**Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar dyfodol ymarfer cyffredinol yng Nghymru**

**This response was submitted to the Health and Social Care Committee consultation on the future of general practice in Wales**

**GP29 : Ymateb gan: Undeb Amddiffyn Meddygol | Response from: Medical Defence Union (MDU)**

# Health and Social Care Committee Inquiry into the future of general practice in Wales

## The Medical Defence Union (MDU)

*Submission*

March 2025

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### About us

1. The Medical Defence Union (MDU) is a medical defence organisation (MDO). We were established in 1885, making us the oldest such organisation in the world. We represent the interests of thousands of healthcare professionals across Wales, including general practitioners and support staff. We are a mutual, not-for-profit organisation, and exist solely to serve the interests of our members.

### Regulation of general practitioners

2. In the event that a general practitioner, either in Wales or in another nation within the UK, is viewed as having potential shortcomings in their conduct or competence, then the General Medical Council (GMC) has the power to launch a fitness to practise investigation into the practitioner in question.

3. The MDU believes that where serious concerns about a medical practitioner are raised, the accusations should be properly investigated, and appropriate measures should be put in place to protect the public.

4. However, the MDU has significant and long-held concerns about the timeliness of GMC investigations and the impact this can have on individual practitioners.

5. Our concerns are not the result of anecdotal evidence, but rather due to the statistical research and findings of the Professional Standards Authority (PSA). Each year, the PSA undertakes a "performance review" into each of the healthcare regulators, including the GMC, and produces a report based on its

findings. These include an examination of the time taken for fitness to practice cases.

6. The PSA Performance Reviews for the GMC in recent years have shown that it takes a significant period of time for the median case to proceed from receipt to final hearing. The latest review by the PSA, which covers the 2023/24 period, found that on average this figure stands at over 100 weeks.[1] Notably, this figure is not an anomaly by the standards of recent years. The last time this figure was below 100 weeks was in Q2 2020/21.[2]

7. Whilst this is a statistic, it is important to remember the people behind the numbers. MDU members tell us that undergoing a GMC investigation is one of the most difficult experiences of their professional lives. During this time, many live with greater levels of stress, with the potential of having their career ended hanging over them.

8. Whilst these cases are ongoing, there is also the risk that access to primary healthcare in certain locations becomes significantly more limited. A GMC investigation can impose interim measures on an individual general practitioner. Depending on the nature of the accusation, this can involve measures that would limit a doctor's ability to see patients, such as requiring supervision. In less populated areas, these provisions may result in a significant challenge for general practitioners who wish to continue with their work, due to a lack of other general practitioners who would be able to undertake duties such as overseeing them. This in turn will likely have a knock-on effect for patients, further reducing access.

9. The fastest way to address this problem would be for a Section 60 Order to be issued by the Secretary of State for Health and Social Care via secondary legislation under the Health Act 1999. This would allow for the GMC to reform its fitness to practice procedures and therefore reduce the time being taken on individual cases overall.

10. Whilst such a move would be a reserved matter for Westminster, we would urge the Senedd to have discussions with the UK Government about the implementation of such an Order, which we believe would have a positive effect for general practitioners throughout Wales.

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[1] Professional Standards Authority, "General Medical Council performance review report 2023/24", accessed 20 March 2025, Periodic Review - GMC 2023-24.

[2] Professional Standards Authority, "General Medical Council (GMC) Performance Review – Monitoring Year 2022/23", accessed 20 March 2025, Monitoring Report – GMC 2022-23.

## Clinical negligence reform

11. The MDU believes that patients harmed as a result of negligence must receive appropriate compensation. However, the law surrounding clinical negligence in the UK has become increasingly outdated and is resulting in significant amounts being paid out that could be redirected to frontline NHS services.

12. This is particularly pertinent within Wales. Towards the end of last 2024, the MDU undertook an audit of the Annual Reports and Accounts of the NHS Health Boards and Trusts throughout Wales for the 2022/23 financial year. This was the most recent year for which all such accounts were available.

13. The findings of this audit were stark. Prior to legal costs being taken into account, we discovered that 3.4% of the health and social care budget in Wales for that financial year was dedicated to addressing clinical negligence compensation. For comparison, Lord Darzi's recent report into the NHS in England identified that 1.7% of the health budget was spent on clinical negligence compensation in the 2023/24 financial year – meaning Wales spent double the proportion of its health budget on clinical negligence in comparison to England.[3]

14. Internationally, this makes Wales an even greater outlier. In Lord Darzi's review, he stated that:

> "the NHS in England is an outlier in clinical negligence payments, devoting double the share of total health spending as New Zealand, ten times the level of Australia, and twenty times as much as Canada."[4]

    Comparatively, this would mean that Wales spent four times the share of total health spending on clinical negligence as New Zealand, twenty times the level of Australia, and forty times the level of Canada.

15. The MDU has identified that part of the reason for the disproportionately high costs of clinical negligence in the UK is due to section 2(4) of the Law Reform (Personal Injuries) Act 1948. This section of the legislation requires courts, when determining compensation awards for clinical negligence payments, to

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[3] Darzi, Ara. "Independent Investigation of the National Health Service in England" (Department of Health & Social Care, September 2024), accessed 20 March 2025, https://assets.publishing.service.gov.uk/media/66f42ae630536cb92748271f/Lord-Darzi-Independent-Investigation-of-the-National-Health-Service-in-England-Updated-25-September.pdf.

[4] Ibid

disregard the existence of NHS care and instead base it on the cost of private care.

16. This section of the law is based on a recommendation made in 1946, two years before the establishment of the National Health Service, which therefore could not take into account the existence of a health service that would be free at the point of use.[5] The committee that made the recommendation even stated at the time that this section of the legislation "might need to be radically altered if a comprehensive health service is introduced".[6]

17. Additionally, one of the reasons for the high costs of clinical negligence claims is the exceptionally high legal costs in comparison to the level of compensation awarded. In one case related to general practice in Wales in which the MDU was involved, the claimant settled for £7,000 in compensation, whilst their legal costs came to £75,000 – more than ten times the amount received.

18. A key reason underpinning these high legal costs is that clinical negligence legal cases are not subject to a system of "fixed recoverable costs" (FRC). An FRC scheme would set the amount of legal costs that can be claimed back from the losing party by the winning party in litigation. This is the standard mechanism in place for the majority of injury claims, but clinical negligence is an exception.

19. Proposals for an FRC scheme have been in place for years. In England, the Department for Health and Social Care launched a consultation on this proposal in 2022, with the recommendation published in 2023 ultimately being that a system of FRC should be implemented.[7]

20. The MDU would strongly encourage dialogue between the Senedd and Westminster to address both the repeal of Section 2(4) of the Law Reform (Personal Injuries) Act 1948 and the implementation of a FRC system for lower value clinical negligence cases. We believe that such changes would result in a significant release of otherwise committed healthcare expenditure, which could be utilised for investment in frontline healthcare services,

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[5] Michael Devlin, "Clinical negligence claims - the compelling case for systematic reform," *Journal of Personal Injury Litigation* 3 (2024): 215–22.

[6] Ibid

[7] Department of Health and Social Care, "Fixed recoverable costs in lower damages clinical negligence claims – Government response", September 2023, accessed 20 March 2025, Government response: fixed recoverable costs in lower damages clinical negligence claims.

including general practice. This would result in no additional funding having to be found through other mechanisms.

## Conclusions

21. The MDU has been repeatedly raising the alarm over the challenges facing GPs as a result of the current regulatory system in relation to fitness to practice cases. We have outlined in this submission how the Senedd can work alongside Westminster to address this issue. Furthermore, we have also detailed the issues relating to the cost of clinical negligence and potential solutions for how to address this, including the repeal of Section 2(4) of the Law Reform (Personal Injuries) Act 1948 and the implementation of a FRC system.

22. Challenges facing general practice in Wales are profound however we believe there are cost-effective and rapid reforms that could help address issues and improve outcomes for practitioners, staff & patients.

*Response on behalf of the MDU provided by Thomas Reynolds, Director of Policy & Communications, Medical Defence Union.*

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