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?

In the experience of FOIL members, there is generally a willingness amongst health professionals to give an apology when an institution or individual is at fault. This approach is supported by guidance provided by the GMC and the Scottish Public Services Ombudsman, as referenced below.

Whilst it may appear to be a minimum step for an apology to be offered – and the issue of often couched in terms of "*all that was wanted was an apology*" the issue raises difficult issues. To adopt the vocabulary of the SPSO guidelines, there may be genuine concerns and differences of view when considering whether an "offence" has been committed and to what extent the institution or the individual has "done wrong". The kind of apology envisaged in the guidelines will not be appropriate in all cases.

It is difficult to reconcile the concept of apology with the litigation process. On the basis that an apology, as set out in the guidelines, includes an acceptance of responsibility, this may not be possible in the context of a claim for financial compensation.

It is unusual for an apology to form any part of the litigation process in Scotland although FOIL members practising in England and Wales report that they find the concept of apology an important part of the process, especially in rebuilding trust between clinician and patient.

It is important that the complexities involved in apology are recognised, and that it not merely accepted as an easy first stage. It may be useful to examine further how apology has become a crucial stage in the litigation process in England and Wales and whether there are changes which can be made within the civil procedure to make this more likely to happen in Scotland. It would assist if legislation in Scotland could mirror Section 2 of the Compensation Act 2006.

[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?

FOIL would place emphasis on the need for the scheme to be affordable; fair, both in terms of the level of compensation and in the treatment of all parties involved; and proportionate in terms of resource and cost.

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?

No

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 likely that the statistics available from claims handled within the scheme will provide information on trends and areas of concern. This may enable patients to be provided with more accurate information on risk. However, as the Scottish process will not be based on an "avoidability" test, claims within the scheme will not necessarily have involved an error or mistake. It should not be anticipated that by providing compensation in cases where an injury has occurred that that will, of itself, lead to improved standards.

There is a risk that the proposals will create an excessive focus on the risks of medical treatment. If claims are to be excluded from the scheme where injury has been caused by a recognised risk which the patient has accepted, it would seem likely that medical practitioners will give more attention to identifying every possible risk and obtaining patient consent. The identification of remote risk is unlikely to improve standards of care and may create anxiety and over-caution on the part of patients and an excessively defensive approach on the part of health professionals.

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?

FOIL does not support the introduction of a no-fault system of compensation in Scotland. It does not believe that the issues have been thoroughly explored in the consultation paper: there is sufficient information on practicalities, impact and cost to justify the introduction of such a scheme.

In FOIL's view the problems which have been identified would be best addressed by improving the current system rather than introducing a no-fault scheme.

<u>Social implications</u>

FOIL is concerned that the ethos behind the proposals raises social concerns. At present the rational for compensation is relatively easy to understand – there is a "guilty party" who has perpetrated a "wrong" against an individual and financial compensation is seen as a way to remedy the situation. Under the proposals there will be no "guilty party" and compensation will be payable in circumstances where high quality care has been provided but injury has still occurred. This significantly moves the line that separates those patients entitled to compensation and those not entitled, in a way which is likely to prove incomprehensible to the public. It may also be considered unjust if claimants who suffer an injury through clinical treatment are so entitled to no-fault compensation whilst other claimants in EL and PL claims, seeking damages from the State and private sector defendants still have to prove negligence.

It must be asked to what extent a policy which responds to any injury, however caused, with an offer of financial assistance, will create a "compensation culture" in Scotland, an issue which has been of concern in England and Wales for some years. There are potential unforeseen consequences here for wider society if the development of a "compensation culture" which sees every injury in financial terms leads to consequences outside the realm of healthcare provision, including the withdrawal of important services on the grounds of risk, a climate of fear of claims, and increased insurance premiums.

<u>Cost and funding</u>

A major concern with the proposals is cost and funding. The details of the Swedish model set out in Annex A indicate that the system there is funded heavily from taxation. The state-run medical injury insurance company covers 90% of health care provision. This

accords with the model of taxation and social welfare in place in Sweden based on high levels of personal taxation, which in turn pays for high levels of social provision. It should not be assumed that this model can simply be overlaid on the very different political and social structure in Scotland.

It is unclear from the consultation paper where the funds will come from to pay for the scheme. How are the costs to be divided between the NHS and the current providers of indemnity insurance cover?

The paper is at pains to emphasise that the costings that have been provided by researchers at the University of Manchester are not an estimate but are based on the costs that would have been incurred if a no-fault regime had been in place over recent years. There are concerns over the assumptions made and the resulting figures.

FOIL does not believe that the figures reflect the full impact that the new regime is likely to have on claims volumes. If all injuries resulting from medical care are to be included, a significant number of claims will arise where at present a claim is not contemplated, including suffering the side effects of drugs and treatment, claims resulting from any failure to offer treatment, and product liability (where at present at-fault claims would be brought against a manufacturer). The researchers estimate that claims will increase by between 20% and 80%, with between 20% and 60% of those claims resulting in compensation. FOIL would anticipate that, in reality, claims numbers and awards will significantly exceed these figures.

Experience shows that where the potential to make a claim is opened up, individuals naturally make use of it. England and Wales has seen a 30%-40% increase in claims year on year over recent years, partly brought about by the introduction of CFAs to fund claims and a well-developed claims management industry that encourages claims to be brought. It is likely that the new regime will have a similar impact on claims in Scotland which is not currently reflected in the figures.

It is anticipated that compensation awards under the new regime will be 20% higher than at present to deter appeals. FOIL expects that compensation costs will rise very significantly, to reach levels well above current figures. Current awards are often discounted to reflect the risk of litigation or a reluctance to pursue a claim to a court hearing. Under the proposed scheme all claimants would receive compensation on a full-liability basis.

Even on the limited figures provided by the Manchester research, which FOIL believes will prove too cautious in practice, at the upper level the cost of providing compensation will rise by around 50% - a rise of over £8m. It is unclear where this additional funding will come from. In the current economic climate it will be difficult to justify this additional burden on public expenditure. However, one of the advantages of the scheme (highlighted on page 8 of the consultation paper) is said to be the "*easing of pressure on health practitioners with regard to escalating insurance premiums*" which seems to suggest that it is not envisaged that the costs will be met through indemnity insurance. It is inappropriate to consider the details of a scheme without the fundamental issue of funding being addressed to make it clear where the financial burden will fall and how it is to be met.

It should also be noted that the proposed transfer of responsibility for care for injured claimants from private providers to the NHS will create a significant burden, both practically and financially. This liability does not appear to have been factored into the costings.

Under the proposed system there will still be a need to prove causation and deal with quantum. No indication is given in the paper of how these will be handled although the

University of Manchester research indicates that there will still be a need for legal advice. Causation arguments are often complex in clinical negligence claims and it seems likely that a significant proportion of the current expenditure on legal costs will still be required. It is difficult to see where significant savings will come from.

Improvements to the current system

FOIL believes that the current system could be improved by the introduction of a binding pre-action protocol for clinical negligence claims which could address issues such as early disclosure of documents, information of grounds of fault, and provide timescales for a defendant response on liability and an outline of any defence. A pre-action protocol along these lines is in place in England and Wales and has proved beneficial in guiding the handling of claims in the initial stages.

It is recognised that there are access to justice issues for claimants wishing to commence clinical negligence claims in Scotland. By their nature such claims are risky and require expert evidence at the outset: it can be difficult for claimant legal representatives to take on such claims on a speculative basis under the current funding regime. It is to be hoped that the Taylor Review on legal expenses will identify funding models which will alleviate the problems and make it easier for prospective claimants to obtain appropriate funding.

FOIL does not believe that too much weight should be given to the claim that there is insufficient expertise available to assist claimants in bringing clinical negligence claims. Although the number of accredited specialists is fairly small this does not represent the extent of the expertise in this area in Scotland. Any individual seeking to bring a claim should be able to find an appropriate legal representative, who, with the support of specialist counsel, will be able to handle the matter.

The introduction of improved case management procedures would be of assistance, along the lines of those currently adopted for commercial cases in the Court of Session. Such procedures increase the focus on the issues and have the potential to reduce the time-scale of claims.

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?

FOIL does not believe that a regime based upon excluding specific injuries is either workable or just. It is of concern that having discarded the "avoidability test" used in Sweden, which has the advantages of being simple, understandable and based on the concept that compensation may be justified where something has gone wrong, no coherent approach or test for the award of compensation has been identified in the consultation paper, save to say that some injuries will be excluded.

It is notably that only one example of an excluded injury has been included in the paper. It seems likely that this approach will result in a significant increase in claims in

unforeseen circumstances, where, for example, the exclusions have failed to keep pace with medical developments.

Exclusions based around known and accepted risk would draw distinctions between different patients which are hard to justify. Why should a patient who suffers an injury which was a small known risk but not one which was routinely explained to patients receive compensation, whilst a patient who suffers an injury that was a known risk and which was explained to him, is denied compensation? There would appear to be no practical difference between these individual cases. Such an approach may result in much more focus on providing information on every risk and obtaining detailed consent, creating anxiety and an overly-cautious approach from patients, and a defensive, tick-box approach from health professionals.

There appears to be confusion within the paper concerning the aim of the proposals. In paragraph 3.3 it is explained that where an error is made "*patients expect staff to make a meaningful apology .....The findings of [the Review Group's] research would appear to support the contention that for many, if not most, patients this is the primary aim of taking a case forward, rather than a financial award*".

Under the proposals it will not be necessary to show any error or failure in care to obtain compensation. If exemplary care is provided but an unforeseen complication arises in treatment which results in an injury, compensation will be payable. The Review Group's research would appear to suggest that this is at odds with most patients' expectations and objectives, who, in general, wish to receive an apology when it is warranted rather than compensation. The current proposals will turn that on its head, providing compensation where no apology would be warranted.

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?

FOIL does not support the introduction of a no-fault compensation regime in Scotland for the reasons set out in this response. However, if such a scheme were to be introduced, excluding certain types of healthcare and some clinicians from the proposals would create injustice and needless divisions between different types of patient. Procedural complexities would also be created in circumstances where a patient's care had been shared between the NHS and an independent contractor such as a GP, which obviously occurs very frequently.

Although FOIL would not wish to see a two-tier system develop by limiting no-fault compensation to NHS care, the difficulties of including independent contractors in the scheme would be considerable. It is difficult to comment further as there are no details within the consultation paper on how the system might include independent contractors or how the proposals may impact upon them but there are concerns at the cost of the proposals, how that will be split between the NHS and providers of indemnity cover, the effect that will have upon indemnity insurance premiums, and whether the current system of indemnity insurance provision would still be viable.

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

Given the paucity of information within the consultation paper it is not possible to indicate at this stage how the system should work. FOIL would like to see a more detailed proposal put forward which gives a better idea of what is proposed and how this will affect independent contractors and the providers of indemnity insurance.

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 development of transitional arrangements is likely to be problematic. What will be the position, for example, of claims which arise after the introduction of the new system but which rest on treatment and conduct several years ago? Presumably such claims would fall to be considered under the existing at–fault system, but the issue is likely to be ripe for satellite litigation.

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?

FOIL takes the view that it is very likely that the figures set out in the University of Manchester research would be exceeded in practice. Claims volumes are very likely to increase In addition, the figures do not reflect payments made outside the NHS.

At present many claims will be settled on a discounted basis to reflect the risk of litigation and claimants' reluctance in some cases to pursue a claim to trial. The cost of compensation will rise if claims are to be paid on a 100% basis. Although providing care through the NHS rather than making payment for private provision would be cheaper, it is to be expected that claimants who, under the current system, could prove negligence, will opt out of the no-fault scheme to pursue higher compensation through the courts as private provision is perceived to be superior. The potential to achieve savings in the cost of care will therefore be much reduced.

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** ☐

In the event that a no-fault scheme is to be introduced FOIL agrees that claimants should retain the right to litigate, either before or after making a claim for no-fault compensation, but that double recovery should be prevented by deducting any no-fault compensation from the litigation award.

An appeal process will be required on points of law or fact.

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?

FOIL believes that the current system could be improved by the introduction of a binding pre-action protocol for clinical negligence claims which could address issues such as early disclosure of documents, information of grounds of fault and provide timescales for a defendant response on liability and an outline of any defence. A pre-action protocol along these lines is in place in England and Wales and has proved beneficial in guiding the handling of claims in the initial stages.

It is recognised that there are access to justice issues for claimants wishing to commence clinical negligence claims. By their nature such claims are risky and require expert evidence at the outset: it can be difficult for claimant representatives to take on such claims on a speculative basis under the current funding regime. It is to be hoped that the Taylor Review on legal expenses will identify funding models which will alleviate the problems and make it easier for prospective claimants to obtain appropriate funding.

FOIL does not believe that too much weight should be given to the claim that there is insufficient expertise available to assist claimants in bringing claims. Although the number of accredited specialists is fairly small this does not represent the extent of the expertise in this area in Scotland. Any individual seeking to bring a claim should be able to find an appropriate legal representative, who, with the support of specialist counsel, will be able to handle the matter.

The introduction of improved case management procedures would be of assistance, along the lines of those currently adopted for commercial cases in the Court of Session. Such procedures increase the focus on the issues and have the potential to reduce the time-scale of claims.

[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** √

FOIL considers that the concerns that have been raised with regard to the practicality and cost of a general no-fault scheme would apply equally to a more limited scheme for neurologically impaired infants.

This proposal raises the same difficult issues over the categories of injured patients entitled to compensation. Is there a discernible difference between a child injured as a result of, perhaps life-saving, treatment at birth or during pregnancy and a child injured as a result of a genetic or neo-natal condition, which would make it justifiable to pay substantial compensation to the former but not to the latter?

As noted, these cases are the most expensive claims faced by the NHS, although it is not clear what proportion of overall compensation is paid in such cases. The cost and funding implications of an increased volume of high-value claims for neurologically impaired infants will need careful consideration.

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 option is only likely to be attractive to claimants in claims which would not be successful under the present system as it is likely that most claimants able to litigate successfully will do so to obtain private provision, which in many cases is perceived to be superior.

The cost of guaranteeing services, including social care, could be significant and costings should be prepared to assist the decision making process.

General Comments

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