

MPS response to the House of Commons Health Select Committee Inquiry into Primary Care

About MPS

1. The Medical Protection Society (MPS) is the world's leading protection organisation for doctors, dentists and healthcare professionals. We protect and support the professional interests of more than 300,000 members around the world. Our membership benefits include access to indemnity, expert advice and peace of mind. Highly qualified advisers are on hand to talk through a question or concern at any time.
2. MPS is a not for profit, mutual organisation with no shareholders. All subscriptions go towards providing members with world class advice, support and protection.
3. Founded in 1892, has a significant understanding and experience of different models of care and service solutions.
4. Our highly qualified, in-house experts assist with the wide range of legal and ethical problems that arise from professional practice. This includes clinical negligence claims, complaints, medical and dental council inquiries, legal and ethical dilemmas, disciplinary procedures, inquests and fatal accident inquiries.
5. Our philosophy is to support safe practice in medicine and dentistry by helping to avert problems in the first place. We do this by promoting risk management through our extensive range of workshops, E-learning, clinical risk assessments, publications, conferences, lectures and presentations.
6. MPS is not an insurance company. All the benefits of membership of MPS are discretionary as set out in the Memorandum and Articles of Association.

MPS and Clinical negligence claims

7. Along with other Medical Defence Organisations, MPS manages claims for clinical negligence brought against GP's, dentists and private doctors, whilst the NHS Litigation Authority manages claims arising in the NHS hospital sector. In Scotland claims are managed by the Central Legal

Office (CLO) in conjunction with the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS) and in Wales the Welsh Risk Pool provides a similar function.

8. Our claims handling philosophy aims to provide an expert, supportive and efficient claims handling service to members who are faced with claims. Where there is no defence and it is clear that a claim will be pursued, MPS will try to effect settlement on fair terms as early as possible. Where there is a good defence to a claim, MPS is robust in pursuing it.
9. Many claims do not withstand detailed legal scrutiny and are successfully repudiated, and MPS successfully defends a significant proportion of claims.

Membership with MPS

10. GP membership with MPS is 'occurrence-based', which means that it allows GPs to request assistance with a claim or complaint that was caused by an incident that occurred during their time as a member - even if they only became aware of it much later and after their membership ended.
11. This is important for doctors because the nature of negligence claims means that it can often be years before a case is brought and fully resolved.
12. We respond to this in how we calculate membership subscriptions. We undertake detailed and robust actuarial work to assess trends in the size of claims and the likelihood of claims for a GP. We use this information when we set membership subscriptions so that we set aside sufficient funds to meet future claims.
13. Membership subscriptions are determined by claims experience and level of risk of each area of practice.
14. We understand that a specific concern was raised during an earlier evidence session that when a GP retires, and then seeks to return to general practice, they are faced with higher subscription costs. We can confirm that returning to the workforce following retirement or long periods of non-working for whatever reason has no bearing on subscription costs. It may be that the increase in subscription costs that all GPs have experienced over recent years may be more noticeable when someone returns to work after an extended period, because they have not been aware of annual increases.

The rising cost of clinical negligence

15. Our analysis of claims demonstrates that GPs are more likely to be sued now than ever before and a full-time GP¹ is expected to be twice as likely to receive a claim for clinical negligence than just seven years ago.
16. A full-time GP can now expect to receive two clinical negligence claims over a typical career².
17. More UK primary care claims were reported to MPS in 2014 than ever before. This appears to correlate with the experience of the NHS Litigation Authority (NHS LA) in the hospital sector. Their annual report and accounts 2014/15 states that there was a 'sustained high level of new claims³'.
18. The NHS LA also reported that they 'continue to receive, and defend, a significant number of unjustified claims. More than 46% of clinical claims and 45% of LTPS⁴ claims concluded in 2014/15 were resolved with no damages payment⁵'.
19. GP claims can cost significant amounts of money. While some claims will run into thousands of pounds, others will involve millions, which far outstrips the amount a GP will pay for professional protection over the course of their entire career. The highest paid claim to date against an MPS GP member involved the failure to refer a baby with breathing difficulties to hospital and settled for over £5.5m.
20. We anticipate that we will begin to see more claims of this magnitude; indeed we have a number of open GP claims that exceed £5m that have not yet been resolved.
21. We are troubled by the rise in the cost of clinical negligence and the financial burden it poses for the NHS and society, as well as the impact that it has on our members. With the NHS Litigation Authority's potential liabilities currently at £28.3⁶ billion, and with pressures on public funding increasing, spending of this magnitude on clinical negligence is clearly a concern for society as a whole and not just healthcare professionals.
22. Tough decisions about healthcare funding are made every day; the costs of clinical negligence should not be seen as separate or unconnected from this. It is crucial that we ask ourselves as

¹ Outside of Scotland

² Typical career defined as 35 years

³ NHS Litigation Authority Annual review 'NHS Litigation Authority Report and Accounts 2014/15, Fair resolution' 2014/15 p 18

⁴ Liabilities to Third Parties Scheme

⁵ Ibid p 19

⁶ NHS Litigation Authority Annual review 'NHS Litigation Authority Report and Accounts 2014/15, Fair resolution' 2014/15

a society whether it is appropriate and affordable to continue to pay such large sums in damages and costs. We believe that these funds could be better spent on patient care for all.

Why claims happen

23. There are a number of complex and interrelated drivers behind the increase in the frequency and size of claims against GPs; these include:

- a. Increasing patient expectations and changes in attitude
- b. An increase in the number of patients being treated by GPs
- c. Time and workload pressures on GPs
- d. Disproportionate claimant legal costs
- e. Increases in life expectancy and the cost of care packages
- f. Greater awareness of the ability to, and knowledge of how to, make a claim or complain
- g. Care shifting towards primary care
- h. Advertising by claimant legal firms
- i. Recent economic experience

24. MPS does not believe that the deterioration in the claims environment is as a result of deterioration in professional standards⁷. Medicine and medical science has improved and we are seeing better health outcomes.

25. From experience we know that there are a number of key themes regularly associated with claims:

- a. Failure to diagnose
- b. Delayed diagnosis
- c. Failure to refer or seek second opinion
- d. Failure to act on tests and results
- e. Failure to meet patient's expectations
- f. Lack of access to full medical records

26. Claims become more difficult to defend where:

⁷ GMC FTP figures do not demonstrate a drop in clinical standards. Since 2006, enquires to the GMC have risen by almost 90%, however the number being referred to panel has actually declined. With regards the outcomes of panel hearings, these appear to be remaining stable.

- a. There is poor record keeping
- b. Consent was not adequately sought or documented
- c. An expectation is not met

27. We also know that there is not a strong correlation between adverse outcomes and claims and complaints⁸. According to one study⁹, 2% of GP consultations can be associated with an adverse outcome. Despite this, only a small proportion of adverse outcomes result in a patient bringing a complaint or claim and a number of complaints and claims arise when there has been no error or negligence. There is evidence¹⁰ that it is often factors other than error that leads to a complaint or claim, with poor communication and unmet expectations resulting in patient dissatisfaction being common contributors.

28. We can explore this further by examining the reasons why patients bring claims. While for some patients financial redress is their main purpose for initiating a claim, for many others it is to achieve a desired outcome that has been unforthcoming without resort to litigation. This can include finding out what happened and why, to receive an acknowledgement, apology, or acceptance of responsibility or to enforce accountability¹¹. When considering what motivates patients to bring claims, it is often as a result of both precipitating and predisposing factors¹².

29. 'Precipitating factors' refers to the incident itself that results in an adverse outcome, reflecting individual and/or system error. For instance, misdiagnosis or incorrect prescribing. System errors might relate to repeat prescribing, continuity problems at the interfaces of care, or management of test results, for example. The safety culture of a General Practice and a range of human factors are also likely to contribute to error and possible harm occurring.

30. 'Predisposing factors', in contrast, relates to the individual's professional behaviours and interpersonal skills, which can include poor communication, lack of empathy, poor listening and

⁸ Goldsmith et al, (2015) "Do clinical incidents, complaints and medicolegal claims overlap?" International Journal of Health Care Quality Assurance, Volume 28, Issues 8 pp 864-871

⁹ De Wet C and Bowie P, The preliminary development and testing of a global trigger tool to detect error and patient harm in primary-care records, Postgrad Med Journal 85 (1002): 176-80 (2009)

¹⁰ Stephen F et al, A Study of Medical Negligence Claiming in Scotland, School of Law, University of Manchester (2012). Available: <http://www.scotland.gov.uk/resourse/0039/00394482.pdf>

¹¹ Bismark MM et al, Accountability sought by patients following adverse events from medical care: the New Zealand experience, CMAJ 175(8): 889-894 (2006) and Bismark, MM et al, Remedies sought and obtained in healthcare complaints, BMJ Quality and Safety 20(9): 806-810 (2011) and O'Connor E et al, Disclosure of patient safety incidents: a comprehensive review, International Journal of Quality health care 22(5); 371-379 (2010) and Vincent C et al, Why do people sue doctors? A study of patients and relatives taking legal action, The Lancet 343:1609-13 (1994)

¹² Bunting R et al, Practical Risk Management for Physicians, J HealthRisk Management 18(4):29-53 (1998) and Stephen et al 2012

issues around manner and attitude among others. These can be important triggers to patients taking action should an adverse outcome occur.

31. Poor handling of an adverse outcome, such as a feeling of abandonment or a wall of silence, can also be a predisposing factor. MPS advocates a policy of full and open communication. An open and honest explanation may be what is needed to reassure a patient and avoid any escalation. If it is clear that something has gone wrong, an apology is called for, and it should be forthcoming. Contrary to popular belief, apologies tend to prevent formal complaints rather than the reverse.
32. The circumstances of the care provided are also important. The benefits of an established professional relationship built on trust are much less likely to be present in an unscheduled/out of hours setting making predisposing factors as perceived by the patient more likely to occur.
33. Reducing precipitating factors and adverse outcomes through patient safety initiatives, clinical governance and risk management may help to improve safety and reduce event frequency. However, precipitating events alone often do not result in patient action. It is the combination of a precipitating event occurring in the presence of a predisposing factor that is more likely to trigger patient action.
34. MPS has an important role supporting its members to prevent claims by addressing both predisposing and precipitating factors. We have invested in our education programmes, that we offer free to members and also make available to non-members, and includes:
 - Communications skills workshops
 - Mastering Adverse Outcomes Workshop
 - Risk Management workshops
 - Complaints management training
 - Online assessments and self-audits
 - Online learning
 - Practice risk assessments and support
 - Publications, case studies and lectures

Scheduled and unscheduled care

35. The environment in which GPs operate is changing, and we are actively working to respond to these changes to support our members.

Why unscheduled care is higher risk

36. Unscheduled care/out of hours is exposed to materially higher risks that can result in larger clinical negligence claims. The experience of our members shows us that claims involving care outside of scheduled opening hours are likely to result in higher costs.
37. We find there are a number of contributing factors, including restricted access to medical records, an unfamiliar working environment, the patient population presenting often having illnesses of a more acute nature, as well as a more limited availability of ancillary staff.
38. This means that the subscription we charge GPs carrying out this work must also be materially higher. If we didn't do this, we'd have to share the additional cost of claims resulting from Unscheduled Care with all GPs. We believe this would be unfair.

Responsive and flexible approach

39. As an organisation we strive to listen and respond to the needs of members and changes in their working environment. Following feedback from members and stakeholders, we recently announced some changes to how we set our GP membership subscriptions.
40. This change is part of our wider commitment to offering flexible membership options and ensuring that we reflect the current and emerging patterns of primary care delivery in England and the rest of the UK.

The change

41. For the majority of GP members we currently set subscriptions based on the number of weekly sessions (half days) undertaken.
42. Previously, we had two levels of pricing to help differentiate between levels of risk in primary care. These were defined as *Core Hours sessions* and *Out of Hours sessions*.
43. So, if a GP undertook sessions outside of their Core Hours (as defined in the GP contract as 8am to 6.30pm Monday-Friday) they could expect to pay an increased subscription rate for their MPS membership.

44. However, if they took part in the Prime Minister's Challenge Fund, or a small amount of Out of Hours work, subscriptions were typically unaffected - we factored in a small number of Out of Hours sessions into their Core Hours subscription rate. For example, if they already worked 10 sessions a week, they could undertake two of those 10 weekly sessions outside of Core Hours at no additional cost.
45. We will continue to calculate a price based on the number of weekly sessions a GP undertakes. However, from the 1 January 2016, instead of sessions being defined as Core Hours and Out of Hours, we are now classing them as *Scheduled Care sessions* and *Unscheduled Care sessions*.
46. What we previously called Core Hours sessions will now be *Scheduled Care sessions*. We define Scheduled Care as work undertaken during the scheduled opening hours of the practice (within 8am-8pm seven days a week) where registered patients are seen by appointment (or during scheduled periods of open appointments for registered patients) and where staff have access to the patient's full general practice records. We also include within this definition, patients from other practices where there is an arrangement to provide care during scheduled opening hours and there is access to full patient records.
47. Out of Hours sessions will now be called *Unscheduled Care sessions*. We define this as any work that falls outside the above Scheduled Care criteria, such as sessions undertaken at any time of day in walk-in/urgent care centres.
48. Of course, we understand that the cost of indemnity for GPs working in Unscheduled Care settings is a concern for both them and the wider profession. To support those members, we allow for a limited amount of Unscheduled Care work within a standard Scheduled Care rate.

New models of care

49. As highlighted earlier, we seek to reflect the environment in which our members operate and have a responsive and flexible approach. MPS recognises the key role that new models of care have to play in healthcare delivery. We want to ensure that our approach to risk supports the new and emerging models of primary care and we are keen to work closely with NHS England to achieve this.

50. It was with this in mind that we made the decision to change our approach to move to scheduled and unscheduled care. We believe this will help GPs offer appointments to their patients seven days a week.
51. However, so that we can be responsive to change, it is important that we fully understand all of the new models and their implications for our members. We are actively assessing the impact that developments may have on the risks that members face.
52. MPS already offers a group arrangement for GP Practices called Practice Xtra. As part of this arrangement, MPS can provide access to indemnity-only membership benefits to nurse practitioners, practice nurses, and practice managers, when they are employed by the practice. MPS can also provide individual associate membership for physician associates working in General Practice as long as the practice in which they are employed is on an MPS Practice Xtra arrangement.

Pharmacists

53. MPS does not currently offer membership to Pharmacists. Presently we feel that there are already well established indemnity arrangements for pharmacists which are more appropriate for them to utilise in general practice, particularly given that the employment of pharmacists in primary care is in its infancy. This position may change in the future as we are keen to meet the demands posed by new models of care. We are willing to consider including indemnity for additional healthcare staff, but we will need to carefully assess the risk they pose.

Other healthcare professionals and risk

54. It is important to remember that employing Physician Associates or Nurse Practitioners within a GP practice will not reduce the overall burden of risk. While they may help to reduce the workload of a GP and possibly take away some of the direct risk from the GP, the Physician Associates and Nurse Practitioners will increase their own risk for which they will require insurance or indemnity either arranged individually or through their employer which will have an attached cost.
55. MPS recognises the expansion of various health professions providing primary care services that will require indemnity arrangements either individual to themselves or arranged through their employer, which in many cases will be the GP. The level of risk attached to any one individual will obviously depend on their role and degree of autonomy, regulatory requirements,

level of delegated authority and most especially the extent of autonomous decision making. MPS continues to actively review this continually developing situation.

Solutions

56. We understand that the cost of professional protection for unscheduled care is probably a contributing factor to the potential reluctance of some GPs to undertake unscheduled care/out of hours. However, it is not the only, and probably not the most significant, factor. Working nights and weekends is, understandably, unappealing to many GPs on top of their increasing daytime workload, and in some instances the GP will be required to travel great distances to provide out of hours care which is unworkable for them.
57. As the provision of unscheduled/out of hours care is crucial, we think that it is important to carefully explore the complexities involved.
58. NHS England recently announced a Winter Indemnity Scheme, which we fully support and are working with them to deliver. This is a short-term solution whereby NHS England covers the cost of professional protection for any *additional* out of hours/unscheduled work undertaken by GPs this winter. However, we believe longer-term, sustainable solutions are needed.
59. We understand that it can appear appealing to suggest that the GP community should fall under the remit of the NHS Litigation Authority in the same way as hospital doctors do. This has been referred to as 'Crown indemnity'. However, the situation is far more complex. Unlike hospital doctors who are directly employed by their Trust, GPs are self-employed. Therefore while for hospital doctors their employers can access indemnity through the NHS LA, GPs, as self-employed individuals, have different arrangements.
60. MPS supports its members as individuals, protecting their reputation and interests. In contrast, in managing claims for Trust members, the NHS LA will liaise with the Trust management, rather than the individual doctors and other clinical staff involved.
61. Ultimately the cost of risk always needs to be paid for. The majority of the costs related to a clinical negligence case are damages and claimant costs. There is no reason to believe that an alternative system would significantly reduce the cost of accessing professional protection, nor reduce the risk. Alternative options may transfer the risk to alternative providers – such as government – but the risk would remain the same.

62. Instead, we believe there are a number of potential medium and long-term legal reforms and education solutions that will begin to tackle the rising cost of clinical negligence, and in particular those associated with unscheduled/out of hours care. These solutions aim to tackle the cost of risk itself.

Medium-term

63. Assess and seek to mitigate the specific risks that occur in unscheduled care/out of hours including:

- a. Access to full patient records to enhance continuity of care
- b. Additional training in out of hours / unscheduled consultations including telephone consultation techniques and triage
- c. Strategies to enhance the prompt diagnosis and management of serious conditions
- d. Improving communication across interfaces of care

64. An increased focus on education and risk management:

- a. Education and risk management initiatives to limit predisposing factors and the issues that make it harder to defend a claim:
 - i. Effective doctor-patient communication skills
 - ii. Effective communication between healthcare professionals
 - iii. Managing challenging interactions
 - iv. Effective communication with patients following an adverse outcome
 - v. Record keeping
 - vi. Consent and shared decision making
- b. Assess the potential for reducing precipitating factors by tackling individual or system errors that can lead to a claim such as misdiagnosis and prescribing errors and prioritising a culture of safety within general practice.
- c. Tackle cultural and environmental barriers to openness and resolution of concerns

Long-term

65. Tort reform and reform of the legal process. MPS published a paper in April 2015 which considers a number of potential reforms.

a. **An ultimate limitation period on bringing claims.** It is not unusual in England and Wales to see late notification of claims. For example, MPS recently received notice of a claim involving the failure to diagnose a disease in a toddler in 1990. We were notified of the claim in 2015 when the claimant was 25 years old. Late notification of a claim means that:

- Records may have been lost or destroyed; hospitals and other institutions are unable to provide records
- Medical staff may have retired, died or cannot be traced
- Medical staff may have little recollection of the facts of the case

Late notification of claims contributes towards delay and higher costs. The longer the delay between the incident and the claim, the greater the opportunity there is for claims inflation to increase levels of damages. There is a balance to be achieved between the rights of claimants and defendants and a public interest in ensuring that claims are pursued as quickly as possible.

b. **Consideration of a limit on future care costs and consideration of a limit on future earnings.** In our experience, damages claims for care costs and future earnings have increased in recent years. As part of the debate around healthcare costs and what society can afford, we should consider the potential impact of limits on future earnings and future care costs in special damages awards.

c. **Fixed costs regime for legal costs in smaller value claims.** It is not unusual for claimants' lawyers' costs to exceed the damages awarded to claimants in lower value claims. Two recent examples include:

- In a recent cosmetic surgery case, damages of £17,500 were agreed within five months of being notified of the claim; however legal costs were claimed in excess of £50,000. The costs were finally settled at £36,000. This is still over double the amount the patient received in compensation.
- In a second case relating to delayed diagnosis of skin cancer, damages of £30,000 were agreed within five months and legal costs were claimed to the sum of £60,000. These costs were eventually settled at £42,000

To ensure that legal costs do not dwarf compensation payments, a fixed costs regime for small value claims should be introduced.

Such a system already exists for road traffic accidents and employer liability claims and should be extended to clinical negligence claims. MPS welcomes the recent Department of Health pre-consultation into how such a system could be introduced in England and Wales, and we look forward to taking part in the fuller consultation early in the New Year.

CONTACT

Should you require further information about any aspects of our response to this inquiry, please do not hesitate to contact me.

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