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?

It would be necessary for there to be legal compulsion upon Health Boards to issue an apology if this has been advised by the SPSO. At present there is no obligation for them to do so, even if the SPSO decide the Board ought to apologise and agree that an error has occurred. I would agree with Farrell et al that the pursuit of a genuine meaningful apology and seeking evidence of the NHS taking steps to prevent errors from reoccurring are the main aims of most patients making complaints.

Nearly a year after making a complaint to an NHS Board, which was then taken up by the SPSO in the absence of a satisfactory response from the Board, I am still waiting for a final decision and have been advised that the SPSO may not be able to secure any apology even although there is clear evidence of a number of mistakes being made in my care and treatment which led to me having unplanned surgery and to my life being put in danger due to the risk of bowel perforation.

My primary aims in complaining were to get a meaningful apology, not for an 'injury' or any specific error, but for a catalogue of below-standard treatment that led to an unnecessary decline in my condition. This was mainly a result of a particular clinician whose communication skills were inadequate and who failed in his duty of care by not requesting my medical records from my previous hospital and ignoring my repeated reporting of symptoms.

I want this clinician to demonstrate learning from my experiences by examining his professional practice and the Board to demonstrate learning from my experience by examining their systems and the overall quality of service they provide to Inflammatory Bowel Disease patients (which I believe falls well below national standards). I would like the Board to show evidence of changes in policy or practice with a view to prevent others having a similar experience to me and my primary aim has never been to seek any kind of financial compensation.

If any money was to be spent as a result of my case, rather than offering compensation to me as an individual, I would wish it to be spent on improving services for IBD patients in that hospital (funding a specialist nurse service, introducing more up to date diagnostic tests, further professional development for the clinician involved in my case etc).

At present the complaints system is lengthy, stressful and difficult for vulnerable people who cannot communicate well by letter or are unwell. It is extremely adversarial and does not view complaints as

[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

opportunities to reflect on and improve quality and person centredness of care. An overhaul of the complaints system should be an integral part of any new compensation system.

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?

I would attach particular importance to ease of use and ensure that guidance and specialist advice on how to use the scheme was available for all sections of society in order to give equality of access to justice. Guidance should be targeted at vulnerable groups including minority ethnic communities, lower socio-economic groups and people with learning disabilities etc.

Ease of use is, of course, linked to the affordability of any scheme and the scheme should be free at the point of use. I do not think that there should be a no-win, no-fee approach where the claimant must pay something if their claim is unsuccessful as this may put off many potential claimants. There should also be recourse to independent appeals for any decision.

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?

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?

There should be an obligation upon Boards and individual clinicians to demonstrate that they have acknowledged and acted upon issues raised around patient safety, quality improvement etc and evidence should be provided to the claimant and to national bodies such as Healthcare Improvement Scotland of these actions. Details of claims made (successful and unsuccessful) and lessons learned must be in the public domain (with identities protected).

Even where claims are unsuccessful there should still be opportunities for constructive dialogue between the patient and the healthcare provider with a view to improving others' experiences in future and offering 'closure' to the patient and their family.

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 √ **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** ☐

If not, why not?

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 √ **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?

The main difficulty I would foresee would be the fact that public money is spent on administration of the compensation scheme and on any awards to claimants.

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

Where appropriate, the costs of administering the scheme and any awards should be recouped from independent contractors and private practice.

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?

As I have discovered, it can take over a year from start to finish to make a complaint through the NHS complaints system and to then pursue a decision through the SPSO (which still holds no weight in terms of getting Boards to admit that mistakes were made). The mandate I have signed prevents me from seeking any legal advice during this time and thus it would likely be impossible for me to obtain any kind of financial compensation under the current system in under two years.

I would hope that were legislation to be passed in the next year or so to introduce a new scheme, that I would be eligible to seek compensation under a no-fault scheme as I would prefer this to going down the legal route.

I do not think any outstanding claims already in process in the legal system should be dealt with retrospectively if the person has already received legal aid. However, once the case was closed, (if it had been unsuccessful) I think the person should be able to claim under the new system. Even if this new claim was to be unsuccessful in the monetary sense, if the new scheme was to include an element of obligation upon healthcare providers to demonstrate learning from the issues raised and prevent future problems, then it would still be worthwhile.

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** ☐

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 do not have any experience of the level of payments under the current system having never taken legal action.

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** ☐

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 ☐ **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?

[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** ☐

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?

Whist I would agree that a family affected by neurological impairment due to an accident at birth should receive this guarantee, I would hope that in a civilised society with a sense of social justice and a welfare state a guarantee of such services would be available to *any* child with a disability whether a claim was made or not.

Any child, whether their impairment was a result of negligence by the NHS, misjudgement on the part of the parents (e.g. refusing an assisted delivery and not realising the implications of oxygen starvation on the baby) or a totally unrelated congenital condition should, in my view, have access to a guarantee of health and social care support that allows them to life a full life and exercise their human rights to live as independently as possible. People should not have to make a claim against the NHS to get access to that kind of support in Scotland through an integrated health and social care system in the future.

Therefore I would suggest that any separate system for these cases does give some kind of monetary sum as well as guaranteeing the support that should be there anyway. This sum should not be vastly inflated in comparison to other pay-outs for medical injuries, but should consider the future implications for the family in terms of things like loss of potential earnings for parents and the effect on other siblings.

General Comments

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

As alluded to in one of my previous responses, I would like to see the option of claimants choosing to have some or all of any money awarded under a new compensation scheme spent of rectifying some of the shortcomings in their care which led to the injury or mistake.

For example, if patient safety had been compromised because a department was short staffed then the claimant could choose to reassign a portion of the claim to the Health Board's staffing budget with the stipulation that it be spent in that area.

The avoidability rule of the Swedish system "compensates patients who have experienced injuries that could have been avoided under optional circumstances, in that the injury would not have occurred in the hands of the best health practitioner or health system known as the 'experienced specialist' rule.

This is what I believe happened to me. The quality of care I was offered fell far short of the IBD Quality Standards published in 2009.A gastroenterologist was in charge of my care, but yet he did not use the full battery of tests available on the NHS to assess my condition and allowed it to decline beyond a treatable level leading to emergency surgery and the removal of my colon (I now wear an ostomy bag and could face fertility issues due to the pelvic surgery). He did not seem to know that the blood test he used to assess my condition was ineffective in 10% of patients and he wrongly referred me for psychiatric care because he thought my symptoms were imagined. This could have been avoided had the consultant had better knowledge and experience.

I would wish to go further than simply giving me financial compensation for the fact the specialist was unaware of this basic fact leading to sub-optimal care. I know that hundreds of other patients are treated by this clinician in that hospital, so I would wish money to be spent on further professional development for the clinician and on introducing a wider range of diagnostic tests (the most up to date of which, the fecal calprotectin test, I am reliably informed is 'cheap as chips' but is still not available in that hospital although it was another Scottish hospital where I was previously treated). I do not want others to suffer and more public money to be wasted on unplanned admissions, surgery and compensation cases in future.

This re-assigning of compensation to the NHS budget could be controversial, but if patients are to truly become partners in their own care and co-producers of health services in future, then I believe this option must be available. People do not just was to be compensated for 'distress caused' and patted on the head, they want to actively improve services with the expertise gained through experience and work together with the NHS to make the best possible use of resources.

We are grateful for your response. Thank you.