

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

As outlined under Q 1, we believe that current systems for incident investigation, complaints handling and early compensation need to be reviewed and amended. We are not convinced that the Measure as it stands will remove all those obstacles which currently make the system less responsive than we would like.

The advantage to us would accrue from a more integrated approach to investigation of incidents at an early stage (subject to the caveats of our response to Q4) which would also benefit the handling of higher value claims. Prompt redress should also reduce the numbers of litigated claims which are made.

The information given does not indicate that the scheme would greatly increase the workload of the Welsh Risk Pool but more detail on mechanisms for payment or monitoring of performance may require revision of that opinion.

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

- Prompt reporting and investigation of negligent adverse incidents.
A number of studies have indicated that negligent clinical incidents are consistently under reported. UK comparisons of retrospective studies of case notes with incident reports indicates that less than 20% may be reported. This level has been increased by a number of initiatives as it probably stood at less than 1% in 1999/2000. The reasons suggested for this are many and varied and while some are cultural or arise from fear of consequences others are down to the differing perceptions of what constitutes a negligent clinical incident or even a lack of realisation that anything untoward has taken place. Whatever the reason for such a low level of prompt reporting, this will hamper the early and effective investigation of a high proportion of incidents.

A number of initiatives to increase the level of reporting could be considered for piloting and inclusion in the Measure.

- Rehabilitation
The concept of providing a customised programme of rehabilitation as part of a package of compensation is very worthwhile. It indicates a willingness to acknowledge harm and demonstrates care. Early rehabilitation, as well as enabling the patient to return more quickly to normality would have the effect of limiting the extent of compensation required.

The practical difficulty lies in the lack of provision of the level of therapy needed, by the NHS or indeed by the utilisation of the private sector.

- Legal Advice
There are potential difficulties in the provision of free legal advice to claimants under the scheme whilst keeping quality high and costs at a reasonable level. Capped cost schemes do not appear to be popular with lawyers and so there may only be a low level of uptake from appropriately qualified and experienced lawyers.

Solicitors may see the scheme as a repository for those cases which they would not normally consider taking further by traditional means. Costs may be incurred, therefore, in cases which would otherwise have been filtered out naturally by the current system.

It is neither suggested nor excluded in the Measure but Advisors other than fully qualified legal professionals may be considered. If this route were allowed then mechanisms to carefully control training, assess competence and monitor performance would need to be introduced. Perhaps, more controversially, we should be asking – should we really be offering free legal advice within such a scheme?

- Primary care

Applying this scheme to primary care in general would pose difficulty engendered mainly by the varied nature of contractual arrangements which exist in that sector. Those GPs, dentists, pharmacists who currently have a contract of employment with a trust or LHB would be covered by NHS indemnity and so this scheme could be applied to them and would not affect their arrangements with medical defence organisations. These are still only relatively few in number however.

The extent of the work necessary to develop a scheme which would not lead to greater alienation of this group and thus recruitment and retention problems would take some time to develop.

Increasing reliance on private nursing homes to provide care normally provided by the NHS will also need to be taken into consideration.

5. Is it appropriate that so much be done by regulations i.e. the details of any scheme will be decided by Welsh Ministers?

It is not inappropriate that high level regulation be applied to this issue and raising the profile will assist in accelerating the pace of change already underway.

With a number of potential obstacles to success, however, it would be useful to have the opportunity to develop solutions and pilot those solutions prior to their inclusion in the final Measure. The current processes have their merits and have evolved over a long period. That they need to be refined to provide a more patient focussed system is not questioned; it is the timescale which endangers the development of a really effective system which will satisfy the needs of the patient and build the confidence of patients and staff in its fairness.

6. No fault scheme

The experience of New Zealand and some other countries who have introduced no fault schemes is not encouraging from the costs perspective. Estimates of the likely increase in demand on the public purse in England at the time that the consultation document “Making Amends” was published in 2003 indicated at least a quadrupling of costs.

The use of a no fault scheme for lower value claims would also create a two tier with different standards for success.