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?

In clinical settings, when something has gone wrong it is usually the senior clinician who discusses the incident with the patient and/or relatives because he or she is the best person to provide clinical advice and discuss any concerns that the patient or relatives have. That doctor is also expected to explain possible next steps and alternatives if the matter needs to be corrected and, of course, apologise if appropriate. It may not be possible for the senior clinician to do all this in all cases, but the expectation is that whoever provides this information will be a doctor who has appropriate knowledge and experience to explain what has happened and to answer any questions fully.

The MDU frequently advises members when something has gone wrong and our advice has been consistent for decades. We expect members generally seek our advice when an adverse incident may have harmed a patient because they want to get it right and because of the potential medico-legal implications. We explain the legal and ethical background and provide any other medico-legal information they need to be aware of to assist them to decide what to do. As well as advising members in person, we publish advice in our publications and on our website. We also promote it through lectures to medical undergraduate and postgraduate audiences and in any other ways we can.

[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

In addition to reminding medical members of current GMC advice (paragraph 30 of *Good Medical Practice*):

> ‘Being open and honest with patients if things go wrong
>
> If a patient under your care has suffered harm or distress, you must act immediately to put matters right, if that is possible. You should offer an apology and explain fully and promptly to the patient what has happened, and the likely short-term and long-term effects.’

the MDU has long advised:

> ‘If something goes wrong, patients should receive a prompt, open, sympathetic and above all truthful account of what has happened. Any patient who has had the misfortune to suffer through an error of whatever nature should receive a full explanation and a genuine apology. We encourage members to adopt this approach. There are no legal concerns about taking this course of action: it is quite different from admitting liability.’

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 ☐ No ☐

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

Other than the need to comply with the European Convention on Human Rights, we would need far more information than is available in the consultation document in order to comment in any detail on the statements made. The 'principles and criteria' are not described in sufficient detail to allow for a yes or no answer as to whether they are essential and there is not enough information provided about how they might be applied.

For example what parameters would be used to define whether the level of compensation to the patient or carer was appropriate and who would define those parameters? While the level of compensation awarded should reflect the claimant's proven needs, it would need to take account of other factors such as whether it was affordable, which is listed as a separate criterion.

Another example of the lack of clarity is that there are three statements about time: that decisions about compensation are timely; that the scheme makes appropriate use of time and resources, and that a reasonable time limit is set for compensation claims. There is a degree of repetition and without any definition of the concept of timeliness, it is difficult to agree or disagree. How is the timeliness of decisions defined? For example in complex cases where the clinical information is difficult to analyse it may be necessary to wait for months or longer than a year or more before the outcome is clear and causation can be determined. In a case where it is suspected that the harm sustained was an inevitable result of the disease process and not caused by any incident that may have occurred during treatment of the disease, it would be vital to wait until it was possible to determine whether this was the case in order to ensure a fair decision based on the facts. Any compensation system would have to allow for this and to ensure that a desire for 'timeliness' did not mean setting of arbitrary deadlines that would disadvantage either party.

Another example is the statement that 'the scheme is easy to access and use without unnecessary barriers, for example created by cost or the difficulty of getting advice or support'. How would this be determined in order to be fair to all parties? To give an example, in England there is currently a portal for RTA claims that is designed to provide easy access for lower value claims and there are fixed fee staged payments. There is a payment of £400 at stage 1 when a claim is lodged even if the solicitor takes no further action. This has given rise to the creation of the '£400 club' for those claims that are lodged and go no further. The claimant is not on risk and the claim goes no further yet the defendant has to pay, which is not fair. Any scheme must

balance ease of access with fairness to both parties and will need to discourage speculative claims that only serve to run up defendants' costs. Claimants must be able to prove they have taken steps to ascertain whether their case merits pursuing and that they are intending to pursue it.

There is no mention of the need to prove negligence before compensation is awarded. We believe a requirement to prove negligence is central to any compensation scheme.

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 ☐ **No** ☐

3.1 Are there any others you think are desirable and should be included?
There is not enough information provided to enable us to answer yes or no.

Whether it is desirable that the public trusts the scheme to deliver a fair outcome depends on what expectations the public has in respect of a fair outcome. If a fair outcome is that claimants are always compensated, that may not be possible or affordable. Certainly the parties involved should trust the scheme to deliver a fair outcome. We referred in our answer to the previous question to the need for a compensation scheme to require proof of negligence. In our view an outcome where compensation was awarded without proof of negligence would not be fair.

If the scheme is to be limited only to financial redress through an award of compensation, then patients and their representatives should be free to explore other areas of non-financial redress. It is possible to develop a scheme which requires the healthcare provider to provide an investigation and explanation, as well as putting the matter right, at the same time as investigating whether there has been negligence, if appropriate.

It is not clear how any scheme might be thought to encourage transparency in clinical decision making as that is not the purpose of a compensation scheme which is intended only to provide compensation. If transparency means that doctors and other healthcare professionals should communicate clearly with patients and relatives (with appropriate consent) about the risk and benefits of proposed treatment

and care, and answer questions and keep patients informed as that progresses, including informing them if something goes wrong, such an ethical duty already exists.

It is not clear how a scheme could contribute to rehabilitation and recovery. Would this be financially or through some other means?

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 NHS Litigation Authority in England has access to all data arising from the claims it handles on behalf of NHS trusts. It has recently begun to publish this data for risk management purposes and its first report on 10 years of obstetric claims was published in October.

http://www.nhsla.com/NR/rdonlyres/F0B204A6-5E48-4D3C-8353-563152CD0BB1/0/TenYearsofMaternityClaimsAnAnalysisoftheNHSLADataOctober2012.pdf

Careful and considered use of claims data published in a similar way should assist with most of the first two bullets mentioned above.

In respect of the third bullet, In Wales there is a redress scheme where there is a duty on the provider organisation to review adverse incidents and to address them appropriately, including considering whether there has been negligence.

In respect of the fourth bullet, no scheme should put any barriers in place for referral to regulators of cases which suggest there are grounds for concern about patient safety or welfare that meet the appropriate threshold. Each organisation should have in place a process for investigating concerns about healthcare professionals and a policy for taking appropriate action, depending on the findings, which might include referral to a regulator. Such a referral should be made irrespective of whether an investigation is taking place to determine whether an action or inaction by a health professional amounted to negligence, and may be made before, during or after a determination on negligence, depending on the circumstances.

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?

No

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

The Review Group did not describe the proposed model for Scotland in enough detail for us to form a definitive view but we have a number of concerns about the suggestions that were made because we do not think the Swedish model could be successfully applied to Scotland, even if changes were made.

The Swedish model is designed specifically to work with the Swedish welfare system that provides a high level of care on which damaged patients can rely. This is reflected in the level of payments that are made under the Swedish scheme which are far lower than payments that are made in clinical negligence cases in Scotland where future treatment and care provided in the independent sector cannot be disregarded. Will the public believe lower compensation payments, and presumably a requirement to rely entirely on NHS provided treatment and care, are preferable to the existing system? We assume repeal of S2(4) of the Law Reform (Personal Injuries) Act 1948 would be required before any no-fault compensation scheme was introduced? This section requires defendants funding compensation awards to disregard NHS funded care for the purpose of determining compensation. As it would be illogical for a no-fault compensation system to pay for independent sector care and treatment so that NHS funds would continue to leave the NHS, we assume S2(4) would need to be repealed.

It is our understanding that in Sweden the system also allows for a residual right to litigate, which would be inappropriate in Scotland as there would be no reason to do so. If a right to litigate were retained it would drive up the costs even higher than estimated by the legal academics from Manchester. Further, there would be no purpose in litigating because there would be a higher barrier of a need to prove negligence and, even if that were successful, it would not provide a higher level of compensation as S2(4) (see paragraph immediately above) would need to be abolished in order to introduce a no-fault compensation scheme – thus the claimant would still have to rely on NHS care.

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

If not, why not?

It is not possible to comment because there is not enough information provided about the type of injuries that would not be eligible for compensation under a no-fault scheme.

The types of injuries would need to be clearly defined and even with tight definitions we would expect the question of whether claimants are eligible for inclusion in the scheme would be a fertile ground for satellite litigation. As the Review Group noted, the Swedish scheme has a high level of applicants turned down – at just under 50%.

In order to be accepted for the scheme, the claimant will need to prove causation – ie that the injury was caused by the organisation/individual as a result of care provided (and was not an accepted risk of the procedure/part of the disease process etc). How will this be funded? Will the claimant be expected to fund expert and legal advice in order to prove eligibility for the scheme – or will the scheme cover costs of initial investigation whether or not the applicant is successful?

The question of whether a patient has given consent for treatment or care is already a common allegation in clinical negligence claims. If an application to the scheme is refused, we would expect that satellite litigation about matters such as the nature of the injury and whether consent had been fully informed and given would be a regular feature of any such scheme. Such litigation would be outside the scheme and would add considerably to the cost of the scheme because it is likely the institution would be joined as a party.

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

n/a

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?

No

If not, why not?

In the absence of any detail about how a scheme would cover all clinical treatment injuries, a number of questions arise.

Does the NHS have the legal power to provide compensation to claimants who have chosen to fund their own care privately – that is not in cases where the independent providers were providing independent care under contract to NHS patients, but in circumstances where it is private care funded privately by individuals or through insurance arrangements? If the NHS does not have such powers, would seeking them offend against the NHS's fundamental principles and values?

Assuming it were possible for the NHS to obtain such powers, should public funds be used to indemnify private patients who have been injured by treatment for which the NHS is in no way responsible? Further, how would such patients be compensated under the scheme? We have suggested above that patients injured by treatment provided by the NHS would have to be eligible for NHS treatment and care only. Would this be acceptable for patients who chose to be treated in the independent sector and who had funded such treatment themselves? Or would they retain a legal right to a higher level of compensation than NHS patients on the grounds they had paid for their own care and had a right to receive compensation to provide a similar standard of non-NHS care going forward? Or would a no-fault scheme only apply to NHS patients who receive care from the independent sector under arrangements agreed with the NHS.

How would compensation in respect of independent sector treatment be funded – by the institution or by individual contributions to a, presumably, NHS run scheme? The same question arises in respect of GPs and dentists.

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

Assuming that GPs, dentists, and doctors working in the independent sector were obliged in future to contribute to an NHS fund that provided no-fault compensation for injury they had caused, how would their historic liabilities be funded? Clinical negligence claims are a long-tail business where many claims are made 3-5 years after the incident (and some times 10, or 20+ years) and where settlements are often paid 5-7 years after the incident. If a no-fault scheme were introduced, how would it address payments for claims that were made to the scheme for incidents that happened before the scheme began?

Any arrangements that were made to include one or more of these groups into a no-fault scheme and to exclude any other group has the potential to disturb the indemnity arrangements for the existing groups.

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

When NHS indemnity was introduced in 1990 for all NHS hospital and community care, the NHS took over all existing and historic liabilities in exchange for a lump sum payment from the medical defence organisations that had taken subscriptions from those doctors to fund future claims. If such an arrangement were not reached in Scotland at the introduction of a no-fault scheme, this would leave the doctors' and dentists' current indemnifiers to fund a tail of claims with no subscriptions going forward. Once those funds were exhausted there would be the prospect of injured NHS patients not receiving compensation.

Please also see our comments at 7.1 above about disturbing the current pooling arrangements.

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?

Please see our comments at 7.2 above.

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?

No ☐

If not, why not?
We assume that the proposal in respect of awards based on need relates only to the award for patrimonial loss. Guidelines for assessment of *solatium* are already used successfully. In respect of damages for patrimonial loss, we do not have a view because the costs of the scheme are likely to determine the funds available and that in turn is the most likely basis on which it will be determined whether compensation could be awarded on need or according to a tariff.

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

We note that the legal academics study made it clear that their assumptions about the potential cost of a scheme were not predictions for the future but estimates of what public expenditure might have been had a scheme already been in existence. Such assumptions were based on existing claims patterns which are only one factor to be considered when attempting to estimate the cost of a no-fault compensation scheme.

Estimates of the cost of a scheme would need to be based not just on claims made in the past but on adverse incidents which might be expected to turn into applications under the scheme. This number is unknown but it will be far higher than that for existing claims. We are not aware of any accurate measure of adverse incidents in the NHS in Scotland because there is no mandatory reporting scheme, thus it is not possible to identify in how many incidents harm arises that may be eligible for compensation under a no-fault scheme – but an estimate of this should be the starting place. The assumption should be, therefore that costs for the start up of a scheme would be considerably higher than those estimated on past claims. While the Study suggested a reduction in claims to the scheme going forward, the likelihood is far greater that there will be a substantial increase in applications to and awards made by the scheme based on a lower threshold for compensation.

Estimates of the cost of a no-fault scheme going forward would also need to take account of the potential for satellite litigation (to which we have already referred) on the grounds that injured patients whose application is refused will be able to resort to litigation in order to prove that they are eligible to be compensated through the scheme.

If the scheme were based on levels of award that provided only NHS funded care going forward, that may result in a significant lowering of the levels of award but this would be reliant on repeal of S2(4) of the Law Reform (Personal Injuries) Act 1948 because otherwise claimants would have an incentive to make a claim in order to achieve an award at a higher level and this would of course substantially increase costs.

No mention is made in the consultation document of the funding source for legal and expert advice that a patient who is harmed will need in order to determine whether that harm may be eligible for compensation under the scheme. These costs may be considerable in complex clinical cases. Applicants who are successful may then incur further costs if they are offered an award and wish to decide whether to accept it or to challenge it by appeal, or to lodge a claim in negligence. Will they be expected to fund any or all of the appeal costs?

For these reasons we suggest any decision on whether awards in respect of special damages should be based on a tariff or need would need to be made in the light of estimates of the scheme that take into account all necessary factors and that provide an accurate and reliable measure of the affordability of such a scheme.

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?

No

If no, why not?

We have doubts about the affordability of a no-fault compensation scheme because it will by definition increase the number of payments made because there will be no need to prove fault. It is also likely to provide new avenues for satellite litigation, for example, from applicants who have been refused but who believe they are eligible to join the scheme. In order to control the costs to the public purse the levels of damages under the scheme would need to be at least as high as those available under litigation in order to deter claimants from litigating if they are not satisfied with the compensation awarded under the scheme.

In respect of the recommendation for the scheme to provide an appeal from the adjudication of the no-fault scheme to a court of law, this would further increase the costs. It would be preferable, in return for acceptance to the scheme, for an applicant to be required to undertake to be bound by any decision the scheme reached. We do not know, however, whether being required to give such and undertaking would be compatible with the European Convention on Human Rights.

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 ☐ No ☐

If yes, what are your concerns?
The consultation document does not provide enough detail but it would not be possible to legislate for a scheme that was not compatible with a person's rights under the EHCR.

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?

No

We would support the introduction of a pre-action protocol, subject to appropriate consultation. Otherwise the Review Group has not provided sufficient evidence to support the comments it makes in respect of the need for improvement to the current system and we would need to see more detail of the precise problems any changes were intended to address.

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

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

We support a pre-action protocol and in respect of any other action we would expect to contribute fully to any consultation on any proposed changes.

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

12. Yes – the proposed scheme would provide faster compensation to more patients with a substantial reduction in legal costs as well as encouraging the retention of public funds within the NHS.

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?

We support this approach. In our view these cases represent a special case in view of the substantial damages that are paid (where negligence can be established) most of which relate to future health and social care needs. In addition, such cases frequently present very complex breach of duty issues often relating to matters that occurred many years ago (there is no limitation period). Since future care needs cannot be finally assessed until the child has reached a certain stage of development, the cases often do not settle for many years after they have been raised.

At present, as a result of s 2 (4) the Law Reform (Personal Injuries) Act 1948, the damages awarded or agreed for future medical and social care needs for children with neurological injuries often include substantial sums to cover the cost of private care, meaning NHS funds flow into the private sector. The proposal 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 would mean that these funds would remain within the system and benefit a wider group of patients. Economies of scale may also be possible, compared to provision in the private sector (which is purchased on an individual basis for each patient). Since final care requirements would not need to be determined before settlement (as the guarantee would include all future care needs) compensation could be provided much more quickly.

General Comments

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

We are grateful for your response. Thank you.