

# **Consultation Report**

## **Consultation on Recommendations for No-Fault Compensation in Scotland for injuries resulting from clinical treatment**

**April 2014**

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# Consultation on Recommendations for No-Fault Compensation in Scotland for Injuries Resulting from Clinical Treatment

## CONSULTATION REPORT

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**Annex B** - Link to consultation and list of consultation questions

**Annex C** - List of respondents by interest group

# Consultation on the Recommendations for No-Fault Compensation in Scotland for Injuries Resulting from Clinical Treatment

## Consultation Report

### 1. Acknowledgements

1.1 The Scottish Government would like to thank everyone who considered and responded to the questions in the consultation on the No-fault Compensation Review Group's recommendations for a no-fault compensation scheme in Scotland for injuries resulting from clinical treatment.

### 2. Introduction

2.1 The No-fault Compensation Review Group, chaired by Professor Sheila McLean, Glasgow University, was established in 2009 to consider the potential benefits for patients in Scotland of a no-fault scheme and whether such a scheme should be introduced alongside the existing clinical negligence arrangements.

2.2 The Review Group's report published in February 2011 (available at: <http://www.scotland.gov.uk/Topics/Health/Policy/No-Fault-Compensation>) set out their view on the essential criteria for a compensation scheme and recommended that consideration should be given to the establishment in Scotland of a no-fault scheme for clinical injury, along the lines of the 'no blame' system in operation in Sweden.

2.3 It is worth reiterating at this point that the No-Fault Compensation Review Group agreed that:

'a compensation system was not just about financial compensation; rather the objective should be to restore the person who had been harmed to the position they had been in prior to the injury, as far as this is possible.'

2.4 The Review Group took a no-fault system to mean one in which there is no need to establish that any individual was negligent. However, they considered that the link between the (in) activity and the harm resulting from it (i.e. causation) would still need to be established.

2.5 The Review Group's recommendations (attached as Annex A) go much wider than NHSScotland suggesting a scheme should cover all clinical treatment injuries that occur in Scotland (i.e. include independent contractors and private healthcare). Recommendation 10 suggests improvements to the current litigation system and these are, where appropriate, being considered by the Scottish Government Justice Directorate in relation to the work on Court Reform.

2.6 Consultation exercises aim to elicit the views and experiences of a wide range of stakeholders. In this consultation we were seeking views on the recommendations made by the No-fault Compensation Review Group. The consultation did not set out to scope what such a scheme might look like as it was considered important first of all to gather views on the Review Group's recommendations and to also gather views on the practical implications of adopting the recommendations. The nature of the submissions varied with some respondents providing comment on some but not all of the questions and others provided more detailed comments on sections of the consultation that were of interest to them. In some instances comments received were relevant to more than one question. Where appropriate, general comments offered at the end of the consultation paper have been incorporated with the comments provided in response to the relevant consultation questions 1 to 12.

2.7 The findings are specific to this consultation exercise and do not necessarily reflect the weight or range of views within the population as a whole. The nature of the consultation and the small number of responses does not necessarily support the presentation of the findings in a quantitative way. We have presented results in percentage form, where possible, but have sought to focus on the qualitative findings. We have also provided information in some sections to show the responses by interest group.

2.8 We have attempted to provide further explanation within this report where we felt respondents would find this helpful and it would provide further clarity.

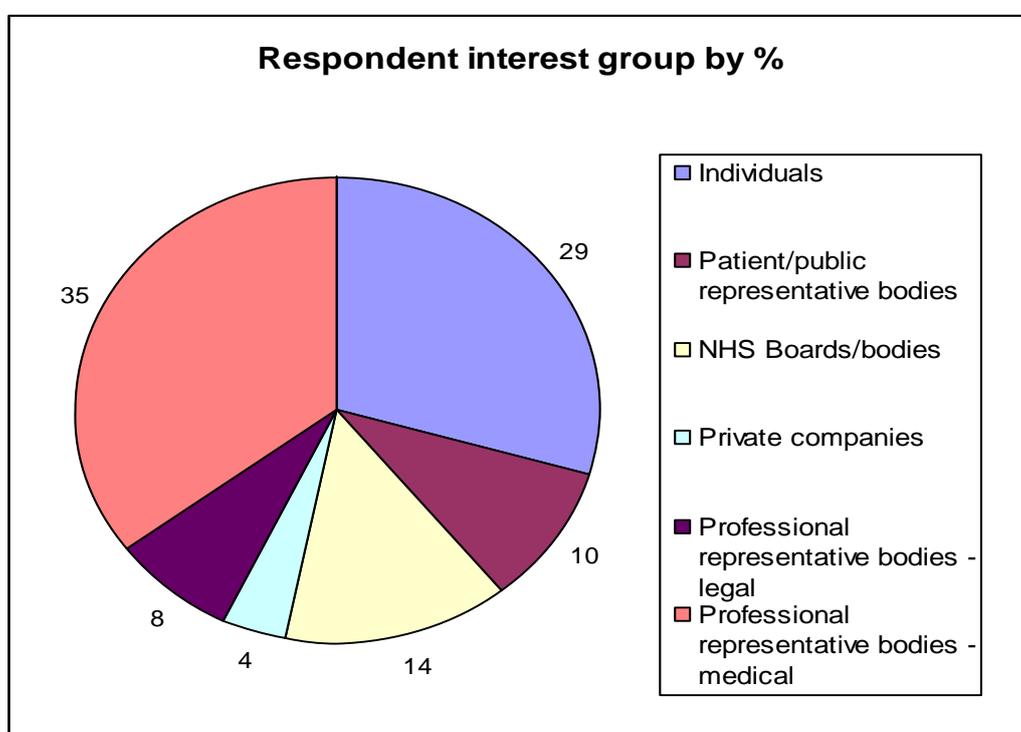
2.9 The closed consultation paper is available at <http://www.scotland.gov.uk/Resource/0039/00399081.pdf>. The full list of consultation questions is given in Annex B. A list of the respondents is given in Annex C.

### 3. Responses

3.1 Of the 51 responses received by the extended closing date of 19 December 2012, 29% were from individuals and 71% were from organisations/bodies. A further letter with comments received after this date from an organisation has not been published but has been taken into account in the analysis of the responses.

3.2 The published responses, where respondents gave permission and their response was received before the closing date, can be viewed on the Scottish Government website at: <http://www.scotland.gov.uk/Publications/2013/02/4882>. The 51 responses received broken down by interest group are as follows:

Interest Group	Number of Respondents	% of responses
Individuals	15	29
Patient/Public Representative Bodies	5	10
Professional Representative Bodies – legal	4	8
Professional Representative Bodies – medical	18	35
NHS Health Boards/Bodies	7	14
Private companies	2	4
<b>Total</b>	<b>51</b>	<b>100</b>



3.3 A list of the respondents is shown in Annex C.

## 4. Approach

4.1 Each response was reviewed in full. A qualitative and thematic analysis of the responses was undertaken. Each response was reviewed by at least two people, and the respondents' comments entered onto a spreadsheet recording answers to each of the 12 questions as well as the general comments provided. The responses were further reviewed by more than one person.

4.2 Quotes have been identified and have been used within this report to illustrate respondents' views.

## 5. Findings

5.1 The consultation paper sought views on twelve questions which focused on:

- meaningful apology (Question 1)
- essential and desirable criteria for a compensation scheme (Questions 2 & 3) and its contribution to wider issues (Question 4)
- the Review Group's recommendations for the introduction of a no-fault scheme (Questions 5, 6, 7, 9 & 10)
- transitional arrangements if no-fault system introduced (Question 8)
- suggested improvements to the current system (Question 11)
- a suggestion for consideration of a limited no-fault scheme for neurologically impaired infants (Question 12).

5.2 The final section of the consultation paper also invited general comments.

5.3 The consultation questions are set out below with a summary of the main points and issues raised in the consultation responses shown under each.

### 5.4 Question 1

5.4.1 The consultation paper explained that the research team supporting the review reported (Farrell et al, 2010)<sup>1</sup> that previous research suggests that when an error has occurred, patients expect staff to make a meaningful apology, provide an explanation and take steps to prevent the error from recurring.

5.4.2 This question (reproduced below) was set against a background that the NHS Complaints Procedure had recently been reviewed to reflect the provision within the Patient Rights (Scotland) Act 2011<sup>2</sup> in relation to the right to give feedback, make comments, raise concerns, or make complaints about NHS treatment and care.

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<sup>1</sup> <http://www.scotland.gov.uk/Resource/0039/00394407.pdf>

<sup>2</sup> <http://www.scotland.gov.uk/Topics/Health/Policy/Patients-Rights>

The revised 'Can I help you?' guidance<sup>3</sup> issued in March 2012 includes advice in relation to handling feedback and complaints and in the provision of an apology where appropriate. The guidance also refers to the guidance on apology<sup>4</sup> issued by the Scottish Public Services Ombudsman (SPSO).

**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?

5.4.3 A total of 47 responses were received to this question. There were mixed views on whether additional steps were required in relation to the provision of a meaningful apology. Some suggested that the existing NHS Complaints guidance coupled with the SPSO guidance and the General Medical Council (GMC) advice (now paragraph 55 of Good Medical Practice updated in 2013<sup>5</sup>) was sufficient.

“We agree with the advice published by SPSO on what makes an apology meaningful.” General Dental Council

5.4.4 There was a suggestion that it would be necessary for there to be a legal duty on Health Boards to issue an apology.

“It would be necessary for there to be a legal compulsion on Health Boards to issue an apology if this has been advised by SPSO. At present there is no obligation for them to do so, even if the SPSO decide the Board ought to apologise and agree that an error has occurred.” Individual

5.4.5 Some responses suggested there should be better support, education and training structures in place for staff and that a blame culture still exists:

“I support the argument for carefully worded legislation to encourage a culture shift. The fear of litigation and the sense that to apologise when things go wrong are, sadly, still issues in public services as a whole. When things go wrong staff need to be supported to acknowledge errors, to explain where there is uncertainty and to involve patients and families in the process of understanding what happened and why.” SPSO

“...healthcare organisations must actively support their staff in fulfilling professional and ethical obligations to be open with patients by providing on-going support, training, mentorship and by equipping senior clinicians to lead by example.” Medical Protection Society

<sup>3</sup> [http://www.sehd.scot.nhs.uk/mels/CEL2012\\_08.pdf](http://www.sehd.scot.nhs.uk/mels/CEL2012_08.pdf)

<sup>4</sup> [http://www.spsso.org.uk/files/2011\\_03\\_SPSO\\_Apology\\_Guidance.pdf](http://www.spsso.org.uk/files/2011_03_SPSO_Apology_Guidance.pdf)

<sup>5</sup> [http://www.gmc-uk.org/guidance/good\\_medical\\_practice/respect\\_patients.asp](http://www.gmc-uk.org/guidance/good_medical_practice/respect_patients.asp)

“...the vast majority of doctors wish to apologise when an error has occurred. For junior doctors in particular, the biggest obstacle was often a fear that apologising would imply that they were somehow legally ‘at fault’ and would lead to them or their consultant being sued. A no-fault compensation scheme would likely increase the number of meaningful apologies by allaying this fear.” Individual

5.4.6 Others questioned the definition of error and the potential for differences in opinion on whether an error has occurred or whether this was the same as a bad outcome.

“There is however room for substantial differences of opinion on whether an ‘error’ has occurred in any particular situation.” Simpson and Marwick Sols

“The definition of error is the major problem we face. No one will wish to apologise for doing something that they do not consider an error on their part. ...The patient wants an apology. The doctor does not agree. What does the NHS do? Since the current system only pays up when negligence is proven, paying up without proving this rather implies that the doctor was negligent. Apologising for good practice is rather akin to admitting negligence.”

Individual

5.4.7 Not all respondents agreed with the researchers finding that suggested for many patients the primary aim of making a claim was to obtain an apology rather than compensation.

## 5.5 Question 2

5.5.1 Question 2 sought views on the principles and criteria considered, developed and agreed by the No-fault Review Group as essential in a compensation scheme. These were:

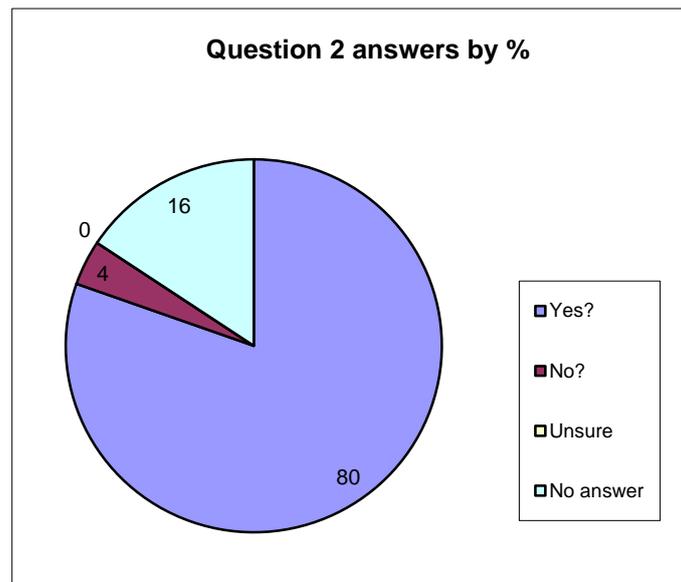
- The scheme provides an appropriate level of compensation to the patient, their family or carers
- The scheme is compatible with the European Convention on Human Rights
- The scheme is easy to access and use, without unnecessary barriers, for example created by cost or the difficulty of getting advice 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

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

5.5.2 A total of 45 responses were received to the first part of this question with 80% agreeing the principles and criteria set out by the Review Group are essential in a compensation scheme. 4% disagreed and 16% did not give a 'yes' 'no' answer but some offered comments.



5.5.3 Although the majority of respondents agreed the principles and standards were essential there were concerns that if events were not handled appropriately through a no-fault system clinicians could be subjected to criminal proceedings. Comments also suggested that individuals should not feel pressure to use the no-fault route when litigation would be more appropriate. The responses also acknowledged that there were many challenges that would need to be addressed if a no-fault system was to be introduced. There was also a view that not all of these principles and criteria were achievable or fair:

**“I do not believe that the second last bullet (i.e. The scheme treats staff and patients fairly/equitably) is viable”** Individual

“I cannot see the point of no-fault compensation unless all further action stops. The doctor accused of the error or negligence must be able to appeal even after compensation is paid. We cannot have a one-sided appeals system.” Individual

### 5.6 Question 2.1

5.6.1 In response to Question 2.1 which asked about priority and importance - Ease of use, independence, access to specialist advice, appropriate compensation, affordability and timeliness were identified as areas of particular importance.

5.6.2 In relation to additional principles and criteria the following suggestions were made:

- “The scheme discourages frivolous or speculative claims
- The scheme encourages responsible behaviour from patients and staff.”  
Organisation anonymous
- “Patients’/families’ rights to litigate through the courts should not be affected by the existence of the ‘no-fault’ scheme. The option of seeking compensation through the scheme needs to be voluntary.” AvMA
- “The scheme must be available and affordable for all people involved in healthcare from direct employed NHS staff to GPs, dentists, Physios, obstetricians/midwives osteopaths, etc etc regardless of whether they are carrying out NHS or private care at the time.” Individual

5.6.3 It was also suggested that:

- “...the introduction of a mediation system would be very effective in bringing resolution to parties.” Individual

### 5.7 Question 3

5.7.1 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:

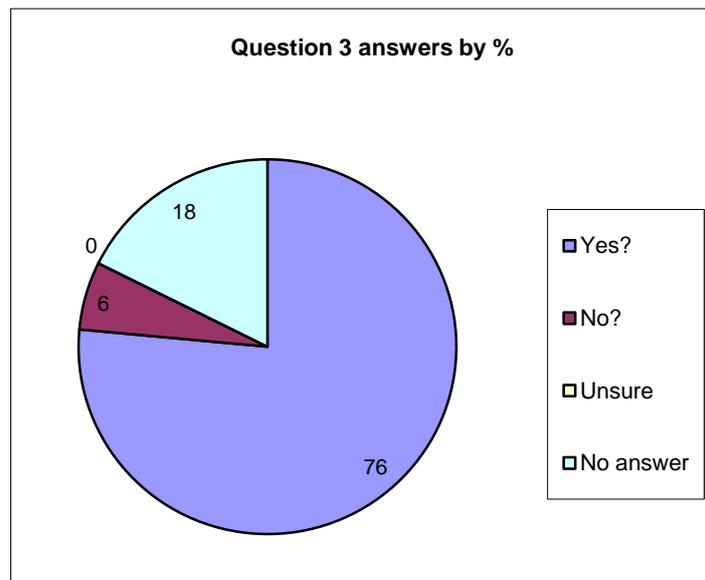
- The public in general trusts the scheme to deliver a fair outcome
- The scheme does not prevent patients from seeking other forms of non-financial redress, including through the NHS Complaints system
- The scheme encourages transparency in clinical decision-making
- The scheme contributes to rehabilitation and recovery.

**Question 3:** Do you agree that these criteria are desirable in a compensation system?

Yes  No

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

5.7.2 A total of 45 responses were received to the main question. 76% agreed that the criteria were desirable, 6% disagreed and 18% did not answer the 'yes' 'no' question but some offered comments.



5.7.3 A few respondents considered that some of these desirable outcomes should be seen as essential and in particular highlighted

- (i) that the public (and the professions, NHS staff and others) ought to trust the scheme to deliver a fair outcome
- (ii) that the scheme encourages transparency in clinical decision-making.

5.7.4 It was also suggested that

“...not only should the scheme not prevent patients from seeking other forms of non-financial redress, it should work alongside the complaints system.... The ideal would be that they would be able to bring their concerns to one place – these would be dealt with and, if financial redress is appropriate or sought, a response should be provided alongside the response to any non-financial redress.” SPSO

5.7.5 In relation to the suggestion that it is desirable that the scheme contributes to rehabilitation and recovery several comments were made that physical rehabilitation and recovery should proceed in accordance with need and are not dependant on the outcome of a compensation claim. Support for relatives was also raised:

“As a relative of a deceased person what I think would also be beneficial would have been specific counselling to have dealt with the trauma... Death is bad enough but to have it happen through a “fault” or negligent act adds so many issues to the death.” Individual

#### 5.8 Question 4

5.8.1 The Review Group also considered and highlighted the importance of the wider issues identified below:

- 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.

5.8.2 Question 4 sought views as follows:

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

5.8.3 A total of 45 responses were received to this question. There was a majority view that if introduced there are benefits to be gained from a scheme designed to contribute to these wider issues in order that lessons are learned and improvements are made. “No-fault” should not mean “no-responsibility”, “no-accountability” or a way to neglect the duty of care. Some thought that the introduction of a no-fault system would provide an unprecedented opportunity to develop a lessons learned and shared approach and ensure seamless working between the scheme, the complaints process, critical incident reviews and organisational learning and quality.

“There should be an obligation upon Boards and individual clinicians to demonstrate that they have acknowledged and acted upon issues around patient safety, quality improvement etc and evidence should be provided to the claimant and to national bodies such as Healthcare Improvement Scotland of these actions.” Individual

“...it is essential that bad practice and its identification are not compromised through the implementation of a no-fault and that learning from adverse events is achieved.” Royal College of Surgeons Edinburgh

5.8.4 Others acknowledged that the thinking that the scheme might contribute to the wider issues was good but likely to be difficult to evidence in reality.

“.....it is naive to think that wider issues will be changed by a no-fault compensation scheme. .... clinician could still face (a) GMC proceedings, (b) giving evidence in a Fatal Accident Inquiry or (c) being pilloried in the press. ...will still have damaged reputation. A no-fault scheme will not lead to a system of complete openness, because of these fears.” Association of Personal Injury Lawyers

5.8.5 Others pointed out that since the review had been commissioned there had been significant steps forward in the field of clinical governance and reporting. It was considered that these should be taken into account in any considerations of a new scheme or improvements to the existing scheme.

## 5.9 Question 5

5.9.1 Question 5 focused on the Review Group’s Recommendation 1 which recommends:

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

(Background information on the “no-blame” system in operation in Sweden was included in Annex A of the consultation paper. This described a system whereby The Swedish Patient Insurance Association, a public company, administers the scheme which is financially supported through contributions made by county councils which are responsible for the provision of health care. Under the Patient Injury Act 1996<sup>6</sup> there is an obligation on both public and private health care providers to obtain insurance that covers claims being made in respect of medical injuries. Insurers that provide such insurance belong to the Patient Insurance Association.)

**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?

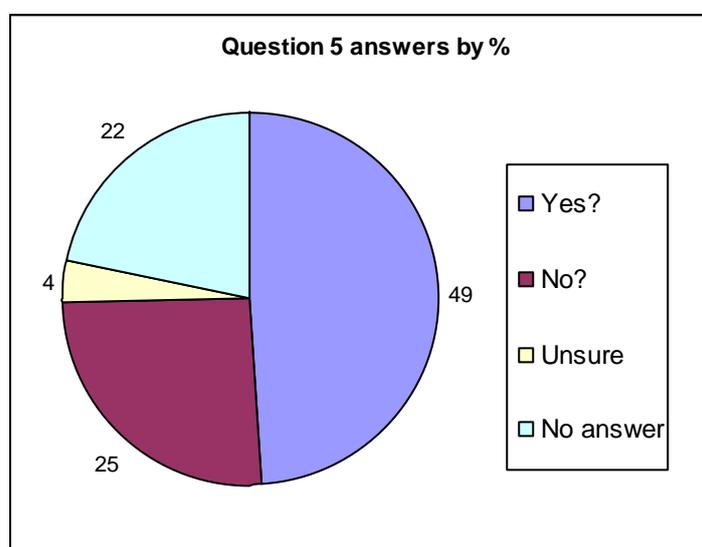
Yes  No

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

<sup>6</sup> [http://www.pff.se/upload/The\\_Patient\\_Injury\\_Act.pdf](http://www.pff.se/upload/The_Patient_Injury_Act.pdf)

5.9.2. A total of 46 responses were received to this question. 49% supported this approach 25% did not support it 4% were unsure and 22% did not answer the 'yes' 'no' question but some provided comments. Responses shown by interest group were:

Interest Group	Yes	No	Unsure	No answer
Individuals	11	3	0	1
Patient/public representative bodies	4	0	0	1
Professional representative bodies – legal	0	3	0	1
Professional representative bodies – Medical	8	2	2	6
NHS Boards/bodies	2	4		1
Private companies	0	1	0	1
<b>TOTAL</b>	<b>25</b>	<b>13</b>	<b>2</b>	<b>11</b>



5.9.3 Several respondents commented and had concerns that the system of social care provision in Scotland was not as well developed as the system in Sweden and were not convinced that a similar scheme could operate successfully in Scotland. They commented that the payments under the Swedish model were lower than payments in Scotland where the provision of future treatment and care in the independent sector could not be disregarded.

“Sweden’s social welfare structure is very different and complements their model of compensation system. ....any Scottish scheme must be devised to reflect the existing social welfare system and available funding” Medical Protection Society

5.9.4 In response to the question about possible alternative systems it was suggested that devising and introducing a low value claims scheme in line with the principles and criteria might be an alternative and potentially less expensive approach:

“There is potential for a voluntary simplified procedure for lower value claims. APIL is already in support of a similar scheme in England. A scheme such as this would most likely be attractive to claimants and medical organisations alike.” Association of Personal Injury Lawyers

5.9.5 Concerns were raised about the long-term costs and whether it would be cost effective. There were also concerns about the potential for the level of compensation to escalate ahead of inflation in the absence of arbitration of the judiciary.

### 5.10 Question 6

5.10.1 Question 6 relates to the Review Group’s recommendation on the eligibility criteria and the compensation paper explains that in Sweden the eligibility criteria are structured around the notion of ‘avoidability’ i.e. patients are eligible to receive compensation if they have suffered injury that could have been avoided. The Swedish scheme also uses the ‘experienced specialist rule’, under which consideration is given to the risks and benefits of treatment options other than the one adopted. A retrospective approach has been taken in some cases in the evaluation of whether the injury was avoidable.

5.10.2 The review group did not favour this approach and instead recommended:

**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.

5.10.3 Question 6 asked for views on this approach.

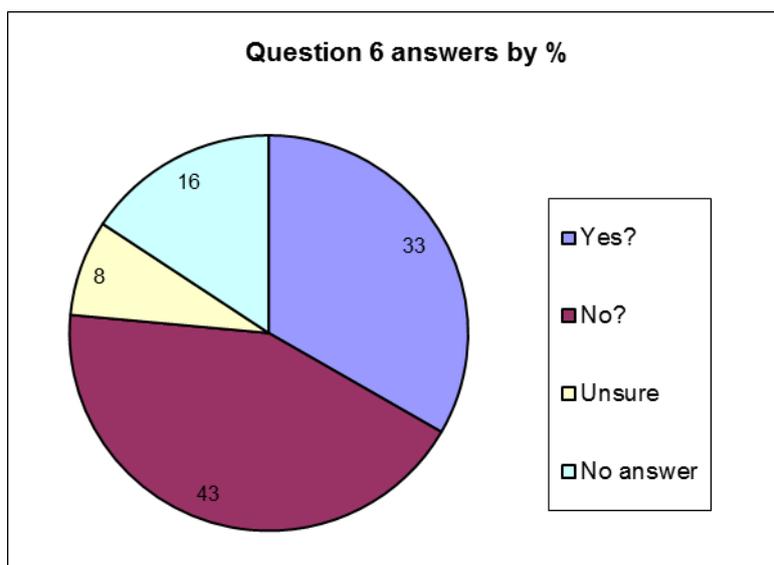
**Question 6:** Would you support the approach in Recommendation 2? This would mean for example that where treatment carries a known risk and the patient has given consent to that treatment it would not be eligible.

Yes  No

If not, why not?

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

5.10.4 A total of 46 responses were received to this question. 33% supported this approach, 43% did not support it, 8% were unsure and 16% did not answer the 'yes' 'no' question but some offered comments.



5.10.5 Responses by interest group were as follows:

Interest Group	Yes	No	Unsure	No answer
Individuals	4	8	2	1
Patient/public representative bodies	1	3	0	1
Professional representative bodies – legal	0	3	0	1
Professional representative bodies – Medical	5	7	2	4
NHS Boards/bodies	7	0	0	0
Private companies	0	1	0	1
<b>TOTAL</b>	<b>17</b>	<b>22</b>	<b>4</b>	<b>8</b>

5.10.6 The majority of respondents did not support this approach and expressed concerns about how such an approach might work in practice given that potentially all surgery and procedures carried some kind of risk.

5.10.7 Some respondents who indicated support also had concerns about the consequences and the difficulties of adopting this approach.

“While by and large I agree with this, care must be taken that it does not lead to pressure to inform patients of every conceivable risk of every procedure. ...confusing and frightening.” Individual

“...this is liable to give rise to very extensive/complicated consent forms having to be devised for every significant intervention.... – to the detriment of patient care and patient throughput.” Scottish Medical and Scientific Advisory Committee

5.10.8 Several respondents considered that the ‘avoidability’ test should be used and expressed views that it was difficult to identify any other just or workable criteria for eligibility under a no-fault scheme.

“...the avoidability test as used in Sweden, is a more appropriate approach.”  
Royal College of Surgeons of Edinburgh

“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.....” Forum of Insurance Lawyers

### 5.11 Question 7

5.11.1 Question 7 asked about the Review Group’s recommendations on the recommended scope and cover of no-fault scheme. The Review Group was of the view that any recommended change to a no-fault system should cover all healthcare professionals including those not directly employed by the NHS. However, some members suggested that there may be difficulties in including independent contractors (such as GPs, dentists etc.) who provide services under the NHS and private practice in any no-fault scheme for a number of reasons, including their existing indemnity arrangements and the need to consider historical liabilities. It was also recognised that introducing a no-fault system for NHS board staff and continuing the present adversarial arrangements for resolving claims against independent contractors, where there is continuity of care between a hospital and independent contractor would present practical difficulties. The group believed that fairness dictated that all patients whether they received NHS or private treatment 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.

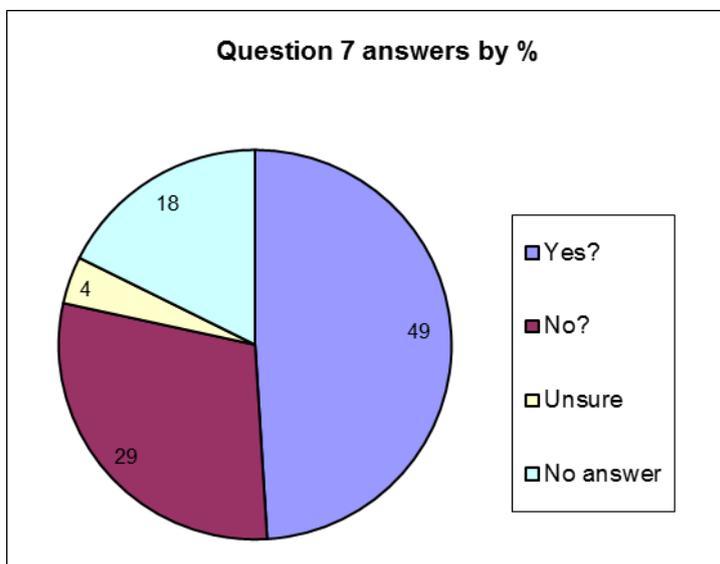
### 5.11.2 The consultation asked:

**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?

5.11.3 A total of 47 responses were received to this question. 49% supported this approach, 29% did not, 4% were unsure and 18% did not answer the 'yes' 'no' question but some offered comments.



5.11.4 Whilst it was acknowledged that, if introduced, it would be logical to extend such a scheme as broadly as possible there were concerns about the complexities and cost of doing this.

“If the scheme is to be introduced, it is logical to extend the scope of it as broadly as possible - all claims relating to medical treatment should be included within the scheme. This is to avoid a bizarre multi-tier system.....APIL fears however, that this would be difficult to enforce in practice, and more thought would need to be given as to how this could be done.” Association of Personal Injury Lawyers

“...an ideal system would cover all clinical treatment injuries and all registered healthcare professionals. ...extremely concerned that such a scheme would be unaffordable in Scotland.” Royal College of Surgeons Edinburgh

“FOIL does not support the introduction of a no-fault compensation regime....However, if such a scheme was to be introduced, excluding certain types of healthcare and some clinicians from the proposals would create injustice and needless divisions between different types of patients. ...the difficulties of including independent contractors would be considerable.”

Forum of Insurance Lawyers

5.11.5 Others thought that a scheme, if introduced, should cover NHS funded care only.

“The scheme should cover all care which is funded by the state – whether provided by the NHS or by private contractors but should exclude private care.” National Services Scotland

...the no-fault scheme should only apply across the NHS and where the treatment is being paid for from the public purse.” Royal College of Physicians of Edinburgh

“...every NHS patient, wherever treated, should be covered by the scheme. It would be a nonsense if primary care where so much NHS care is provided and many medical accidents occur, were not covered.” Action against Medical Accidents (AvMA)

5.11.6 Comments offered also acknowledged the huge amount of time and effort spent in dealing with claims under the current system and raised concerns and highlighted the unknown scale of liability of including independent contractors and private practices.

5.11.7 Community Pharmacy Scotland and Optometry Scotland both suggested their members be excluded as they considered that they already offered and operated an effective service for dealing with claims.

#### 5.12 Questions 7.1 and 7.2

5.12.1 These questions sought further views on potential difficulties of implementing Recommendations 3 and 4 and how these might be addressed.

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

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

5.12.2 As indicated earlier (paragraph 5.11.1), some members of the Review Group had raised concerns about how historical liabilities would be handled. Respondents also highlighted this and raised concerns about the complexity and potential impact of including independent contractors and the fact that a significant proportion of GPs in Scotland are likely to have 'occurrence based indemnity protection'. This means that they are able to seek help with an incident that occurred when they were a member of a Medical Defence Organisation even if the claim is brought many years later.

“Considerable thought would need to be given to how historic claims would be managed and funded in the future. This is particularly pertinent as a claim for clinical negligence is often brought many years after an adverse incident occurs. ....There are 14 hospital boards in Scotland that are members of CNORIS but nearly five thousand GPs and over three thousand dentists. Opening a new scheme to incorporate GPs and dentists would mean devising a much larger and more bureaucratic scheme. This would be even more complex if individual GPs and dentists remain vulnerable to personal claims. .... Any new scheme that widens the basis on which a patient will be compensated must take into account issues of retroactivity. At present a GP in Scotland might be sued for negligence once in 75 years. However under a no fault scheme is it foreseeable that the same GP might be involved in a compensation claim once in every five years because of the breadth and accessibility of the scheme. It would be unfair for an MDO who had offered occurrence based protection” Medical Protection Society

5.12.3 Several respondents raised concerns about the cost of indemnity and insurance for independent contractors and whether insurance companies would withdraw their services as a result.

“There may be concerns for GP’s, dentists and those in private practice regarding the costs of insurance for them..... Presumably a fund would be set up into which everyone pays ..... Yet those who are paying in may not have control over how much they are contributing, and this could result in those independent contractors refusing to be a part of the no-fault scheme.”  
Association of Personal Injury Lawyers

“There would be a danger that insurance premiums and indemnity memberships may increase. Consideration would require to be given to whether insurance companies would withdraw their services from the medical market in Scotland if the requirement to contribute to a no fault scheme made that market unprofitable.” Stephen and Marwick Solicitors

“The cost of Insurance will also be a significant factor. ....There is also uncertainty as to how the insurance market would respond to the introduction

of a scheme and whether indemnity arrangements which exist at present would still be available.” Law Society of Scotland

“...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.” Forum of Insurance Lawyers

5.12.4 It was also suggested that if introduced the scheme should also cover "alternative medicine" practitioners, such as chiropractors and osteopaths:

“...this might be a useful route towards applying regulation to a sometimes well-intentioned and competent but also a sometimes dangerous and exploitative sector of healthcare.” Individual

5.12.5 It was also suggested by a few respondents that if a no-fault system was to be adopted that it would be much more likely to succeed if it was done in stages. For example by introduction in the NHS hospital sector in the first instance and only extended to the Primary Care providers and private sector once the scheme had been properly established and funding evidence obtained.

### 5.13 Question 8

5.13.1 Question 8 advised that, if introduced, the no-fault system would not be retrospective. The question sought views on transitional arrangements if a new system was introduced.

**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?

5.13.2 A total of 43 responses were received to this question. Views offered were mixed with some suggesting that outstanding claims or those arising from consequences of treatment prior to the new system should be recompensed under the no-fault system. Others suggested outstanding claims should complete the process under which they were started. Views offered included:

“MPS believes the scheme should not apply to incidents that occur prior to its establishment. There are two types of outstanding claims and both need to be taken into account when determining future provision. The first type is a known claim; put simply this is an adverse incident that has occurred and a

claim has been initiated. The second type is known as incurred but not reported (IBNR) and is more complex. ...A significant proportion of GPs in Scotland are likely to have occurrence based indemnity protection through a medical defence organisation (MDO) meaning that they are able to seek help with an incident that occurred when they were a member even if the claim is brought many years later.....It would be unfair for an MDO who had offered occurrence based protection and collected subscriptions on one basis to have to provide compensation on an entirely different basis and this must be taken into account when assessing how to deal with outstanding claims. A pilot and staged approach...would also help to simplify the transfer between old and new systems.” Medical Protection Society

“Our view is that the scheme should be retrospective. This has been acknowledged by successive Westminster Governments in respect of people infected with HIV and Hepatitis C, and more recently the Scottish Government’s decision to include widows and dependants of individuals who had died of hepatitis C as a result of NHS treatment.” Scottish Infected Blood Forum

“The scheme should only apply to ‘incidents’ arising after the date of implementation, and existing claims should continue to be dealt with under current legal rules.” Royal College of Nursing

“We would suggest that a date is set after which either any unsettled case will be considered by the scheme, or a date after which an incident occurring after that date can be considered by the scheme.” Action against Medical Accidents

#### 5.14 Question 9

5.14.1 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.

5.14.2 The consultation asked:

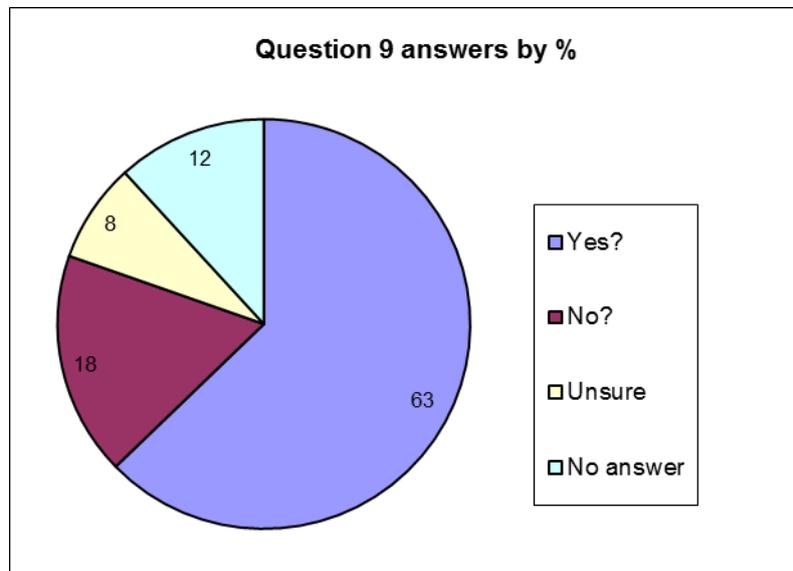
**Question 9:** Do you support the approach in Recommendation 5?

Yes  No

If not, why not?

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

5.14.3 A total of 44 responses were received to this question. 63% supported this approach, 18% did not, 8% were unsure and 12 % did not answer the 'yes' 'no' question but some offered comments.



5.14.4 Although the majority of respondents supported this approach some respondents commented and had concerns that 'need' was a subjective assessment. They considered that the needs-based element was more contentious and difficult to quantify and agree, and would result in different compensation to different people for the same harm which was inequitable.

5.14.5 Concerns were raised that payments would divert resources from the NHS:

“The idea of a tariff based system would not be supported. An assessment based on need would require that there is some future review of on-going need or change in circumstances....It would be vitally important that payments from the scheme did not divert resources from the NHS with additional funding being supported by the Government to cover costs.” NHS Greater Glasgow and Clyde

5.14.6 Concerns were raised about the increase in the number of claims and potential costs of a no-fault system pointing out that:

“Given the estimated level of adverse incidents within the healthcare system and the number of complaints relating to clinical treatment, a comprehensive no-fault scheme where payment was automatically available for injury resulting from treatment or missed diagnosis, would open up the potential for tens of thousands of claims per year.” BMA Scotland

“At present almost all claims settled extra-judicially are settled at a discount from their full value.....the faculty anticipates that the discounted rate will no longer be achieved. If so, it is likely that the overall level of payments made to claimants will increase substantially even if the number of claims remains the same.” Faculty of Advocates

“Present settlements in clinical negligence case will often be discounted for litigation risks. Claimants may also accept less compensation than they would necessarily be entitled to on a full liability basis due to a genuine reluctance to go to court and to avoid the stress of the litigation process.” Law Society of Scotland

“Although providing care through the NHS rather than making payment for private provision would be cheaper, it is 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.” Forum of Insurance Lawyers

5.14.7 Concerns were also raised in relation to the robustness of the assumptions and calculations used to provide the lower and upper estimates given in the Manchester University Study<sup>7</sup>, which examined the current system for claiming for medical negligence in Scotland.

5.14.8 Comments included:

- an increase on appeal or through legal suit in the award could make a material difference to the average award on settlement and the sensitivity of the Study results to other uplift percentages should be considered
- the £4,000 estimated cost of reaching a decision on a claim under the no-fault scheme was too low given the need to prove causation and the greater scope for appeals and further legal redress
- the assumed settlement figure of £20,000 for additional claims appears low
- anticipated higher claim activity
- a no-fault system would result in an increase to public expenditure to a material degree
- need to consider impact of changes in the Ogden discount rate<sup>8</sup> or of the increases in the settlement of claims using structured payments.

### 5.15 Question 10

5.15.1 The Review Group was satisfied that a no-fault scheme established as they described would be fully compatible with the requirements of the European Convention of Human Rights (ECHR), based in particular on the need – as in

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<sup>7</sup> <http://www.scotland.gov.uk/Publications/2012/06/2348>.

<sup>8</sup> [http://www.gad.gov.uk/services/Other%20Services/Compensation\\_for\\_injury\\_and\\_death.html](http://www.gad.gov.uk/services/Other%20Services/Compensation_for_injury_and_death.html)

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, the Review Group considered that the retention of the right to litigate would ensure that those for whom the no-fault system is felt to be inappropriate would 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.

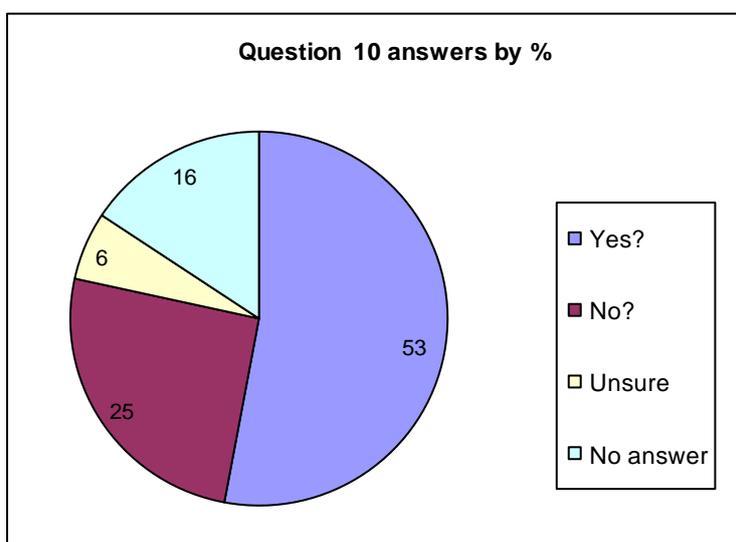
5.15.2 The consultation asked:

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

Yes  No

If no, why not?

5.15.3 A total of 45 responses were received to this question. 53% supported these recommendations, 25% did not, 6% were unsure and 16% did not answer the 'yes' 'no' question but some offered comments.



5.15.4 There was an acknowledgement of the need to comply with the European Convention of Human Rights but also concern about the implications of the recommendations and the right of the clinician and the potential for them to be held to account twice and that this would lead to contractors paying two insurances.

“...strongly support the inclusion of an appeals mechanism.... However, concerned that there is the potential for a system to be created in which a clinician is held to account twice (through the no-fault system initially and then through any subsequent civil or criminal action.” Royal College of Surgeons of Edinburgh

“...may be compatible with Human Rights Legislation as far as the patient is concerned, but has the right of the clinician been considered in the same terms?” NHS Greater Glasgow and Clyde

5.15.5 Several suggested that they did not support the residual right to litigation if a no-fault system was introduced with others suggesting if a person chooses to litigate that there should be no right to claim under the no-fault scheme.

“... there is no good reason to retain the residual right to litigation once a no-fault compensation scheme and appeals system is introduced.” Royal College of Nursing

“The Faculty does not support a residual right to claim under the no-fault scheme where a person has chosen to litigate.” Faculty of Advocates

“If a claimant opts for litigation, they should forego the right to access the no-fault system as a disincentive to seek greater recompense in the knowledge of a back-up plan of the no-fault system.” Individual

“Should someone fail under no-fault compensation, it is considered unlikely that they will go on to claim negligence as the burden of proof, costs and risks are significantly higher.” BMA Scotland

#### 5.16 Question 10.1

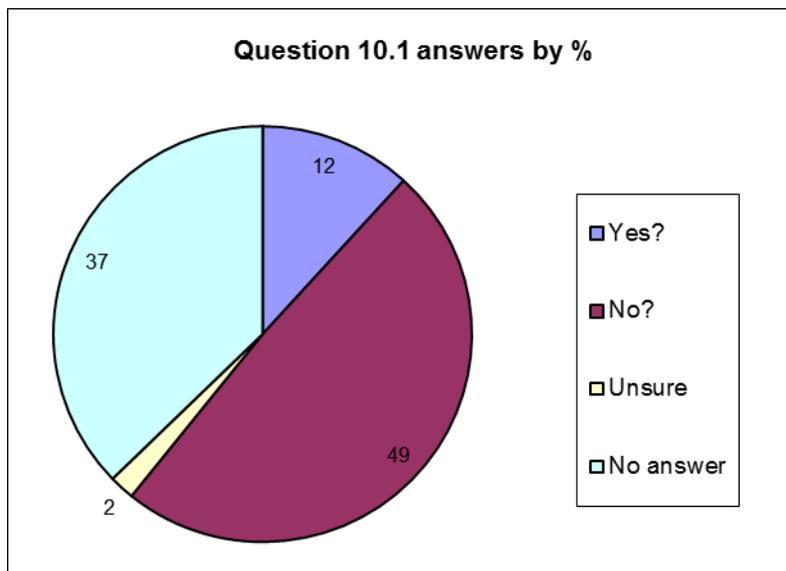
5.16.1 Question 10.1 asked about any concerns in relation to compatibility with the European Convention of Human Rights.

**Question 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?

5.16.2 In relation to question 10.1 - 12% had concerns, 49% did not, 2% were unsure and 37% did not answer the 'yes' 'no' question but some offered comments.



5.16.3 Two respondents raised concerns that the recommendations would be open to challenge under Article 1 Protocol 1 of the European Convention of Human Rights (ECHR)<sup>9</sup>:

“Article 1(A1), Protocol 1(P1) [of the ECHR] protects the right to property. ...a compulsory levy to fund the scheme imposed on healthcare professionals who wished to practise might be seen to be an interference with possessions within A1, P1. Faculty of Advocates

“...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 professionals and insurers’ property rights.” Optometry Scotland

5.16.4 Concerns were also raised about legislation that is “open to interpretation by the case managers” and applied differently by different people.

### 5.17 Question 11

5.17.1 The review group made recommendations for improvements to the existing system.

**Recommendation 10** - 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.

<sup>9</sup> [http://www.equalityhumanrights.com/uploaded\\_files/humanrights/hrr\\_firstprotocol.pdf](http://www.equalityhumanrights.com/uploaded_files/humanrights/hrr_firstprotocol.pdf)

The consultation paper explained that the review Group’s recommendation would be taken forward by the Scottish Government Justice Directorate as part of their proposed consultation on the Courts Reform Bill. The consultation also noted in addition that Sheriff Principal Taylor’s Review of Expenses and Funding of Civil Litigation in Scotland<sup>10</sup> would also consider a range of issues.

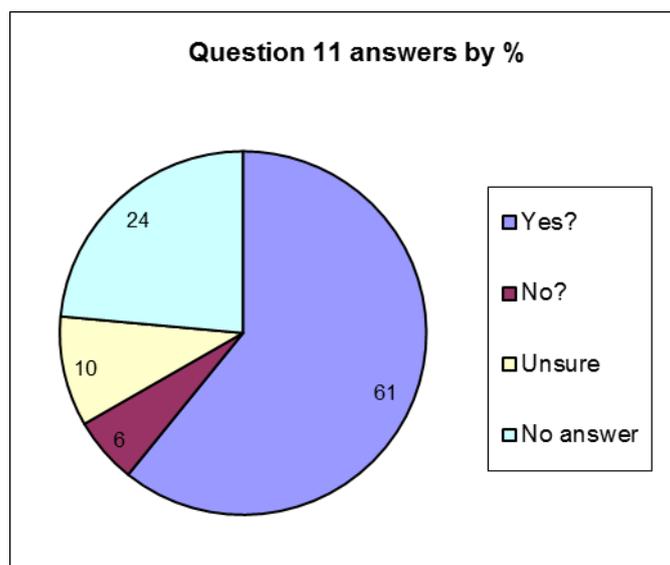
5.17.2 Question 11 asked:

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

Yes  No

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

5.17.3 A total of 41 responses were received to this question. 61% agreed, 6% did not, 10% were unsure and 24% did not answer the ‘yes’ ‘no’ question but some offered comments.



5.17.4 There was support for the introduction of a pre-action protocol and agreement on the suggested improvements with some suggesting that if these improvements were introduced a shift to a no-fault system would not be necessary.

“We would strongly recommend the use of pre-action protocols which would help resolve clinical negligence claims without the need to issue proceedings.”  
Medical Protection Society

<sup>10</sup> <http://scotland.gov.uk/About/taylor-review>

“...the suggested improvements to the existing system would address the principal criticisms made against it such that a wholesale shift to a no-fault compensation scheme would not be necessary.” NHS Lanarkshire

“The issues identified are real but also mask a lack of transparency by pursuers in taking forward claims.” NHS Greater Glasgow and Clyde

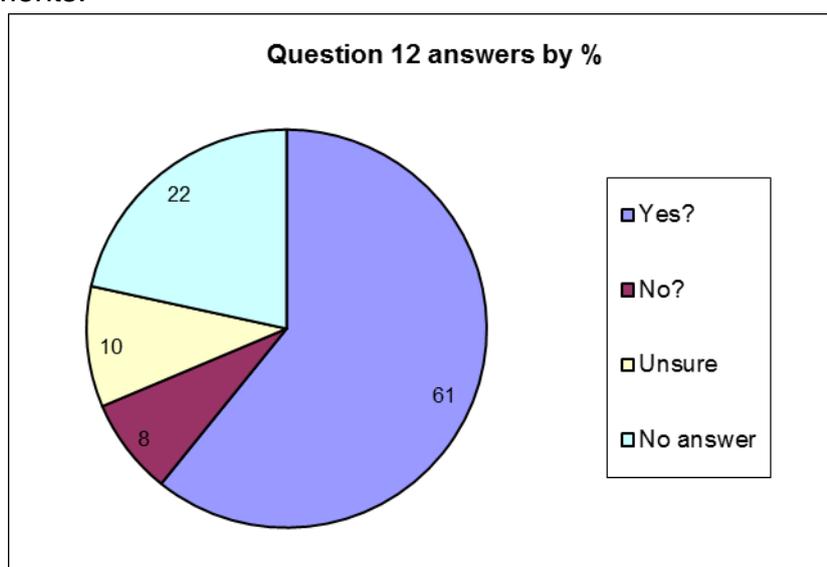
### 5.18 Question 12

5.18.1 The Review Group was of the view that the establishment of a scheme specific to neurologically impaired infants should be considered in the event that it was decided that a general no-fault scheme would not be introduced. Question 12 sought views on this:

**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

5.18.2 A total of 44 responses were received to this question. 61% supported, 8% did not, 10% were unsure and 22% did not answer the ‘yes’ ‘no’ question but some offered comments.



5.18.3 Although the majority of respondents indicated they supported this recommendation there were still concerns about what this would mean in practice. Comments received were mixed and included:

“...the current system is grossly unfair. Those who can establish that their brain impairment was caused by negligence receive multi-million pound settlements while the majority who cannot are left with no compensation at all. We would like to see funds set aside for the effective treatment of all brain impaired children who have been harmed by poor obstetric or antenatal care regardless of whether blame can be proved.” Medical Protection Society

5.18.4 There were concerns that if introduced this could mean compensating parents for the failure of biological development for different reasons rather than the failings of clinical care and that this would set a precedent that any child deemed less than perfectly formed would be entitled to compensation and that this would be challenging and perhaps impractical.

“Some neurological insults to the brain can occur in the ante-natal period. If there is no requirement to prove fault then the scheme would be allowing mothers who may have taken excessive alcohol, illicit drug use during pregnancy to obtain compensation.” Royal College of Nursing

5.18.5 There were concerns about the cost and the impact this would have on the level of compensation awarded:

“...although the establishment of a scheme specific to neurological impaired infants would be ideal as it would allow for compensation in every case involving a neurological impaired infant; we would fear that this is unrealistic, as these claims are hugely expensive. ....the amount of compensation that they would receive would be reduced drastically...the compensation would simply not be enough .....” Association of Personal Injury Lawyers

“The Faculty is of the view that to establish a scheme specific to neurologically impaired infants would be iniquitous. Children who are neurologically impaired after birth and neurologically impaired adults are equally deserving of compensation.” Faculty of Advocates

“...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.” Forum of Insurance Lawyers

5.18.6 It was also suggested that all competent providers of maternity care (including independent midwives who are currently denied personal indemnity insurance) be included if a limited scheme specific to neurological impaired infants was introduced.

#### 5.19 Question 12.1

**Question 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?

5.19.1 Although this was thought to be laudable and could be effective concerns were raised that the effectiveness of such an approach would depend entirely on the quality and level of social welfare support and hospital care being universally and comprehensively available. Other points raised included:

“...good in theory but sadly there are limitations which in practice are very difficult to administer. This can also take away some basic human rights such as making decisions for your own child/self.” Individual

“Whilst initially appealing, there are potential issues in such an approach. For example, if the family involved were to move into or outside of Scotland, how would this be applied? Would their guaranteed services be converted into a lump sum payment or would payment be made to support their care in whichever county they moved to?” Royal College of Surgeons of Edinburgh

“I would hope that in a civilised society with a sense of social justice and welfare state a guarantee of such services would be available to any child with a disability whether a claim is made or not.” Individual

## 5.20 General comments

5.20.1 This section of the consultation invited any additional general comments respondents wished to offer. As indicated in the Introduction, where appropriate, the comments offered in this section have been incorporated with the comments provided in response to the consultation questions 1 to 12. The additional points offered/raised included:

- personal experiences of the current clinical negligence scheme and also experiences of no-fault system in other countries
- Ensuring system included victims of breaches of data protection
- Impact of the integration of health and social care
- Clarification on what happens if a Scottish patient is sent to England for NHS treatment.

## 6. Scottish Government Response - Action taken or proposed

6.1 This section of the report sets out action already taken or proposed in response to the feedback received. The consultation paper sought views on twelve questions which focused on:

- meaningful apology (Question 1)
- essential and desirable criteria for a compensation scheme (Questions 2 & 3) and its contribution to wider issues (Question 4)
- the Review Group's recommendations for the introduction of a no-fault scheme (Questions 5, 6, 7, 9 & 10)
- transitional arrangements if no-fault system introduced (Question 8)
- suggested improvements to the current system (Question 11)
- a suggestion for consideration of a limited no-fault scheme for neurologically impaired infants (Question 12).
- The final section of the consultation also invited general comments.

6.2 Where appropriate the actions and/or the Scottish Government proposals are shown below against the relevant questions.

### 6.3 Question 1

6.3.1 In response to Question 1 the general view was that the new NHS "Can I Help You?" guidance<sup>11</sup> issued in March 2012 (which reflects the requirements of the Patient Rights (Scotland) Act 2011 in relation to the handling and learning from feedback, comments, concerns and complaints) together with the SPSO<sup>12</sup> and GMC<sup>13</sup> guidance provides sufficient advice for staff to ensure that they understand that when an error has occurred patients should receive a meaningful apology.

6.3.2 Some respondents also suggested that better education and training structures should be in place to support staff. The revised "Can I Help you?" guidance mentioned above acknowledges that training, initially through induction is key to ensuring that staff are empowered to handle feedback, comments, concerns and complaints if the procedures are to work effectively. The guidance also makes it clear that NHS Boards and their health service providers have a responsibility to ensure that their staff are competent and confident, as appropriate to their role, in dealing with feedback, comments, concerns and complaints in a manner that is person-centred and aims to resolve issues as they arise and to get it right first time.

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<sup>11</sup> [http://www.sehd.scot.nhs.uk/mels/CEL2012\\_08.pdf](http://www.sehd.scot.nhs.uk/mels/CEL2012_08.pdf)

<sup>12</sup> [http://www.spsos.org.uk/files/2011\\_03\\_SPSO\\_Apology\\_Guidance.pdf](http://www.spsos.org.uk/files/2011_03_SPSO_Apology_Guidance.pdf)

<sup>13</sup> [http://www.gmc-uk.org/guidance/good\\_medical\\_practice/respect\\_patients.asp](http://www.gmc-uk.org/guidance/good_medical_practice/respect_patients.asp)

## **Action 1 – Training and Education programme**

6.3.3 The Can I Help You? guidance<sup>14</sup> advised of a two year education programme during (2012/13 and 2013/14) led by NHS Education Scotland (NES), the Scottish Public Services Ombudsman (SPSO) and the Scottish Government Health and Social Care Directorates to provide core education, training and learning materials to help support NHSScotland meet the requirements of the Patient Rights (Scotland) Act 2011<sup>15</sup>. Launched on 31 May 2013 the online educational resource developed for NHSScotland staff and their service providers (such as GPs, dentists, pharmacists and optometrists and their staff) provides training on handling and learning from feedback, comments, concerns and complaints. The modules also raise awareness of topics such as the value of apology and of encouraging feedback.

6.3.4 The modules are available for use via the learning management system (LMS), or for those who do not have access to an LMS, via the NES website [www.knowledge.scot.nhs.uk/making-a-difference.aspx](http://www.knowledge.scot.nhs.uk/making-a-difference.aspx). A training DVD has also been developed and Master classes were provided for Executive and Non-Executive Board members during 2013-14. Consideration is being given to further training opportunities that will be provided.

## **6.4 Questions 2 and 3**

6.4.1 These questions sought views on the essential and desirable criteria suggested by the Review Group for a compensation scheme, those which were regarded as a priority and of high importance and any additional essential criteria that should be added. You told us that you considered that priority and high importance should be placed on - Ease of use, independence, access to specialist advice, appropriate compensation, affordability and timeliness.

## **Action 2 – revised essential criteria for a compensation scheme based on responses**

6.4.2 The criteria considered essential for a compensation scheme have now been revised to include additional criteria suggested by respondents. The essential criteria revised to take account of views expressed are now as follows:

- 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

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<sup>14</sup> [http://www.sehd.scot.nhs.uk/mels/CEL2012\\_08.pdf](http://www.sehd.scot.nhs.uk/mels/CEL2012_08.pdf)

<sup>15</sup> <http://www.scotland.gov.uk/Topics/Health/Policy/Patients-Rights>

- 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

#### Additional essential criteria

- The scheme discourages frivolous or speculative claims
- The scheme encourages responsible behaviour from patients and staff
- The public (and the professions, NHS staff and others) trust the scheme to deliver a fair outcome (moved from desirable)
- The scheme encourages transparency in clinical decision-making (moved from desirable).

### **Action 3 – revised desirable criteria based on responses to consultation**

6.4.3 Respondents considered that two of the desirable criteria considered under Question 3 of the consultation were actually essential and these have been included in the essential criteria as indicated above. This means the desirable criteria are now:

- The scheme does not prevent patients from seeking other forms of non-financial redress, including through the NHS Complaints system
- The scheme contributes to rehabilitation and recovery.

6.4.4 A relative of someone who had died suggested that it would have been beneficial to have had access to specific counselling to help deal with the trauma.

### **Action 4 – Shaping Bereavement Care**

6.4.5 Guidance in the form of a framework for shaping and improving bereavement care services was issued under Chief Executive Letter CEL 9 (2011)<sup>16</sup> in February 2011. The good practice guidance includes advice in relation to support for those who have been bereaved, including bereavement counselling, where this is appropriate for bereaved relatives. The Scottish Health Council<sup>17</sup> was commissioned to review progress and the impact of the framework and the Scottish Grief and Bereavement Hub<sup>18</sup>. Following on from this funding has been agreed from 1 July 2014 for a Project Lead within NHS Education Scotland to assume responsibility for promoting and developing Bereavement Care Education in Health and Social Care.

<sup>16</sup> [http://www.sehd.scot.nhs.uk/mels/CEL2011\\_09.pdf](http://www.sehd.scot.nhs.uk/mels/CEL2011_09.pdf)

<sup>17</sup> [http://www.scottishhealthcouncil.org/about\\_us/about\\_us.aspx](http://www.scottishhealthcouncil.org/about_us/about_us.aspx)

<sup>18</sup> [http://www.scottishhealthcouncil.org/publications/evaluation\\_reports/grief\\_bereavement\\_hub.aspx](http://www.scottishhealthcouncil.org/publications/evaluation_reports/grief_bereavement_hub.aspx)

## 6.5 Question 4

6.5.1 Question 4 sought views or ideas on how a compensation scheme could more effectively contribute to the wider issues namely:

- 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.

6.5.2 The general view was that, if introduced, there were benefits to be gained from a scheme designed to contribute to these wider issues in order that lessons are learned and improvements are made.

### **Action 5 – review of the management of and learning from adverse events**

6.5.3 Following the launch of this consultation Healthcare Improvement Scotland (HIS)<sup>19</sup> was asked by the Cabinet Secretary for Health and Wellbeing to review the management of adverse events by the 14 territorial NHS Boards, The State Hospital, NHS 24, Scottish Ambulance Services, National Services Scotland (NSS) and National Waiting Times Board and to develop a national approach to learning from adverse events. The aim is to provide a clear, consistent governance framework for managing adverse events that supports preventative measures and reduces risks of serious harm to people.

6.5.4 A national approach has been developed following consultation and engagement with NHS Boards, clinicians, patients and a number of national groups and organisations. Its development has also been informed by the rolling programme of adverse event reviews across NHS Boards, between November 2012 and April 2014. The national approach provides a framework to support standardised processes of managing adverse events across all care settings within NHSScotland. It is intended for all health professionals and has been designed to produce achievable and measureable changes in Board systems to support learning and improvement after adverse events.

6.5.5 The national approach outlines the actions to be taken when an adverse event occurs and provides consistent definitions and categories of events.

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<sup>19</sup> [http://www.healthcareimprovementscotland.org/about\\_us.aspx](http://www.healthcareimprovementscotland.org/about_us.aspx)

6.5.6 The level of review will largely be determined by the category of the event and whilst the national approach will provide a guide to promote a consistent national response, NHS Boards will be ultimately responsible for determining the action that should be taken and for ensuring that decisions are clearly documented. The framework includes a requirement to ensure that the patient, their family and staff members are involved and kept informed of the progress of the review.

6.5.7 The national approach provides a framework that is applicable to clinical and non-clinical events, across specialties and services, with principles, which support the Healthcare Principles, set out in the Schedule to Patient Rights (Scotland) Act 2011<sup>20</sup>. These principles are also reflected in the 'Can I help you?' good practice guidance<sup>21</sup>, for handling and learning from feedback, comments, concerns or complaints about NHS health care services, issued in March 2012.

6.5.8 All NHS Boards have been reviewing their policies and processes to reflect the definitions outlined in the national approach. It is proposed that a phased approach will be taken, with initial focus on acute and managed community services. This will be aligned with the health and social care integration agenda.

6.5.9 Healthcare Improvement Scotland will be reviewing and updating the national approach guidance in 2014 following the completion of the programme of adverse event reviews and following initial feedback regarding implementation of the approach.

#### 6.6 Questions 5, 6, 7, 9 and 10 – Review group recommendations 1 to 9

6.6.1 Questions 5, 6, 7, 9 and 10 within the consultation sought views on the No-Fault Compensation Review Group's recommendations (reproduced in Annex A).

6.6.2 We did not attempt to set out or scope within the consultation what such a no-fault scheme might look like as it was considered important first of all to gather wider views from key stakeholders on the Review Group's recommendations and to seek to better understand the practical implications of adopting these recommendations.

6.6.3 The following paragraphs seek to recap on the main points raised in the consultation responses to Questions 5, 6, 7, 9 and 10 with the details of action proposed given at paragraph 6.10.

6.6.4 **Recommendation 1** (question 5) suggests the introduction of a system along the lines of that in Sweden. Fewer than 50% of respondents supported this approach with several of the others commenting and raising concerns that the system of social care provision in Scotland was not as well developed as the system in Sweden and they were therefore not convinced that a similar scheme could

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<sup>20</sup> <http://www.scotland.gov.uk/Topics/Health/Policy/Patients-Rights>

<sup>21</sup> [http://www.sehd.scot.nhs.uk/mels/CEL2012\\_08.pdf](http://www.sehd.scot.nhs.uk/mels/CEL2012_08.pdf)

operate successfully in Scotland. They commented that the payments under the Swedish model were lower than payments in Scotland where the provision of future treatment and care in the independent sector could not be disregarded.

6.6.5 It is worth noting at this point that the calculations/assumptions made by the researchers in calculating the estimated costs assume that if a no-fault scheme was introduced in Scotland the level of payments under this would be similar to those made under the current clinical negligence system in operation in Scotland and not at the level in Sweden.

6.6.6 Respondents raised major concerns in answer to question 6 which sought views on **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. There were concerns about how this might work in practice given that all procedures carried a risk. It was suggested that the 'avoidability' test should be used and that it would be difficult to identify any other just or workable criteria for eligibility.

6.6.7 Question 7 focused on **Recommendations 3 and 4** and the scope and cover of a no-fault scheme. Fewer than 50% of respondents supported 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 employed by NHSScotland. Others acknowledged that whilst it would be logical to extend such a scheme as widely as possible there were lots of concerns about the complexities and cost of doing so. Some thought that a scheme should cover NHS funded care only and others suggested that it was much more likely to succeed if it was done in stages i.e. introduce for NHS hospital care and only extend to Primary Care providers and the private sector once the scheme had been properly established and funding evidence obtained.

6.6.8 Major concerns were raised about the complexity and potential impact of including independent contractors. There were concerns about how historical liabilities would be managed and funded given that a significant number of GPs in Scotland would have 'occurrence based protection' and given that there were nearly five thousand GPs and three thousand dentists. It was suggested that at present a GP might be sued for negligence once in every 75 years and that under a no-fault system this might result in a claim once in every five years.

6.6.9 Several respondents raised concerns about the cost of indemnity and insurance and whether insurance companies would withdraw their services as a result.

6.6.10 The majority of respondents supported **Recommendation 5** (question 9), which suggests compensation should be based on need rather than a tariff system, but concerns were expressed that 'need' was a subjective assessment and that the

needs-based element was more contentious and difficult to quantify and agree, and would result in different compensation to different people for the same harm which was inequitable.

#### 6.6.11 Concerns were raised about:

- the potential for tens of thousands of claims if a no-fault system was introduced given the estimated level of adverse incidents and complaints relating to clinical treatment
- the increase in the overall level of payments even if the number remains the same because almost all of the current claims are settled extra-judicially at a discount from their full value
- the robustness of the assumptions and calculations used to provide the lower and upper estimates given in the Manchester University Study<sup>22</sup>
- the impact of changes to the Ogden discount rate<sup>23</sup>.

6.6.12 We acknowledged in the then Cabinet Secretary's foreword to the consultation that further work was 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 and that we would seek to explore this further with the relevant stakeholders. To allow us to take account of any comments respondents may have had on the assumptions and calculations used in the Manchester University Study<sup>24</sup> we waited until the consultation had closed before seeking co-operation from the medical defence organisations.

6.6.13 It is worth reiterating here that the lower and upper estimates produced in the Manchester University Study<sup>25</sup> suggested that at the lower end the costs of a no-fault scheme would be similar to the existing scheme, while at the upper end costs in a typical year could increase by one half.

6.6.14 These estimates were calculated based on a range of assumptions about the potential increase in claims; the level of award for the additional successful claims; and the lower cost of processing claims. The estimates used for actual awards settling under the proposed scheme are based on the average awards for settled claims made under the current system and claims handled by the Central Legal Office between the period 2004 and 2009. The report notes that the proportionate increase in public expenditure represented by the upper estimate is considerably lower than that previously estimated for the introduction of a no-fault scheme in England.

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<sup>22</sup> <http://www.scotland.gov.uk/Publications/2012/06/2348>

<sup>23</sup> [http://www.gad.gov.uk/services/Other%20Services/Compensation\\_for\\_injury\\_and\\_death.html](http://www.gad.gov.uk/services/Other%20Services/Compensation_for_injury_and_death.html)

<sup>24</sup> <http://www.scotland.gov.uk/Publications/2012/06/2348>

<sup>25</sup> <http://www.scotland.gov.uk/Publications/2012/06/2348>

6.6.15 We are grateful to the Medical and Dental Defence Union Scotland (MDDUS) for their co-operation and for the work they did to help us calculate total additional costs. We should make it clear at this point, however, that the information provided was based on assumptions we provided and should not be taken to imply in any way that MDDUS accept the validity of the assumptions or of the methodology used. The assumptions provided for use in the calculations were in line with those detailed in the Manchester University Study<sup>26</sup>.

6.6.16 The estimates provided by the MDDUS suggest a Lower Bound percentage increase of 37% and Upper Bound percentage change of 110% from the actual expenditure had the No Fault Scheme been fully operational during the period 2004-2009 and had it been extended to MDDUS members in Scotland.

6.6.17 MDDUS has stressed that it is important to note that all of these figures are very sensitive to the many assumptions set. They are also sensitive to the years selected and a different set of years would have produced a different set of outcomes.

6.6.18 We also acknowledge and are grateful for the additional work undertaken by the Central Legal Office to help identify the scale of costs associated with expert reports commissioned in relation to the consideration of claims.

6.6.19 **Recommendations 6, 7, 8 and 9** (question 10) seek to ensure that the scheme would be fully compatible with the European Convention of Human Rights (ECHR) and provide appropriate appeals mechanisms with an ultimate right to the courts on a point of fact or law.

6.6.20 Just over half of respondents confirmed they supported these recommendations. However, concerns were raised about the rights of the clinician and also the potential for challenge under Article 1 Protocol 1 of the ECHR.

6.6.21 Any legislation required to introduce a no-fault scheme would be drafted appropriately to ensure that it would be fully compatible with the European Convention of Human Rights (ECHR).

## 6.7 Question 8

6.7.1 This question sought views on what transitional arrangement should be put in place given that, if introduced, the no-fault system would not be retrospective. Very mixed response to this question with some suggesting the scheme should only apply to incidents that occur after its introduction and others suggesting the scheme should be retrospective.

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<sup>26</sup> <http://www.scotland.gov.uk/Publications/2012/06/2348>

6.7.2 The Medical Protection Society (MPS) raised the point that there were two types of claims and that both would need to be taken into account when determining future provision. The first type is a known claim (an incident has occurred and a claim has been raised) and the other is known as incurred but not reported (IBNR) and is more complex.

#### 6.8 Question 11 – review Group’s Recommendation 10 in relation to problems with the existing system

6.8.1 The consultation paper explained that the Review Group’s analysis of the problems with the current system would be considered and taken forward by the Scottish Government Justice Directorate as part of their proposed consultation on the Courts Reform Bill. The paper also noted in addition that Sheriff Principal Taylor’s Review of Expenses and Funding of Civil Litigation in Scotland<sup>27</sup> would also consider a range of issues.

6.8.2 The comments received in response to this question and views expressed on the analysis of the problems with the current system were shared with colleagues in Scottish Government Justice Directorate in order that these could be taken into account in the consideration of the Courts reform Bill. This included a suggestion that if the current system was improved there would be no need to move to a no-fault system.

#### **Action 6 – Consultation on Courts Reform (Scotland) Bill**

6.8.3 ‘Making Justice Work - Courts Reform (Scotland) Bill’<sup>28</sup> - A consultation paper published on 27 February 2013 sought views on proposals to restructure the way civil cases and summary criminal cases are dealt with by the courts in Scotland. The proposals provide the legal framework for implementing the majority of recommendations of the Scottish Civil Courts Review, led by Lord Gill the former Lord Justice Clerk and now Lord President of the Court of Session. The proposals discuss a redistribution of business from the Court of Session to the sheriff courts, creating a new lower tier of judiciary in the sheriff court called the summary sheriffs with jurisdiction in certain civil cases and summary criminal cases. Other proposed measures include the creation of a new national sheriff appeal court and a new national specialist personal injury court.

6.8.4 A total of 115 responses were submitted from a variety of different bodies, organisations and interest groups as well as individuals. There were many responses from judiciary and judicial bodies; stables or other groups representing Advocates; arbitration and mediation services; solicitors and groups representing or providing access to solicitors; advocacy groups including consumer bodies; unions; public bodies; local authorities; insurers or insurers groups; business other; and

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<sup>27</sup> <http://scotland.gov.uk/About/taylor-review>

<sup>28</sup> <http://www.scotland.gov.uk/Publications/2013/02/5302>

others. The non-confidential responses received have been published at:

<http://www.scotland.gov.uk/Publications/2013/06/2336>.

6.8.5 The analysis of the responses to the consultation<sup>29</sup> was published in September 2013. This Scottish Government Courts Reform Bill<sup>30</sup> was introduced to the Scottish Parliament, by Kenny MacAskill MSP, on 6 February 2014.

6.9 Question 12 – Review Group’s suggestion for scheme specific to neurological impaired infants in the event that it was decided that a general no-fault scheme would not be introduced.

6.9.1 Although the majority of respondents indicated they supported this recommendation there were still concerns about what this would mean in practice and that if introduced it could mean compensating parents for the failure of biological development for different reasons rather than the failings of medical care and that this would be challenging, expensive and perhaps impractical.

### **Action 7 – Proposed way forward**

6.10 We have noted and recorded in this report the significant concerns raised about the introduction of a no-fault compensation scheme and in particular the major concerns raised in relation to costs and the complexities involved if such a scheme was to be introduced and extended to independent contractors and private healthcare providers.

6.10.1 However, we are still committed to ensuring that patients who have been harmed as a result of clinical treatment have access to redress in the form of compensation, where this is appropriate and that they have access to this without the need to go through lengthy court processes. We will continue to work towards developing a fair system and in doing so will aim to ensure that this will not be at the expense of other essential NHS services.

6.10.2 The Manchester University Study – Summary of their research findings<sup>31</sup> notes that:

‘Fault-based schemes focus solely on the need to prove negligence and it has been argued that this does little to improve the quality of care, produces defensive medical practices, discourages error reporting and institutional learning, and blocks transparency. While it has been argued that no-fault schemes may address some of these problems, the primary goal should be to prevent errors from occurring in the first place.’

For scheme providers and their members, costs of claims need to be contained, and while savings can be made by minimising costs associated

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<sup>29</sup> <http://www.scotland.gov.uk/Publications/2013/09/8038>

<sup>30</sup> <http://www.scottish.parliament.uk/parliamentarybusiness/Bills/72771.aspx>

<sup>31</sup> <http://www.scotland.gov.uk/Publications/2012/06/2048/1>

with litigation, such as excessive legal fees and expert reports, the most significant cost driver is the number and extent of claims.”

6.10.3 NHSScotland aims to provide high quality care that is safe, effective and person-centred. The national approach to learning from adverse events explained earlier (paragraph 6.5.3) provides guidance for the whole of NHSScotland on how to develop and implement effective adverse event management systems. Safety is one part of high quality healthcare services and the national approach contributes to delivery of our NHS Quality Strategy (2010)<sup>32</sup> and 2020 vision<sup>33</sup>. It is proposed that the national approach be reviewed in 2014.

6.10.4 The Scottish Patient Safety Programme<sup>34</sup>, plays a significant role in delivering the Safe Quality Ambition and aims to reduce adverse surgical incidents and healthcare associated infection, while improving critical care outcomes and organisational and leadership culture on safety.

6.10.5 The Patient Rights (Scotland) Act 2011 and the revision of the ‘Can I help you?’ guidance also seek to support the development of a culture that actively encourages and welcomes feedback, comments, concerns and complaints in order to learn from people’s experiences and make improvements. As part of this process NHS Boards are required to publish anonymous details annually on patient feedback, comments, concerns and complaints which provides evidence that action is or has been taken, where appropriate, to improve services and show where lessons have been learned. The NHS Board reports for the first year have been received and reviewed by the Scottish Health Council<sup>35</sup>. The Scottish Health Council followed up on the review with a meeting with each NHS Board to discuss the learning from the first year of reporting, to share examples of good practice and to highlight common challenges. The findings from these discussions will be published in the spring of 2014 and considered by the Scottish Government with the aim of ensuring that NHS Boards across Scotland consistently listen to and learn from feedback, comments, concerns and complaints.

6.10.6 The national roll-out of Patient Opinion<sup>36</sup> from March 2013, the patient experience surveys<sup>37</sup> and the Patient Advice and Support Service<sup>38</sup>, established in April 2012, also provide routes for patients and their families to provide feedback and comments on their experience in order that the NHS can learn and make improvements.

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<sup>32</sup> <http://www.scotland.gov.uk/Publications/2010/05/10102307/0>

<sup>33</sup> <http://www.scotland.gov.uk/Topics/Health/Policy/2020-Vision>

<sup>34</sup> <http://www.scottishpatientsafetyprogramme.scot.nhs.uk/programme>

<sup>35</sup> [http://www.scottishhealthcouncil.org/publications/research/review\\_of\\_nhs\\_feedback.aspx](http://www.scottishhealthcouncil.org/publications/research/review_of_nhs_feedback.aspx)

<sup>36</sup> <https://www.patientopinion.org.uk/>

<sup>37</sup> <http://www.scotland.gov.uk/Topics/Statistics/Browse/Health/InpatientSurvey>

<sup>38</sup> <http://www.cas.org.uk/patientadvice>

6.10.7 Improvement work is also being taken forward across NHSScotland, Social Care and the third sector through the Person-centred Health and Care Collaborative launched by Mr Neil, Cabinet Secretary for Health and Wellbeing, in November 2012. The aim is to enable care to be centred on people by December 2015, through improvements in care experience, staff experience and co-production.

6.10.8 We will monitor the progress of the measures which have been put in place to improve the quality and safety of the services provided. In particular we will monitor:

- the implementation and effect of the national approach to learning from adverse incidents
- claims handled by the Central Legal Office
- Improvements and actions taken as a result of feedback, comments, concerns and complaints
- Improvements made through the Scottish Patient Safety Programme and the Person-centred Health and Care Collaborative.

6.10.9 We will also continue to progress and monitor the impact of the work being taken forward in relation to the Courts Reform (Scotland) Bill and how this will improve the existing legal claim system.

6.10.10 Given the complexity of the issues and the potential costs we will proceed with caution to:

- Explore the scope, shape and development of a no-fault compensation in Scotland for injuries resulting from clinical treatment and the subsequent introduction of such a scheme. This will involve further detailed work especially in relation to projected cost and eligibility criteria; and
- consider how the scheme could more effectively contribute to patient safety, learning, improvement and how it links with and supports safe disclosure of adverse events and aligns with the complaints and claims procedure. We will also link this with the HIS review of the national approach to learning from adverse incidents and plans to review clinical governance arrangements in NHS Boards.

6.10.11 We will develop and consult on draft proposals once the work outlined above has been completed.

## No-fault Compensation Review Group recommendations

### Recommendation 1

We recommend 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

### Recommendation 2

We recommend 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

### Recommendation 3

We recommend 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

We recommend that the scheme should extend to all registered healthcare professionals in Scotland, and not simply to those employed by NHSScotland

### Recommendation 5

We recommend that any compensation awarded should be based on need rather than on a tariff based system

### Recommendation 6

We recommend that claimants who fail under the no fault scheme should retain the right to litigate, based on an improved litigation system

### Recommendation 7

We recommend that a claimant who fails in litigation should have a residual right to claim under the no fault scheme

### Recommendation 8

We recommend 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

We recommend 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

### Recommendation 10

We recommend 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.

## Link to consultation and list of consultation questions

The consultation paper is available at:

<http://www.scotland.gov.uk/Resource/0039/00399081.pdf>

### Consultation questions

1. The research team supporting the review reported (Farrell et al, 2010<sup>39</sup>) 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<sup>40</sup>. 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?

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

<sup>39</sup> <http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/No-faultCompensation/Volume-II-report>

<sup>40</sup> [http://www.spsso.org.uk/files/2011\\_03\\_SPSO\\_Apology\\_Guidance.pdf](http://www.spsso.org.uk/files/2011_03_SPSO_Apology_Guidance.pdf)

- 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

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

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

**Question 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?

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

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?

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

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

**Question 8:** The intention is that if introduced the no-fault system will not be retrospective. However, consideration will need to be given to when and how we could transfer to a new system and how outstanding claims could be handled if/when a no-fault system was introduced. What are your views on how outstanding claims might be handled?

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?

**Question 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?

**Question 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<sup>41</sup> 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<sup>42</sup>, which is due to report at the end of 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

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

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

**Question 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?

### General Comments

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

<sup>41</sup> <http://www.scotcourts.gov.uk/about-the-scottish-court-service/the-scottish-civil-courts-reform>

<sup>42</sup> <http://scotland.gov.uk/About/taylor-review>

## List of respondents by interest group

<b>NHS Health Board/Body</b>	
NHS Ayrshire and Arran	NHS Healthcare Improvement Scotland
NHS Fife	NHS National Services Scotland
NHS Lanarkshire	Scottish Ambulance Service
NHS Greater Glasgow and Clyde	
<b>Individuals</b>	
Donna Carpenter	Dr Nicholas Walker
Dr Matthew Wilkes	Navid Siddique
Ronald Bassy	6 x anonymous
Ms Nancy Greig	2 x confidential
Mrs Jayne Maclennan	
<b>Patient/Public Representative Group</b>	
Action against Medical Accidents	Scottish Infected Blood Forum
Citizens Advice Scotland	Scottish Public Services Ombudsman
Scottish Independent Advocacy Alliance	
<b>Professional Representative Body – medical</b>	
Royal College of Nursing	Royal College of Surgeons, Edinburgh
Royal College of Physicians of Edinburgh	The National Pharmacy Association
British Dental Association	British Medical Association (Scotland)
Scottish Medical & Scientific Advisory Committee (SMASAC)	Independent Midwives UK
Scottish Independent Hospitals Association (SIHA)	General Dental Council
Community Pharmacy Scotland	Optometry Scotland
Lay Advisory Board Royal College of Physicians and Surgeons of Glasgow	Medical Defence Union
Scottish Committee of the Royal College of Obstetricians and Gynaecologists	Medical Protection Society
Scottish Dental Practice Board	1 x confidential
<b>Professional Representative Body – legal</b>	
Law Society of Scotland	Association of Personal Injury Lawyers
Faculty of Advocates	Forum of Insurance Lawyers
<b>Private Company</b>	
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