Medical Protection Society and Dental Protection Limited joint submission to the consultation – Proposed NHS Redress (Wales) Measure Committee

Introduction

We are pleased to have the opportunity to respond to the Measure Committee's consultation on the proposed NHS Redress (Wales) Measure. The Measure has the potential to bring significant changes to the way in which patients receive redress following an adverse incident.

We are supportive of the ethos of the redress scheme with its emphasis on open disclosure, learning lessons and streamlining access to a comprehensive package of redress. However, we do have a number of concerns about the proposed scheme including:

- The introduction of the scheme in primary care has significant financial implications and practical challenges because of the complexity of existing arrangements
- There is the potential for healthcare professionals to be treated unfairly
- Integration of the NHS redress system and complaints system may cause confusion among patients and in our experience is likely to encourage an unrealistic expectation of compensation for complaints.

About the Medical Protection Society (MPS)

The Medical Protection Society is the world's leading indemnifier of health professionals. As a not-for-profit mutual organisation, MPS offers expert support and advice to doctors

and other healthcare professionals with legal and ethical problems that arise from their professional practice.

Dental Protection

Dental Protection Limited (DPL) is part of the Medical Protection Society (MPS). DPL provides expert advice and legal representation to dentists and other dental care professionals.

MPS, including DPL, has a worldwide membership of more than 245,000 healthcare professionals. In Wales we have over 6,000 doctors, dentists and other healthcare professionals in membership comprising 50% of all doctors and over 70% of all dentists.

Clinical negligence claims in primary and secondary care

The way in which clinical negligence claims are dealt with in primary and secondary care is fundamentally different; there are two separate sets of arrangements.

Secondary care

The Welsh Risk Pool provides an indemnity for the cost of clinical negligence claims brought against NHS Trusts and Health Authorities in Wales. All clinical negligence claims against NHS Trusts and Health Authorities are managed by the Welsh Health Legal Services, which is an in-house team of lawyers employed by the NHS in Wales.

Primary care

In contrast, MPS and other Medical Defence Organisations ("MDOs"), in return for a subscription fee, provide an indemnity against the cost of clinical negligence claims brought against independent contractors such as GPs, dentists, DCPs, pharmacists or optometrists. MDO's also manage all clinical negligence claims against independent contractors through a team of in-house or panel solicitors and medicolegal advisers.

The overwhelming majority of doctors and dentists, regardless of whether they work in primary or secondary care, are members of MPS and other MDOs which also provide legal and ethical expert advice and legal representation for other proceedings such as medical and dental council hearings, disciplinary hearings, inquests and criminal proceedings.

Responses to the Measure Committee's questions

1. **Why is a Redress Scheme required?**

We are broadly supportive of the underlying principles of the NHS Redress Measure with its aim of increasing the efficiency, effectiveness and accessibility of redress available to patients who have been injured as a result of substandard hospital treatment in the NHS.

Shifting the balance away from settling clinical negligence claims purely with financial compensation toward a more comprehensive package of redress for patients including an apology, explanation and remedial treatment is a positive development. We hope that such initiatives will help foster a greater culture of openness within the NHS in which lessons can be learned constructively and risks reduced. We have long advised doctors and dentists who have made a mistake to provide a full explanation, apologise to the patient and consider what they might do to prevent similar errors occurring in the future. It is one of the constant messages in the majority of the risk management materials produced by both MPS and Dental Protection

However, we do have reservations about the need to establish a separate NHS redress system and wonder whether the primary objectives could be delivered by enhancing an existing framework such as the NHS complaints system. This would allow the primary focus to remain on complaints resolution rather than redress and compensation.

Enhancing the current complaints system with an emphasis on thorough investigations, explanations, apologies and learning lessons would achieve many of the objectives of the NHS redress system. We believe that the way clinical negligence claims are dealt with, particularly in primary care, works well at present. The Measure creates no additional legal rights for claimants and we have seen no convincing evidence that patients, deserving of compensation, are going uncompensated.

2. **Does the proposed Measure achieve the policy objective?**

It is not possible to give a definitive answer because the proposed measure is too broadly worded and much of the operational detail will be contained in statutory instruments.

3. What are the views of stakeholders who will have to work with a redress system?

Primary care

We are strongly opposed to the introduction of a redress scheme in primary care. We believe that the current arrangements for claims handling in primary care work well. Our philosophy is to compensate patients who have been harmed as a result of negligent medical or dental treatment fairly and swiftly. It is our policy to settle claims under the clinical negligence protocol in an effective way. Indeed, we have taken steps to streamline the process for lower value clinical negligence claims to ensure that claims are dealt with in the most efficient and equitable way for all parties.

Financial implications

There are major financial implications in extending the NHS redress scheme to primary care. If introduced into primary care the scheme would need to take on the costs of compensating patients which are currently met by MPS and the other MDOs.

We believe that the creation of an NHS redress system will lead to a greater demand for financial compensation and an increase in the number of claims, not least because the new scheme will place an obligation on members to identify eligible cases and initiate action under the scheme. An increase is likely to heavily outweigh any savings in legal costs. We have prepared a projection of the compensation payments that the NHS would have to make in both primary and secondary care based on the percentage of NHS complaints which convert to claims (see the grid in annex A). The impact of 4% of NHS complaints converting into claims settling for £20,000 would be £5.3m based on 2005/06 NHS complaints statistics (6,666 NHS complaints in Wales at 31 March 2006). The impact of 25% of NHS complaints converting into claims settling for £20,000 would be £33.3m.

Currently, GPs' subscription fees to MPS and other MDOs are reimbursed by the Department of Health. Subscription fees paid by dentists are not refunded and again this is an additional cost which must be factored in to discussions about the introduction of the redress scheme in primary care.

General dentistry

Where general dental practice is concerned there are particular problems because of the mixed economy with much treatment straddling both NHS and private contract. The National Health Service Regulations allow for open mixing of private and NHS treatment subject to certain conditions. It is not uncommon for a patient to have both NHS and private components in the same course of treatment. This would pose particular problems for any redress scheme which was exclusively for NHS care. In any event NHS treatment comes with certain statutory guarantees for replacement and there is protection for the patient when treatments fail within a 12 month period.

An additional complication that occurs in dentistry is where a patient seeks remedial treatment following a complaint or claim. Remedial treatment is often provided on a private basis by another practitioner because of lack of availability of NHS provision and the fact that the majority of specialists do not work in the NHS. We believe for this reason that the interface between publicly funded and privately funded dental care is complex and would present real difficulties for any redress scheme. These problems have been starkly highlighted in reviews of the NHS complaints scheme in recent years.

Taking into account the challenges posed by the inclusion of primary care in a redress scheme we believe that it makes sense to trial the scheme in secondary care where the Welsh Health Legal Services has amassed expertise in dealing with these claims. A decision can be taken later on whether to expand the scheme to primary care. Once such a scheme is introduced in primary care it may be difficult to revert to the original arrangements in the unfortunate event that the scheme proved to be unsuccessful.

Impact on professional regulation

The development of an NHS redress scheme cannot be considered in a vacuum. The introduction of a new scheme may have significant professional regulatory implications for both doctors and dentists.

A critical determinant of the redress scheme's success will be its ability to balance swift resolution with thorough investigation. When an adverse incident occurs it is essential that there is a careful examination of the facts. An investigation that fails to consider all

aspects of the care provided could lead to doctors and other healthcare professionals being unfairly criticised. This could leave doctors and other healthcare professionals open to further unwarranted investigations and disciplinary hearings and would ultimately undermine the morale of healthcare professionals.

Integration with the NHS complaints system

We understand that the Welsh Assembly may consider integrating the complaints system with a redress scheme. While we accept that it is sensible to consider the relationship between the complaints system and a redress scheme, we believe that a blurring of the edges between the complaints procedure and compensation system would be unwise and unwelcome. Compensation should not be awarded as a matter of expediency where there is no established negligence irrespective of the desire to reduce legal costs on small claims. We are concerned that the suggestion for an integrated complaints and redress system will cause confusion and may encourage people to believe that the 'automatic next step' after lodging a complaint is to seek compensation. There are many situations where a complaint could be upheld but a patient would not be entitled to compensation because of the absence of negligence.

It is our view that the two systems should remain distinct and separate. The complaints system and the compensation system serve different purposes. Access to the systems should be sequential. Once a patient has used the complaints system to gather the facts of the case they should then be free to pursue redress or litigate through the courts where appropriate. Many people express concern by registering a complaint and they deserve an explanation and apology but do not necessarily seek any other remedy. The complaints procedure should only be a route into the redress scheme if harm has occurred that requires a remedy beyond an explanation or apology.

4. What will be the practicalities of making the system work and does the proposed Measure make provision for these?

In addition to the considerable difficulties posed by the introduction of a redress scheme in primary care as outlined above, a further practical challenge is the framework in which GPs and dentists work. GPs, dentists and other independent contractors as single units under a redress scheme will not, unlike hospitals, have access to the expertise or

administrative support to run an NHS redress scheme. It would be unrealistic for every GP or dentist to be expected to identify suitable cases for the redress scheme. We also question who will conduct investigations for potential redress claims in the primary care sector. We do not believe that there is an appropriate existing structure or body with the necessary expertise and resources to co-ordinate and carry out investigations in primary care.

5. **Is it appropriate that so much be done by regulations, i.e. the details of any scheme or schemes will be decided by Welsh Ministers?**

It is appropriate for the details of the scheme to be created by regulations. However, we are concerned that only the first set of regulations will be subject to the affirmative procedure and any subsequent exercise of powers will be subject to the negative procedure. There may be fundamental changes to the NHS redress scheme at a later date and, therefore, it is our view that all regulations under the Measure should be scrutinised and debated in Plenary.

In order for the scheme to be successful it is crucial that it commands the confidence of patients, the public and the professions. We are pleased to see a commitment in the Explanatory Memorandum to the proposed Measure that the regulations setting out the detail of the scheme will be subject to full consultation with stakeholders. We would like to see any subsequent amendments to the redress scheme developed in consultation with key stakeholders.

6. **Would it be better for the Assembly to seek the power from Westminster to introduce a 'no-fault scheme'?**

We can understand the appeal of the "no-fault" principle and accept that there are cogent social and moral justifications for the introduction of such a scheme. We have promoted the concept of a no-fault scheme for severely neurologically impaired babies since the early 1990s. The current system is grossly unfair; those who can establish that their brain impairment was caused by negligence receive multi-million pound settlements while the majority who cannot are left with no compensation at all. We would like to see funds set aside for the effective treatment of all brain impaired children who have been

harmed by poor obstetric or antenatal care regardless of whether blame can be proved. Our motivation for supporting such a scheme stems from the doctors we represent wishing to see fairness in the provision of treatment to brain impaired children.

While we strongly believe that a no-fault system should be created for the most catastrophic injuries we are not convinced that a no-fault system is appropriate for injuries below this level. The cause of less catastrophic injuries is more difficult to determine under criteria in a no-fault system and there is a real concern that lesser value claims might be paid out of expediency. The most significant flaw of a no-fault system is the considerable cost to public funds. The support of a strong social welfare system is an essential component of an effective no-fault scheme.

The existence of a no-fault scheme does not necessarily reduce regulatory proceedings against healthcare professionals. In New Zealand we have found that the no-fault scheme has undermined morale in the medical profession, increased the number of disciplinary proceedings and dented public confidence in the healthcare system. In addition no fault systems are open to the risk of abuse.

As an international organisation, MPS has experience of no-fault schemes used in other jurisdictions, particularly in New Zealand which has operated a no fault system since 1972. We would be pleased to provide the Measure Committee with further information on no-fault systems if that would be helpful to the committee's investigations.

Annex A

Grid projecting level of compensation payments in both primary and secondary care based on the percentage of complaints converting to claims

Total amount of compensation payable per year	£5.3M	£13.3M	£33.3M	£66.7M	£80.0M	£100M	**£20,000**
	£2.7M	£6.7M	£16.7M	£33.3M	£40.0M	£50.0M	**£10,000**
	£1.3M	£3.3M	£8.3M	£16.7M	£20.0M	£25.0M	**£5,000**
	£0.7M	£1.7M	£4.2M	£8.3M	£10.0M	£12.5M	**£2,500**
	£0.3M	£0.7M	£1.7M	£3.3M	£4.0M	£5.0M	**£1,000**
% of complaints* →	**4**	**10**	**25**	**50**	**60**	**75**	↑ **Amount of compensation per claim**

*** Percentage of complaints based on a total of 6,666 NHS complaints in both primary and secondary care in Wales in 2005/0**