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 Board agrees with the view that an expression of apology does not amount to an admission of liability and actively encourages open, transparent and honest exchange with patient/family when things go wrong.

All NHS Board's should have robust internal Complaints Procedures and Significant Adverse Event Review (SAER) processes in place. During both processes the patient/family should be given the opportunity to have a full and frank discussion with clinical staff and this should be followed by an apology from the staff involved in the care where fault has arisen or where there are system failures. The SAER process should include a focus on the concerns of the patient/family whilst being supportive to the staff being investigated. The staff involved in SAER investigations should be trained in root cause analysis and reports produced should be shared openly with the patient/family and staff involved.

The Board has found family involvement invaluable during SAER investigations and openly shares the report with the patient/family.

It is the Board's experience that despite assurances from patient/family that they wish to prevent a recurrence and do not wish financial award, many of the complaint responses and SAER reports are thereafter passed to solicitors to intimate 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

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?

It is the Board's view that the principles 'The scheme treats staff and patients fairly/equitably' and 'Decisions about compensation are made through a robust and independent process' whilst admirable cannot be met from the perspective of the staff if 'there is no need to establish that any individual was negligent.' This would be biased against the staff.

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** √

There is already an underlying compensation culture in Scotland and the scheme may encourage development of this.

If there is no need to establish negligence then the scheme as described has the potential to encourage vast amounts of unsubstantiated claims.

Would the complaints process run in tandem with the system? There is the potential for the patient/family to by-pass the complaints process with an added bonus of recourse to litigation if the expected financial award falls short of what is desired by the patient/family.

Accepted that emotional rehabilitation may not commence until the litigation is resolved. Physical rehabilitation should proceed regardless of whether there is a claim. In a minority of cases it would appear that the claimant relies on being physically incapacitated throughout the process.

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?

Learning from litigation is currently shared across the Board and there is no reason why a simple sharing system could not be implemented to allow National sharing without requirement for the scheme.

The Board already shares Significant Adverse Event Review reports with patient/family and learning is published on the public website.

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?

Any no-fault scheme is likely to be an increased cost pressure upon the public purse. The Board perceive that the well established system in place within the NHS for self-insuring and risk sharing to be adequate; that being the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS).

The scheme does not cover issues such as employer's liability, public liability, and product liability and as such CNORIS will continue to be required for these areas of liability. There will be enormous costs involved in setting up and administering another scheme entirely for clinical matters.

Suggested alternative system

The Board would be prepared to be involved in a pilot system which has the aims of the scheme in mind (i.e. reducing the costs to the public purse and the time taken to process and settle clinical negligence claims) but without incurring additional costs in implementation and administration.

The proposal would be for the Government to make legislative changes to the way in which clinical negligence cases are handled to make them more cost efficient and be resolved quicker, e.g. within 3 years of intimation. Put simply, this could be accomplished by the claimant obtaining medical expert opinions on liability and causation from those in the appropriate field and sharing these with the Board at time of intimation of claim. If the Board clinicians were to accept the expert opinion then settlement negotiations could commence at this stage as opposed to several years down the line. If the Board clinicians did not accept the views of the expert opinion then the Board would instruct its own expert reports and share these with the claimant to facilitate without prejudice negotiations to take place. A very simple plan whereby standard operating procedures could be agreed prior to implementation.

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** ☐

There is the potential that this may lend itself to the clinician practising defensive medicine. The clinicians may spend increased amount of time explaining every potential risk to the patient. The potential knock-on effects may be:-

(a) increasing the time spent explaining all the risks to patients reduces the number of patients who can be seen in the clinic; this in turn increases the waiting times for out-patient clinic appointments.

(b) having been made aware of all the risks, in glorious technicolour, they refuse to consent to the procedure; this in turn increases the requirement for primary care input and continuing additional medication costs.

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?

The scale of the liability is unknown. Independent contractors should have their own insurance arrangements in place, this being a contractual requirement. These bodies are not covered by the current CNORIS arrangements.

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

The scale of the liability is unknown. Doctors should be encouraged to retain their own defence membership. In the unlikely event that they carry out actions which were against Board Policies or Procedures and litigation ensued, this would result in a conflict of interest and the clinician would be advised that they should contact their own defence union to ensure they are fully protected in litigation actions. Currently, should such a conflict of interest occur there requires to be separate representation for the Board and the clinician involved.

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

There would require to be changes to legislation and contracts.

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?

On current system, CNORIS has a residual claims mechanism.

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?

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?

Recommendations 6 and 7 are biased toward the claimant.

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?

Refer to Question 5 answer for suggested alternative system.

The Board always considers the cost to the public purse when debating whether to proceed with a court action and one of the issues considered is the costs associated with running the case against the costs of economic settlement.

[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** √

Some neurologically insults to the brain can occur in the ante-natal period. If there is not a requirement to prove fault then the scheme would be allowing mothers who may have taken excessive alcohol or illicit drug use during pregnancy to obtain compensation.

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?

Agree that future care component of compensation should be a guarantee of delivery of services, not just to meet the needs of the child but to meet the needs throughout adulthood.

General Comments

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

The Board's main concerns are:

- The potential costs of the scheme.
- The scheme will not be cost effective.
- The increasing number of claims that will be received, in particular unsubstantiated claims.
- The unknown scale of liability of involving independent contractors and private practices.
- The removal of the requirement to establish negligence.
- There will continue to be a requirement to continue to administer the CNORIS scheme for other litigation, e.g. employer's, public and product liability.

We are grateful for your response. Thank you.