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?
The Scottish Infected Blood Forum welcomes the opportunity to respond to this consultation and in relation to the matter of apologies would wish to begin by recognising that historically there has been a culture where doctors are not encouraged to make apologies for errors. We believe this requires a cultural change since it is no longer appropriate in these modern transparent times with a view to establishing a mutual NHS in Scotland.

We would also recognise the considerable effort s that are recently being expended to ensure that health professionals are specifically aware of the value of communication when dealing with patients or clients.

Also as a preamble we would seek to establish greater clarity in relation to the scope of medical personnel involved since not all care givers are recognised professionals.

In relation to the steps required when an error has occurred we would respond as follows;
- Where an adverse incident within a health care establishment then that should be reported immediately by the person who discovers it (who could be the person who causes the error) this reporting would normally be to their line manager.
- The line manager ensures that the patient receives an apology at that point assuming that they are still on the premises when the incident is discovered
- Patients should be advised immediately, preferably at the time the incident has happened, that they can be involved in a meeting to discuss the incident and what it might mean for them.
-They should also be advised of the procedure4s for such a meeting including the right of having a friend or supporter to accompany them, this meeting should be arranged as soon as possible.

[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

- At the meeting the error should be fully explained and a formal apology given if it has not already been offered there should also be an opportunity to discuss any possible effects rising from the error and any treatments as necessary.
- At the meeting the patient should be encouraged to ask questions.

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?
We believe that the list is in general agreeable and would make the following comments in relation to clarity and priority;
. "Appropriate" – We would hope that there would be greater clarity in what is meant by an appropriate level of compensation. We would suggest that any guidelines to establish appropriateness would be agreed up by a representative and independent body which includes a significant number of patients or lay representatives

. "Affordable" – We wish to record that in terms of affordability any no fault compensation scheme should not be compromised by suggesting that the resources to pay compensation makes patients feel they are removing front line care resources from other people. On this matter we

would suggest that a separate pot of money be established out-with NHS budgets.

. "Proportionate" – As with the case for appropriate the concept of proportionality needs to be independently agreed by a process that involves all representatives with an interest in these matters and in particular patient representatives.

. "Robust and Independent Process" – We would strongly advocate that any involvement by a patients representatives should be far more than a token gesture. There should be a fair balance perhaps with equal numbers of professional's advisors and lay decision makers. Lay decision makers should not be appointed by professional cohorts or government but by a fully transparent process. The same should apply to independence and balance of the appeal process.

. "Reasonable Time Limit" – We would seek clarity on the basis to what would represent reasonable time perhaps basing that on the experience of other non- medical compensation schemes or at least taking the best practice from these.

. We would add the essential criteria that any no fault compensation schemes would not involve any form of a patient signing away their rights to further action as a condition of receiving that compensation.

. We would also add that a no fault scheme should not be used as a "Soft Option" to avoid genuine cases of malpractice or negligence.

. In general we welcome these well meaning principles but are concerned that they are described in some what woolly terms and that has been reflected in our comments above.

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?
We would seek to establish that a scheme does not just deliver a fair outcome but also a just outcome.

On the matter of transparency that would ensure that it would not only be one clinician involved alone in dealing with no fault issues.

Overall we believe there is an urgent need for a no fault scheme which is based on a greater clarity and fairness. However it is our view that describing these

criteria as desirable is insufficient and that they too should be seen as essential, e.g. it should not just be desirable that the public trust the scheme but we would argue that it is essential.

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 would welcome in general the identified wider issues and the expectation that they would be influential in the design of the no fault scheme in particular we would wish to highlight the issue that for lessons to be learned this should involve a formal reporting and monitoring procedure. Further on the matter of safe disclosure this should equally apply to patients feeling safe when dealing with adverse events and not just medical personnel.

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?
We would raise the following issue even though we have indicated support for the general recommendation for establishing a scheme. A reservation is that the Swedish model is not appropriate for the Scottish situation as it is based on a Government benefit scheme which is very different from that of Scotland and the rest of the United Kingdom. We think it should be recognised that throughout this document and the Annex A materials there is frequent reference for a no fault scheme to be complemented by suitable social security provision. Given the current political debate about independence and the fact

that social security benefits fall within the competence within the UK parliament then those involved in designing a scheme would need to seriously reflect on the complications that would arise, or any future independent Scottish Government policy would be with respect to social security benefits.

We would strongly suggest that an alternative scheme as proposed by Lord Ross when he chaired the Expert Group in 2002-2003 should be considered. Equally there are schemes such as the McFarlane Trust which is funded through Westminster (in relation to HIV), and also the compensation scheme operating in the Republic of Ireland in relation to infected blood.

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?
We believe that the approach described in recommendation 2 is too proscriptive. In the example given we would suggest that just because a patient has given consent an error could still have been avoidable. Also this method would be unsatisfactory in the case of many people living with long term conditions.

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?
We would seek to ensure that a scheme would cover all patients treated in Scotland even if they are now living else where.

While agreeing with the view we would seek to extend the persons covered by it to include non professional health care staff such as auxiliaries who could commit an error that would cause a detriment to a patient while they themselves are not considered to be a "professional". For example a patient in hospital may have been designated as "nil by mouth" but the person is serving meals does not notice this and feeds the patient to their detriment.

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

As previously mentioned the basis for designing a scheme should be by basing it on the agreed principles and criteria, for example as set out in Question 2.

It will be of utmost importance to ensure that any scheme is independent of the medical profession and Government, particularly insofar as decision-making is concerned. For this reason it is also important that it is fully transparent and open to scrutiny.

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?

Our view is that the scheme should be retrospective. This has been acknowledged by successive Westminster Governments in respect of people infected with HIV and Hepatitis C, and more recently the Scottish Government's decision to include widows or dependents of individuals who had died of Hepatitis C as a result of NHS treatment. This also has been acknowledged in the cases of Thalidomide.

In relation to the question of on-going claims, surely the essential principle of fairness must apply.

Further, we would wish to highlight the need to be fair to the families or carers of people who have suffered serious adverse effects and require family members to give up employment to care for their relative, rather than the individual having to be institutionalised at greater expense to the public purse.

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?

We do not agree with a tariff scheme, but that there should be a scheme which recognises the specific detriment to an individual and their capacity to carry out their regular work or other activities. We are aware that one cannot put a price on one's life or the minimising effect that may result from an error physically and psychologically.

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

8. The Review Group was satisfied that a no-fault scheme established as they describe would be fully compatible with the requirements of the European

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

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

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

Yes ☐ **No** ✓

If no, why not?

We agree with Recommendations 6, 7 and 9. We believe that Recommendation 8 is too proscriptive and unnecessary. It is our understanding that in a litigation settlement it is already normal practice for other awards to be taken into consideration.

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** ☐

At this stage we are not sufficiently familiar with the Convention to fully comment.

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** ✓

We do not agree with this suggestion, in particular the motivation that appears to be behind it. It should not be the case that people receive limited degrees of fairness or justice based on cost-cutting initiatives. While we would support efforts to maximise the value of the public pound, there are already too many examples of where clinical decisions are made that are detrimental to individuals and are motivated by purely cost-saving measures.

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

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

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

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 ✓

While we recognise the tragic situations under these specific circumstances, we believe that all groups should benefit together under a scheme. We would be concerned that provision for this group alone would lead to a possible staged introduction that only benefits one cohort of patient and further delay introduction of the scheme for everyone.

We would encourage the precedent established by these cases (where the whole set of needs including those of carers and wider factors) be applied when dealing with other groups of injured patients.

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 are not confident that such an arrangement would be safe from postcode care threats, future changes to care provision, or other unpredictable factors. Also, this approach runs coulter to the new measures being introduced where care is personalised and the management of care through choice of purchase is given to the patient.

Also, as mentioned before, this matter bears relation to the matter of family members having to make major life changes to care for someone affected by a medical error.

Where care services are purchased from the private sector, strict inspection regimes should exist via the Care Commission or such regulatory bodies.

General Comments

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

“No fault” should not mean “no responsibility”, “no accountability” or a way to neglect the duty of care.

The scheme should provide easy access, particularly for those who are not competent or confident self-advocates. There need to be a “level playing field” so that the “small person” (patient who has been harmed) does not feel intimidated or overwhelmed by the mighty medical establishment.

The concept of “Avoidability” need to be further explained, with examples. Also, how does it relate to concepts of negligence, fault attribution, malpractice, etc.

Ignorance of best professional treatment should not be a viable defence.

There needs to be more work around incidents when a patient or group of patients are harmed not by the error of a medical practitioner, but because of a policy or systemic failure.

Deadlines should not be imposed in cases where the effects of a detriment are not immediately obvious, such as a viral infection that is undetected and lies dormant for many years before affecting the patient.

There should be more work to consider situations of negligence to disclose a detriment, being a form of “commission vs. omission”, or doing harm by doing nothing or not fully informing.

In relation to “infection injury”, some are avoidable and some may be considered unavoidable. There needs to be a new category similar to treatment injury.

Access to support (such as psychological therapies) should be in addition to any financial compensation, unless the cost of this is already included in the compensation package.

The principle of “Full Cost Recovery” as agreed by the Scottish Government in relation to other settings should be applied to compensation for patients under this scheme. Full cost recovery will provide a useful balance to minimalising interpretations of “appropriate level” and “affordable” payments. This should include a fair compensation for factors such as expected loss of earnings for the period of illness of for life if permanent impairment is the result.

The has been little recognition of the matter of informed consent and this should be developed futher.

Some people will require advocacy or advisory support and this should be made available through a separate body.

With respect to "Delict" and "Tort" it is unclear how the matter of proving causation, or not, say for cases of suspected negligence applies. This need to be further explained.

Any awards made by a compensation scheme should be disregarded in relation to future benefit claims so that the benefit of the compensation which may be required to last for a long period or while life is not lost due to an inappropriately applied means tested process. This should be backed by legislation.

On the matter of lessons learned, there needs to be a formal review process so that "no fault" does not become "no-change". When errors are pointed out such that making an apology is involved but no real change of behaviour occurs, then it may simply become a hazard of the job.

It is important to stress again the need for an independent process, including the provision of a Commission or Ombudsman type role.

Also, of very great importance is the need for any post-legislative guidance to be drafted by an Expert Group that gives a fair representation not just to medical practitioners, but also to a range of patient and carer interest groups.

We believe that if a meaningful no fault system is introduced then the general public will have greater confidence and would do away with the public perception of the medical profession "closing ranks".

Where adverse incidents arise against an individual medical professional, there should be a system of maintaining a record which would highlight a recurring problem.

Within our answers to the questions we have mentioned a situation where somebody has been treated in Scotland but now lives elsewhere. The converse to this is given that due to various specialist treatments the situation of a patient being treated in England has not been addressed in respect of this report.

There appears to be no consideration of the issue of Mediation. A report on which was published by the Royal Scottish Society (chaired by Lord Ross), and this should be a reference document to the Review Group.

We are grateful for your response. Thank you.