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 that when an error has occurred, patients receive a meaningful apology?

When the complaint involves personnel, the apology should come from the staff involved and their management, rather than an administration or Trust Lawyer. An apology should only be issued where required and it should be clear about what is actually being apologised for – if there is no liability of personnel then there is only an apology to be made if there is failing of a service or similar, and that apology would have to come from the administration.

It should include evidence of 'lessons learned' and relevant improvements to the service (including competence of personnel) to demonstrate that your grievance has been properly acknowledged.

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

[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

- 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 x No ☐

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

The claimant must have the ability, in tandem, to seek redress via complaints procedure or otherwise, where there is an issue with professional misconduct or personnel competency. No fault compensation schemes should not protect the jobs/licenses of staff whose actions are unacceptable to the patient, Administration or the relevant professional body.

The scheme must be available and affordable for all people involved in healthcare from direct employed NHS staff to GPs, Dentists, Physios, Obstetricians/Midwives, Osteopaths etc etc regardless of whether they are carrying out NHS or Private care at the time.

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 x No ☐

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

As well as ‘transparency’, the scheme should require full disclosure so that patients are making fully informed consent (including refusal) of treatments and this should be respected. Doctors should not be able to misrepresent or withhold options from patients purely to protect themselves in such a scheme (e.g. insisting a woman has a CS for breech baby, where the CS is obviously causing physical harm to the woman and the ‘forced’ nature of the CS causes mental harm), patients should be able to have redress/compensation where this sort of behaviour takes place.

Outcomes from the scheme should be evidence based, even where this evidence may be contrary to some currently accepted/applied protocol and particularly where some organisations may have accepted the more recent evidence but it has yet to be accepted by the hospital governance – e.g. 2012 update to recommendations on infant cord clamping which has been accepted by RCM but will not be implemented by NICE until 2015. Personnel should not be able to hide behind these discrepancies, particularly where a patient has expressed a particular leaning towards one option but the opposite was carried out.

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 how a compensation scheme could more effectively contribute to the wider issues identified above?

The scheme must be a single scheme for all of Scotland and not delivered by individual health boards. This will allow free sharing of information, disseminated down from a single regulatory body, to the benefit of patients and health professionals.

Recording of information in claims should be centralised to ensure it is carried out consistently across different healthboards – otherwise it will not be possible to draw meaningful data on the number/type of claims and provide feedback on where improvements to the service/protocol/training are required.

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?

Yes x **No ☐**

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

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.

Yes ☐ **No x**

If not, why not?
Because everything carries risk, the question is to what extent the risk was not minimised i.e. avoidable. By allowing risk to enter into the debate we will find less choice and freedom in our medical care as the insurance provider will want to have control over potential payouts and therefore which treatments are provided. This will have particular impact in maternity care where women are often bullied to accept care options they do not want because insurance based protocols do not allow practitioners to use their full skill set, preferring instead to 'recommend' the simpler CS. It should be noted that the European Court of Human Rights has already made one ruling in 2012 in favour of a woman being able to choose her pregnancy path, and there are other similar cases pending. The best holistic interests of the individual patient should determine treatment path and not the best interests of the group compensation scheme.

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

6. The Review Group was of the view that any 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 that fairness 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?

Yes x **No ☐**

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?

How the fees are divided between the groups i.e. the cost to the individual. If more than one scheme exists such that it is cheaper for the person to take 3rd party insurance rather than join the national scheme, this could create a problem for the patient care. Also any medical practitioner who combines NHS and private practice, should hold insurance for both, this is most likely to apply to physios, obstetricians and midwives who may work part time in the NHS and have a private/independent clinic or client base. If their NHS premium is provided by the healthboard then it should not cover their private activities, however the cost to the individual (i.e. premium per person) should be consistent whether the practice is NHS or private.

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

Liability distributed evenly across all participants regardless of employer, profession or the liability of that profession – i.e. every participant pays the same. This may be difficult to employ as some areas are inherently higher risk, or have historically higher liability, than others.

The premiums should be paid by the individual in all cases – this will make people think about what it is they are paying for and why. Research into PII requirement (as part of EU legislation) shows that it is private/independent medical providers that are being pushed out of business via unaffordable premiums when in actual fact most of the claims are made in the NHS against practitioners who aren't even aware they have insurance on their practice! Promote individual responsibility and liability will decrease. Plus making the individual pay will force the premiums into an affordable level for the independent providers.

The scheme should consider whether initially it would be easier/cheaper to cover the premium for all participants in the first year until data is available on which departments and NHS/private cost the most in claims. Then it would be possible to revisit how the premiums are divided between the participants – provided this division was not used to force certain private groups out of the market (c.f the current Independent Midwifery situation). Where it is the cost of claims and not the number of claims which may make premiums difficult to afford, the scheme should look to reinsure the premiums, particularly where loss of a service would be detrimental or contravene a patients right to choice.

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?

There will have to be a cut off date from which the scheme will start. The answer may lie in the number of legacy claims and the length of time since the legacy claim was raised.
Even though the new scheme will be the default for all new cases after date X, the claimant will still have the ability to use the old system where there is a case for clinical or systematic negligence, hence it will not be impossible to deal with claims raised prior to date X on the old system. Claimants who are pursuing a case on the old system should be offered the choice, via their legal representation, to transfer to the new system, if for example their complaint is considered 'simple' or was made less than 2 years prior to the new scheme commencement. Any payouts eventually made to those choosing to transfer to the new method would have to be met by the original (current) compensation provider as the new scheme will have no premiums/leverage to cover it, however as it is believed that the new scheme methodology will incur lower costs overall due to reduced timescales and slightly lower payouts, this should actually be in the best interest of the current provider, reducing their financial liability for the legacy cases.

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?

Yes x **No ☐**

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?

I would expect compensation payments to cover treatments/rehabilitation to be the same as nothing else has changed. I would expect the legal costs elements to be reduced as the number of hours should be less and solicitors should be prevented from escalating their hourly fees to make up the difference.

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 x **No ☐**

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?

Yes x **No ☐**

If yes, what are your concerns?

That the scheme may, either from inception or as a result of financial claims made against it, begin to reduce the ability of the patient to choose the treatment and healthcare provider they wish to use, contravening the right to personal autonomy and the right to choose the personal circumstances of life, particularly where it could be demonstrated that the reduction in choice (in order to protect the insurance provider) does adversely affect the outcomes of individuals, even if only on a statistical basis. This is most likely to be relevant within Maternity care.

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 x **No ☐**

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

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

No

11**.** The Review Group also 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.

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 x **No ☐**

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?

It is a noble aim but undeliverable in the current system. If changes can be made such that the child is guaranteed the services it requires at the exact time it requires them (without onerous reviews/assessments etc which currently drag on for months), then yes, this would be acceptable. However if it cannot be guaranteed then without access to funds the parents are unable to make their own provision. Until such a guarantee can be delivered then a monetary award should be made on the proviso that if the services are available to the child then the care giver should use part of that award (an amount set out at the time the award is made) towards the services i.e. pay it back into the NHS.

General Comments

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

With regard to Q12, a maternity only scheme. Should this be progressed then this scheme should be available to all competent providers of maternity care, including Independent Midwives who are currently denied PII. Those who work within the NHS and privately should have to hold insurance which covers both. To ensure affordability it should be up to the individual and not the institution (including the NHS) to cover the premium. The contribution to reflect the likely claim which would be made e.g. midwives should not be made to pay for cover for death/injury as a result of procedures or instrumental/surgical deliveries which they would never carry out. Historically this was the stumbling block for IMs to access PII – the only policy

available was one which covered all aspects of obstetrics, designed for doctors and was therefore unsuitable and unaffordable for midwives who would expect to have far fewer and far less severe claims made against them.

In general with regard to a centralised scheme which provides for the PII requirement for professional registration as per the EU Directive. It should be cautioned that insurance is not a substitute for competence and merely a cover for incompetence and in some cases unprofessional behaviours. Effort should be made to ensure that competence and professionalism are not undermined or sidelined purely to make a scheme or fulfil EU law.

We are grateful for your response. Thank you.