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?

What is required is a shift in NHS culture. A blame culture still by and large exists. The consequence is that as a result staff members tend to practice defensively. When something goes wrong the tendency may be for a swift, often knee jerk response often without a broad triangulation of the factors contributing to the incident. Often if an analysis does take place it may be from a blame perspective and not one of learning and improvement.

The pressure within the system currently is significant and exploring ways to reduce this should be paramount.

Attention needs to be paid to what could promote a shift in culture from one of performance management to a more supportive developmental culture where the focus is on appraisal, personal development and collective contribution for improvement.

Working within a more supportive managed system would enable staff to take responsibility and be accountable.

The key issues in this respect are timeliness, an explanation in terms that are understandable to the patient/family, and which include the participation of the relevant clinicians.

Post graduate training should also be offered and there is a need for appropriate training at medical/nursing schools.

[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?

That the scheme makes proportionate use of time and resources and does not open floodgates to petty/opportunistic claims which will consume vast amounts of clinical and managerial time

It is essential to have clear principles. However, it is unclear which are principles and which are regarded as criteria. Therefore, this area needs sharpening up. High level principles and specific criteria would be helpful.

One question is whether the proposals are compatible with other legislation - for example - Equality and Diversity.

It would be helpful if roles and responsibilities were clearly specified and an evaluation of the scheme should be built in from the outset.

There is no mention of governance of system or processes.

There are issues of:-

- T imeliness
- Appropriate level (proportionality)

- Fairness to patients and 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** ☐

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

Could this section not be incorporated in the preceding section?

The criteria as stated are too general and there are questions around how they would be measured.

Staff would also need to trust the system.

Wider issues

- The scheme contributes to:
  - organisational, local and national learning
  - patient safety
  - quality improvement
- Lessons learned can be used to influence organisational risk management in the future
- The scheme encourages and supports safe disclosure of adverse events
- The scheme does not put barriers in place for referral to regulators of any cases which raise grounds for concern about professional misconduct or fitness to practise.

Question 4: Do you have views or ideas on how a compensation scheme could more effectively contribute to the wider issues identified above?

There is the potential for such a scheme to facilitate a change in culture, perhaps even by its very introduction and thereafter over time.

The role of management is crucial at Board/Executive Directot level.

There should be a formal mechanism for analysis and publication of events and actions taken (suitably anonymised)

5. When considered the Review Group's suggested essential principles and criteria against other schemes and the Swedish model came out on top. Based on this the Review Group offered:

> **Recommendation 1 -** that consideration be given to the establishment of a no-fault scheme for medical injury, along the lines of the Swedish model, bearing in mind that no-fault schemes work best in tandem with adequate social welfare provision.

Question 5: Based on the background information on the system in operation in Sweden given in Annex A would you support the approach suggested in Recommendation 1?

Yes √ **No** ☐

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

> **Recommendation 2 -** that eligibility for compensation should not be based on the 'avoidability' test as used in Sweden, but rather on a clear description of which injuries are **not** eligible for compensation under the no-fault scheme.

Question 6: Would you support the approach in Recommendation 2? This would mean for example that where treatment carries a known risk and the patient has given consent to that treatment it would not be eligible.

Yes √ **No** ☐

However, this is liable to give rise to very extensive/complicated consent forms having to devised for every significant intervention that might be undertaken (to help obviate claims) – to the detriment of patient care and patient throughput

Those that are not 'severe' and/or 'long lasting' – thresholds would need to be defined

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** ☐

It would be practically difficult if not, especially as care may span across multiple boundaries.

If not, why not?

As a private business, practitioners/organisations in the private sector should finance their own insurance arrangement. Otherwise this will be a subsidy of the private medical sector. I suspect the majority of the public and NHS staff would find that unacceptable.

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

There would be difficulty in delineating what was NHS work, and what was "private" in this context.

In relation to independent contractors, any real issues in bringing independent contractors into such a scheme, who work directly for the NHS such as GPs and dentists. There is a possible issue as to whether a breach of duty would still have to be demonstrated.

On that basis, presumably independent contractors would be required to sign up to the scheme?

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

The NHS contract with these practitioners for that portion of NHS - funded work should indicate that work undertaken in that context would be covered by the scheme.

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?

They should complete the process under which they were started.

There are questions around how outstanding claims would be handled.

In relation to independent contractors, in general practice, many claims cease or a settlement is reached without fault being admitted. In effect, many are dealt with on a no fault basis.

These would have to be subject to the provisions in force, pre-transfer.

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** ☐

Demonstrable rather than perceived need.

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?

The level of payment should be assessed without reference to a "going rate". There is an opportunity here to assess afresh what is appropriate compensation, and keep that under review to take account of inflation etc.

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

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

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

Yes √ **No** ☐

If no, why not?

10.1 Do you have any concerns that the Review Group's recommendations may not be fully compatible with the European Convention of Human Rights?

Yes ☐ **No** √

If yes, what are your concerns?

9. The Review Group offered suggestions for improvement to the existing system and these are reproduced in Annex B. The group recommended:

> **Recommendation 10 -** that consideration should be given to our analysis of the problems in the current system, so that those who decide to litigate can benefit from them.

10. It is proposed that the suggested improvements will be taken forward as part of the forthcoming consultation on the Courts Reform Bill later this year by the Scottish Government Justice Directorate. In particular the Scottish Civil Courts Review[21] recommended that pre-action protocols should be made compulsory and it is considered that this would assist in resolving many of the areas identified by the Review Group In addition, Sheriff Principle Taylor's Review of Expenses and Funding of Civil Litigation in Scotland[22], which is due to report at the end the year will consider a range of issues.

Question 11: Do you agree with the Review Group's suggestions for improvements to the existing system?

Yes √ **No** ☐

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

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

11. The Review Group also considered whether or not the establishment of a scheme specific to neurologically impaired infants should be created (in the event that a general no-fault scheme is not introduced). Members considered that this group of patients arguably represents a special case and certainly accounts for the most significant sums awarded in compensation and legal costs. The Group were of the view that this was worthy of consideration.

Question 12: Would you support the establishment of a scheme specific to neurologically impaired infants if a general no-fault scheme is not introduced?

Yes √ **No** ☐

Most of the time you would be compensating parents for the failure of biological development rather than the failings of medical care! Such patients are already cared for by the NHS and Social services.

At what threshold of neurological disability would you compensate – for examply, minimally impaired vs autistic vs slight limp vs 'major' immobilisation?

Indeed you would set a precedent that any child deemed less than perfectly formed would be entitled to compensation!

This is challenging, perhaps impractical.

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?

This is better

General Comments

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

One specialty adviser commented: I would support such a process. Having been very heavily involved in NHS X with legal claims when I was Divisional Medical Director for the Acute Services, I am acutely aware that the amount of time and effort in dealing with claims is huge and anything that reduces the burden on clinicians and administrators in preparing reports and counter reports would be very welcome.

There are very substantial legal costs both from the CLO to the NHS and to the patients if they do not have legal aid. For those patients that do have legal aid cost is then borne indirectly by the tax payer. This change in process should substantially reduce these costs to the NHS.

What is not clear is who would judge that the patient has been harmed even though proof of negligence would no longer be required. One would need to be comfortable with how such a judgment would be reached.

This may have a favourable impact on clinicians who may otherwise shy away from very high risk procedures which their patients actually need but are not offered because of concerns about legal issues if things do not go as well as planned.

The paper and response document could be clearer on whether it is referring to medical negligence or to all forms of harm to patients. The first question in the response document relates to apologies for errors, mention of medical negligence is made, but elsewhere the document states it is examining what to do about injuries caused by medical treatment. Clearly the latter may not be a result of negligence. (If the point is that the process to prove negligence is byzantine, then if it is simplified, this will increase payouts of spurious merit, as well as making fair claims easier to handle - has the Government got the money to support this?)

With regard to errors and negligence, the view is that patients should receive an apology, appropriate compensation, and steps should be taken to change the system to reduce the chance of future recurrences. Our current problems are three-fold:

1. The hospital complaints procedure seems divorced from the primary care one, so if your complaint crosses both boundaries (as it often will do), you won't get satisfaction as the two areas have no effective communication with regards to handling complaints

2. Complaints in hospital are handled by a 'complaints department', who tend to produce a narrative of the event gleaned from all medical parties involved, rather than necessarily answer the complainant's questions and give some solutions, and this on occasions just irritates the complainant further

3. The usual response to errors is to introduce more extensive documentation, which simply makes the whole situation worse by taking staff away from caring for their patients and assuming that errors can be prevented by protocols - they often can't and sometimes the protocols make things worse.

I have given medico-legal advice both for the 'defence' and 'litigant', and in some former cases it is clear that no negligence or even 'harm' has occurred but the patient has died due to the statistically likely outcome of their disease but the family just cannot accept this and are looking to blame someone. Compensation in these cases is clearly inappropriate but seems to need medico-legal reports (and in some cases attendance at court) to show that no 'harm' or negligence was involved. How would the no fault compensation deal with these cases?

We are grateful for your response. Thank you.