No-Fault Compensation for injury resulting from medical treatment: Consultation Questions

1. The research team supporting the review reported (Farrell *et al*, 2010[19])that previous research suggests that when an error has occurred, patients expect doctors to make a meaningful apology, provide an explanation and take steps to prevent the error from recurring. The findings of their research would appear to support the contention that for many, if not most, patients this is the primary aim, rather than a financial award.

2. The Scottish Public Services Ombudsman (SPSO) has published advice in relation to apology[20]. This advice was referenced in the guidance issued to NHSScotland in March 2012 on the handling and learning from feedback, comments, concerns and complaints.

Question 1:What, if any, steps do you feel are necessary or appropriate to ensure thatwhen an error has occurred, patients receive a meaningful apology?

Human performance limitations are acknowledged as a component part in errors made within complex systems. Most high risk industries recognise that such errors, by virtue of human involvement will occur and take the steps necessary to mitigate against this error and the potential harm that any such error may cause.

Recognising that, despite the best efforts, this risk cannot be eliminated, it is important that where an error occurs patients, their family and carers are given a timely apology, adetailed explanation of the sequence of events that led to the error, an explanation of the action being taken to prevent a repeat of the event and subsequently an apology that, the error that has occurred.

It is our view, that an explanation for causality is equally important to an expression of contrition. Moreover, the concept of utilising ‘avoidability’ as an index of acceptance of responsibility for the harm caused as opposed to a requirement to prove negligence is a particular attraction and will not be easily replaced by a list of eligible/ineligible conditions or circumstances.

Furthermore, the perception that an apology immediately implies guilt can hamper the delivery of a timely apology to patients, their families and carers. In order to support clinicians guidance and / or training should be developed to ensure that they can be confident in delivering a timely and meaningful apology to patients without the fear that this would compromise them at a later date.

[19] http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/No-faultCompensation/Volume-II-report
[20] http://www.spso.org.uk/files/2011_March_SPSO%20Guidance%20on%20Apology.pdf

3. The Review Group considered that the following were essential criteria for a compensation scheme for injuries resulting from medical treatment:

- The scheme provides an appropriate level of compensation to the patient, their family or carers
- The scheme is compatible with the European Convention on Human Rights
- The scheme is easy to access and use, without unnecessary barriers, for example created by cost or the difficulty of getting advice or support
- People are able to get the relevant specialist advice in using the scheme;
- Decisions about compensation are timely
- People who have used the scheme feel that they have been treated equitably
- The scheme is affordable
- The scheme makes proportionate use of time and resources
- The scheme has an appropriate balance between costs of administration (e.g. financial or time) and the level of compensation awarded
- Decisions about compensation are made through a robust and independent process
- The scheme has an independent appeal system
- The scheme treats staff and patients fairly/equitably
- A reasonable time limit is set for compensation claims.

Question 2. Do you agree that the principles and criteria set out above are essential in a compensation system?

Yes.

2.1 Are there any to which you would attach particular priority or importance? Are there any others you would add?

It is important that the scheme is accessibleand functional, with equity in access being particularly important. It is also essential that there are mechanisms for accountability, quality assurance and externality evident to all involved in the scheme as well as the general public. It is also important, therefore, that the scheme is well publicised in order to facilitate patient engagement. The fact that this aspiration has not been achievedwithin the New Zealand scheme is noted. Access to the relevant advice will also help achieve this aim.

That the scheme is seen to be equitable will be important in ensuring that it is successful. The inclusion of an appeals process will assist in this respect. It is also vital that the scheme is affordable and sustainable in the longer term. The detail provided concerning the potential costs does not allow this evaluation to be made. Whilst we accept the merits of the proposed scheme in reducing contest between expert witnesses, expediting resolution of compensation and being generally fairer to all concerned it must not compromise accountability where negligent care has been given.

We have concerns in this regard since we are not aware of any information or evidence that suggests no-fault compensation actually reduces the volume or size of claims and that dissatisfaction with the level of awards at civil level may prompt pursuit through the criminal system.

Key to engendering public trust in the scheme and ensuring it is perceived to be fair will be ensuring suitable independence in assessing eligibility for no fault claims and in deciding on the level of awards given.

4. The Review Group identified a number of issues it believed were relevant to the likely success of any system and agreed that the following criteria were desirable, and considered and highlighted the importance of the wider issues detailed below:

Desirable

- The public in general trusts the scheme to deliver a fair outcome
- The scheme does not prevent patients from seeking other forms of non-financial redress, including through the NHS Complaints system
- The scheme encourages transparency in clinical decision-making
- The scheme contributes to rehabilitation and recovery.

Question 3: Do you agree that these criteria are desirable in a compensation system?

Yes – The College believes that these criteria are not only desirable but essential.

3.1 Are there any others you think are desirable and should be included?

The College believes that the scheme should inform patient safety programmes in Scotland and contribute to the continuous improvement of clinical practice.

Wider issues

- The scheme contributes to:
  - organisational, local and national learning
  - patient safety
  - quality improvement
- Lessons learned can be used to influence organisational risk management in the future
- The scheme encourages and supports safe disclosure of adverse events
- The scheme does not put barriers in place for referral to regulators of any cases which raise grounds for concern about professional misconduct or fitness to practise.

Question 4: Do you have views or ideas on howa compensation scheme could more effectively contribute to the wider issues identified above?

The College believes that it is essential that bad practice and its identification is not compromised through the implementation of a no fault scheme and that learning from adverse events is achieved. Notification of adverse events and episodes of harm, as well as ensuring reporting and learning from these episodes, are the key processes that need to be imbedded into the scheme in order to achieve the above.

One potential means of achieving this would be a requirement that the employing body considers the outcome report of any use of the scheme within their area of authority and produce an action plan to ensure that the problem does not reoccur. This could be further supported through the production of regular (six monthly or annual) reports on concluded cases and the actions that have been taken as a result of them.

5. When considered the Review Group's suggested essential principles and criteria against other schemes and the Swedish model came out on top. Based on this the Review Group offered:

> **Recommendation 1 -** that consideration be given to the establishment of a no-fault scheme for medical injury, along the lines of the Swedish model, bearing in mind that no-fault schemes work best in tandem with adequate social welfare provision.

Question 5: Based on the background information on the system in operation in Sweden given in Annex A would you support the approach suggested in Recommendation 1?

Partially support.

If not, why not and what alternative system would you suggest?

The College is, in principle, supportive of this approach and the benefits it can bring in terms of driving improvements in patient safety.Although, we do stress that the litigation culture in the UK is different to that in Sweden (or indeed that of the other Countries discussed in Annex A of the consultation document) and, as such, it is important to avoid assuming that a simple extrapolation of from the Swedish model to Scotland can be made.

As stated previously, we would endorse the notion of 'avoidability' being an appropriate context for consideration of no-fault compensation. We do, however, harbour significant concerns about the detail behind the approach. For example, we would query the use of 'root cause analysis', as often there is not a single root cause and errors are a result of multiple serial failures of care and interventions and result from systemic as well as team and individual failure. Additionally error detection and attempting to mitigate against harm may also have failed in these instances.

It is also important to be careful in the use of the “expressed professional” as outlined, as the judgements can be affected by hindsight bias and may be based on information that was not available to a clinician at the time of the event.

Recommendation 2 - that eligibility for compensation should not be based on the ‘avoidability’ test as used in Sweden, but rather on a clear description of which injuries are **not** eligible for compensation under the no-fault scheme.

Question 6: Would you support the approach in Recommendation 2? This would mean for example that where treatment carries a known risk and the patient has given consent to that treatment it would not be eligible.

No – The College does not support this proposal. We believe that the ‘avoidability’ test, as used in Sweden, is a more appropriate approach.

Giving consent does not itself exempt clinicians from responsibilities in reducing/obliterating harm as a consequence of care delivery. Better clarity must be provided in this proposal around the differences between complications of care particularly when comorbidity exists and the issue of harm as an unintended consequence of treatment. The consultation paper does not articulate this difference well

If not, why not?

The College feels that there is risk in the use of a list of instances where compensation is not available, as it will be difficult for a comprehensive list to be compiled and maintained. This will be between the circumstances affecting the delivery of same treatment to different individuals exacerbated by individual differences and where individuals with the same condition have different comorbidity.

We do however, also support the opportunity for new and emerging treatments to be offered to patients who are made fully aware of the risks and offer their consent.

If yes, what other injuries would you consider should not be eligible?

6. The Review Group was of the view thatany recommended changes to a no-fault system should cover all healthcare professionals including those not directly employed by the National Health Service. The group believed thatfairness dictated that all patients whether treated by the NHS or privately should have access to an improved system if possible. If this proved impossible, the group nonetheless believed that there were benefits that could be obtained by a move to no-fault for NHS patients. The group’s preference was that **all** patients should be covered by the no-fault scheme and offered:

Recommendation 3 - that the no-fault scheme should cover all medical treatment injuries that occur in Scotland; (injuries can be caused, for example, by the treatment itself or by a failure to treat, as well as by faulty equipment, in which case there may be third party liability)

Recommendation 4 -that the scheme should extend to all registered healthcare professionals in Scotland, and not simply to those employed by NHSScotland.

(As explained in the Cabinet Secretary's foreword we acknowledge that further work is needed to help in our understanding of the volume, level and cost of compensation claims handled by the Medical Defence Unions and private healthcare providers. We will seek to explore this further with the relevant stakeholders during the consultation period.)

Question 7: Do you support the view that, if introduced, a no-fault scheme should cover all clinical treatment injuries (e.g. Private healthcare and independent contractors) and all registered healthcare professionals and not just those directly employed by NHSScotland?

Partially support. The College believes that an ideal scheme would cover all clinical treatment injuries and all registered healthcare professionals. We are, however, extremely concerned that such a scheme would be unaffordable in Scotland at the current time and there is insufficient evidence contained within the consultation document to challenge this view. As such, it may not be possible to achieve this desired coverage; especially in the short to medium term. It is important to note that several countries utilising no-fault compensation, notably New Zealand, are finding it difficult to sustain this approach on fiscal grounds and this should serve as a note of caution in the development of any such scheme in Scotland.

The question of affordability is crucial, it is essential that any scheme introduced is sustainable. In order to ensure this, the scheme would require proportionate contributions to be made by all bodies, regardless of the sector in which they are based. We understand it may be difficult to get disclosure of the costings from the different agencies involved.

It may also be necessary to implement a reduced scheme initially and then to grow the scheme over time, in order to ensure that it can be sustained and that there are sufficient funds to support it. The College does, however, recognise that were a schemenot to cover all treatments and healthcare professionals, there may be equity issues and it may lead to risk adverse behaviours from clinicians working out with the NHS with disproportional liability potentially resulting for the NHS sector.

The College is also concerned that levels of compensation have not been discussed within the document and would like to seek clarification as to whether the proposals include incorporation of Central Legal Office costs when looking at a "Total Cost Model".

If not, why not?

7.1 What, if any, difficulties do you foresee in including independent contractors (such as GPs, dentist etc) and private practice?

The costs of remediation will need to be included for patients who are treated in Scotland but outside the National Health Service.

There is perhaps a greater reputational risk for private dental practitioners, for whom agreement to no-fault compensation might result in adverse publicity. If the option of defending a complaint under the traditional system were not available, the dentist or dental care professional might be disadvantaged.

7.2 What are your views on how a scheme could be designed to address these issues?

Question 8: The intention is that if introduced the no-fault system will not be retrospective. However, consideration will need to be given to when and how we could transfer to a new system and how outstanding claims could be handled if/when a no-fault system was introduced. What are your views on how outstanding claims might be handled?

The College considers it important that a transition board is established to assist with the effective implementation of the scheme and to consider outstanding claims.

7. The Review Group did not favour the use of a tariff system for compensation, as it felt that this would not address individual needs and it was unlikely that people would buy into a system where compensation was based on a tariff. The group therefore offered:

> **Recommendation 5 -** that any compensation awarded should be based on need rather than on a tariff based system;

Question 9: Do you support the approach in Recommendation 5?

Partially Support–It is felt that a banding system should be applied. This allows for needs based decisions but also avoids wide disparities in the awards made in respect of individuals with similar conditions without necessarily imposing a ceiling tariff for individual bandings. This would allow flexibility for individual cases to be accounted for and also ensure a degree of consistency in the payments made to individuals with similar conditions. Each “band” would be supported by appropriate descriptors and appropriate tariffs applied recognising the risk in applying a common tariff across each "category/band".

If not, why not?

9.1 What are your views on the assumption that the level of payments will be similar to those settled under the current system?

8. The Review Group was satisfied that a no-fault scheme established as they describe would be fully compatible with the requirements of the European Convention of Human Rights, based in particular on the need – as in Sweden and New Zealand – to build in appropriate appeals mechanisms, with an ultimate right to appeal to the courts on a point of fact or law. In addition, retention of the right to litigate will ensure that those for whom the no-fault system is felt to be inappropriate will still be able to raise claims using this route. The group recommended:

> **Recommendation 6 -** that claimants who fail under the no-fault scheme should retain the right to litigate, based on an improved litigation system
>
> **Recommendation 7 -** that a claimant who fails in litigation should have a residual right to claim under the no-fault scheme
>
> **Recommendation 8 -** that, should a claimant be successful under the no-fault scheme, any financial award made should be deducted from any award subsequently made as a result of litigation
>
> **Recommendation 9 -** that appeal from the adjudication of the no-fault scheme should be available to a court of law on a point of law or fact.

Question 10: Do you support recommendations 6 – 9 as proposed by the Review Group?

Yes–We strongly support the inclusion of an appeal mechanism, which we see as an essential part of any such scheme.

We are, however, concerned that there is the potential for a system to be created in which a clinician is held to account twice (through the no fault scheme initially and then through any subsequent Civil or Criminal actions). The College believe that, whilst compensation may be considered at various levels, accountability should be a "one-off" exercise.

There will also need to be facility for external review in some sub-specialty situations, particularly where the number of clinicians providing care in that particular speciality in Scotland is small (eg Paediatric Surgery/ Liver transplantation etc.) and there is a need for peer review of complex clinical scenarios.

If no, why not?

10.1 Do you have any concerns that the Review Group's recommendations may not be fully compatible with the European Convention of Human Rights?

No.

If yes, what are your concerns?

9. The Review Group offered suggestions for improvement to the existing system and these are reproduced in Annex B. The group recommended:

> **Recommendation 10 -** that consideration should be given to our analysis of the problems in the current system, so that those who decide to litigate can benefit from them.

10. It is proposed that the suggested improvements will be taken forward as part of the forthcoming consultation on the Courts Reform Bill later this year by the Scottish Government Justice Directorate. In particular the Scottish Civil Courts Review[21] recommended that pre-action protocols should be made compulsory and it is considered that this would assist in resolving many of the areas identified by the Review Group In addition, Sheriff Principle Taylor's Review of Expenses and Funding of Civil Litigation in Scotland[22], which is due to report at the end the year will consider a range of issues.

Question 11: Do you agree with the Review Group's suggestions for improvements to the existing system?

Yes.

11.1 Do you have any comments on the proposed action in relation to these suggestions?

11**.** The Review Groupalso considered whether or not the establishment of a scheme specific to neurologically impaired infants should be created (in the event that a general no-fault scheme is not introduced). Members considered that this group of patients arguably represents a special case and certainly accounts for the most significant sums awarded in compensation and legal costs. The Group were of the view that this was worthy of consideration.

[21] http://www.scotcourts.gov.uk/civilcourtsreview/
[22] http://scotland.gov.uk/About/taylor-review

Question 12: Would you support the establishment of a scheme specific to neurologically impaired infants if a general no-fault scheme is not introduced?

Yes. The issue of the attribution of causality, the extended time period over which the individual is impacted by such injuries and the high costs of awards in this area all support this category being given special status. There may, however, be other exceptions that should also be considered for the inclusion in such a reduced scheme; in the event that the general no fault scheme is not introduced. Compensation paid to individuals who have suffered 'Never Events' could perhaps constitute the basis for such an extension to the specific scheme suggested.

It is also important that any such scheme integrates seamlessly with the welfare system and does not become a substitute for it or in any way impact on the level of welfare support provided to an individual.

12.1 What are your views on the Review Group's suggestion that the future care component of any compensation in such cases could be provided in the form of a guarantee of delivery of services (both medical and social care) to meet the needs of the child, instead of by way of a monetary sum?

Whilst initially appealing, there are potential issues in such an approach. For example, if the family involved were to move into or outside of Scotland, how would this be applied? Would their guaranteed services be converted into a lumpsum payment or would payment be made to support their care in whichever country they moved to? If the latter, what if the costs of care differ significantly to those in Scotland? Is there the potential for such an approach to have an un-intended consequence that prevents such individuals from being able to re-locate to another country? The College would be very concerned to ensure that this does not become a replacement for social welfare support for unavoidable complications.

General Comments

We would welcome any further general comments you may wish to offer here.

The Royal College of Surgeons of Edinburgh would also like to make the following comments:

We are concerned that in the events of a grievance, that is not handled suitably through a no-fault scheme, that civil law is dispensed with and the clinicians are then subject to criminal proceedings. There is also a concern that in some cases individuals may feel pressure to use the no fault scheme, in order to achieve a more timely resolution to their claim, when in fact the litigation route may be more appropriate.

The College would be interested to know if any thought has been given to how cross-border issues would be handled under such a scheme. For example, some patients in Scotland require treatment in English centres (such as in the case of retinoblastoma, which is treated in Birmingham) and so how would the scheme apply in such cases?

We are grateful for your response. Thank you.