Priorities for the next government - 2015-2020

April 2015

Funding restraint, changing demographics and integrating health and social care will be major issues in healthcare for the next government. To meet these challenges, it is crucial that the next administration has a vision for how to engage with healthcare professionals and give them a voice in the development of health policy.

This year's annual NHS Staff Survey[1] shows that healthcare professionals are remaining steadfast when services are under strain. However, the survey also shows increasing pressure being placed on those same NHS staff.

These pressures can come from regulators and a fear of litigation, both of which can harm staff morale.

A Medical Protection Society (MPS) survey of 600 GP members revealed that 67% of respondents are fearful of being sued by patients. Of those, 85% feel that the fear of being sued impacts negatively on the way they practise. This fear is not without foundation, as MPS analysis of claims shows that a full time UK GP is expected to be twice as likely to receive a claim from their work this year, as they were just seven years ago.

There continues to be a rise in patient expectations, alongside which we are seeing an increase in the number of cases referred to the General Medical Council (GMC). In 2013, the number of complaints the General Medical Council received represented a 64% increase on the number of complaints in 2010.[2]

Doctors are also finding themselves under considerable pressure when under investigation by the GMC. An MPS survey of 180 doctors investigated by the GMC in the last five years found that 72% believed that the investigation had a detrimental impact on their mental and/or physical health. We also conducted a separate survey of 140 dental members who had been investigated by the General Dental Council (GDC). The survey revealed that 94% felt it had an impact on their stress and anxiety, and 33% said they had considered leaving the profession because of the experience.

1. National NHS Staff Survey 2014 results: www.nhsstaffsurveys.com/Page/1006/Latest-Results/2014-Results
2. General medical Council, October 2014, 'The state of medical education and practice in the UK report: 2014

Creating a collaborative, open learning culture and promoting professionalism and accountability

An MPS member survey of more than 500 doctors earlier this year revealed that 68% of respondents either agreed or strongly agreed that the current culture in healthcare is one of blame and shame, and that it will be difficult to overcome this.

The vast majority (72%) felt that education and training would encourage openness in the profession and 65% pointed to the need for better top-down support from management. Mentoring was also considered an important factor with 50% pointing to this. Only 16% said that they felt that legislation could be used to improve openness in healthcare.

The next administration needs to empower and support healthcare professionals to do what they entered healthcare to do – care for patients. Removing a culture of fear, and in its place creating one of openness and learning, should be a focus for government.

Recommendation: A moratorium on the introduction of new regulations on the healthcare profession

Safeguarding the public and improving patient care must be a priority for government; however regulation is not always the best way of achieving this.

For example, although there is consensus that openness should be encouraged in healthcare, there is a debate about how best to achieve the desired change. MPS does not believe that blunt legislative tools are the most effective method.

A statutory duty of candour now exists in England and Wales. Consultations on similar statutory duties are ongoing in Northern Ireland and Scotland respectively. However, MPS strongly believes that a change in culture would be far more effective at promoting openness, professionalism and accountability amongst those working in healthcare. Focusing on legislation and regulation as the key methods of driving behavioural change will undermine this.

MPS has similar concerns about the recent introduction of a criminal sanction for ill-treatment or wilful neglect. 65% of hospital doctors that responded to an MPS survey stated that they believed that the introduction of such a sanction will create a culture of fear in hospitals.

In MPS's experience, a reliance on legislation and regulation risks creating defensive behaviours, where self-preservation becomes a dominant influence, instead of a focus on the best interests of the patient. It is crucial that the next government resists introducing new regulation of a similar nature on individual doctors and dentists.

Recommendation: Explore and invest in alternatives to regulation

MPS would like to see a greater focus on encouraging healthcare professionals to want to be accountable. Accountability requires open disclosure and an open learning culture which brings with it willingness to apologise. Mandating actions and threatening sanctions is unlikely to deliver sustainable cultural change.

Continuously legislating to govern the behaviours of healthcare professionals risks the creation of a 'tick-box' mentality. This mentality runs counter to the intensely sensitive, personalised and patient-centred conversations that should happen with patients and their families when something has gone wrong.

For a cultural shift to be effective and far-reaching, the government and healthcare managers need to facilitate this type of environment by encouraging organisations to develop policies and processes to support open communications and the notification of adverse events and near misses. As our statistics demonstrate, doctors believe that better top-down support from management, alongside education and training, will encourage openness.

MPS supports members by providing risk management training, helping healthcare professionals improve patient safety and reduce risks. MPS stands ready to play its part, and urges government to invest further in continuous training for healthcare professionals in order to support them to meet their professional obligations.

Tackle the rising cost of clinical negligence

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)

The cost of clinical negligence is taking valuable funds away from the care of patients. It is important to have a debate as to whether the rising cost of clinical negligence is affordable for society.

Tough decisions about healthcare funding are made every day; the costs of clinical negligence should not be seen as separate or unconnected from this.

The NHS Litigation Authority's total outstanding liabilities (the expected cost of settling all outstanding claims) potentially runs to £25.7bn.

MPS analysis of claims shows that GPs are more likely to be sued now than ever before and a full-time UK GP is expected to be twice as likely to receive a claim from their work this year as they were just seven years ago.

It is not unusual for claimants' lawyers' costs to exceed the damages awarded to claimants in lower value clinical negligence 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.

Added to this, MPS continues to be notified of claims where patients have entered into legal costs arrangements with their lawyers which predate the civil litigation cost reforms brought into effect by the Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPO) in April 2013. This Act was intended to reduce the costs of civil litigation, but has not yet had this anticipated impact.

Recommendation: 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.

In Australia, some states operate a long-stop period. This is 12 years in South Australia, Western Australia and New South Wales. All US states have statutes of limitation for clinical negligence claims. In California this stands at three years or one year from discovery with a maximum limit of three years. In Texas it stands at two years with a 10 year maximum.

However, MPS recognises the need for judicial discretion in certain circumstances, for example where the parents of a seriously injured child are unaware that the child might have a claim in negligence until many years after the incident date.

Recommendation: Fixed costs for small value clinical negligence claims

MPS recommends:

- A fixed costs regime for small value clinical negligence claims to be established in statute

It is not unusual for claimants' lawyers' costs to exceed the damages awarded to claimants in lower value claims.

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 urges government to take the lead on this and introduce such a system in statute.

Recommendation: Reform rules relating to claimant expert reports covered by 'after the event' insurance

MPS recommends:

- A limit on the number of expert reports that can be commissioned to support a case – one breach expert and one causation expert
- A cap on the amount that can be spent on an expert witness
- Greater transparency over the way in which the premiums paid by losing defendants are calculated

It is disappointing that LASPO reforms continue to allow the costs of expert witnesses in clinical negligence claims to be covered by after the event insurance, without any limits. The premiums for this insurance are payable by the defendant if the claimant is successful. These costs are no longer recoverable in any other personal injury claims. The regulations do not provide for a limit on the number of expert reports covered by the insurance premium or a cap on the experts' costs.

Recommendation: A debate on the merits of a limit on special damages

MPS recommends:

- Consideration of limits on special damages, including:
  - A limit on future care costs
  - A limit on future earnings which recognises national average weekly earnings

In our experience, special damages claims have increased in recent years. Special damages seek to compensate the claimant for incurred and expected financial losses as a result of the incident. This includes compensation for future care costs and future earning capacity and other financial losses.

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.

Other countries have introduced such limits. In some Australian states there are limits on the loss of earnings at typically a multiple of two or three times the average weekly earnings. Tasmania puts a limit on loss of earning capacity at 4.25 times the adult average weekly earnings. We need to explore whether a limit based on average weekly earnings would have benefits in England.

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About MPS

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 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.

Our 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.

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