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

The Scottish Government

Dear Sir/Madam

CONSULTATION ON RECOMMENDATIONS FOR NO-FAULT COMPENSATION IN SCOTLAND FOR INJURIES RESULTING FROM CLINICAL TREATMENT

Responding to this consultation paper
We are inviting written responses to this consultation paper by **23 November 2012**. To aid our analysis of the responses please complete the consultation questionnaire provided with the Respondent Information Form and send this to:

nofaultcompensation@scotland.gsi.gov.uk

or by freepost to:

No-fault Compensation Consultation
FREEPOST RLXC-UYZU-HXHG
Mailpoint 1
Patient Support and Participation Division
St Andrew's House
Edinburgh
EH1 3DG

If you have any queries please contact Sandra Falconer on 0131 244 2399.

Handling your response
We need to know how you wish your response to be handled and, in particular, whether you are happy for your response to be made public. Please provide details on the Respondent Information Form as this will ensure that we treat your response appropriately. If you ask for your response not to be published we will regard it as confidential, and we will treat it accordingly. All respondents should be aware that the Scottish Government are subject to the provisions of the Freedom of Information (Scotland) Act 2002 and would therefore have to consider any request made to it under the Act for information relating to responses made to this consultation exercise.

Next steps in the process
Where respondents have given permission for their response to be made public and after we have checked that they contain no potentially defamatory material, responses will be made available to the public via the Scottish Government Library, and on the Scottish Government consultation web pages by **21 December 2012**. You can make arrangements to view responses by contacting the SG Library on 0131 244 4552. Responses can be copied and sent to you, but a charge may be made for this service.

What happens next?
Following the closing date, all responses will be analysed and considered along with any other available evidence to help us consider the way forward. We aim to issue a report on this consultation process along with our response to it in early 2013.

Comments and complaints
If you have any comments about how this consultation exercise has been conducted, please send them to the address given above.

Yours sincerely

Sandra Falconer
Patient Support and Participation Division
St Andrew's House
EDINBURGH
EH1 3DG
Email: nofaultcompensation@scotland.gsi.gov.uk

NO-FAULT COMPENSATION

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

Responses are invited by 23 November 2012

Chief Nursing Officer, Patients, Public and Health Professions Directorate, Scottish Government Health and Social Care Directorates

Electronic publication and additional copies:

This consultation paper is available via the internet at:
http://www.scotland.gov.uk/Consultations/Current
You can use this link to find out more about the consultation.

Or if you want paper copies of the consultation paper, or if you or someone you care for requires the consultation paper in a different format or language, please contact us at:

No-fault Compensation Consultation
FREEPOST RLXC-UYZU-HXHG
Mailpoint 1
Patient Support and Participation Division
St Andrew's House
Edinburgh
EH1 3DG

Or e-mail to: nofaultcompensation@scotland.gsi.gov.uk

Copies of the documents mentioned in this paper can also be obtained from these addresses.

This consultation is being conducted in line with the Scottish Government's consultation process Consultation: Good Practice Guidance[1]

This consultation, and all other Scottish Government consultation exercises, can be viewed online on the consultation web pages at http://www.scotland.gov.uk/consultations. You can telephone Freephone 0800 77 1234 to find out where your nearest public internet access point is. There will be no charge for this call.

[1] http://www.scotland.gov.uk/Resource/Doc/1066/0006061.pdf

A Public Consultation on Recommendations for No-fault Compensation in Scotland for Injuries Resulting from Clinical Treatment

This consultation is for anyone who would be affected in anyway by a change in the compensation arrangements for injuries resulting from clinical treatment. There are a number of interests at stake – for example, NHS and private patients or staff, patient's families, carers, NHS Boards, healthcare professionals, NHS and private healthcare providers, equipment suppliers, regulatory bodies, Royal Colleges, medical defence associations, the legal profession.

The consultation paper explains the background to the work undertaken by the No-fault Compensation Review Group established by the Scottish Government in 2009. It should be read in conjunction with the Review Group's report[2] and the Study report[3] of the researchers supporting the work of the group. In particular the consultation seeks views on:

- the essential criteria for a compensation scheme for injuries resulting from clinical treatment
- the recommendations of the no-fault compensation group
- the implications of the introduction of a no-fault compensation scheme in Scotland
- how a no-fault scheme could work in practice, both for the benefit of individual patients and the good of the health service as a whole.

The consultation questions are included within the text of the paper in Part 1 and for ease these are repeated as part of the Respondent Information Form included as Part 2.

[2] http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/No-faultCompensation/NFCGReport
[3] http://www.scotland.gov.uk/Publications/2012/06/2348 and http://www.scotland.gov.uk/Publications/2012/06/2048

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

Content **Page**

Part 1

Part 2

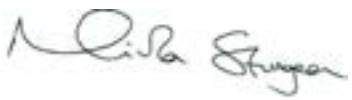
Ministerial Foreword

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

The Review Group's report[4] published in February 2011 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. The recommendations go much wider than NHSScotland suggesting a scheme should cover all clinical treatment injuries that occur in Scotland.

In my response to the report I made it clear that we would undertake some further work around the cost implications and investigate thoroughly how such a scheme would work in practice, both for the benefit of individual patients and the good of the health service as a whole. The report[5] of the study conducted by the researchers from Manchester University who supported the Review Group was published on 7 June 2012. Part of the study explored the potential expenditure implications of a no-fault scheme based on the analysis of data on closed cases dealt with by the Central Legal Office (CLO) under current arrangements. Cost estimates have been calculated based on a range of assumptions about how a no-fault system might operate; the volume and value of claims; as well as costs of the current system in recent years. The researchers have stressed that the estimates produced are not predictions of what a no-fault scheme would cost in the future but are estimates of what public expenditure would have been in a typical year over the recent past for cases handled by the CLO had the proposed no-fault scheme been in existence. It is therefore important to note that further work is still needed to help in our understanding of the volume and level 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.

No decision has been made in relation to whether a no-fault system should be introduced and I do not underestimate the complexity of introducing such a system. This consultation seeks wider views on the Review Group's recommendations in order to help in our understanding of what the practical implications are. Your views will help us make an informed decision and assist in our consideration of the scope and possible options for taking this forward. We want to ensure that those affected by injury through clinical treatment receive appropriate redress without the need to go through a lengthy court process. I would encourage you to respond to this consultation.



Nicola Sturgeon
Deputy First Minister and Cabinet Secretary for Health, Wellbeing and Cities Strategy

---

[4] http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/No-faultCompensation/NFCGReport
[5] http://www.scotland.gov.uk/Publications/2012/06/2348 and http://www.scotland.gov.uk/Publications/2012/06/2048

1. Introduction

1.1 The consultation on the possible content of a Patient Rights (Scotland) Bill undertaken in 2008 indicated that no-fault compensation was the Scottish Government's favoured way forward for the NHS in Scotland. The consultation paper also acknowledged the need for further work on the practical implications and potential costs of any such change in compensation arrangements and made it clear that the Scottish Government would explore the potential benefits for patients in Scotland of a no-fault compensation scheme before taking any firm decision on future arrangements.

1.2 The No-fault Compensation Review Group was established in 2009 to consider the potential benefits for patients in Scotland of a no-fault compensation scheme and whether such a scheme should be introduced alongside the existing clinical negligence arrangements. The Group's Report[6], published in February 2011, set out its view on the essential criteria for a compensation scheme and recommended that consideration should be given to the establishment of a no fault scheme for medical injury, along the lines of the system in operation in Sweden.

1.3 This consultation seeks your views on the Review Group's recommendations, which go wider than the NHS, to help inform our consideration of whether a no-fault scheme should be introduced and, if so, what the extent and scope of such a scheme should be.

1.4 The vast majority of the care delivered in our NHS is of the highest quality, but it is important that people who have suffered as a result of clinical treatment should have some form of redress.

1.5 The Scottish Government is of the view that appropriate redress should not be delayed because a compensation claim can take years to go through the courts nor should precious NHS resources be spent on expensive legal fees.

2. Current system

2.1 Currently "*the NHS does not pay compensation when it has no legal liability for the harm suffered by the patient*". In order to obtain compensation for harm arising out of clinical treatment patients need to show that there was negligence i.e. "damage wrongfully caused". The test for establishing negligence requires the pursuer to establish three elements. There must be loss, injury or damage; a breach of a duty of care; and this breach must have caused the harm complained of (causation).

2.2 Consideration of claims for payment of compensation under the current Scottish scheme can be a lengthy and difficult process for those involved (see Annex B for the Review Group's analysis of problems with the existing system).

[6] http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/No-faultCompensation

2.3 The Central Legal Office (CLO) handles claims on behalf of NHS Boards and successful claims can result in an out-of-court settlement or successful litigation. The NHS funds awards on claims made against directly employed staff of NHS Health Boards whilst claims against independent Primary Care Service providers, (such as GPs, dentists, opticians and pharmacists) and private healthcare practitioners, are handled by their respective defence organisations.

3. No-fault Compensation Review Group's approach and recommendations

3.1 The No-Fault Compensation Review Group established in 2009 to review the potential benefits for patients in Scotland of a no-fault compensation scheme, 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'.*

3.2 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.

3.3 The research team supporting the review reported (Farrell *et al*, 2010[7]) 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. The findings of their research would appear to support the contention that for many, if not most, patients this is the primary aim of taking a case forward, rather than a financial award.

3.4 The Scottish Public Services Ombudsman (SPSO) has published advice in relation to apology[8]. This advice was referenced in the guidance issued to NHSScotland in March 2012 on the handling and learning from feedback, comments, concerns and complaints.

Question 1: What, if any, steps do you feel are necessary or appropriate to ensure that when an error has occurred, patients receive a meaningful apology?

(In relation to this we note the consultation[9] by Margaret Mitchell MSP launched on 29 June 2012 on "*A proposal for a bill to provide that an expression of apology does not amount to an admission of liability and is inadmissible as evidence, for the purposes of certain legal proceedings" and* will watch the outcome with interest.)

3.5 The Group explored several well-established no-fault schemes in other countries with a particular focus on the systems in New Zealand and Sweden. Although these two schemes are different, each aims to facilitate access to justice;

[7] http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/No-faultCompensation/Volume-II-report
[8] http://www.spso.org.uk/files/2011_March_SPSO%20Guidance%20on%20Apology.pdf
[9] http://www.scottish.parliament.uk/parliamentarybusiness/Bills/52684.aspx

the provision of adequate compensation for injured patients; and the appropriate adjudication of claims. These are in line with what the Review Group believed should also inform the system of compensation in Scotland.

3.6 The research team's literature review (Farrell *et al*, 2010[10]) also identified specific advantages and disadvantages that are said to arise from no-fault schemes. These may be useful to you as you consider this consultation and the implications of introducing a no-fault compensation system. It should be noted that the advantages and disadvantages (reproduced below) reflect published studies of no-fault systems in other countries and are not necessarily definitive of how the systems actually work in practice:

3.6.1 Advantages (from literature review)

- A principled social/community response to personal injury which includes a recognition of community responsibility; comprehensive entitlement; full rehabilitation; fair and adequate compensation; and administrative efficiency
- Expanded eligibility criteria for cover that facilitate greater access to justice for patients who suffer medical injury than would be the case in relation to clinical negligence claims brought under delict/tort-based systems
- Greater scope to collect data on, as well as learn from, medical error with a view to enhancing patient safety
- Greater access to justice for patients who have suffered medical injury, which includes providing a clearer 'road map' towards obtaining suitable redress
- Promotion of better, as well as less defensive, relationships between patients and health practitioners when medical injury has occurred
- Greater efficiency in terms of both time and costs than would be the case in relation to the management of clinical negligence claims brought under delict/ tort-based systems
- Rehabilitation can proceed in a more timely fashion, without having to wait until legal action in the courts is resolved
- Easing of pressure on health practitioners with regard to escalating insurance premiums, the availability of liability and the threat of litigation
- These schemes work well when combined with well-established and well-funded national social security systems and independent patient complaints processes
- Reduction or elimination of the need to take legal action in the courts for medical injury, thus lessening the cost and administrative burden on the courts and interested parties, as well as reducing distress and tension between injured patients (pursuers) and health practitioners/health institutions (defenders).

[10] http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/No-faultCompensation/Volume-II-report

3.6.2 Disadvantages (from literature review)

- Potential lack of affordability, particularly in the context of large national populations
- Financial compensation/entitlements in the existing schemes are set lower than would be the case in successful clinical negligence claims brought under delict/tort-based systems
- The removal of the threat of litigation which is sometimes said to provide an incentive for health practitioners and health institutions to avoid unsafe practices and promote institutional and professional accountability and learning in relation to (preventable/avoidable) medical injury
- A significant increase in the potential number of claims arising out of medical injury, which in turn could promote the development of a compensation culture
- The schemes only work well in terms of providing adequate financial compensation/entitlements for medical injury in the context of a well-funded national social security system
- There is still a requirement to prove causation in no-fault schemes (thresholds may vary). This is often the most difficult aspect to establish in clinical negligence claims brought under delict/tort-based systems. Difficulties in establishing causation may therefore act to prevent greater access to justice under no-fault schemes
- Although eligibility criteria may seem more expansive under no-fault schemes, allowing for a greater number of injured patients to obtain cover, existing schemes have a significant rate of rejection as a result of failure to satisfy eligibility criteria
- No-fault schemes which provide for payments based on set amounts or fixed tariffs are not sufficiently responsive to the individual needs of injured patients
- No-fault schemes do not automatically guarantee that key elements of redress desired by injured patients, such as explanations, apologies and accountability of health professionals, are provided
- Restriction of access to the courts in no-fault schemes may potentially infringe human rights law (depending on the jurisdiction), and may also encourage injured patients to seek redress/accountability in other ways (e.g. through the criminal law).

3.7 Principles and criteria essential in a compensation scheme

3.7.1 The Review Group considered, developed and agreed that the following principles and criteria were essential in a compensation system:

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

3.7.2 In addition 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:

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

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

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 comments on how a compensation scheme could more effectively contribute to the wider issues identified?

3.8 Review Group's recommendations

3.8.1 Having considered the existing Scottish system; the existing system with some suggested improvements; and the New Zealand and Swedish systems against the principles and criteria set out at item 3.7.1 the Review Group's report[11] offered ten recommendations. This included:

> **Recommendation 1** - that consideration be given to the establishment of a no-fault scheme for medical[12] 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 is included in Annex A. This describes 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 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: Would you support the approach suggested in Recommendation 1? 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.

(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.)

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. What other injuries would you consider should not be eligible?

[11] http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/No-faultCompensation/NFCGReport

[12] For the purposes of this paper references to 'medical' treatment will include 'clinical' treatment.

3.9 Scope and cover of no-fault scheme

3.9.1 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 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.

(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? If not, why not?

What, if any, difficulties do you foresee in including independent contractors (such as GPs, dentists etc) and private practice? What are your views on how a scheme could be designed to address these issues?

3.9.2 The intention is that if introduced the no-fault system will not be retrospective. However, we would need to consider 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.

Question 8: What are your views on how outstanding claims might be handled?

3.10 Level of payments under no-fault system

3.10.1 The Review Group did not favour the use of a tariff system for compensation, as it was considered 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.

3.10.2 One of the essential criteria identified by the Group and shown at item 3.7.1 is that 'the scheme is affordable'. It is worth noting at this point that the lower and upper cost estimates given in the Study[13] by the researchers are calculated based on a range of assumptions about how a no-fault system might operate; the potential increase in successful claims; as well as costs of the current system in recent years. The Study suggests that at the lower end (based on a 20% increase in successful claims) the costs of a no-fault scheme would be similar to the existing scheme, while at the upper end (based on an 80% increase in successful claims) the proportionate increase in public expenditure in a typical year could increase by one half. It should also be noted that the calculations are based purely on data on closed NHS Board cases handled by the Central Legal Office under the current arrangements. The calculations are based on an assumption that the level of payments under no-fault will be similar to the payments under the existing system. The researcher's report acknowledges that currently the majority of successful claims are settled out of court.

3.10.3 The disadvantages shown at item 3.6.2 indicate that in other countries the 'financial compensation/entitlement in the existing no-fault schemes are set lower than would be the case in successful clinical negligence claims brought under delict/tort-based systems'.

Question 9: Do you support the approach in Recommendation 5? If not, why not? What are your views on the suggestion that the level of payments will be similar to those settled under the current system?

3.11 Compatibility with the European Convention of Human Rights

3.11.1 The Review Group was satisfied that a no-fault scheme established as they describe would be fully compatible with the requirements under the European Convention of Human Rights. This is because they proposed – 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. They also thought that the retention of the right to litigate will ensure that those who feel the no-fault system is not appropriate will still be able to raise claims using this route. The group recommended:

[13] http://www.scotland.gov.uk/Publications/2012/06/2348

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? If no, why not? Do you have any concerns that the Review Group's recommendations may not be fully compatible with the European Convention of Human Rights? If yes, what are your concerns?

4. Problems with current system and suggested improvements

4.1 The Review Group also examined and identified problems with the current system which included:

- **Length of time** – many claims can take months, if not years, between initial investigation and final resolution by way of Judgement or settlement.
- **Adversarial culture** which can lead to:
  - Delay in disclosure of expert opinions or information – parties frequently do not 'show their hand' until the parties are well advanced into the adversarial process
  - Delay in focussing the issues – crucial issues in dispute frequently do not become focussed until late into the dispute when the facts may be clarified
  - Uncertainty of outcome – Again, parties sometimes have no idea as to the likely outcome until the adversarial process is well advanced
  - Perception of lack of openness – a perception by many claimants that there has been a lack of openness by clinicians or those representing clinicians
- **Disproportionality of legal expenses** – the legal expenses of investigating and pursuing the claim can be disproportionate to the value of the claim.

4.2 Potential improvements suggested in chapter 5 (Item 5.4e) of their report[14] are attached as Annex B. In relation to this the Group offered:

[14] http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/No-faultCompensation/NFCGReport

Recommendation 10 - that consideration should be given to the Review Group's analysis of the problems in the current system, so that those who decide to litigate can benefit from them.

4.3 Please note that it is proposed that the suggested improvements will be taken forward by the Scottish Government Justice Directorate as part of a forthcoming consultation on the Courts Reform Bill later this year. In particular the Scottish Civil Courts Review[15] 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.

4.4 In addition, Sheriff Principal Taylor's Review of Expenses and Funding of Civil Litigation in Scotland[16], which is due to report at the end the year will consider a range of issues.

Question 11: The Review Group's suggestions for improvements to the existing system are reproduced in Annex B. Do you agree with these suggestions?

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

5. Limited no-fault compensation scheme for neurologically impaired infants

5.1 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 Review Group was of the view that this was worthy of consideration and provided an outline of a possible approach. The outline of a possible limited scheme is included as Annex B to the group's report[11].

5.2 The group considered that the possible benefits of the suggested approach would be that:

- More children would obtain compensation, because of the removal of the requirement to prove fault
- Compensation could be awarded much more quickly, because:
  a. There is no need to prove fault
  b. Care needs would be met by a guarantee of ongoing care provision by the state, obviating the need to wait until the child's needs are fully established (which may be a matter of ten years or more) to avoid under-compensation

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

c. The award could be made by administrative means or tribunal, rather than following an adversarial process
d. Money currently leaving the NHS would be retained in the system, thus improving NHS resources overall
e. There may be a considerable saving in legal fees.

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

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?

ANNEX A

SWEDISH COMPENSATION SCHEME FOR MEDICAL ACCIDENTS

Extracts from Chapter 3 of Volume II - No fault Compensation Schemes for Medical Injury: A Review[17]

"Sweden

Administration

3.8 The Swedish Patient Insurance Association (Patientforsakringsforeningen or PFF) is a public company which administers the scheme. It is financially supported through contributions made by county councils which are responsible for the scheme. It is financially supported through contributions made by county councils which are responsible for the provision of health care."

"3.11 The scheme was originally established as a voluntary scheme in 1975. The scheme was placed on a statutory footing as a result of the Patient Injury Act 1996 (PIA 1996). The legislation came into effect on 1 January 1997. While many of the provisions contained in the PIA 1996 draw on the earlier voluntary scheme, there were certain important changes governing the right to compensation as a result of medical injury and the obligation of both public and private health care providers to hold what is called 'patient insurance' to provide for such compensation."

"**Funding**

3.12 Under the provisions of the PIA 1996, health care providers are required to obtain insurance that covers claims being made in respect of medical injuries. Insurers that provide such insurance belong to the Patient Insurance Association.

3.13 There are 21 regions in Sweden each with their own directly-elected Parliaments. Each region is responsible for the provision of healthcare within their 40 boundaries. Health care is financed by regional income tax, which represents 10% of the income of those resident within regions. A small proportion of health care (1-2%) is financed by private means or through private health insurance. Doctors are employed by regional hospitals. GPs are either employed by regions or operate as independent contractors paid by regions.

3.14 The regions mutually own and operate a medical injury insurance company (LOF). The insurance policy for medical injury is held by regions rather than by doctors or hospitals. The LOF covers medical injuries in regional hospitals and primary care centres, as well as for all private care (through contracts signed by private health providers). The premiums paid to LOF by the regions are drawn from regional income tax. They are not risk-based and are instead based on the number of inhabitants per region. It is estimated that LOF covers 90% of health care provision in Sweden. The remaining 10% is covered by private insurance companies which provide cover for doctors and dentists operating in private practice, chiropractors, physiotherapists and nursing homes."

[17] http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/No-faultCompensation/Volume-II-report

"3.26 Under the Patient Torts Act 1996, a claimant is entitled to bring tort-based claims in the courts arising out of medical injury. Health care providers are required to carry liability insurance to cover such claims. The claimant must show with reasonable certainty that the health care provider's conduct caused the alleged injury.

3.27 Where a claimant has sustained an injury due to the alleged negligent failure to provide information or obtain consent in relation to the provision of medical treatment, then a claim must be brought under tort law principles in the courts (Espersson 2000a; 2006; 2009).

Review and appeal mechanisms

3.28 If claimants are unhappy with the decision made regarding their eligibility and/or entitlements under the scheme, they may apply to the Patient Claims Panel. This Panel consists of a chairperson who is, or has served as, a judge, and six other members who are appointed for three year terms. The members bring differing areas of relevant expertise to the work of the Panel. The Panel aims to promote fair and consistent application of the terms of the PIA 1996 and issues opinions at the request of claimants, health care providers, insurers or the courts. The Panel is an advisory body and therefore its opinions operate as recommendations only, but there is a high level of compliance. It is estimated that in 10% of claims brought before the Panel their recommendation was that cover be granted by the PFF (Espersson 2000a; Hellbacher et al. 2007; Essinger 2009), with 70% of claims being settled in 6 months.

3.29 Bringing a claim before the Panel is free of charge for the claimant, who benefits from being able to have the matter heard by experts in the field before making a decision on whether to bring a tort-based claim in the courts. The claimant is entitled to choose whether to bring their claim before the Panel or to proceed directly to court (Espersson 2000a).

Complaints process and professional accountability

3.30 Independent Patients' Advisory Committees operate in every region in Sweden. The Committee assists patients who experience difficulties in their relationship with health practitioners. The Committee does not have any decision making powers but aim to take a practical approach to resolving complaints.

3.31 The Medical Responsibility Board (HSAN) deals with complaints where patients allege incompetence on the part of health practitioners. HSAN has the power to issue 'soft' warnings (reprimands) to health practitioners as well as bring disciplinary proceedings. Disciplinary action is kept entirely separate from the no-fault scheme (Essinger 2009).

Medical error and patient safety

3.32 The analysis of medical error with a view to enhancing patient safety is encouraged in Sweden through the use of root cause analysis of events which led to claims for medical injury under the no-fault scheme. This is economically incentivised by LOF (the national medical injury insurance company). Senior medical figures at regional hospitals receive regular updates providing details on all claims for medical injury under the no-fault scheme that originated in their hospitals. The reasons for such claims are followed on a regular basis through visits by LOF representatives to

the hospitals. Discussions are held on the data, as well as what can be done to avoid such medical injuries in the future. National Patient Safety conferences are also held on a regular basis and are attended by representatives from the Hospital Federation, the National Board of Health and Welfare and the medical profession. It is expected that new patient safety legislation will come into force in 2010 which will implement a range of specific initiatives to bring about quality and safety improvement in the provision of health care in Sweden (Essinger 2009: 5-7)."

ANNEX B

THE REVIEW GROUP'S SUGGESTIONS FOR IMPROVEMENTS TO EXISTING MEDICAL NEGLIGENCE SYSTEM

An extract from chapter 5 (Item 5.4e) of the Review Group's[18] report showing

"potential improvements to the existing system, based on the problems which were identified in chapter 2.

(ii) **Length of time**: many reparation claims can take months, if not years, between initial investigation and final resolution by way of judgement or settlement. This is one of the major failings of the current system, yet this is an area where reform could be made and could lead to efficiency savings. One of the most striking features of the existing Scottish system is that, in stark contrast to England, and indeed stark contrast to other types of claims even in Scotland (such as personal injury claims or non-medical professional negligence claims), there is no framework which regulates how potential claims should be made, processed or resolved. (It should be noted however that with brain injuries at birth, it will not be known for many years, the extent of the residual developmental deficits which may arise with such patients.)

(iii) The main legal time limit is that court proceedings must be commenced within 3 years of the date of the negligence happening or coming to light, or in cases involving children, by the child's 19th birthday. While Court procedures have been reformed (and further reforms will follow as a result of Lord Gill's Scottish Civil Court Courts Review), these reforms to Court procedure do not deal with the vast majority of claims that are made and resolved without the need for litigation and within the three year period.

(iv) While England has had a pre-action protocol for a number of years, Scotland has been slower to follow suit. A voluntary pre-action protocol was introduced on 1 January 2006 in respect of personal injury cases and a voluntary pre-action protocol in professional negligence (non-medical) cases is also now in place in Scotland. Unlike in England and Wales, there is no statutory basis for these pre-action protocols. They are, however, widely used and followed in other areas of law in Scotland.

(v) **Delay in disclosure of information**: parties frequently do not 'show their hand' until the parties are well advanced into the adversarial process.

(vi) Those representing clinicians complain of not being given sufficient notice of the factual allegations by those representing the patient as to exactly what is being alleged so that a proper investigation can be carried out. Those representing the patient complain of not being given information regarding internal Critical Investigation Reports and not being able to obtain access to the medical practitioner or colleagues to obtain a factual statement as to what happened. This can lead to a patient's case being dependent on the contents of what happens to be in the medical records, whereas there may be other relevant evidence not known to the patient or

[18] http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/No-faultCompensation/NFCGReport

the patient's representative. This information sometimes is not disclosed /shared/ reciprocated until matters are well advanced.

(vii) At present, the quality of internal Critical Incident Reports varies from operational unit to operational unit and whether those reports are disclosed to the patient also varies from hospital to hospital. Consistent disclosure of such reports at an early stage so that material and relevant facts are identified would reduce the identified delays.

(viii) **Delay in focussing the issues**: crucial issues in the dispute frequently do not become focussed until late into the investigation. Problems can arise in practice because of the mobility of medical personnel who can frequently rotate from one job to another as part of a natural career progression. Imposing an obligation on health staff to co-operate with previous employers would enable potential claims relating to them to be dealt with more swiftly.

(ix) A problem can frequently be encountered in terms of the provision of reports by independent medical experts. Experts, who it should be noted are entirely voluntary, if they are to accept instructions could be required to agree to provide a report within a certain period of time. (This can bring its own problems as the pool of available experts in a number of specialities, is small). Early identification of all relevant issues and disclosure of those issues would reduce the likelihood of delays and would enable detailed information to be provided by clinicians while events are still comparatively fresh in their minds, enabling earlier exploration of issues with a view to resolution before parties become entrenched in a long running adversarial process.

(x) **Uncertainty of outcome**: parties sometimes have no idea as to the likely outcome until the adversarial process is well advanced. No system is perfect in terms of certainty, but the stress associated with this could be reduced by much swifter negotiation and resolution through an agreed set of procedures, particularly if those procedures are designed to reduce the need for parties to proceed to or threaten litigation.

(xi) **Perception of lack of openness**: there is a perception by many claimants that there has been a lack of openness by clinicians or those representing clinicians. It is the perception of some clinicians and representatives that clinicians will apologise for an obvious error, but the reason that an apology might not be made is that the clinician might only know there has been negligence once an opinion is obtained from an independent expert as to whether the treatment in question was negligent or not.

(xii) From the perspective of those representing patients there is a perceived reluctance on the part of clinicians to acknowledge error. It may also be that while some clinicians are prepared to tell a patient about an error, with or without an apology, patients' representatives are clear that a significant number do not. Further, even of those clinicians who may be prepared to advise a patient of an error, not all will agree on what is an obvious error and so clinicians will have 'variable thresholds' for disclosure. From a professional standpoint, the GMC makes the position clear.

(xiii) Section 30 of the GMC Guidance of 'Good Medical Practice' states that:

> "if a patient under your care has suffered harm or distress, you must act immediately to put matters right, if that is possible. You should offer an apology and explain fully and promptly to the patient what has happened, and the likely short term and long term effects."

(xiv) Section 31 continues

> "Patients who complain about the care or treatment they have received have a right to expect a prompt, open, constructive and honest response including an explanation and, if appropriate, an apology. You must not allow a patient's complaint to affect adversely the care or treatment you provide or arrange."

(xv) That the patient should have a right to know in England and Wales is reflected at page 25 of the Coalition Government Programme published on 20 May 2010 which states 'we will require hospitals to be open about mistakes and always tell patients if something has gone wrong'. Increased disclosure and sharing of Critical Incident Investigation reports would also reinforce this ethos of openness.

(xvi) **Access to Justice**: there is a significant shortage of solicitors and advisors who have the expertise to deal with medical negligence cases in Scotland. As a result, many claimants can receive poor or inadequate advice, with a low number of cases leading to 'satisfaction'. This can also lead to 'Inequality of arms' – clinicians will generally be represented by specialist lawyers, but patients frequently are not.

(xvii) This is a major issue in Scotland, where there are only 6 accredited claimant clinical negligence specialists. A significant factor is the lack of resourcing and training for lawyers and representatives in this field.

(xviii) What should be a comprehensive network of solicitors in private practice throughout Scotland is, in fact, patchy. Consideration needs to be given as to how to improve and increase access to justice. In addition, it should be considered whether a review of legal aid rates and the fee structure would attract practitioners prepared to deal with this type of work. This would also help to redress the current imbalance between clinicians generally having expert representation and patients frequently being without it.

(xix) **Expenses**: many patients who have suffered injury feel unable to take matters forward because of the expense of instructing a solicitor, or an inability to recover all expenses even if successful. At present, there are four main avenues of potential funding open to a client, namely:

- legal aid/legal advice and assistance through the Scottish Legal Aid Board, assuming the client is financially eligible;
- the client pays solicitor fee on a private basis;
- 'before the event' insurance, typically a DAS type household insurance covering legal expenses (this is comparatively unusual). This insurance covers the legal costs involved in pursuing or defending a claim. Legal costs include the appointment of solicitors, barristers and expert witnesses; or

- 'after the event insurance' frequently in conjunction with a 'no win no fee' speculative agreement. It is, however, unusual for a solicitor to take on a clinical negligence case on a speculative basis because of the highly risky nature of the case and the considerable expense of the insurance premium which can run into thousands of pounds. In addition, even if the client is ultimately successful in the claim, the client cannot recover the insurance premium. In England, the 'after the event' insurance premium can be recovered as part of the legal costs if the party is successful. We noted, however, that proposals, from Lord Justice Jackson's review of civil litigation costs strongly recommend that recovery of after the event insurance premiums be abolished in England.

(xx) Although changes have been made to the availability of legal aid to take a case to Court, these changes do not affect the vast majority of potential claimants who seek to resolve their case without litigation and who are dependent on legal advice and assistance, which has more limited eligibility criteria than full legal aid.

(xxi) **Disproportionality of legal expenses**: the legal expense of investigating and pursuing the claim can be disproportionate to the value of the claim. At present, similar steps can be taken by both claimants and defenders regardless of the value of the claim. A complex report on *Hunter v Hanley* negligence may require to be obtained from an expert irrespective of the value of the case. Similarly, reports on causation can be just as expensive for low value claims as for high value claims. It is, of course, possible that the parallel existence of a no-fault scheme might encourage claimants to use this when the value of their claim is low and, if so, this would be a direct benefit."

ANNEX C

DEFINITIONS

We have set down below some broad definitions for certain words or phrases referred to in this consultation paper in order to set the context for some of our considerations.

Avoidability Test – tests to establish whether the harm would have been avoided by the use of 'best' practice.

Causation - As well as proving breach of duty, a pursuer must also prove that the breach of duty caused the loss or harm complained of, or at least materially contributed to it.

Compensation - Compensation is a wider term than damages, and covers the provision of something to the injured person (or the injured person's dependants in the case of death) in consequence of the injury or harm, and for the purpose of removing or alleviating its ill effects.

Delict – in Scots Law is, amongst other things, the responsibility to make reparation caused by breach of a duty of care or, arguably, the duty to refrain from committing such breaches. The equivalent in English law and other common law jurisdictions is known as tort law.

Experienced specialist rule – This rule considers whether injuries could have been avoided under optimal circumstances, in that the injury would not have occurred in the hands of the best health practitioner or health system.

Harm – this may include flawed or inadequate consent; affront/outrage; breach of confidentiality; pain and suffering caused through unnecessary Treatment; loss of a probability of a cure/successful treatment.

Injury - Physical injury (an incident or condition causing physical pain will, in general, be regarded as injury e.g. Inadequate anaesthetisation), psychiatric injury as confirmed by a Consultant Psychiatrist or Consultant Psychologist; wrongful birth (a mother who gives birth following a failed sterilisation to an otherwise healthy baby will be awarded damages for the pain and suffering of the childbirth even although medically, this might not be regarded as "injury").

Independent contractor - Most GPs, opticians, dentists and pharmacists are independent contractors. This means that they are not employed directly by the NHS but are contracted to provide services to patients for which they are paid by the NHS. In addition, independent contractors may also carry out private work which is not funded by the NHS.

Clinical Error - is "the failure of a registered health professional to observe a standard of care and skill reasonably to be expected in the circumstances". This, by definition, requires proof equivalent to that of proving negligence; that is malpractice, in the same way as a clinical malpractice claim under delict law.

NHS Indemnity - NHS bodies are legally liable for the negligent acts and omissions of their employees or agents in terms of the principle of vicarious liability, and should have arrangements for meeting this liability. NHS Indemnity applies to staff in the course of their NHS employment, as well as GPs or dentists, who are directly employed by Health Boards. It also covers people in certain other categories whenever the NHS body owes a duty of care to the person harmed, including, for example, locums, medical academic staff with honorary contracts, students, those conducting clinical trials on NHS patients, volunteers and people undergoing further professional education, training and examinations. NHS Indemnity does not apply to general medical and dental practitioners (or their employees) working as independent contractors under contract for services. General practitioners are responsible for making their own indemnity/insurance arrangements, as are other self-employed health care professionals such as chiropodists and independent midwives. NHS Indemnity does not apply to employees of private hospitals (even when treating NHS patients) local education authorities or voluntary agencies.

Negligence – failure to exercise a duty required by law to show reasonable care, when doing or omitting to do something, in order to avoid loss or harm to others. It is not always medical practitioners who cause or contribute to injury – nurses, clinical support staff, laboratory staff, blood transfusion staff, pathology staff, administrative support staff may also contribute to injury.

No-fault compensation - we use this to refer to compensation which is obtained without the need to proceed against the person responsible for the harm.

Professional Negligence - A medical practitioner, like others exercising professional skills, must display and apply reasonable care and a reasonable standard of professional competence in order to avoid loss or harm to others. There is no automatic liability for accidents, and the test often depends on what is usual and normal practice. Deviation from usual and normal practice is negligence only if the course of action adopted is one which no professional man of ordinary skill would have taken if they had been acting with ordinary care. (*Hunter* v *Hanley* 1955 SC 200) However, the practice relied on must have been accepted by a responsible body of medical experts skilled in the field, their opinion must have had a logical basis, and the experts must have applied their minds to the comparative risks and benefits. *(Bolitho v City and Hackney Health Authority 1998 AC 232)*

Redress – this may include investigations when things go wrong, remedial treatment, rehabilitation and care when needed; explanations and apologies; and financial compensation in certain circumstances.

Tort - in English Law is, amongst other things, the responsibility to make reparation caused by breach of a duty of care or, arguably, the duty to refrain from committing such breaches. The equivalent in Scots law and other common law jurisdictions is known as delict law.

Treatment – includes the giving of treatment; diagnosis of a medical condition; a decision to treat or not to treat; a failure to treat or treat in a timely manner; obtaining or failing to obtain informed consent to treatment; the provision of prophylaxis; application of any support systems including policies, processes, practices and

administrative systems which are used by the treatment provider and directly support the treatment. It also includes failure of equipment, devices or tools which are used as part of the treatment process, whether at the time of treatment or subsequently. Failure of implants and prostheses are included, except where the injury is caused by general wear and tear.

Part 2

Respondent Information Form and consultation questions

No-fault Compensation for injuries resulting from clinical treatment

RESPONDENT INFORMATION FORM

Please Note this form **must** be returned with your response to ensure that we handle your response appropriately

1. Name/Organisation

Organisation Name

Title **Mr** ☐ **Ms** ☐ **Mrs** ☐ **Miss** ☐ **Dr** ☐ ***Please tick as appropriate***

Surname

Forename

2. Postal Address

Postcode	**Phone**	**Email**

3. Permissions - I am responding as…

Individual ☐ / **Group/Organisation** ☐

Please tick as appropriate

(a) Do you agree to your response being made available to the public (in Scottish Government library and/or on the Scottish Government web site)?

Please tick as appropriate ☐ **Yes** ☐ **No**

(b) Where confidentiality is not requested, we will make your responses available to the public on the following basis

Please tick ONE of the following boxes

Yes, make my response, name and address all available ☐

or

Yes, make my response available, but not my name and address ☐

or

Yes, make my response and name available, but not my address ☐

(c) The name and address of your organisation ***will be*** made available to the public (in the Scottish Government library and/or on the Scottish Government web site).

Are you content for your ***response*** to be made available?

Please tick as appropriate ☐ **Yes** ☐ **No**

(d) We will share your response internally with other Scottish Government policy teams who may be addressing the issues you discuss. They may wish to contact you again in the future, but we require your permission to do so. Are you content for Scottish Government to contact you again in relation to this consultation exercise?

Please tick as appropriate ☐ **Yes** ☐ **No**

No-Fault Compensation for injury resulting from medical treatment: Consultation Questions

1. The research team supporting the review reported (Farrell *et al*, 2010[19]) that previous research suggests that when an error has occurred, patients expect doctors to make a meaningful apology, provide an explanation and take steps to prevent the error from recurring. The findings of their research would appear to support the contention that for many, if not most, patients this is the primary aim, rather than a financial award.

2. The Scottish Public Services Ombudsman (SPSO) has published advice in relation to apology[20]. This advice was referenced in the guidance issued to NHSScotland in March 2012 on the handling and learning from feedback, comments, concerns and complaints.

Question 1: What, if any, steps do you feel are necessary or appropriate to ensure that when an error has occurred, patients receive a meaningful apology?

[19] http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/No-faultCompensation/Volume-II-report
[20] http://www.spso.org.uk/files/2011_March_SPSO%20Guidance%20on%20Apology.pdf

3. The Review Group considered that the following were essential criteria for a compensation scheme for injuries resulting from medical treatment:

- The scheme provides an appropriate level of compensation to the patient, their family or carers
- The scheme is compatible with the European Convention on Human Rights
- The scheme is easy to access and use, without unnecessary barriers, for example created by cost or the difficulty of getting advice or support
- People are able to get the relevant specialist advice in using the scheme;
- Decisions about compensation are timely
- People who have used the scheme feel that they have been treated equitably
- The scheme is affordable
- The scheme makes proportionate use of time and resources
- The scheme has an appropriate balance between costs of administration (e.g. financial or time) and the level of compensation awarded
- Decisions about compensation are made through a robust and independent process
- The scheme has an independent appeal system
- The scheme treats staff and patients fairly/equitably
- A reasonable time limit is set for compensation claims.

Question 2. Do you agree that the principles and criteria set out above are essential in a compensation system?

Yes ☐ **No** ☐

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

4. The Review Group identified a number of issues it believed were relevant to the likely success of any system and agreed that the following criteria were desirable, and considered and highlighted the importance of the wider issues detailed below:

Desirable

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

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

Yes ☐ No ☐

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

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?

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

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?

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?

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

Yes ☐ **No** ☐

If yes, what are your concerns?

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

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

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

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

Yes ☐ **No** ☐

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

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

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

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

Yes ☐ **No** ☐

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.

We are grateful for your response. Thank you.

ISBN: 978-1-78045-999-8 (web only)

The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

Produced for the Scottish Government by APS Group Scotland
DPPAS13252 (08/12)

Published by the Scottish Government, August 2012

w w w . s c o t l a n d . g o v . u k