No-Fault Compensation for injury resulting from medical treatment:

Thank you for inviting Optometry Scotland to comment on this consultation.

Optometry Scotland represents all Optometrists and Dispensing Opticians in Scotland plus the UK national representative and professional bodies – the Association of the British Dispensing Opticians, the Association of Optometrists, the College of Optometrists and the Federation of Opticians (FODO).

We appreciate that the consultation in 2008 indicated that no-fault compensation was the Scottish Government's favoured way forward for the NHS in Scotland (paragraph 1.1). However, we are pleased that the Minister has recognised that "no decision has been made in relation to whether a no-fault system should be introduced" and that [she does] "not underestimate the complexity of introducing such a system." (Ministerial Foreword).

This is because we do not believe that the optical sector should be brought within these arrangements (or at least not until they have been proven to work and to be cost-effective for NHS Scotland).

The reason for this is that in community optical practice in Scotland, we already have a very good complaints and compensation system which works rapidly, fairly and cost-effectively for both patients and practitioners.

Our system is based on regulation by the Scottish Government, local Health Boards, the General Optical Council (our optics specific regulator) and our professional indemnity insurances.

All the evidence we have shows that our system meets the objectives that the Scottish Government has set for the NHS as a whole (including the shortcomings of the main NHS system set out at Annex B of the Consultation Document).

In optics, there is no problem about patients or complainants having access to investigation, justice or redress. Before touching on the formal mechanisms for redress, we would like to add that the vast majority of complaints are resolved informally through discussion between the patient and practice. Through operating in an open and competitive market, optical practices are incentivised to satisfy their patients' needs and desires, and if they do not, their patients choose another provider. Where a patient feels unable to return to the practice, or has exhausted this route, they can opt instead for more formal channels and complain to the appropriate Health Board, the General Optical Council, or indeed the Health Service Ombudsman. These bodies will help them frame their complaint and investigate the complaint on their behalf.

Equally, should a complaint lead to an insurance claim, our professional indemnity insurers will also investigate, including calling consulting expert witnesses, and where appropriate agree compensation which is matched both to the level of any

harm caused and the rehabilitative and other needs (including emotional needs) of the patient where this is appropriate.

This system already moves fairly rapidly compared with standard NHS procedures and the GOC is committed publicly to speeding up its processes further by the appointment of case examiners to ensure speedier resolutions both for complainants and optical practices.

The system also has the benefit of the costs of investigation and compensation being borne by practitioners and optical practices themselves through their indemnity insurance premiums. This provides an additional and direct incentive for practitioners and practices to learn from complaints experience, to correct any errors throughout the system - a direct and personal incentive which does not exist in the rest of the NHS.

In terms of cost control, the risks are also spread not only across Scotland but across the four other UK countries and, in the case of one of the insurers, across the Republic of Ireland as well. This widens the learning pool – helping minimise risk across the entire sector - as well as keeping costs down and within affordable limits.

The system also has the benefit of being entirely privately funded with no burden on the NHS or government.

Having studied the Consultation proposals closely, it is clear that the no-fault proposals have been developed primarily in response to shortcomings in the existing NHS Scotland system.

The Minister is right to recognise the difficulty of introducing such a scheme, especially the issues of cost control, double jeopardy (whereby the complainant can use both the no-fault system and then go on to the courts, etc) and the risk of creating rather than staunching a compensation culture in Scotland, all of which are likely to lead to more rather than less costs and potentially extend the length of time to resolution which is in nobody's interest.

It seems sensible therefore for the Scottish Government to test the system first within NHS Secondary Care and, if that works, proves to be cost-effective and brings savings to the public purse, then to consider with the national optical bodies whether, and if so how, the system might be extended to community optometry and the other primary care contractors.

It is against this background, and support for the general principle of no-fault compensation where this is appropriate, that we respond to the specific consultation questions below.

Consultation Questions

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?

Answer 1: We can do no better than cite Professor Roy Lilley below:

Here are Roy's Rules for handling complaints!

"Listen, don't justify, sympathise, make notes, agree a course of action and follow through.

Listen: Say to the person with the complaint; 'I want you to tell me exactly what's wrong. I want to listen to you and find out'. Tell me, exactly what happened.

Don't justify; if you were plagued with staff sickness, the phones were down, the computers didn't work, the post was late... is of no interest to the person with the complaint. Focus on them. Justification will look like an excuse.

Sympathise: Saying; 'From what you tell me this must have been: very cross-making; painful; disappointing; distressing' - is not the same as admitting liability.

Make it clear you are **making a note**; 'I just want to make a note of all this so I can be sure I understand'. It's part of active-listening and demonstrates you are really interested.

Agree a course of action: 'I'll talk to the nurses/receptionist/ doctor and make sure it doesn't happen again/change it/fix it. Is that OK with you?' Or; 'I don't have all the details to deal with this and I'll look into it and ring you tonight... tomorrow... next week with the answer'.

And, the deal-maker/breaker; **follow through**. Do what you said you would do and tell 'em if you can't."

It follows that contact with the complainant should be immediate and updates on progress given to the patient regularly (at prescribed intervals) before a final letter is sent.

The circumstances around the error should be investigated independently of the immediate staff involved.

This is the system which operates where a complaint becomes an insurance claim and we would argue serves the patient much better than the proposed 'no fault compensation for injuries'.

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 X **No ☐**

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

Answer 2: Affordability, fair treatment of staff and patients and reasonable time limits for any compensation are the most important in our view.

As noted in the introduction, the systems already in place to resolve optical complaints already operates according to these principles.

In line with the current law in Scotland,the scheme should not compensate a carer who is not a member of the patient's immediate family.

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 x **No ☐**

Answer 3: However we do have two concerns.

Firstly, it is right that the scheme should not prevent patients seeking other forms of recovery but this does open up the possibility of double jeopardy for practitioner at no risk to the complainant This, and the fact that this would most likely increase costs, for a low risk profession like ours (which already operates effective and cost-effective complaints, investigation and compensation arrangements) provides a clear example of why we should not to be included in the scheme (at least not in the early years);

Secondly we are concerned about the criterion "contributes to rehabilitation and recovery". If a patient has a need for these services they should be provided by the NHS and social services in accordance with need and should not be dependent on compensation payments. We hope this is not what is implied.

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

The scheme should be published and reviewed every five years.

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?

Answer 4: The existing arrangements in community eye care already deliver all the benefits listed and the open market and highly competitive system in which we operate provides strong incentives to learn from mistakes and not repeat them to keep down costs.

Our insurers already provide annual feedback on claims and issues to be addressed to the profession generally and in the case of large providers cross-comparison with their peers.

In addition the cases that build up and issues raised can be used for Peer review or Peer discussion processes as part of Continuing Professional Development and Personal Development programmes. This could be developed further, locally by Health Boards, or preferably nationally by National Education Scotland in liaison with our national insuring bodies.

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?

Answer 5: A qualified Yes, as not every part of the Swedish scheme is ideal. The funding mechanism for the scheme in particular should be clear as the Scottish social welfare system is less well provided than in Sweden.

In Scotland professional regulation already requires registered optical practitioners and businesses to have professional indemnity insurance cover which operates effectively without the superstructure and cost of a Patient Insurance Association. We can see no reason for going down this road in the community optical sector.

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** X

If not, why not?

Answer 6: We cannot immediately see why the 'avoidability' test should not apply including in cases where the patient has given informed consent to an intervention which carries a known risk. These are difficult matters and each case should be judged on its own merits. This is why, in the case of optics, we would prefer to leave these matters to our insurers based on expert clinical opinion.

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

In our sector, injuries are often caused by patient non-compliance with the treatment plan or recommended hygiene or wearing regimes (eg in contact lens wear). This is why we think, again, that it is better to let insurers assess any damage and how the injury occurred based on the patient records and expert clinical opinion.

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?

Answer 7: For the reasons outlined above, the scheme should not apply to community optical practice and public funds should not be used for this purpose – at least not in the early years and until the effectiveness for complainants and NHS Secondary Care, and particularly cost-effectiveness, have been tested and demonstrated to work.

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

Answer 7.1: As outlined above

- doubts about the wisdom of moving from a tried and tested system that works well for both complainants and the sector to an additional system which can only increase costs with a consequent effect on patient care
- double jeopardy for practitioners and optical practice
- increased administrative costs as in migrating from one system to another and the confusion that this would cause for all parties.

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

Answer 7.2: Substantial negotiations with primary care contractors and their insurance and professional indemnity providers.

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?

Answer 8: There is good case law in place, and indeed natural justice, which suggests that outstanding claims should be handled under the scheme that was in place when the event occurred pertaining to that claim.

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?

Answer 9: Under any system there should however be ranges of financial compensation for injuries of minimal, moderate and severe types. Except in exceptional circumstances this guidance should provide upper limits to the amount that could be claimed or awarded.

Any new scheme would need to ensure that it did not simply duplicate the disputes which currently exist under the existing model as to what reasonable needs are. The scheme would also require a mechanism to deal with causation. If a claimant had a range of problems some of which were caused by an incident covered by the scheme then the scheme would need to address the issue of causation in a reasonable way to ensure that neither the state nor private providers/insurers were meeting costs for problems they did not cause.

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

Answer 9.1: The overall level of payments is almost certain to increase: society in general is becoming more litigious, the legal profession is actively seek out claims to pursue and no-fault compensation whilst in part possibly stemming this tide still - rightly – leaves open the option for seeking further redress through the insurance system and the courts.

The assumptions that a meaningful apology, explanation of the error and steps to avoid the error recurring are the principal drivers for clinical negligence claimants are untested.

We will be interested to see how successful the scheme is for NHS Secondary Care and then what lessons can be read across to our own sector.

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 ×**

Answer 10: Every attempt should be made to ensure that the no-fault compensation is fully used, as one of the main benefits will be a reduction in investigation, review and legal costs. If both the no-fault compensation scheme and litigation proceed for a large number of cases then overall costs will increase, with two separate parallel systems for assessing and awarding damages. This would effectively allow for forum shopping.

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 × x **No**

If yes, what are your concerns?

We believe there is a risk that the proposed scheme is open to challenge under Article 1, Protocol 1 of the ECHR on the basis that it interferes with health providers',health professionals' and insurers' property rights.

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[19] 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[20], 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 support compulsory pre-action protocols and believe it would be desirable for there to be be a bespoke clinical negligence protocol with an appropriate fee scale for settled cases.

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

Answer 11.1: If there are problems with apologies, delay of or non-disclosure etc these should be addressed by amendments to professional Codes of Conduct (as the GMC has done for doctors) rather than introducing new requirements under a new scheme. In community optical practice any non-compliance in these regards can then be taken into account in assessing the continuing fitness-to-practice of both registered professionals and optical practices.

[19] http://www.scotcourts.gov.uk/civilcourtsreview/
[20] 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?

Answer 12.1: Good idea, as it would provide continuity of care to the patient, which is the most important part of compensation in this patient category. However, if providers outside NHS Scotland such as ourselves were to be included, the impact on existing insurance arrangements would need to be carefully assessed and compared with current arrangements to see what would suit the needs and wishes of children and parents best.

General Comments

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

Although we argue strongly that a new no-fault compensation scheme should not apply to community optical practice (which is low risk and already has effective and cost-effective compensation arrangements in place) at least not initially, we would like nevertheless to continue to be involved in development work in case there are any lessons we can learn for our own schemes, any insights we can offer from our own experience and in case the scheme should be extended to our sector in future.

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We are grateful for your response. Thank you.