research developing, including from people like Paul Fenn at Nottingham University, which seems to suggest that those Trusts which have high risk management standards which are at levels 2 and 3 of the assessment standards that we assess against are in fact experiencing a better claims experience. There is no necessary correlation between the two, because lots of things happen that wouldn’t give rise to a claim, or vice-versa, but, for example, they have just completed a piece of work which I know is embargoed, so I can’t tell you the details, but it will be presented this year to the Royal Statistical Society.

I will tell you a joke at my own expense. I got this report pre publication and I went to the conclusions where it says “Yes, you seem to be doing it right, Litigation Authority”. I thought “Great. Tick; I am going to say ‘All right to publication’”. Then I read the whole thing. There is a section in the middle which is all about the statistical methods they used to prove their case and – this is absolutely true – I thought it was a spoof. I cannot reproduce the language. I nearly brought it tonight in case I needed a light moment. I wish I had now. I sent it to our actuaries and asked them to proof read it for me and send me a glossary and they said, “We don’t know what some of these terms mean.”

Well, that is at my expense. I am ignorant, so forgive me. But the conclusion is that where we are finding on independent assessment high adherence to the standards that we proposed – and the tick boxes are just to prove to us that they have done it, because anyone could say they are doing it – there does seem to be a correlation between that and improved outcomes in many spheres. It is not massive; you know, we haven’t stopped things occurring, but we have maybe stopped some occurring that otherwise might have done. It is very hard to prove the negative, as you know; it is one of the few things I do know about statistics.
Mr Samuels: Alec Samuels, lawyer. If you are doing well, or doing better, or winning, one asks one’s self what are the possible reasons. Is it perhaps that doctors are more careful than they used to be? Is it that there is increasing pressure from judges and everybody else that things should, as you indicated, be settled or go to mediation? Is it that the Legal Services Commission are more difficult to persuade to fund? Is it that you can’t find good experts so easily as perhaps you used to? Is it because, with respect, sir, if you are representing the defendant, well, that is likely to be a pretty tough proposition for a claimant? I mean, do any of these reasons, as it were, ring a bell with you?

Mr Walker: Well, I love the last one. (Laughter.)

Mr Samuels: And finally, for the future, do you see the Compensation Act as likely to reduce liability and have any effect on your work, and do you see the Corporate Manslaughter Act, if we get it this year, having any, as it were, civil spin-off which might make hospital authorities more liable, of course, than they have previously been?

Mr Walker: Okay. There is a lot in that. I think one of the factors you have mentioned that contributed to claim numbers staying at pretty much the same level is that there is no doubt that for many people who can’t get access to legal aid it is difficult to bring a claim. There was, as far as I am concerned, a conjuring trick pulled when the former Lord Chancellor allowed himself to be led into believing that conditional fee arrangements would replace legal aid. Conditional fee arrangements are available, but they are not cheap and I hear examples of people paying tens of thousands of pounds. The worst I have seen, and I am sure there are worse, was a £90,000 insurance premium to protect them against us coming after them for our costs if we were successful. I think in that case £90,000 would have been a good buy because we went after them for £110,000 after we had won the case. There is in this room a representative of the firm of solicitors in question, our solicitors, the ones who won, that is. But funding is a problem for a lot of people, there is no question about that. Query: is it right that society asks people to play high stakes gambling effectively in order to secure their rights? My dilemma is I am just so reasonable I can see both sides of all the arguments. The other side of the coin is: is it right that people should have a punt on the lottery, which is how some people see damages and compensation, without buying the ticket, as it were? So I can see both sides of that argument. But it would be dishonest of me to say the Legal Services Commission hasn’t had an impact.

I don’t think the judiciary has had very much to do with it. We are assessing claims earlier and we are not seeing the try-on claims that we used to see ten years ago; I think we have persuaded people that they won’t get away with that, whereas historically maybe they did once in a while against Trusts and Health Authorities; so I will take a little bit of credit for that. I just don’t think there is a compensation culture. I also think, interestingly, the National Health Service – this is going to sound really twee, but I honestly believe it – I think a lot of people think “I am not going to sue the National Health Service. They looked after my granny, they delivered my kids, I am still walking. Hey, I am not going to sue them.” I honestly believe a lot of people walk away from the potential claim against the National Health Service. How else can you account for tens of thousands, if not hundreds of thousands, of adverse incidents and 5,000 claims a year? I really believe that.

The Compensation Act – I have already got into trouble in certain quarters for saying this, so I might as well repeat it – I don’t think it will make any difference whatsoever. You are talking about the clause about doing good work. Well, the NHS, clinical work generally; you know, what is a better job to be doing than that? But the truth is, unlike volunteering to run a scout troop or taking kids away on a school holiday, there is no evidence that people are walking away from doing it. I don’t think it will make any difference at all.

Corporate manslaughter: well, we have been talking about that for a long time; most of my working life actually. I don’t think it will make a lot of difference. I think it will leave some people vulnerable to prosecution who aren’t at present. I don’t really know if that is a good thing,
because I don’t think anyone makes a decision about the management of their organisation thinking, “Well, what about that Corporate Manslaughter Act, will I be…?” You know, I just don’t think people think like that. I don’t think Board members think like that, I don’t think managers think like that. It could have a negative impact, in that the gentleman I spoke to a couple of minutes ago was talking about the fact that surgery is implicitly a risky business; a lot of our activities are; and we have politicians on the one hand saying “We don’t want to deter risk takers and entrepreneurs” and on the other hand “We want to sue the bastards if they get it wrong”. I think there is a potential for a negative impact if it causes people to curtail activities because they’re looking over their shoulder in fear of a prosecution. Whether it will or not, I don’t know, I think the jury is out. But one thing you can be sure about with legislation is that it will have unanticipated consequences. There is no Act of Parliament across which I have ever come in my working life which has not had consequences that weren’t even debated at the time that the Bill was in Parliament, so watch this space on that one. I am in two minds about it. I have seen lots of examples where, with the media whipping it up, it has been easy to say “Yeah, they should be prosecuted” and have been. But in the cold light of day in some of those cases you think “Well, hang on a minute, they didn’t do that”. I am not happy about some of the manslaughter prosecutions that have been attempted against junior doctors in recent years. I personally think that is a step too far, and it is no surprise that they are usually thrown out if they are pursued all the way. In the only successful one I think the guy pleaded guilty. I am not a “big stick” man. I am just a reasonable man. That is my big weakness, as I keep telling you.

Ms Leigh: Linda Leigh; I am a solicitor. I have a couple of observations I would like to make for your comment. The first is I think you are very lucky that you are not in the legal profession as such, because we are told that there is an under supply of legal complaints and that we have got to go out and advertise and find more. So, you know, you should be grateful.

Mr Walker: Are you inviting me to complain?

Ms Leigh: No, no. Well, you can feel free.

Mr Walker: Can I just make the comment that that is one of the big downs of risk managers; they thrive on high volumes of complaints and they feel that they have been successful in imparting a culture of reporting if they get a lot of complaints. So, all the lawyers, watch your back, yes. Sorry. Go on.

Ms Leigh: My next observation is that in my time in practice – and I have continued to see this looking at other people’s cases – I feel that there has been a great advance in terms of making earlier admission and taking fewer cases to trial than was the case ten years ago, but I still think there is a great deal of work to be done and there is still a lot of delay in making admissions. There is another problem which I am still seeing – I had a couple of cases last week at the Trust level – where there are blocks and delays put in place by the legal department which are completely unnecessary, and although that is only a small value in terms of overall claims, if you magnify that through the whole country, then that is a sizeable chunk of money that has been wasted.

Mr Walker: Sure.

Ms Leigh: And I hope that you will continue to press for that.

Mr Walker: I think they are both fair comments actually; I am not disagreeing with you.

Ms Leigh: I think in terms of the cost of care and who pays, I know that you are a compassionate man and I am sure that you can see it from –

Mr Walker: Don’t believe everything you hear at these sessions.

Ms Leigh: Well, you faked it well though. But, you know, when you look at cases I have had where, if you look at the level of care that is provided before the claim is settled and the burden that places and the stress on that family and the difference of compensation rates for individual children, no-one could say that that is a waste of money.
Mr Walker: You have never heard me use the words “waste of money” in that respect. For legal costs I say that. Money going to patients I’d never say is a waste of money.

Ms Leigh: No, but the vagaries of government policy and any promises they may make about care today cannot be relied upon by a claimant tomorrow and I cannot see any moral justification for any more campaigning for the concept that the claimant should rely on care provided by the local authority.

Mr Walker: Well, we have seen cases of both being provided, where we have paid compensation and, because the benefits that they were entitled to weren’t means tested, the family continued getting the benefits. So that is one of the reasons why I can’t give public money away until that point at least has been tested on individual cases, but I agree absolutely with what you have said. I meet quite a lot of parents of children with cerebral palsy, typically, and you don’t have to persuade me that these are not life’s winners. If I give them seven million quid, they haven’t won the pools, I know that. That is not an issue for me. The point I was trying to make was that your solicitors and barristers shouldn’t be having to argue with my solicitors and barristers about this. We should have certainty, we should have finality. Personally, you know, if I got the sack tomorrow and I could stand for office somewhere, I would be campaigning to make sure that everyone who needs that level of care was getting it regardless of having someone that they could blame for the condition they are in. That would be the ideal situation, but I have to tell you – well, I don’t have to tell you because you know – there is no political will to do that and I can’t see that is going to come, not in my lifetime.

Ms Leigh: Could we not try and force this in a lobby? (Laughter.)

Mr Walker: I think you have more influence than me on that front.

Mr De Navarro: Michael De Navarro, Counsel. Steve, in relation to the last point, the point which I know I have had in a number of cases and I know is useful to the local authority, are they going to pay or not pay, is to take out what is called a reverse indemnity, either active or passive litigation in effect. It prevents double recovery and it prevents the state paying twice, until it is sorted out. I did one up in Birmingham last week and fought it on that basis. It seems to be a sensible solution which avoids a good deal of cost.

Mr Walker: Well, it still needs to be argued and debated. The idea of a reverse indemnity is that the claimant agrees that should they continue to access or begin to access public funds from another route they will either pay us back what we have paid or reduce what we are paying or they will stop claiming from the other body. It just stops a double recovery. I still maintain that the whole situation should be rationalised. That would just be fairer to everyone and it would make a lot of sense financially.

Mr De Navarro: It is a short-term solution.

Mr Walker: Absolutely. I couldn’t agree more.

The President: I honestly think that I had better call a halt. It is about as probable as Newcastle United winning tonight that AvMA are going to vote for reverse indemnities. If we all go outside we can find a drink in the atrium. Thank you very much indeed for a fascinating lecture. (Applause.)