Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor ar y Mesur Arfaethedig ynghylch Gwneud Iawn am Gamweddau'r GIG
The Proposed NHS Redress (Wales) Measure Committee

Cyfnod 1
Stage 1

Dydd Iau, 11 Hydref 2007
Thursday, 11 October 2007

Cynnwys
Contents

Cofnodir y trafodion hyn yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir cyfieithiad Saesneg o gyfraniadau yn y Gymraeg.

These proceedings are reported in the language in which they were spoken in the committee. In addition, an English translation of Welsh speeches is included.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Val Lloyd	Llafur Labour
Jonathan Morgan	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Committee Chair)
Jenny Randerson	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

Eraill yn bresennol
Others in attendance

Dr Stephanie Bown	Cyfarwyddwr Addysg a Chyfathrebu, Cymdeithas Gwarchod Meddygol Director of Education and Communications, Medical Protection Society
Dr Tony Calland	Cadeirydd, Cymdeithas Feddygol Prydain (Cymru) Chair, British Medical Association Wales
Dawn Davies	Pennaeth yr Uned Cynorthwyo Llywodraethu, Ymddiriedolaeth GIG Bro Morgannwg Head of Governance Support Unit, Bro Morgannwg NHS Trust
Dr Raj Rattan	Cynghorydd Deintyddol-gyfreithiol, Dental Protection Cyf., Cymdeithas Gwarchod Meddygol Dento-legal Adviser, Dental Protection Ltd, Medical Protection Society
Caroline Whitney	Arweinydd Proffesiynol ar gyfer Hawliadau, Ymddiriedolaeth GIG Bro Morgannwg Professional Lead for Claims, Bro Morgannwg NHS Trust

Swyddogion Gwasanaeth Seneddol y Cynulliad yn bresennol
Assembly Parliamentary Service officials in attendance

Keith Bush	Prif Gynghorydd Cyfreithiol a Chyfarwyddwr Gwasanaethau Cyfraith Chief Legal Adviser and Director of Legal Services
Carolyn Eason	Prif Swyddog Ymchwil Iechyd a Pholisi Cymdeithasol, Gwasanaeth Ymchwil yr Aelodau Senior Research Officer in Health and Social Policy, Members' Research Service
Joanest Jackson	Cynghorydd Cyfreithiol Legal Adviser
Lewis McNaughton	Dirprwy Glerc Deputy Clerk
Siân Wilkins	Clerc Clerk

Dechreuodd y cyfarfod am 2.16 p.m.
The meeting began at 2.16 p.m.

Cyflwyniad, Ymddiheuriadau, Dirprwyon a Datgan Buddiannau
Introduction, Apologies, Substitutions and Declarations of Interest

[1] **Jonathan Morgan:** Good afternoon. I welcome everyone to the second evidence-taking session on the Proposed NHS Redress (Wales) Measure. It is nice to see you all this afternoon. We are taking evidence from four organisations today. First, I remind people in the gallery and in the room to ensure that any electronic items, such as BlackBerrys, pagers, mobile phones and so on, are switched off. I remind members of the public that the committee operates bilingually and that headsets are available for translation or to be used as an induction loop, to hear the proceedings more clearly. I remind people around the table not to touch the microphones, as they will come on automatically.

[2] We have received two apologies for absences. The Minister for Health and Social Services is unable to be with us, and we have also received an apology from Helen Mary Jones. I am delighted that my colleagues, Val Lloyd and Jenny Randerson, are here to participate in what is a very important process.

2.17 p.m.

Y Mesur Arfaethedig ynghylch Gwneud Iawn am Gamweddau'r GIG (Cymru) 2007: Tystiolaeth
The Proposed NHS Redress (Wales) Measure 2007: Evidence

[3] **Jonathan Morgan:** We are delighted to have a number of organisations in this afternoon, namely Bro Morgannwg NHS Trust, the Medical Protection Society, which is here with Dental Protection Ltd, and the British Medical Association, which is coming in a little later. We have received a significant amount of written evidence on the proposed Measure, but it is also very useful for us as a committee to take oral evidence. We have gone through the written evidence, and thank you very much indeed for what you have provided. I ask you to state your names for the Record, and then we will get on with the questions.

[4] **Ms Davies:** Good afternoon. I am Dawn Davies.

[5] **Ms Whitney:** I am Caroline Whitney.

[6] **Jonathan Morgan:** Thank you, both. We wish you a very warm welcome. In your written evidence, you have referred to a number of the possible difficulties with regard to the current NHS complaints and compensation system. You refer specifically to the performance targets that are allied to it. Could you outline for the committee what the main issues are and how you think the system provided for in the Measure will help to resolve those difficulties?

[7] **Ms Davies:** I think that one of the problems at the moment is that we do not have a joined-up pathway; we have a system that is predicated on a number of individual processes, and that gives rise to silo structures and working. We need to have a joined-up pathway. When something has gone wrong, we need to be thinking about what is the right thing to do in response to that. We need a process that allows you to work through what that right thing to do is, from start to finish, without having to be mindful of, say, 'At this point, it hits this process with this requirement, and at that point, it hits that process with that requirement', and having to work through the fact that, sometimes, those requirements may rub up against each other.

2.20 p.m.

[8] On timescales, from our perspective, the issue is very much to do with the timescales

of the complaints procedure, which do not often give us enough time to conduct an investigation along the lines of our approach. Our approach is to understand what happened, how it happened, why it happened, and what its effect has been for the patient concerned. It is a significant challenge when we are working to a timescale of trying to achieve that within 20 days, because clinicians may be unavailable at certain points, may need to call in records from other organisations, and we may need to have an understanding of what happened to the patient, and where they are at this point in time.

[9] **Jonathan Morgan:** When looking at the legislation, do you believe that we should outline timeframes, because some of the evidence has suggested that open-ended, or very broad, timescales are inconsiderate towards patients? We had evidence from the community health councils, which suggested that, in many cases, claims take many months, or longer, to settle. Should a timescale be enshrined in the legislation?

[10] **Ms Davies:** The main thing to remember is that, to reach a settlement, there are many steps to go through in the claims process. Our own experience is that—and I am sure that Caroline will add to this, being our lead for claims—it is usually relatively quick to establish whether there have been some failures. It tends to take rather longer to establish the effect of those failures, and the impact on a patient. However, once you have got to that point of saying, 'Yes, both of those exist, and there is an action in negligence', you have to look at the prognosis for the patient, and you have to call in a significant amount of information to be able to come to a reasoned decision on appropriate quantum. In some instances, you need to have some time available to understand, for the future, what the impact will be on a patient—often in situations where you are dealing with children.

[11] **Jonathan Morgan:** Do you believe therefore that there should perhaps be two stages? The first stage could perhaps have a time constraint, so that, within the first stage, the assessment is made as to whether there is a question to answer, and then, beyond that, there is a little more flexibility? I appreciate the need for some kind of timeframe, so that people could have an initial response as to whether there is a case to answer. Do you think that that is the best way forward?

[12] **Ms Davies:** We would support that. The most important factor in all this is to have a frequent and open dialogue with the patients, or their relatives, so that they have an understanding of where you are, and why certain things may be taking longer than expected. As long as that exists, there is not normally a problem.

[13] **Ms Whitney:** At the same time as coming up with an explanation as to what has happened, there should not be any reason why remedial actions, or steps to improve patient safety, cannot be taken at the early stage, as opposed to a later stage.

[14] **Jonathan Morgan:** In your evidence, you mention the fact that you have made significant changes to structures and processes and ways to bring about an integrated approach to dealing with risk incidents, complaints and claims. What were the main changes that you brought about, what were the initial deficiencies that were identified, and how did you go about making those changes?

[15] **Ms Davies:** At the outset, you have to look at culture and behaviour. We have been on a journey for several years, so there is work to be done there. However, there is also work to be done in saying that it is not appropriate to have teams reporting to different individuals, or in different locations; you must all come together. You want individuals, because a patient or their representative wants continuity in this process as well, and I believe that staff dealing with these cases want to stay involved to deliver that continuity. So, we stopped the hand-offs and the waste in the process by saying, 'Something has gone wrong; we want this individual member of staff to deal with it, and they will take it through to its ultimate conclusion'. So,

we had to put those types of structures in place, and back them up with several policies and procedures. However, our biggest challenge remains—and I am sure that Caroline will comment further on this—putting in place the skills and the level of competence that you need, because they are in very short supply.

[16] **Ms Whitney:** I agree. It is especially true when we are trying to aim for an investigation that is done once, and is done completely at the outset; that often includes making some complex judgments about the standards of medical treatment provided, and whether they have led or contributed to the injuries. Again, this is something that the proposed Measure and any eventual scheme will have to grapple with. It does require a certain amount of thought and complete co-operation with the doctors and commissions involved to ensure that they retain ownership of the investigation and do not feel that solutions or answers are being imposed on them.

[17] **Ms Whitney:** A big element of our work has involved working closely with our clinical colleagues so that they understand what we are doing and what we aim to achieve.

[18] **Val Lloyd:** On page 2 of your evidence, you touch on the fact that you think that any regulations should require investigation of any adverse event that could result in a potential liability. As currently drafted, section 4 of the Measure provides that Welsh Ministers may specify in those regulations that anyone who is reviewing a case relating to a patient should actively consider whether or not redress should be available. What specific steps do you think the regulation should require relevant organisations to take?

[19] **Ms Davies:** There are two that we believe are fundamental. The first is that the regulations need to apply from the very first point in time when it is identified that something has or could have gone wrong. So, these regulations ought to apply from the time when we think something adverse has happened, not at the point when a complaint may come in.

[20] The second point is that we would question what benefit would be derived if there is not a requirement to be proactive in communicating to the patient the fact that your investigation has led you to a conclusion that you believe that there is a liability in tort.

[21] **Ms Whitney:** The upshot of that is that the investigation itself might have to have constituent parts so that you may be directing either through regulation or code of practice the substance and conclusions that an organisation must reach in its investigation to allow the process to move on and the correct position to be made.

[22] **Val Lloyd:** So, if I could clarify that, you are suggesting that there should be some definitive directives.

[23] **Ms Whitney:** Yes, and not on the basis that it must be regulated; we can show that it can be done without being regulated, but you would need to ask yourselves whether trusts would do that voluntarily or whether a directive would be required.

[24] **Val Lloyd:** Thank you for clarifying that. In your evidence, you state that you consider it essential that there is sufficient time to conduct a thorough investigation, working with all parties. I am sure that everyone would agree with that. However, one major complaint about the current system is the amount of time that it can take to conclude a case. So, how do you think these two priorities can be reconciled?

[25] **Ms Davies:** I think that delay is possibly inherent in the current system. Something can have gone wrong and you may even have identified it as an adverse incident, but because not everyone works in the way that we do, the investigation may be taken so far under the adverse incident, reporting and management procedures, but never be taken far enough to its

ultimate conclusion. It could come in as a complaint, and so you are likely to end up revisiting it. It could then come in as a claim, and you will then revisit it once again, backtracking, to a certain extent, every time. That is clearly wasteful of everyone's time and is a matter of frustration. Our approach is predicated on doing the investigation early, doing it once and doing it thoroughly. You are, therefore, on the front foot when it comes to any other steps that you may need to take. That inherently, therefore, eradicates a lot of wasted time from the process, but it will not resolve the issue that once you have got to the point of being comfortable that there is a qualifying liability in tort, there are certain steps that you need to go through in order to be able to assess quantum appropriately, and that can be quite time consuming.

2.30 p.m.

[26] **Val Lloyd:** So, to put that in very simple terms, you are saying that you have a streamlined system, but you have done very thorough work to arrive at that, so the results of that thorough work can be used in a number of ways.

[27] **Ms Davies:** We aim to eradicate the need for a patient to feel that they have to go through a complaint or a claim process. We want to try to satisfy patients that we have already identified that something may be untoward and that we are going to take it to its ultimate end point, and that they do not need to access those other processes to get the result that they deserve.

[28] **Val Lloyd:** So, you are bringing confidence into it, too.

[29] **Ms Davies:** That is our aim.

[30] **Val Lloyd:** This is my last question for the moment. An important aim of the Measure is to ensure that, where a mistake has been made, lessons are learned for the future. You have touched on that in an earlier answer. Section 9 of the Measure allows for regulations to require that organisations charge an individual with responsibility for advising the body about lessons learned and requires organisations to publish an annual report about cases involving redress, which is what most would do. How does your organisation currently ensure that, where appropriate, lessons are learned? Do you think that the Measure will add anything to that process?

[31] **Ms Davies:** We tackle it on several levels, as I am sure that most organisations do. The first thing is that we encourage local ownership of the problem and, therefore, the solution. So if it is a given clinical speciality, we go back to that speciality and say, 'These things happened and these failures were identified; we would like you to consider what actions you can take that are appropriate and would minimise future risk.' We have processes whereby departments such as ours would give support to their actions in that respect. We may work with them and say, 'We are not convinced that that is the most effective thing to do.' Eventually it will work its way up to corporate processes. We have a very robust and dynamic operational-risk management group. Four members of our executive team, and one of our non-executive directors, sit on that group. We will give consideration to the actions that teams and specialties are putting forward, and a great deal of experience and knowledge is thereby brought to bear. We may accept those actions as being effective and appropriate, or, occasionally, they get rejected because we do not believe that they are going to address the problem and we revert back, saying, 'We need to have another think about this'. Once they have been approved, they are taken through reporting processes, through our organisation, up to our board and then there is a subsequent cascading back down, whereby we say, 'These things have happened, these were the failures that we identified and these are actions that we are putting in place, but these things could equally apply to teams sitting here, so understand what happened and what is being done and give proactive consideration to whether you need

to be taking these actions too'. So, it comes up from the bottom and it goes back down to the bottom.

[32] **Jenny Randerson:** In your evidence, you suggest that consideration should be given to the establishment of an overseeing body to deal with guidance and questions from within the NHS while ensuring ownership of the process at a local level. In your view, is there a particular body best placed to perform that overseeing role and do you not think that, by retaining local ownership of the process, there is a danger that different local redress schemes could emerge?

[33] **Ms Davies:** When we wrote that, what we had in mind was being able to access an individual, a department or a body for day-to-day, practical advice. We put that forward because of our own experience of working in this way on a daily basis. There are always going to be cases that arise that have circumstances that you have not met before, and you will always have to have a debate within your team as to what is the right thing to do. In this sort of system, there needs to be some degree of consistency. What we were proposing is that where those types of questions arise, there ought to be somebody, whether an individual or a department, that organisations can access and say, 'This has come in, we have not met this before and we do not quite know how we should apply the regulations in this respect. Do you have any advice to offer? Have you met this type of problem before?' That body could also give advice about whether what was being proposed was really in the spirit of the Measure and its regulations, which I think is also an important factor. We have thought about whether there is an existing body that could do that: we considered a number of them, but I do not think that we reached a definitive conclusion.

[34] **Ms Whitney:** No, we did not.

[35] **Ms Davies:** We thought about bodies such as Welsh Health Legal Services and the Welsh Risk Pool, but because our view is that it is very much about being able to access advice about the practical day-to-day application of the regulations, for various reasons, we were not convinced that those bodies were right.

[36] **Ms Whitney:** I think that we were thinking about a more central function.

[37] **Jenny Randerson:** What about the danger of local variation if you keep local ownership?

[38] **Ms Whitney:** I would say that it is a danger in the same way as it is working with the NHS complaints process. We feel that the importance of local ownership outweighs any risk of people interpreting things differently. The publication of cases throughout the year and, no doubt, scrutiny by, say, the ombudsman, will keep that in check.

[39] **Ms Davies:** To build on Caroline's point, we understand from the Welsh Risk Pool that there are some aspects of the NHS complaints procedure in Wales where, potentially, every NHS trust is interpreting slightly differently. This type of individual or body could, hopefully, bring together the types of queries that arise and filter out those lessons and thereby effect consistency within the system.

[40] **Jenny Randerson:** If you keep local ownership, are you not in danger of having a system that becomes more complex again? I will give you an example. If someone goes to a GP in one area and, as is frequently the case, a hospital in another, there could be a complaint against both the GP and the hospital on a very closely associated issue. It might be a case of deciding whether the GP or the hospital has responsibility for the problem.

[41] **Ms Davies:** I think that the risk is there. The risk is definitely there and is potentially

inherent within the current processes. Where we encounter those sorts of issues, it is about communication with all concerned to try to rationalise out those differences.

[42] **Val Lloyd:** In your evidence you say that, on occasion, you need to seek external independent opinion in relation to the handling of cases. That, of course, can be expensive and can also take time. Could you let us know in what circumstances you currently seek independent advice and, generally, from whom would you seek it?

[43] **Ms Davies:** We would probably put the occasions when we would seek external independent advice into four categories. The first is that there may be occasions when clinicians are unable to reach a consensus. That can happen. There can also be occasions when it is quite a unique point and nobody feels too sure exactly as to whether it would be considered one thing or the other, so we may go out for an opinion just to see what somebody external has to say about it. That might arise, for example, where you have a clinician saying, 'I think this is simply a recognised complication that would not give rise to a case of negligence'. So, you might go out just to test that. There are instances in which nothing will satisfy the patient or his or her representatives other than an external, independent opinion. There is probably a final category in which the gravity of the matter is such that it is appropriate to consider that.

2.40 p.m.

[44] **Val Lloyd:** Most cases would fall into one of those three examples, would they?

[45] **Ms Davies:** Yes. In terms of who we access, there are several clinicians on a panel set up by the independent review secretariat. Sometimes, we will contact the secretariat, ask who it has on its panel for a particular specialism, and we will make a choice from there. We are beginning to build up our own database of individuals that we have contacted previously who have provided good service, and we may use those again. We also go to Welsh Health Legal Services and ask if it is aware of experts whom we might approach. So, there is a number of avenues.

[46] **Ms Whitney:** But it should not be underestimated that it can still be very difficult to find clinicians that are willing and able to do it within the required timescales, especially when you have lengthy clinical histories or an unusual specialty.

[47] **Ms Davies:** Yes, and there may be very few individuals who are willing to give you a report, and it can therefore take quite a lot of time.

[48] **Val Lloyd:** What would you qualify as being a good service?

[49] **Ms Whitney:** Timescale, for us.

[50] **Ms Davies:** I think that there are a number of criteria. Timescale is one, the cost is another, and then there is the quality of the report that you get back, because we need it to be completely objective. There are occasions when the nature of the report that you get means that you have to keep going back and forth, asking for a number of clarifications, and that introduces more time into the process. There are some approachable individuals who are perhaps more experienced at providing those types of report, in which case you can run with the report that you get, and you never need to go back.

[51] **Val Lloyd:** This may be asking you to make a bit of a guesstimate, but do you anticipate that the cost of handling complaints will increase under the scheme proposed in the Measure?

[52] **Ms Whitney:** Are you talking about costs in terms of legal fees, or do you mean damages as well?

[53] **Val Lloyd:** It would be useful to have your opinion on both.

[54] **Ms Davies:** Probably, the only thing that we could say is that, in our experience, we have neither seen an increase in the number of cases nor an increase in the finances associated with those cases as a result of the approach that we have taken.

[55] **Ms Whitney:** We would hope that, as a sufficient number of cases worked through, you would see a benefit in terms of the legal costs associated, but it is certainly too early to assess that.

[56] **Ms Davies:** The important point is that what we already do is what is proposed in the Measure, in that we base our ways of working and our decisions on whether we believe there is a case of negligence. It is only once we believe that that case has been established that we move forward. So, we are not using a different basis of judgment.

[57] An element of additional cost comes into play in relation to the amount of resource required in the organisation to run this approach, which, really, cannot be underestimated.

[58] **Jenny Randerson:** In your written evidence, you suggest that consideration needs to be given to where the primary and secondary sectors can be included under the same redress system. The committee has received other evidence that suggests that GPs and dentists should not be included, at least initially, under the scheme. As you know, the UK legislation excluded primary care from the English scheme. What is your view on whether the proposed redress system should include primary care as well as secondary care?

[59] **Ms Davies:** The principal point is whether, if we do not include primary care, we have an inequitable system.

[60] **Jonathan Morgan:** Are you saying that the system in England is inequitable?

[61] **Ms Davies:** From a patient's perspective, if you believe that you have been the subject of a medical mishap, why should you be treated differently if that happened as a consequence of primary care as opposed to secondary care? Nevertheless, we recognise that there are many challenges, because the two systems are currently different. However, we would simply ask whether the redress system would be equitable if was not applied across the board.

[62] **Jonathan Morgan:** The Subordinate Legislation Committee—a different committee to this one—which has responsibility for looking at legal issues and structures of legislation, has been taking evidence about the process that we are going through, and about the nature of the Measure itself and the prospect of Ministers introducing secondary, subordinate legislation. That committee has noted that the Measure itself does not really contain much in the way of substantive provision—it is more about giving Ministers the authority to produce additional legislation. I understand that much of the work behind this was effectively the outcome of the Putting Things Right project, which I believe you are part of. Is there any aspect of the redress system that you think is of such great importance that it should be enshrined in the Measure itself, as opposed to merely left to Ministers to design in secondary legislation?

[63] **Ms Davies:** We consider two aspects to be fundamental. The first is the question of when the regulations apply, and we believe that they should apply from the very first point when you identify that something has gone wrong, or may have gone wrong. The regulations

should not come in half way down the line. Secondly, this must be predicated on an open basis, which means that we ought to be proactive by saying that we are looking at a case, we believe that there is a case in negligence, and we will look at an appropriate package of redress—as opposed to the patient having to push to take it to the next stage. We think that those two things are fundamental.

[64] Beyond that, our view is that there will be a lot of bedding down. This process will address things that may not have been addressed before—it needs to be responsive, and it will probably need to be changed on a number of occasions. On that basis, we feel that it would be appropriate to embody those types of things within regulations as opposed to the Measure itself.

[65] **Jonathan Morgan:** Bearing in mind that it is quite useful to be able to look at all the detail at one time, do you think that, in January, when we start the line-by-line consideration of the Measure, it would be useful if the Government were to provide the regulations? At least we would have the detail to look at, because when the scheme starts, it will be important to get it right. Some people have suggested that it would be a good idea to look at the regulations at the same time as we do that line-by-line scrutiny.

[66] **Ms Davies:** That would be helpful for a lot of people. It is easy for me and Caroline to sit here—we try to work in a way that enshrines these principles and this framework, so we are already working in this way on a daily basis, and the members of the Putting Things Right project board already understand what the aims are. There are many people who are obviously interested in this and are watching it, and they do not understand what the practicalities are, and, for those people, it will be useful to see the regulations.

[67] **Jonathan Morgan:** I have one final question. As you are on the board, it is quite useful that you have been able to come in wearing two hats. We are quite keen to look at what stage the project board is at, and how much work remains. We were told last week that the board had not quite finished all of the work. When we get a look at the detail of the legislation next year through line-by-line consideration, and possibly by suggesting amendments, will all the detailed policy work that you are doing on the board be completed?

2.50 p.m.

[68] **Ms Davies:** There is a project board meeting tomorrow, so I will get an update on precisely where all of the work streams stand in relation to the timetable. I do not have the fullest information for you now.

[69] **Jonathan Morgan:** Has a timetable been set out for future meetings, or does the board meet as and when things arise?

[70] **Ms Davies:** The scale of the work that needs to be done has been set out, but I do not believe that a timescale has been set for each individual work stream. However, it may be that the project manager is going to talk to us about that tomorrow. I am sorry that I am not able to offer any further concrete information in that regard.

[71] **Jonathan Morgan:** I am very grateful for the response. It is useful because we have not been provided with an understanding as to where the project board is with the work being undertaken. From your understanding, is there still a significant amount of work that the board is doing and will need to do?

[72] **Ms Davies:** Yes.

[73] **Jonathan Morgan:** Things are a fair way off completion, by the sound of it.

[74] **Ms Davies:** As an example, I am involved in a work stream looking at investigations and what constitutes a quality investigation and so on. That is being chaired by Adam Peat, the Public Services Ombudsman for Wales. Our first meeting will be held next week.

[75] **Jenny Randerson:** That more or less answers my question. I was going to ask when you started work.

[76] **Ms Davies:** I hope—and I think I speak for my project board colleagues—that, because we have been working with an integrated approach for two years now, we can speed up the process to a certain extent, by helping others and sharing with them what our experiences have been, what difficulties and challenges we have faced, and how we have overcome them. We can thereby give an assurance that there is a way through those difficulties—a way forward can be found. Therefore, I hope that, on the basis that we are already working in that way, it is possible that we will be able to shorten the timescales. We could be seen as a pilot.

[77] **Jonathan Morgan:** Thank you very much for your time. It was very much appreciated.

[78] **Ms Davies:** Thank you for the invite.

[79] **Jonathan Morgan:** I welcome our next witnesses from the Medical Protection Society and Dental Protection Limited. It is a pleasure to have you with us. Perhaps you can give your names for the record, and we will get cracking with the questions.

[80] **Dr Bown:** I am Dr Stephanie Bown from the Medical Protection Society.

[81] **Dr Rattan:** I am Dr Raj Rattan from Dental Protection Limited.

[82] **Jonathan Morgan:** Thank you. It is nice to see you both.

[83] Looking at the background to the Assembly Measure, you state in your written evidence that you are broadly supportive of its underlying principles. However, you also state that you have reservations about the need to establish a separate NHS redress system, and wonder whether the primary objectives could be delivered by enhancing the existing frameworks, such as the NHS complaints system. That is not evidence that we have heard from anyone else, but it is an interesting angle and one that I would like to explore with you. Can you clarify why you have reservations about the proposed system? What advantages do you think could be gained by enhancing the current complaints system?

[84] **Dr Bown:** We warmly welcome an approach that meets the needs of patients and complainants and has the objective of learning from adverse events. The complaints system is one of the richest sources—if used properly, it is the richest source—of improving patient care. The approach of the redress scheme, which involves giving open disclosure, investigating thoroughly, giving a full explanation, and an apology where appropriate, is something that we feel should be underpinned in the existing NHS complaints procedure. Our concern about making that part of the redress scheme is that there is potential for confusion about the scope of compensation. Every adverse event is a learning opportunity. That should be done within the complaints system. If you merge, or if there is any confusion or blurring of, the distinction between the lessons to be learned from complaints and what happens in the redress system, we are concerned that there is a risk of raising patients' expectations inappropriately—that there will be an expectation that there will be compensation when there is no qualifying liability in tort.

[85] **Jonathan Morgan:** Earlier, when we talked to colleagues from one of the NHS trusts, I asked about the prospect of having almost two stages. The first would be an initial look at the problem to decide whether there is a case to answer; that is, a qualifying liability in tort and one that would then need the redress scheme to kick in. Would that clarify or bring focus to what you think is a blurred picture? You would then have that process before having the full investigation into what qualifies as a liability?

[86] **Dr Bown:** It would indeed. Our view is that the two processes—the complaints process and the redress scheme—are there for different purposes. We must not lose the important lessons that come out of complaints, which may not have the elements of a qualifying liability in tort. So, we think that it is important that they are separate and, perhaps, sequential.

[87] **Jonathan Morgan:** Thank you. Are there any supplementary questions on that before we move on to Jenny's point? I see not.

[88] **Jenny Randerson:** What do you expect will be the financial and resource implications from the proposed Measure? How have you arrived at your assumptions? You have already stated that you believe that it could lead to an expectation of financial compensation. So, I assume that you have done some work on this.

[89] **Dr Bown:** We have drawn up some projections of the possible cost implications in annex A of our written submissions. Our concern is that, if someone goes into a scheme where it is envisaged at the outset that the package will include financial compensation, that is what their expectation will be at the outset. It may be that they do not have a qualifying liability in tort and that that should have been dealt with, as I have said previously, under the complaints system.

[90] In terms of how we came up with the projections in annex A, we took the number of complaints dealt with in Wales in 2005-06 as published, I think, by the Department of Health—just over 6,500 complaints—and then projected from that what the cost implications would be of changing a complaint into a claim for compensation at different percentages, and what those claims might settle for. So, at the lowest, if 4 per cent of complaints translate into compensation at a level of £1,000, the figures work out, on the basis of the number of complaints that you had last year, at £0.3 million. However, if 4 per cent of complaints settle for about £20,000, you are looking at £5.3 million. That is just the cost of the compensation; that does not include the cost of administering the scheme and the very important upfront costs that would be needed in terms of training and skilling people to do this properly and effectively. Does that answer your question?

3.00 p.m.

[91] **Dr Rattan:** To add to that, and to pick up on something that Stephanie said earlier, I am coming at this from a dental point of view; my role at Dental Protection is part time, and I am a practising general practitioner as well as an adviser to a couple of primary care trusts. So, wearing those different hats, I see what happens when complaints arise and when errors are made in clinical practice. The starting point, as Stephanie emphasised, which is really important, is that there is an old and lovely line in industry—and I know that industry does not translate into healthcare—that says that you should treat each defect as a treasure. The point is that, when there is error, for whatever reason, we have good analytical tools for managing human error in healthcare. To begin with the end of that process in mind, the purpose should be to enhance patient care and limit the scope for error in the long term; then we will build a safer healthcare system. So, if we have a true vision for the future, we must embody the principles of analysing the adverse events, learning from them and disseminating good practice at local level. That will give long-term tangible benefits. It has the added

advantage that the instant patient expectation is not financial remuneration, because, certainly in dental clinical practice, most patients are not looking for a financial result. They are looking for remedial treatment, and most of them, if asked, would rather have it done by the practitioner who carried out the treatment in the first place. Those processes happen automatically, and the reason why is that the patients pay at the point of delivery. It is in the interests of the practice, the practitioner and the PCT that those processes are handled in-house. I wanted to clarify that from a dental point of view, following on from what Stephanie was saying.

[92] The second point is about the cost of the Measure. We have locally implemented review groups and we have trained local dentists to look at adverse events. Ladies and gentlemen, the cost of those measures in terms of process is absolutely enormous, and often the same outcome could have been achieved at practice level, without going through that long process. It is not only about looking at a set of papers; it is about training people in clinical, medical and legal issues and patient management. I often find, certainly in dentistry, that the benefit of the process is far outweighed by the cost of setting it up in the first place.

[93] **Jenny Randerson:** That moves me on neatly to my next question, because we have heard other evidence that suggests that most patients are not motivated by the desire for some form of compensation: they simply want an apology and assurance that the system has been put right. There seems to be a slight difference of view as to whether having this system would encourage more people to look immediately for compensation and to assume that it would be available. Do you have further views on that?

[94] **Dr Bown:** If you have a redress scheme for adverse events that has, from the outset, financial compensation as one of its components, I cannot think of many human beings who will say, ‘No thank you, I’ll take the rest and leave the money’.

[95] **Dr Rattan:** It is a feature of the human psyche that you will get more of the behaviour that you reward. If patients see an adverse event leading to a monetary reward, their behaviour will change to reflect the fact that they want to see that monetary reward.

[96] **Val Lloyd:** In your written evidence, you highlight the importance of investigating cases thoroughly and warn that any investigation that fails to consider all aspects of the care provided could lead to doctors and other healthcare professionals being unfairly criticised. What safeguards should be put in place to avoid that, in your view, unfair criticism?

[97] **Dr Bown:** It comes back to something that you have already touched on, which is the absolute importance of ensuring that the people who are tasked with conducting these investigations are properly trained. The fact that somebody might be a competent manager or clinician does not, in itself, equip them with the skills to conduct a fair, robust and well-evidenced investigation, which will have ramifications for all those involved in an adverse event—not least, of course, the patient. As you heard from Raj, the cost implications for that are not insignificant. I heard from the earlier evidence that the investigation involves access to skill sets that are difficult to find; you need to ensure that one has these proper skills. We have many years experience of supporting doctors and dentists at the sharp end when something goes wrong, and of being the subject of investigation. The wide range in the quality of investigation should not be underestimated. If you get a sound and robust investigation, everyone benefits, but if it is not sound, robust and well-evidenced, it gives rise to a potentially protracted adversarial problem.

[98] **Val Lloyd:** Thank you. Do you want to add anything, Mr Rattan?

[99] **Dr Rattan:** No, that evidence reflects my own experience.

[100] **Val Lloyd:** Section 5 of the Measure requires that regulations must make provision for the findings of an investigation to be recorded in a report and, normally, for a copy of that report to be provided to the individual seeking redress. Do you think that that is appropriate? Are there any specific occasions where you think that such reports could be withheld from the patient?

[101] **Dr Bown:** With a scheme that is underpinned by the principles of openness, candour and learning from lessons, that must be the right approach. Where there could be circumstances, on a case-by-case basis, where it would not be appropriate to disclose the report, it is right that the Measure accommodates that possibility. It is difficult to imagine circumstances where that might be the case. It is the same principle as the disclosure of medical records. If there is a risk that disclosure might pose a threat of serious harm to the health or welfare of an identifiable individual, that is the type of situation where disclosure might not be appropriate. You would have to consider whether or not it would be appropriate to disclose if you were concerned about the impact on the complainant under the scheme, or whether or not it might be appropriate to deal with that by disclosure to the advocate or adviser. Those are the types of issues that I would have in mind.

[102] The only other thing that has occurred to me is that if, during the course of the scheme, someone decides that they want to opt out of the scheme and recourse to tort by civil litigation and yet the report has already been written, I would question whether or not it would be appropriate to disclose the report if it could compromise the defence in a civil claim. I just raise that as a possibility.

[103] **Jonathan Morgan:** One of the issues that we will look at—it has already been raised in oral and written evidence—is the possibility of the Measure and the regulations being extended to cover primary care. We know from our own research that the NHS Redress Act 2006 in England does not cover primary care; in fact, the Subordinate Legislation Committee was told by Alan Trench, who is a senior research fellow at University College London's constitution unit, that, had the redress measure in England been put forward to cover primary care, it would probably have been rejected. It was the narrowness of the redress scheme that made it successful in Parliament. So, there is potential for the redress scheme in Wales to go further. Can you outline why you are opposed to the system applying to primary and secondary care?

[104] **Dr Bown:** Perhaps I could start, and then there are specific issues to do with dentistry that I would like Raj to speak to.

3.10 p.m.

[105] As a protection organisation, we currently handle claims that arise from primary care, made against our members who are dentists and doctors. Our approach is to make sure that patients are compensated as swiftly, efficiently and fairly as possible. We have no wish whatsoever to line the pockets of lawyers, and so we avoid that whenever possible. That is our philosophy, which our members like.

[106] **Jonathan Morgan:** My wife is a barrister, and so I take issue with that remark; our bank manager certainly would. [*Laughter*.]

[107] **Dr Bown:** We are not aware of any problem with the way in which claims are dealt with in primary care. So, if it is not broken, why try to fix it, certainly not right up front?

[108] We also have other concerns. We are very experienced in dealing with claims in primary care, and it would be a challenge to build the structure that you would need to be able to take on claims in primary care. I can see how the existing structure for dealing with claims

that arise from secondary care could be modified to accommodate the scheme, but there is no existing organisation that would easily take on this very significant amount of work.

[109] There are potentially very significant financial issues, which I have touched upon. There is also the question of whether it is realistic to ask individual practitioners to identify whether something that has gone wrong falls within the scheme. In secondary care, you are working in a system where there is a structure that might pick this up and you are not dependent on an individual practitioner being able to identify it when something has gone wrong. It is about that objectivity.

[110] In our view, it would be wise to roll it out into secondary care. It is a really ambitious project and we support it; it has the best objectives. It is a scheme that needs to command the confidence of patients, the public and doctors. If you do it in secondary care, there are bound to be glitches, and so learn from those and get it right. Find out also what the financial implications have been and who is right in terms of the evidence that you have been hearing, and then consider whether it is appropriate to roll it out to primary care. Perhaps it would be much more difficult to roll it out right across the board and then to think that you want to come back out of primary care. It would be very difficult to do it in that way. There are also some very specific issues to do with the complexities of dentistry, which I will ask Raj to speak about. It is in dentistry that the majority of claims would fall under the £20,000 or £25,000 limit.

[111] **Dr Rattan:** On the dental side, the fundamental principle to grasp, which is not always immediately obvious, is that there is a tendency to translate the patient from the medical sector into the dental sector and to assume that everything is equal. It is fundamentally different for three reasons. First, the patient has a relationship with the practice, which is based on trust, as it is in medicine, but there is also a commercial relationship, because healthcare is delivered and there is payment at the point of delivery. That fundamentally changes the nature of the transaction. It is not a totally passive transaction in healthcare; it is coloured by that commercial element. Secondly, there is no such thing as the NHS patient. That sounds like a quirky statement to make, but allow me to explain. There are many treatment options open to patients. Let us say that someone comes in with a simple problem, such as that they have just lost a basic restoration from a tooth, there are nine different ways in which that tooth can be restored, ranging from relatively simple treatments that work but do not look particularly attractive, to restorations that would mimic a natural tooth and you would be pushed to see whether or not something had been done to it. If you are to get informed consent from patients, it is a requirement to sit down with them and say, ‘We have a range of options here, which one would you like?’. The aesthetic and cosmetic options are specifically excluded from the NHS, and that is set out in a letter that the chief dental officer has written to dentists. So, what you will find is that, in complex treatment plans, patients will also often have a combination of NHS and private treatment. It is possible that the two types of treatment have been carried out on the same tooth, possibly at the same appointment. How on earth would you unravel that in a scheme that looks to reward the patient with some sort of compensatory mechanism? It would be impossible.

[112] At the moment, in practice, it is unravelled in this way. The dentist and the patient, by and large, both want to preserve the professional relationship that they enjoy, and, in general practice—in primary care—the most precious thing that we have is our reputation. If you let one patient down, half the street will know about it. So, there is an in-built safety net for patients. I do it, my colleagues in my practice do it, and every dentist that I know does it—at the first sign of any difficulty, I promise you, we inform the patient, we come up with a remedial solution, and reassure the patient that the remedy will not in any way impact on them financially. We also aim to provide the remedy speedily, because that is another facet of complaints management—you need to do it as close to the source as possible, and as quickly as possible. If you then look at how patients respond to that process, you will find that they

often become ambassadors for the practice, because they accept that things have gone wrong, but they are impressed by how the process has been handled.

[113] If you take them away from that process, and you set them onto a different process, which is externalised and long-winded, and the remedy and the solution may be delayed, not only do you destroy the relationship with the practitioner, but you may not get the outcome that you want for the patient, and you would do little to enhance quality, because people would not have that opportunity to deal with the event, or to learn from it. In a practice that is focused on delivering quality care, all these things happen intuitively. There is a fundamental difference there, because the nature of our work is such that it is all about intervention. Errors can usually be spotted at the time that they occur, so it is not a delayed response, and there is an opportunity there and then, or certainly within a few days, to do something about it.

[114] **Jenny Randerson:** You have answered part of my next question. When we look at this trial period for secondary care, how long do you think such a trial period might last, and what outcomes would convince you that it could be expanded into primary care? I am conscious that you might have two different answers.

[115] **Dr Bown:** I will go first. In England, the proposal was to revisit whether primary care should be included in the English scheme after a period of at least three years, as I recall. That would be based on a larger population, so, rather than setting something in stone, it would be an ongoing learning process of how it is going. However, if it is proposed that it will take, say, three years before one revisits it in England, one might suggest that it would be at least that, and possibly rather longer, if it is going to take longer with the smaller population that we have in Wales. However, I am just floating that as a possibility,

[116] I am sorry, but I cannot remember your second question.

[117] **Jenny Randerson:** Regarding the secondary care scheme, what outcomes would convince you that the scheme could be expanded into primary care?

[118] **Dr Bown:** It would have to be demonstrated that the scheme in the secondary care system is working well and has the confidence of all those involved, and at the core of that will be the skills set and the competency of those conducting the investigations. It would also have to be demonstrated that professionals feel that it is a fair system, and that patients feel that it is fair and that there is independence and that that structure is working, together with looking at the costs of doing that.

3.20 p.m.

[119] We are not necessarily trying to hold on to it, because the clinical negligence work is only 20 per cent of the work that we do in primary care. We have all the regulatory work—medical council hearings, inquests, complaints—and we do a raft of things that do not involve clinical negligence, but we think that it is really important that it is a system that is fair to patients and fair to professionals, and does not undermine confidence.

[120] **Dr Rattan:** I agree with all of that, and I would just add one other point. If it were demonstrated that, by engaging in that external process, lessons were learned that would improve the quality of healthcare outcomes in clinical practice in the future, it would be a scheme that would be worthwhile adopting. There are two timeframes that we must look at: the immediate timeframe of looking after the patient at that moment in time, and a longer timeframe. It must be a process of continuous quality improvement, and my fear is that an external scheme will do very little to add value to that process of quality improvement. If you could demonstrate that it did, that would be to the benefit of every member of the public.

[121] **Val Lloyd:** My question is hypothetical. If you make the assumption that the NHS redress scheme would apply to secondary care, and that, at a later date, primary care would come on board, it would then be made by regulations subject to the negative procedure and so would not be open to detailed scrutiny. Do you consider that that would be appropriate?

[122] **Dr Bown:** Our strong wish is that there should be robust consultation, because it is in everyone's interests that the scheme works well and that it delivers its overall objectives, so, while it might use the negative process, that does not need to set aside the importance and the role of detailed consultation pleas.

[123] **Jonathan Morgan:** In the evidence, you refer to the existence of a no-fault scheme in New Zealand, and you say that it has undermined morale in the medical profession. Can you point out what sort of abuse, if any, a no-fault scheme, such as that in New Zealand, might lead to?

[124] **Dr Bown:** I will take that question in two parts. One is the undermining of morale, and you may be aware of the qualifying test in New Zealand, which is one of 'treatment injury', and that has been the case since July 2005. That means personal injury arising from the treatment, not the underlying condition, and not an anticipated consequence of the intervention. However, there is no requirement to find fault. In that scheme, the compensation is much more limited than that which would be available in tort, so the amount of money the patients get is far less. Our experience there is that patients are seeking to top up the purse by going down a number of different routes, so, for instance, if your experience has been one that might engage the interest of the privacy commissioner, you could have an additional remedy by going down that route. So, you go down many different routes to get as much as you can into your financial package, as a consequence of the fact that what you will get through the no-fault scheme compensation is far less than what you might have got in tort.

[125] There is an obligation under the New Zealand scheme to report if you think that the incident poses a risk of harm to the public, and there is also an obligation to inform the person who is claiming about the role of the health and disability commissioner, who investigates professional conduct. What we see is what we refer to in our organisation as feeling like death by 1,000 arrows—one adverse incident gives rise to so many different routes for a patient to go down that the professions feel completely under the cosh and attacked from every side. There is also a feeling that if it is a no-fault scheme, there is no accountability, and so you get a lower threshold for people wanting to make a complaint to the medical council, because they want accountability. So, those are the factors that feed into the challenge to morale.

[126] On the risk of abuse, there is a concern that it is just too easy with a no-fault scheme to fill in the form and say, 'Well, between us, you are a bit dissatisfied with that outcome; it was not a qualifying treatment injury, it was not negligent or sub-standard, but you are unhappy, let's just fill in the form and claim that way.' Unless you have a very robust assessment process for looking at these claims, then there is that risk of abuse.

[127] **Jonathan Morgan:** Do you have experience of any no-fault schemes other than New Zealand's?

[128] **Dr Bown:** I think that New Zealand's is the one of which we have most comprehensive experience. There are other no-fault schemes. For example, Sweden has an avoidable injury scheme, but we do not operate in Sweden. Another thing about no-fault schemes is that they work best where a very strong social care system has been established. The social care system in Sweden is very robust. So that is in response to your questions about morale and the risk of abuse.

[129] **Dr Rattan:** We do not use the term 'no-fault scheme', but we have an equivalent for

which we use the word ‘goodwill’. It translates into exactly the same concept whereby if patients have had some treatment done and it has not worked—because not everything works for everyone all of the time—and both parties agree that it is not anyone’s fault, to preserve the relationship and the reputation, we will often say to those patients that as a gesture of goodwill we will remedy it for them today, tomorrow or next week, and everything is fine. That is the unique beauty of primary dental care. That is probably happening somewhere in a practice near here as we speak this afternoon. Lessons are being learned; people are learning from that experience and they are sharing the experience with colleagues and the patients are happy because they are getting the remedy and it is on a no-fault basis.

[130] **Jonathan Morgan:** Okay. I see that there are no further questions. That is great; thank you for your time, it is much appreciated.

[131] It is my great pleasure now to welcome the chairman of the British Medical Association in Wales, Dr Tony Calland. I will not ask you to introduce yourself because I think that you are fairly well-known to most people around the table. It is a great pleasure to welcome you.

[132] I thank you for the written evidence that has been submitted. If it is okay with you, we will get straight to questions.

[133] **Dr Calland:** That is fine.

[134] **Jenny Randerson:** In your written evidence, you state that:

[135] ‘A clear, accountable redress system is required to help patients avoid the costs, stress and delays of going through the legal system.’

[136] In your view, does the scheme proposed in this Measure meet that requirement?

3.30 p.m.

[137] **Dr Calland:** There are a number of balances to be struck. I should just let you know that I am here speaking on behalf of doctors this afternoon. That does not mean to say that we are not well aware of all of the problems that patients have and run into when things go wrong in the NHS, but I am primarily looking at this from the point of view of the doctors.

[138] In any mishap, the one thing that must happen first, after acknowledging to the patient that there is some form of recognition of a mishap, is a proper, full and competent investigation of what went on. That is probably the most important bit of any investigation, be it in the complaints procedure or in any redress through the tort system. We feel that that investigation should be independent. We have a worry that, under the redress system, having, for instance, the trust investigate the complaint means that there is a conflict of interest, because the trust might be encouraged to advise the practitioner to admit liability so that the matter can be settled quickly, primarily, but also without a great deal of fuss—which would be a success for the patient. The problem is that it would be at the expense of the practitioner who would have to accept liability, which would have, these days, very considerable consequences for that practitioner’s career and career progression. In these days of revalidation, re-licensing, all the General Medical Council stuff, the change to the standard of proof around the GMC and so on, and the much greater pressure, I suppose, on management to refer cases of difficulty to the GMC, we feel that if a practitioner has done something wrong, incompetently or whatever, that should be recognised, but they need to have the security that they have been treated absolutely scrupulously fairly and then they have to suffer the consequences of whatever follows. That is why we feel that there is a conflict if the trust investigates its own difficulty or mishap. Also, and more so in secondary care than in primary

care, the mistakes that occur are often, although not always, part of a larger system, and the system is also partly to blame for the failure. Therefore, we want to ensure that any independent investigation of what went wrong would look not only at the practitioner's clinical skill and whether it was wanting, but at whether the trust management system was also at fault or could be improved. That would be more difficult to achieve if the trust were investigating itself.

[139] **Jenny Randerson:** You have already cast some doubts on the proposal and in your evidence you contrast the adversarial relationship between patient and doctor that exists under the current, tort-based procedures with the mutual trust that should exist. Do you consider that the proposed redress scheme would help to improve the patient-doctor relationship, notwithstanding the conflict that you have referred to? Would it also encourage more openness and frankness on the part of doctors?

[140] **Dr Calland:** It was mentioned earlier that most patients want a recognition that their complaint is justified, an explanation of what happened and why, and an apology. Sadly, in both secondary and primary care, those things do not happen frequently enough. I do not think that it is right to say that we do not support the Measure: we support the principle of the Measure, but exactly how it is designed and functions is crucial to whether it will work or not. If there were a robust investigation process that had the confidence of patients, professionals, and management, I think that we could move away from the adversarial system. If there was a recognition that a particular event had generated a liability in tort, and therefore there was going to be some compensation, all the arguments about what happened and why are removed from the patient. The patient is going to get an apology, presumably, if the case was proven—they are going to get redress. Therefore, the only argument is about what goes on in the systems within the trust and with the doctor, and that will depend on the circumstances. So I think that the Measure could improve the system, but it has to be set up in such a way that everybody has confidence in it. If it is not set up in that way, sooner or later it will fall into disrepute, which would be an opportunity lost.

[141] **Jenny Randerson:** The evidence that Bro Morgannwg NHS Trust gave us referred to the need for local ownership, with some kind of oversight to ensure that there were standard procedures and so on. You are fundamentally saying that the procedure should be taken out of local ownership and should be done at a higher level.

[142] **Dr Calland:** You can argue it both ways, to be honest, because if you look at the primary care complaints system for general practitioners, where that works well is when it is done on a practice-based system, which is about as local as you can get. If it is done properly, patients go away feeling that they have been taken seriously, they have had some sort of apology and they have seen things change—that is a good bit of local practice. From that point of view, I would support a local process. The problem is, as we all know, in the primary care system that is extremely variable in the way that it functions; it depends upon local management, local practitioners and everything else. If you are looking at something like this, which is a national scheme, you must have consistency. Therefore, you need a national body to look at the process, so that the same scheme can be applied evenly across all parts of the country.

[143] **Jonathan Morgan:** You referred in your evidence to the indemnity arrangements for GPs, dentists, opticians and pharmacists and the fact that they are different. You said that the arrangements work effectively and that there is little, if any, reason for them to change. Looking at the financial burden and the fact that it rests with private insurance companies in the case of GPs and other practitioners, you said that this would potentially shift to the public sector if the redress scheme was expanded to include the primary care sector. Can you give an indication to the committee as to what you might expect the cost to amount to and any practical difficulties that might be experienced under such an arrangement?

[144] **Dr Calland:** We have no reasonable way of estimating the cost; we cannot do that. We just have not got into that bit. What happens is that, as a general practitioner, you pay your subscription fee to your medical defence organisation, which is a tax-allowable payment. So, in a way, the public—the taxpayer—picks up the tab for that. However, it does not come out of the NHS budget, but out of the bigger taxation budget of the United Kingdom—the Treasury really. If you brought in a redress scheme for primary care, as I understand it, that would bring the costs of any compensation that would be paid through that scheme into the Assembly. I am not sure that the Treasury will necessarily give you an extra sub to cover it. So, you are shifting a cost into Wales that is currently a UK-wide cost. Is that what you want to do?

3.40 p.m.

[145] **Jonathan Morgan:** That is an interesting question. The evidence shows that there has been a rise in the cost of compensation claims, certainly over the past eight years. Do you think that there is any evidence to suggest that a redress scheme extended to cover primary care could encourage people to submit claims purely because the wonderful rainbow behind the cloud would suggest a compensation payout?

[146] **Dr Calland:** You have only to look at the television, or even the cinema these days, to see no-win, no-fee lawyers advertising constantly. They have driven a compensation culture in some sectors of society. If you bring in a scheme from which it is deemed to be easier to get compensation, I would be surprised—and delighted—if the number of claims did not go up. It is counterintuitive, is it not? You would think that the number of claims would go up, because people would think, ‘Let us give this a whiz; it is not a great hassle; my arm really hurts after having had that blood taken; I have had agony and nights awake’ and so on. You can just see it, in some areas, generating a wave of its own, carried on the jungle drums and all that.

[147] **Jonathan Morgan:** Some witnesses have suggested that we ought to examine how successful the scheme is with regard to secondary care, and then look to expand it to primary care, unlike the process and the system adopted in England. Will any elements of the redress scheme be applied to secondary care that you think ought to be applicable in primary care, and ought we to be looking at certain outcomes that might convince you that the extension to include primary care is a good thing?

[148] **Dr Calland:** One of the benefits of the scheme as it is proposed is the speed at which the patient gets redress. There is also the fact that he or she will be taken seriously, and they will probably get some form of explanation and an apology, if they are going to get the report coming back and everything else.

[149] In many ways, this goes back to my remarks about primary care and that, when it is done well, it works very well anyway, because all those things happen. The patient has a mishap at the surgery, makes a complaint, the practice manager, and probably the senior partner, sees the patient, discusses it, explains it and, where it is a genuine and reasonable complaint, hopefully, an apology is offered and an explanation given of what has changed. As a result of that, most people are quite happy. They do not expect compensation at that level because they just have a gripe because they feel that they have been treated badly. Once you start to bring the compensation scheme in, that will change their way of thinking. So, I am not sure that primary care needs to enter the redress scheme at the moment because, as long as the complaints procedure and the extended complaints procedure using independent review panels and so on is in place, and as long as that works well, then, as Dr Bound said, ‘If it ain’t broke, why are we fixing it?’.

[150] **Jonathan Morgan:** The written evidence refers to unintended consequences for doctors if the redress scheme were applied to primary care. What would be 'unintended consequences'?

[151] **Dr Calland:** There was an issue, as I have mentioned, around the interaction between a redress scheme and revalidation and re-licensing, or the employment issues for your future career. We would be unhappy to see doctors put in a position where they might feel that they have to accept liability even if they do not think that they are liable, as that would have consequences for their career in the future. That would bring in a degree of difficulty and distrust between the trust and the doctor. If the investigation panel was independent of the trust, then there would be less scope for any kind of pressure within the system, and therefore the doctor might feel more comfortable. Obviously, if doctors were found wanting in their practices, it would be perfectly reasonable for them to expect some kind of action to follow. It is all about having confidence and maintaining good relationships not only between patients and doctors, but between employers and doctors. I would be anxious about that.

[152] The General Medical Council is trying to bring in the revalidation process, and doctors are, by and large, going along with that at the moment. They see the value of it, and, although that process is having a difficult birth, it is well on the way. It would be a shame if an ill-thought-out redress Measure suddenly malfunctioned and created a degree of unhappiness among the profession, particularly because of the consequences of revalidation and the way that the GMC works these days. So, this is the same point that I made earlier—perhaps members of the public do not understand what going to the GMC means for doctors. Doctors would rather have their arms and legs cut off slowly than go anywhere near the General Medical Council, even if they are found not guilty—the fact that they have been there is recorded, and it is available for everybody to see for the rest of time. So, any scheme that got them there easier, or quicker, through a method that was not entirely fair, would generate enormous unhappiness in the profession, and you then get into avoidance behaviour, secrecy, tricks, and everything else.

[153] **Val Lloyd:** Following your line of argument, are you suggesting that the Measure will lead to those circumstances?

[154] **Dr Calland:** I am not suggesting that it would. I want to be clear that the BMA is supportive of the principle. We are keen to support a system of implementation that is robust and fair, and seen to be fair, for everybody. I am not suggesting that the redress scheme would have those consequences no matter what. If everybody agreed how it was set up, and if everybody was happy with the way it functioned, then I do not think that it would have those consequences. However, if it is done in a way that does not have the wholehearted support of the profession, you run the risk of getting into those consequences.

3.50 p.m.

[155] **Jonathan Morgan:** Val, do you want to pursue the questions on the regulations?

[156] **Val Lloyd:** Yes, thank you. You suggest in your evidence that the Measure is enabling legislation and does not provide much in the way of detail on the way in which the redress system will work in practice. What type of cases do you think should be covered by the scheme? Should the Measure refer to an upper cost threshold?

[157] **Dr Calland:** I do not think that we have any strong views on the sort of cases that should be included in the scheme. Again, it could be argued both ways. If you start to compile lists, you are going to get into difficulty with things that should obviously be covered by the scheme but that are not on the list. Also, this is a personal view rather than a BMA view—because the whole of the BMA has not debated it—but if you stipulate an upper limit, I would

worry that people would say, to pick a figure out of the air, 'I might get £20,000 for that; let's have a punt at that', and sort of ramp up their case to meet that figure. If you did not put a ceiling in, people would understand the way that it worked almost by case law. Unless the first five cases were all awarded £20,000, people might think that they would get, say, only £500 and that it was not worth it. Therefore, I would say that you should not put a figure in and that you should not have a list.

[158] **Val Lloyd:** That is very clear. Thank you. Is there any aspect of the system that you consider to be of such importance that it should be enshrined in the Measure itself, rather than be left to be introduced by the Minister in regulations?

[159] **Dr Calland:** As an association, we are always a bit wary about changing things by regulations, because we see that as being ministerial whim, rather than a proper parliamentary process. I am certainly not a lawyer—although as a member of the BMA and I am an amateur lawyer because there are 130,000 of them—but I do not know of a particular thing that should be included in the Measure. I do not understand the legal significance of that. However, as I have said, I would certainly want any investigation process to be centralised and independent.

[160] **Val Lloyd:** That is very clear. I think that you were present when I asked this question of the previous witnesses, but with regard to the negative or affirmative procedure, as currently drafted, the Measure requires that only the first set of regulations be considered under the affirmative procedure and, therefore, they would necessarily be subject to approval by the whole Assembly. Any subsequent regulations, such as those relating to primary care, would be handled through the negative procedure. Do you think that this is appropriate?

[161] **Dr Calland:** I think that this is public money and Parliament or the Assembly are the custodians of public money, and therefore any change that might incur a change to public money should be decided upon by the whole Assembly rather than by Ministers.

[162] **Val Lloyd:** Finally, the proposed Measure provides that people will have the right to make a complaint about the administration of the redress arrangements but not the outcome. If claimants disagree with the decision, they retain the right to take legal action. Do you think that the lack of provision for an appeals process in the Measure as currently drafted is appropriate?

[163] **Dr Calland:** If there was not an independent body looking into the investigation, there should certainly be an appeals process for the practitioner or the management of the trust, because that would be fairer.

[164] As for the patient, what we do not want is people having a lot of bites at a lot of cherries, and that is what I presume this is about. The BMA would be anxious about this mechanism being used as a trial to see if you can get anywhere by going through litigation in tort. So, if you want to have a system that everyone supports, there is a strong argument to have some kind of appeals mechanism built into it, for patients, practitioners and management. Having said that, you do not want to create a bureaucratic monster that will take even longer than what you are trying to replace. As soon as you get into appeals, this sends everyone back to square one and you start the whole thing over again, in a way.

[165] So, in answer to your question, if you can set it up so that everyone is happy and accepting of the process, you could probably get away without an appeals mechanism for patients or doctors. However, if you set it up where there is vociferous unhappiness about a particular aspect of it, then not putting in an appeals process runs into problems of natural justice. I am not sure of the legality of a situation where, having gone through this process successfully, a patient could then say, 'I have £5,000 out of this; that was a pretty damning report on the trust and the doctor, so I will go to my local solicitor and we will have another

crack to see if we can get some more money'. I am not sure in law whether it would be possible to do that. I would be anxious if putting this system in created a series of hoops through which the doctor and the trust had to go while patients sit there rubbing their hands looking at a gravy train of compensation.

[166] **Val Lloyd:** We will take legal advice on the query that you have raised.

[167] **Jenny Randerson:** In what circumstances, if any, do you think it appropriate to withhold an investigation report from the patient concerned?

[168] **Dr Calland:** As Dr Bown said, there should be very few. If this is to be a transparent process, it has to be a transparent process. There may be circumstances where potential damage to children would be involved—I cannot think of a case off the top of my head—or where other people not involved in it may be damaged. Even so, if the complainant knew that there was some dark secret in all of this that they did not want to come out, why are they going down that line? If they are worried about that so much, I am not sure that it is up to us to devise a system to take account of it. If they choose to go down this path, it is like when you go to litigation for anything: you are not quite sure where it will end up. If you have dark secrets in the cupboard, you have to take account of the fact that they may come out. It is a risk.

[169] **Jonathan Morgan:** Are there any further questions? I see not. Thank you, Tony, for being with us this afternoon. I also thank all of the witnesses for attending. It has been extremely useful for us. We have a lot more evidence to take between now and December, when we must report on our findings to the Assembly.

4.00 p.m.

[170] The committee clerk will send you a transcript of today's proceedings, and if you wish to correct anything before we publish it, please let us know. If there are additional points that arise over the next few weeks that you wish to write to us about, please do so, because we are very much in a new environment; this is the first Assembly Measure that is being considered, so we need to get it right. Do not feel constrained. If you feel that you need to do so, you can write to us—we extend this invitation to all of our witnesses—if there are aspects that you did not manage to cover today.

[171] We are meeting next Tuesday morning to take evidence from the Royal College of Nursing and the Law Society. The Minister for Health and Social Services will be at the Subordinate Legislation Committee meeting next Tuesday, at the ungodly hour of 8.15 a.m., and I intend to go along to listen to her evidence about the Measure. Following the last meeting, I wrote to the Minister for Health and Social Services, asking her about the Putting Things Right project board, in terms of where it was with its work, because there is clearly an issue about ongoing policy work and how that will impact on our ability to scrutinise the legislation from January 2008. I have also written to the Counsel General regarding the balance between what is enshrined in the Measure and what would be permitted for Welsh Minsters to do, because that is an issue that we may want to examine from January. Is there anything else? I see that there is not, so that concludes business for today.

Daeth y cyfarfod i ben am 4.01 p.m.
The meeting ended at 4.01 p.m.