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?

An appropriate expression of regret – a full, unreserved and meaningful apology and reassurance that steps have been taken to avoid such an incident ever happening again. The SPSO guidance on an apology is hugely helpful in these circumstances – in addition the Patients Rights Act cover this area.

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.

[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

Question 2. Do you agree that the principles and criteria set out above are essential in a compensation system?

Yes x☐ No ☐

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

In responding to this question we need to look at the Advantages and Disadvantages set out in the preceding section.

Are the Advantages at bullet points 9 – well established and well-funded social security system and independent complaints processes; and 10 – reduction in the elimination of the need to take legal action in the courts as well as reducing tension and distress between patient and clinician, real advantages when the proposed scheme will possibly encourage further "claims" and a lack of understanding by clinicians that they are not at fault in what they have done – but may be held to account for something that has happened. Also there is no mention in this section of what happens where it is a Policy decision which has caused the problem in the first case.

Looking at the Disadvantages it is important to highlight bullet point 6 – there is still a requirement to establish causation – and hence need for investigation and for engagement between the organisation and the patient or their representative. It sounds like one of the key considerations "fault" has been renamed to provide an easier route for redress.

How do we ensure that with all these advantages, the organisation also can feel that there is merit in putting this pre-court process in place? It could be a passive position and a pre-court process that claimants will avail themselves of, plus an appeal and then court, thereby adding to the costs of compensation. There needs to be some boundaries in that process for Pursuers.

On the Principles themselves:

Essential
It is not clear how people will get the relevant specialist advice in using the scheme – is this still via a solicitor?

Affordability is an important factor.

There is no certainty expressed as to how the scheme will be run – is it more by way of a Tribunal than a Court?

Do clinical staff get to have a say in the decision making process and in reviewing the actions of their peers? The second last bullet point is essential, particularly for clinical staff – the new scheme must not prejudice clinical staff. Clinical staff must continue to have the confidence to be able to carry out their clinical work and judgements in a supportive and learning environment.

Should the scheme have an upper monetary value to bring the no fault compensation scheme more into the realms of the "small claims court"?

Should there be a limit on costs recoverable?

If there is prima facie evidence of professional misconduct that would lead to a referral to a professional regulatory body. We do not feel that the no fault scheme would be appropriate as there is then the problem that a person's actions are judged twice and all the problems that this brings in which process takes priority. Also relevant to Question 3 below.

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?

Desirable

That the scheme adds to learning outcomes must feature here.

The concept that this is a preliminary stage before full litigation (bullet point 2) we do not see as desirable. The statement that the scheme does not put barriers in place for professional regulatory referral appears inappropriate.

In relation to the second last bullet point, the scheme must not prejudice clinical staff. Clinical staff must continue to have the confidence to be able to carry out their clinical work and judgements in a supportive and learning environment.

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?

It is doubtful whether it will. It may add a further level of complexity.

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 x☐

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

No because it limits the scheme to medical injury. The questions also confuse the issue of who the scheme will apply to i.e. NHS or private contractors and private healthcare providers. If a scheme is to be introduced, in Human Rights terms, it should apply to all, but it does not mean that the system between the three sectors has to be organised on the same basis. For the NHS it would be far simpler if the scheme were centrally funded

[1] The consultation document does acknowledge that for medical we are to read clinical

> **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 x☐ No ☐

It is assumed that the Swedish system used the "avoidability" test as to try to be prescriptive in legislation as to what injuries are not eligible is inherently difficult.

It will be very difficult to describe a full list of injuries that are not eligible - this might also clash with existing court rules governing liability, and the Hunter versus Hanley test - a doctor of ordinary skill acting with ordinary care and so on.

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 x☐

If not, why not?

Preference for health services scheme – but if not accepted, then they do not need to be administered or funded on an identical basis. So far as GPs and others in Private Practice are concerned this could continue to be part of their obligations to carry indemnity type insurance.

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

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

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?

The Scheme, if introduced, should be implemented from a date in the future based on the date when after the passage of the relevant legislation the event occurred. There should be no retrospective element of the scheme. This needs to be a parallel system until all cases are through the existing processes - to open this to existing claimants will cause chaos and confusion, and may only lead to further delays.

7. The Review Group did not favour the use of a tariff system for compensation, as it felt that this would not address individual needs and it was unlikely that people would buy into a system where compensation was based on a tariff. The group therefore offered:

> **Recommendation 5 -** that any compensation awarded should be based on need rather than on a tariff based system;

Question 9: Do you support the approach in Recommendation 5?

Yes x☐ No ☐

If not, why not?

The idea of a tariff based approach would not be supported. An assessment based on need would require that there is some future review of on-going need or changes in circumstances directly related to the event that was the subject of the scheme. There would also be benefit in placing a financial limit on the total amount of payments made in terms of costs and "compensation", which could be subject to future inflation proofing. It would be vitally important to ensure that payments from the scheme did not divert resources from the NHS with additional funding being supported by the Government to cover costs.

We also need to recognise that past precedent and tables used by Counsel for issues such as Solatium do already use what could be regarded as tariffs. However, it should be based on need.

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 x☐

Scheme as promoted may be compatible with Human Rights legislation so far as the patient is concerned, but has the right of the clinician been considered in the same terms?

If the analogy to be used here is akin to a small claims court, which is reasonable given a lower standard of proof required/easier access, there should be some agreement in advance that the process would be no fault, with an appeal mechanism but not recourse to the courts, otherwise, a claimant unsuccessful in the no fault process will simply migrate to the court processes.

Recommendation 6 – Not clear why this is considered necessary. Already stated that there would be a right of appeal on a point of law.

Recommendation 7 – Not supported as this means potentially we have to go through the cost of two processes.

Recommendation 8 – Yes, if that right exists.

Recommendation 9 – Can see why there is a right of appeal on a point of law, but it would be unusual to allow a right of appeal on a point of fact e.g. the current NHS Tribunal does not provide for this.

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 Principal 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?

The issues identified are real, but also mask a lack of transparency by pursuers in taking forward claims. Often organisations are presented by a very general statement of claim which following further investigation can sometimes proves to be inaccurate. Some claimants do not actively pursue their claims and then resort to litigation as the triennium approaches. In a few cases there are good reasons for this. What may be more relevant in the context of the current consultation is details of the procedures that the Government would expect the parties to follow and the timescale for seeking resolution. These need to be clear, require a claimant to be specific as to the nature of the loss suffered and where and when and still allow time for local investigation and assessment of our position.

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

On the specific changes to legal procedure mentioned in paragraph 4.3 this is best dealt with through the process suggested.

The length of time and delay in disclosure issues in annex B are linked, and if disclosure could be brought within a reasonable timeframe, the length of time taken to conclude litigation could be reduced dramatically, however it is not in the Pursuer's interest at times to do so, and they choose to apply pressure in the weeks and days before a proof hearing to seek to settle the action out of court knowing how much the defender is going to have to commit to defend the claim, and especially in legal aid cases, even if successful, unable to recover costs.

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?

Whilst apparently sound the recommendations do raise the issue in the current organisational context of having to agree between health and local authorities the respective responsibilities for future care and how this may best be delivered in consultation with the child's parents. A similar procedure to that applying under the NHS Continuing Care Provisions may be an appropriate way forward which would ensure that future changing needs are taken into account.

We think there is merit in looking at neurological impairment completely separately, these cases tend to settle out of court and there is now a great deal of precedent in terms of long term care and costs in terms of settlement (usually by staged/periodic payment). These by necessity need to be delayed until developmental needs are assessed, and their is merit in dealing with these cases in a different way, where liability tends to be accepted very early on, and both sides work together to agree the needs of the patient and the long term care costs.

The presence and impact of legal aid can lead to a situation where, even in the face of very robust Defenders expert reports, and very weak Pursuers expert reports, there can be a tipping point, especially in cases set down for more than a week, where the economic settlement is the best outcome in terms of protecting the public purse from expensive legal costs. Therefore an economic settlement can be made in the absence of the three elements set out as tests.

General Comments

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

Overall Principles

The proposal is one which is commendable in providing greater access to those who have suffered a loss through the non-negligent acts or omissions of practitioners in providing treatment. However, consideration also needs to be given to the position of the clinicians acting reasonably and using recognised skill and acting within acceptable standards of care. Recognition needs to be given to the genuine mistake and negligence. As has been stated earlier, the scheme must not prejudice clinical staff. Clinical staff must continue to have the confidence to be able to carry out their clinical work and judgements in a supportive and learning environment.

Current System

Paragraph 2.1 describes the current system as being one where no compensation is paid unless there is established a legal liability of negligence. This is not strictly true. A decision on whether to pay compensation is based on the presence of negligence, but also on a pragmatic view of the likelihood of a claim succeeding and the cost of defending that action where there is a degree of doubt. Cases are settled on an economic basis. To prove that there was no negligence or a lack of evidence to support this would on a judgement call taken with our solicitors. NHS Boards are stewards of public finances and are charged with their most efficient and effective use.

Clinical/medical

It is also difficult to see how, other than through the payment of compensation the scheme is designed to place ***the person who has been harmed in the position they had been in prior to the injury, as far as possible***. Does this imply remedial treatment or some other form of recompense? The Consultation document quotes well know research [23] that the primary desire of patients is to receive a meaningful apology and a re-assurance that the organisation will take steps to avoid a re-occurrence. This is an aim secured through the Patients Rights (Scotland) Act 2011.

We are grateful for your response. Thank you.

[23] Paragraphs 3.3. and 3.4