

The stated purpose of the redress scheme is to provide:

- The making of an offer of compensation in satisfaction of any right to bring civil proceedings in respect of the liability concerned;
- The giving of an explanation
- The making of an apology; and
- The giving of a report on the action that has been or will be taken to prevent similar cases arising.

Most of these requirements, such as a thorough investigation of the circumstances leading to the incident, an explanation and an apology, and a means of learning from an incident so that action can be taken to prevent similar incidents in future, are already part of the complaints procedure. They are not, however, part of the claims process, which is only about determining if there was negligence and, if negligence is proven, deciding upon the level of compensation to be awarded. Currently, it is not possible to continue with a complaint under the NHS complaints procedure if there is a claim ongoing on the same facts, but we believe that this should change. It is in everyone's interests for there to be a robust process for answering complaints, in the manner described above, and we can see no reason why a patient should be prevented from bringing a claim at the same time as making a complaint. Indeed if a complaint is properly investigated, the report that is provided should be of assistance to all parties in determining if there has been negligence.

If the regulations were amended so that it was possible to continue with a complaint at the same time as bringing a claim, there would be no need to make the complaints procedure an integral part of the redress scheme, as the two could run concurrently. The purpose of a redress scheme would be to provide for a thorough and local investigation of a negligence claim in cases where the compensation sought was below a certain threshold, and to provide rehabilitation and financial compensation if appropriate. And at its end point, in common with the complaints procedure, the redress scheme would also ensure that lessons were learnt from whatever went wrong, and practical steps taken to ensure that problems do not recur.

Thus, we support the principle of a redress scheme, but we would not support a scheme that was a 'joined-up' version of the complaints and claims procedure because we believe they should be kept separate. (We commented on this in detail when a redress scheme was first mooted in 2003 in the Chief Medical Officer's consultation paper *Making Amends* and I enclose a copy of that response for information. Please see pages 12-19.)

The benefits for claimants of a redress scheme are expected to be ease of access to the scheme and speed of the process, though they should not forgo legal or expert advice. We do not know the legal costs for low value claims in Wales, but the MDU's experience is that the associated costs of such claims are invariably higher than the awards themselves. For the NHS there may also be cost savings, principally in legal and experts' costs, but these would need to be offset against an increase in cases where compensation is sought and paid.

We understand that the redress scheme, when it begins, is intended to apply to secondary care provided to NHS patients and in cases where damages are below a monetary threshold, likely to be £20,000. It is important that in any redress scheme, the payment of financial compensation must be linked to a qualifying liability in tort, and the Bolam test (that the doctor acted, or did not act, in a way that a reasonable body of opinion would have considered appropriate) will need to be retained.

We are not aware of any evidence that suggests that the redress scheme, as it is set out in the Measure, is required for, or would be appropriate for primary care at its inception. We note that while the measure provides for the scheme to cover primary care, paragraph 5.8 of the explanatory memorandum makes it clear that the initial regulations are unlikely to apply to primary care. We agree with this because primary care is different in many ways, including the types of claims and claims experience, and indemnity arrangements for GPs who are independent contractors. We do not think that any research has been conducted into the need for such a scheme in primary care. Further, dentistry in primary care is often a mix of NHS and private care which would bring with it problems in trying to run a redress scheme. We suggest, therefore, it would be more appropriate for the redress scheme to operate in hospitals for a trial period, say three years, in order to determine if it would be necessary or appropriate to introduce a similar scheme in primary care.

2. Does the proposed Measure achieve the policy objective?

No comment.

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

The detail of the scheme will become clearer in the regulations and it is difficult to comment at this stage because the measure is generally an enabling measure. It is important therefore that all stakeholders are consulted about the regulations and their contributions are sought to inform the way in which the scheme is expected to operate.

Given that the intention is for ease of access to the scheme by patients, and that there will be a duty upon NHS staff to consider if a case may be eligible for redress and, if so, to take steps under the scheme; we expect there will be a substantial increase in the number of patients seeking compensation of under £20,000 in hospital cases. As a proportion of these cases will succeed, there will also be a rise in the number of cases where compensation is awarded. From the clinicians' point of view, this will mean an increase in the number of clinicians who are involved in cases where claims are investigated and where awards are made under the scheme.

There will need to be safeguards built into the scheme so that clinicians are not unduly stigmatised because of their increased involvement in cases that are brought and settled. The claims procedure is not intended as a means of determining whether there are concerns about a doctor's fitness to practise, but it is about establishing whether and how much financial compensation should be awarded to a patient. It is not an indicator of poor performance for a clinician to be involved in a claim, or even to have a claim settled on his or her behalf. A settled claim is merely an indicator that something went wrong at a particular time, and claims are brought and settled

for many reasons that have nothing to do with individual clinicians. (Given the need for brevity in this response, we will not go into more detail here, but have prepared a paper on this subject and enclose it separately for your information.)

It is important that decisions taken about awarding compensation under the scheme are made after thorough investigation, with appropriate involvement of the clinician(s) concerned, and in the light of appropriate expert evidence. It is in the interests of all parties that the system set up to administer the scheme needs to be able to demonstrate that decisions to award compensation are made fairly and consistently throughout all the organisations covered by the scheme. Further, the application of the Bolam test needs to be consistent with the way the test is applied to clinical negligence claims that fall outside the scheme. This will be particularly important with cases that fall under the scheme where an offer of compensation is made, but where the claimant rejects that offer and decides to exercise his or her right to seek compensation through the clinical negligence procedure.

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

Please see our comments above. It is difficult to comment at this stage because most of the detail of the scheme will be in the regulations.

There would be considerable practical and other difficulties in a scheme that took in primary care from the start because of the independent contractor status of general medical and dental practitioners, and other practitioners in primary care who are not covered by NHS indemnity and are separately indemnified. But if, as outlined in the explanatory memorandum, the regulations do not include primary care from the scheme's inception and it is confined to secondary care, that would allow time to undertake a feasibility study on the application of the scheme to general practice. If, after a thorough analysis, it was thought necessary to extend the scheme at some later date, it would also benefit from any lessons learned during the first few years of the scheme's operation for hospital 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?

Yes, as long as the stakeholders are involved in consultations on the detail of the scheme and have an opportunity to comment on the draft regulations.

The Measure relates to redress in relation to liability in tort, i.e. where some fault is established without recourse to the courts. Would it be better for the Assembly to seek the power from Westminster to introduce a 'no-fault scheme'?

In most countries where a 'no-fault scheme' operates, the state provides compensation to parties who have sustained personal injury through some sort of accident or incident. There is usually a test, but the nature of that test differs considerably from country to country. It is not clear what sort of scheme was intended in the 3 July 2007 debate when the Measure was introduced in the Welsh Assembly, but we take the comments in the plenary debate to describe a 'no-fault scheme' that would provide compensation on a no-fault basis **only** for 'medical mishaps' sustained in NHS hospitals. It would appear, further, that it may be envisaged that such a scheme may be linked to complaints about

NHS treatment so that it would, in effect, provide compensation for complainants, without the need for the complainant to prove fault. It is not clear whether the no-fault scheme would operate only for cases where the awards were under a certain threshold, say, £20,000, or whether it would apply to all clinical negligence claims. Further, would it be intended to apply to claims that are not currently state-indemnified and where healthcare practitioners currently make their own indemnity arrangements? Would there need to be a qualifying incident or accident for a patient to receive compensation; or would it be enough for a patient to assert that he or she was not happy with the outcome of the treatment he or she did, or perhaps did not, receive?

It was not clear from the debate why it is considered that there may be a requirement for such a scheme and what it would be expected to achieve; or what it might be expected to cost. These questions would need to be answered in order to determine what, if any, scheme might be appropriate in Wales.

There are a number of other considerations.

The MDU is not opposed to no-fault compensation schemes and would support the introduction of such a scheme, UK-wide, for babies with neurological damage. Our experience does not suggest, however, that there is any need for compensation on a no-fault basis for any other types of claims, and particularly not as a 'fast-track' method of determining entitlement to compensation, without the current legal test which provides for fairness and consistency and which assures that compensation is only paid if it is appropriate. We have said above in respect of the redress scheme that there are considerations of proportionality in respect of small claims, and the redress scheme is proposed to address such concerns. The Bolam test should be retained to provide consistency with all other clinical negligence and personal injury claims.

If the Assembly were to seek power to introduce a 'no-fault' scheme, it would need to be made clear what the rationale for a no-fault scheme is and what sort of scheme is envisaged. For example, if it was proposed to introduce a state funded no-fault scheme for medical mishaps, the Committee would also need to consider what effect this might have on all other personal injury claims where there remained a need to prove negligence, including other clinical negligence claims that were not covered by the 'no-fault' scheme. Some times a clinical negligence claim is inextricably linked to another type of personal injury claim. For example, a motorist who is suing for alleged negligence injury in a car accident may also be suing as a result of allegedly negligent treatment received for that injury.

We expect, therefore, that there may be legal difficulties for the state in attempting to provide compensation on a no-fault basis for a small and clearly defined sector of society, whereas all other citizens making personal injury claims would be expected to prove negligence in the usual way. Further, we do not think it would be possible or desirable to prevent injured claimants who were unhappy with offers made under a no-fault scheme from rejecting such offers and asserting their right to bring a clinical negligence claim instead, thus negating any savings that might have been made on legal and other costs. If the state were the defendant in such a claim it would then be presented with an admission on a no-fault basis for a claim that would then need to be considered using the Bolam test.

We expect, therefore, that there would be considerable legal difficulties in introducing a no-fault scheme and these would need to be explored in detail before any proposals were produced. Our further comments relate to other practical difficulties with a 'no-fault scheme' of the type that we believe was proposed in the plenary debate.

General comments

We do not believe that it would be possible to introduce a 'no-fault scheme' that was part of the complaints procedure. There is a fundamental difference between complaints and compensation procedures, which both have different aims and objectives. While we believe that the two can run concurrently, and that it could be beneficial for the detail and conclusions of a complaints investigation to be fed into the claims process, the two procedures should not be linked in any other way.

Currently, tort law provides that compensation can only be paid if negligence can be proven. That is:

- A duty of care exists
- The duty of care was breached
- Harm arose from that breach (causation is established).

The test used to establish negligence is the Bolam test.

If a 'no-fault scheme' was introduced and there was no need to prove negligence for cases falling within the no-fault redress scheme, this would create an anomaly because there would still remain a need to prove negligence for cases that are outside the scheme's limit of, say, £20,000 in compensation. For cases that were valued at around £20,000, it would invariably be more attractive to a patient to seek compensation within the 'no-fault scheme', rather than through the courts, and this would generate an even greater number of cases falling within the scheme.

In 2006 there were 4,182 hospital complaints and 2,484 arising from primary care in Wales. Hospital complaints rose by 4% over the previous year, and those relating to primary care had risen 14%. We do not know how many of these complaints might have been eligible for compensation if a 'no-fault scheme' had existed, but the figures are a useful indicator. If a complaints procedure had as its end result the payment of compensation on a no-fault basis, we expect there would be even greater increases in complaints. It is not clear how many complaints will be deemed eligible for no-fault payments (see below) and it will be necessary to prepare various models exploring the number of complaints that may be made and the potential pay-outs.

We expect that any payment under a 'no-fault scheme' will amount to compensation and that the provisions of the Social Security (Recovery of Benefits) Act 1997 will apply in respect of recovery of state benefits. The Committee may wish to seek the views of the Compensation Recovery Unit (CRU) about the many practical problems that such a change would introduce.

Questions for the Committee

The Committee may also wish to consider the following questions:

5. What would be the purpose of the no-fault compensation scheme? Is it intended to save money by disposing of the need to determine fault and, if so, how much would any savings be offset, or far eclipsed, by payments made to increasing numbers of complainants seeking to take advantage of the scheme?
6. Given that no-fault compensation does not operate, nor is it planned, anywhere else in the UK, would such a scheme only be available to Welsh patients or, for example, to English patients or even patients from other countries such as other EU states who are eligible to receive treatment in Wales? If other patients were eligible, any financial model would also need to consider the potential for 'health tourism' to Wales that might ensue if it were the only country to run a 'no-fault scheme'.
7. Would there be any qualifying test to distinguish between damage that attracts compensation, such as damage sustained as a result of accident or injury; and some other cause, say congenital abnormality, which may not attract compensation? To give an example, below is a typical example of five patients who sustain similar damage, through different causes, and yet who will have similar treatment and care needs. We do not think it is intended that a 'no-fault scheme' would compensate all patients, but which, if any, patients would it compensate?
 - A patient whose left arm is damaged as a result of a surgical procedure where such damage is a known complication, which the patient was warned about, and not caused by negligence.
 - A patient who sustains similar damage as a result of a car accident.
 - A patient who sustains similar damage as a result of a disease process.
 - A baby whose left arm is damaged as a result of a birth injury.
 - A baby whose left arm is damaged as a result of congenital abnormality.
8. Would compensation be available in any other circumstances, for example, when there was no actual damage, but the patient sought compensation for mere discomfort or because he or she was not happy with the treatment received, or not received?
9. To determine which patients should be compensated, what qualifying test would apply and how would it be applied consistently and how would it relate to the Bolam test?
10. How would the level of damages payments be determined?
11. Would there be a minimum threshold for claiming compensation and a cap on the level of damages awarded?
12. We assume it is intended that the state would fund such a system as, without a qualifying tort or any sort of fair procedure to determine fault, it would be inequitable and punitive to expect 'no-fault' payments to be funded by those providing services to the NHS, such as independent contractors. Indeed such a

requirement might be in contravention of the European Convention on Human Rights.

13. How would such a scheme be administered? We are not aware of any body at present that could undertake such work. Such a body would also need to be able to demonstrate that any decisions to make no-fault payments were made fairly and consistently in all NHS organisations covered by the scheme.
14. Would there be an appeals process for patients who are refused compensation under the scheme?
15. What provision will be made for clinicians to play a part in the decision-making process if payment is to be made on a 'no-fault basis' for treatment they have provided?
16. If primary care was included, what would happen in cases where care was mixed between the NHS and the private sector, for example in general dental practice? Would patients who have received mixed treatment be barred from the 'no-fault scheme', or would they only be eligible for compensation for that part of the treatment they received from the NHS?
17. If the state becomes the compensator under a 'no-fault scheme', what effect would that have on the powers that the NHS has to recover NHS care costs from defendants in personal injury cases?

We do not argue that the tort system is the best framework for dealing with medical injury. An effective complaints procedure should provide a swift investigation and, wherever possible, a resolution of grievances; and, where issues of financial compensation arise, cause and fault need to be examined and resolved. While we support the principle of a redress scheme that achieved these aims, we believe it would be inappropriate, inefficient and expensive to introduce a scheme that would provide 'compensation' on a no-fault basis. We would be happy to explain our comments above in more detail to the Committee if that would be helpful.

I look forward to hearing from you.

Yours sincerely

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