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?

MPS is wholly committed to promoting openness in healthcare and has long supported members in being open with patients when something has gone wrong.

In all of our publications and advice we encourage members to acknowledge mistakes, apologise, explain what went wrong and put things right quickly and effectively.

When Margaret Mitchell MSP tabled the Apologies (Scotland) Bill earlier this year, MPS strongly supported the initiative and we have called for similar legislation to be enacted in England and Wales.

In addition to the features set out in the Apologies (Scotland) Bill, we suggest that an effective apology must be timely as well as sincere and honest.

We believe healthcare organisations must actively support their staff in fulfilling professional and ethical obligations to be open with patients, by providing ongoing support, training, mentorship and by equipping senior clinicians to lead by example.

[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 ☐ **~~No~~** ☐

We strongly believe that patients who have suffered harm from negligent treatment should receive fair compensation.

MPS supports reform that aims to address the current barriers faced by patients seeking redress and enable us to move away from the present adversarial system which can be stressful for both patients and healthcare professionals.

We agree that the principles set out above are essential in a compensation scheme, but would suggest consideration is also given to other methods of achieving these principles/ objectives. This is an approach currently being assessed by the NHS Litigation Authority (NHSLA).

For example, devising and introducing a low value claims scheme in line with these principles and criteria might be an alternative and potentially less expensive approach.

Annexe B of this consultation document refers to the Review Group's suggestions for improving the existing medical negligence system and we believe these suggestions merit greater consideration whilst the costs and logistics of a no-fault scheme is investigated further.

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

All of these principles and criteria are important and as such it is difficult to determine a hierarchy. However, the affordability of the scheme must rank highest because if the scheme is drawn up in such a way as to make it unaffordable it will fail at the first hurdle. We also believe that the scheme must have an independent appeal system in order for patients and doctors to have trust in the process and that staff as well as patients are treated fairly. Doctors always set out to do the best for their patients and are often deeply affected if something goes wrong. We have seen first-hand on numerous occasions the impact clinical negligence can have on the doctor or doctors involved, and we would wish a new system to take account of these issues as well as the more obvious patient needs.

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~~ ☐

Trust and transparency must be central to any compensation scheme alongside a renewed emphasis on rehabilitation and recovery. We also recognise the importance of access to other routes of non-financial redress such as the complaints procedure.

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

Again, we would emphasise here the importance of a shift in culture within NHS Scotland to foster a greater culture of openness and improved communication. Research shows that improving communication between doctors and patients can enhance the quality of consultations and reduce dissatisfaction.

In our view, openness is the first part of a three stage journey. The second stage is supporting healthcare professionals in being open with each other in reporting adverse events and near misses so that they can be explored and analysed.

The third stage is a commitment to implement the learning to prevent the same mistakes from happening again.

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?

We support the issues identified and believe a core objective of any new compensation scheme should be the desire to learn from adverse incidents and to actively implement that learning.

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?

We recognise the benefit of drawing on the Swedish model to help shape a Scottish scheme but have concerns about the transferability of the scheme to Scotland.

One attractive aspect of the Swedish scheme is the emphasis on supporting greater openness and improved communication between doctors and patients.

Yes ☐ **No ☐**

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

A particular consideration for the Scottish government would be how easily transferable the Swedish model would be to Scotland. Sweden's social welfare structure is very different and complements their model of compensation system. The country's comprehensive system of social welfare was a key factor in helping to ease the transition to 'no fault/no blame' in the 1970s.

Whilst it is important to draw on the experiences of other active models any Scottish scheme must be devised to reflect the existing social welfare system and available funding.

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 ☐~~**

If not, why not?

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

We are supportive of this approach but do have concerns and caution that drawing up a tightly worded list of non eligible injuries would be difficult, be subject to challenge and might change over time.

We know from our experience in New Zealand that the scope of the Accident Compensation Corporation (ACC) has had to be re-considered on a number of occasions.

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 ☐ No ☐

We agree in principle that it would be sensible for a no-fault compensation scheme to cover all clinical treatment injuries occurring within the NHS however it will be complex to incorporate independent contractors.

We do not believe it is appropriate for the scheme to extend to the private sector.

If not, why not?

We question the appropriateness of using state funds to compensate individuals who have chosen to opt for private treatment. If for example an individual has opted to have cosmetic treatment privately that would not be available from the NHS, would it be appropriate for them to receive compensation from the government? If the funds for compensating patients are finite, the inclusion of private treatment would dilute the funds available for patients who have received treatment from the NHS and could be perceived as inequitable.

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

Changing this system would be complex. At present, patients seeking compensation for clinical negligence in the hospital sector seek compensation from the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS) whereas claims against GPs and dentists are managed by medical defence organisations.

Considerable thought would need to be given to how historic claims would be managed and funded in the future. This is particularly pertinent as a claim for clinical negligence is often brought many years after an adverse incident occurs. Incidents that occur under the existing arrangements, perhaps just a few months before the establishment of a new scheme, might not come to light for several years and might not be settled for many more years after that.

There are fourteen hospital boards in Scotland that are members of CNORIS but nearly five thousand GPs and over three thousand dentists. Opening a new scheme to incorporate GPs and dentists would mean devising a much larger and more bureaucratic scheme. Instead of interfacing just with a small number of hospital administrators those managing the scheme would need to involve many hundreds if not thousands of dentists, GPs and practice managers.

This would be even more complex if individual GPs and dentists remain vulnerable to personal claims.

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

We would strongly support a pilot scheme to test the workability of a no-fault scheme. We would also advocate a staged approach so that the scheme is initially rolled out only in the hospital sector where it is likely to be simpler to administer than in primary care.

Through piloting and staged introduction, the scheme can be carefully evaluated and experience assessed. Once public confidence has been established and medical professionals have trust in the scheme, consideration could then be given to the inclusion of GPs and dentists.

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?

Retrospective can mean two different things. It can mean that the scheme does not apply to past cases or it can mean that it does not apply to past incidents. MPS believes the scheme should not apply to incidents that occur prior to its establishment.

There are two types of outstanding claims and both need to be taken into account when determining future provision. The first type is a known claim; put simply, this is an adverse incident that has occurred and a claim for negligence has been initiated. The second type is known as incurred but not reported (IBNR) and is more complex. Because of the frequent delay between an adverse incident occurring and a claim being reported, it is essential that complexities of this type of claim are not overlooked if a no-fault scheme is established.

A significant proportion of GPs in Scotland are likely to have occurrence based indemnity protection through a medical defence organisation (MDO) meaning that they are able to seek help with an incident that occurred when they were a member even if the claim is brought many years later. Any new scheme that widens the basis on which a patient will be compensated must take into account issues of retroactivity. The following illustrative example helps to demonstrate the issue. At present a GP in Scotland might be sued for negligence once in 75 years. However under a no fault scheme is it foreseeable that the same GP might be involved in a compensation claim once in every five years because of the breadth and accessibility of the scheme. It would be unfair for an MDO who had offered occurrence based protection

and collected subscriptions on one basis to have to provide compensation on an entirely different basis and this must be taken into account when assessing how to deal with outstanding claims.

A pilot and staged approach, as outlined in our answer to question seven, would also help to simplify the transfer between old and new systems.

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** ☒~~ **No** ☐

The concept of need is subjective and introducing this subjectivity is likely to lead to significant legal involvement, defeating one of the primary aims of the proposal – that of developing a non- adversarial system.

If not, why not?

Using a tariff based system would be a simpler approach and would enable more effective budgeting. Opting for a tariff based approach is likely to make the scheme more affordable in the long term.

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

Whilst the level of payments might be similar, evidence from other jurisdictions demonstrates that costs burgeon in the first few years of a no fault system. This impact combined with the continuing right to pursue a claim through the courts is likely to mean that the overall cost of clinical negligence in Scotland will increase markedly.

This is another reason why further consideration should be given to a tariff based approach.

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 ☐ **No** ☐

We understand the need to adhere to the requirements of the European Convention of Human Rights and agree that the proposals will meet this obligation; however we are concerned that having a no-fault scheme running in tandem with the right to litigate could be problematic. In our view, operating a no fault system alongside an improved version of the existing system, with the option to opt into the no fault scheme if the litigation process is unsuccessful, could still result in protracted settlements and effectively undermine the key principles outlined by the government, namely reducing the time and costs of the current system. The cost of running the two systems will also divert resources away from developing the adequate social welfare system required to support a no fault scheme.

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?

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 ☐ **~~No~~** ☐

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

We agree with the issues identified in the current system. We would strongly recommend the use of pre action protocols which could help resolve clinical negligence claims without the need to issue proceedings. The clinical negligence protocol in England and Wales provides for a timed sequence of steps to encourage early disclosure of information and identification of issues between parties and a similar protocol in Scotland could meet concerns about delays in disclosure.

We agree that changes to the availability of legal aid to eligible claimants will support greater access to justice. If the Scottish government is considering allowing litigation funding by CFA arrangements, we would strongly advise that consideration is given to the recommendations of Lord Justice Jackson's extensive review of civil litigation costs in England and Wales, which are largely adopted in the Legal Aid, Sentencing and Punishment of Offenders Act, and which will limit the circumstances where success fees and ATE insurance policies can be recovered from unsuccessful defendants.

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

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 ☐ **~~No~~** ☐

Yes, we would strongly support the creation of a scheme of this type. We have promoted the concept of a no fault compensation scheme for severely neurologically impaired babies since the early 1990s. In our view the current system is grossly unfair. Those who can establish that their brain impairment was caused by negligence receive multi-million pound settlements while the majority who cannot are left with no compensation at all. We would like to see funds set aside for the effective treatment of all brain impaired children who have been harmed by poor obstetric or antenatal care regardless of whether blame can be proved. Our motivation for supporting such a scheme stems from the doctors we represent wishing to see fairness in the provision of treatment to brain impaired children.

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 believe this idea warrants further investigation and a pilot study should be established to consider the implications in more detail.

General Comments

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

Another issue to consider is the impact of the scheme on people living near the England - Scotland border. Would the scheme apply to location of treatment rather than the patient's permanent residence?