"**No-blame" Redress Scheme in Scotland for Harm Resulting from Clinical Treatment**

Questions:

1. The Ministerial commitment is that any scheme will contribute to patient safety, learning and improvement and we would therefore propose to integrate the scheme with the NHS Scotland feedback, complaints, adverse incident reporting and Duty of Candour processes as the scheme is being developed.

2. Under the national approach to learning from adverse events set out in the National Framework issued by Healthcare Improvement Scotland (HIS) and the forthcoming introduction of a statutory duty of candour in health and social care settings, the patient (and their families) should be informed when and why an error, which has resulted in harm, has occurred. A report setting out details of the incident and the report of the full investigation will be prepared and will be used in consideration of whether the eligibility criteria for redress has been met.

Question 1: Do you agree that it is appropriate to integrate the process for the redress scheme with the incident investigation, duty of candour and complaints processes to ensure consistency, improvement and shared learning?

Yes ☑ No ☐

If you disagree please briefly explain why:

The majority of respondents agreed it was appropriate to integrate the redress scheme with other related processes. It is also important to be transparent about other reasons for introducing this scheme, including helping to manage and protect valuable NHS resources. This does appear in the consultation document but could be more explicit.

It is important that incidents are investigated with transparency and consistency- it is not clear as to whether the independence of the incident investigation can be guaranteed. The current variation in approach to review of adverse events and quality of reporting could pose a significant problem for this element of the proposed scheme. If the process is to proceed, there would need to a need for some focused work in reviewing and supporting improvements in the quality and consistency of adverse event reports.

We also received remarks which disagreed with the redress scheme because the reporting of errors and near misses are already in place within the NHS, with systems and processes changed as a result. Linking this to a redress scheme could alter the ethos and focus on individuals rather than learning. The two are for separate purposes and need some degree of separation.

3. Eligibility criteria are a feature of all "no fault" or "no-blame" schemes worldwide, with common features including: thresholds, limitations on the extent of cover and additionally limitations or caps are applied to the sums payable. In working to scope and shape a fairer and importantly affordable Scottish scheme a number of approaches were considered. Those options have been narrowed down and our preferred approach for the initial establishment and testing of a no-blame redress scheme in Scotland is set out in this paper.

4. Additional information gathered for the NHS in Scotland in relation to complaints, adverse events and claims has been considered. This has permitted further exploration of possible approaches for the development of eligibility criteria which would allow the introduction of a fairer, faster and simpler approach to handling compensation claims and one which is affordable. The proposal is that the scheme will be based on the following broad principles:

 Compensate quickly and fairly for avoidable harm where the investigation establishes the harm would have been avoided by the use of „reasonable care". (Will exclude cases where the unfavourable outcome was one of the unavoidable risks of the procedure.)
 Defend medically reasonable care
 Reduce patient injuries (and therefore claims) by learning from patients" experiences

Question 2 - Do you agree with the broad principles for the scheme?

Yes ☑No

If you disagree please briefly explain why:

In terms of no blame culture, redress, candour, complaints, etc, the process needs to be underpinned by strong medical engagement and leadership.

5. Given the concerns highlighted at 2.3 of the consultation document (in relation to the original Recommendation 2) we would propose that, as in Sweden, the eligibility criteria should be structured around the notion of "avoidability"; i.e. the test is whether the harm caused by the treatment was avoidable. The proposed scheme will therefore be „no-blame" rather than a true „no-fault" scheme, which would potentially cover avoidable and unavoidable harm. 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 and a retrospective approach has been taken in some cases in the evaluation of whether the injury was avoidable.

6. The draft proposals for the no-blame redress scheme combine a new approach for dealing with compensation for **causally connected avoidable harm where the harm has been or is likely to be, experienced by the person for a continuous period of at least 6 months** with improvements to the existing legal process.

Question 3 - Do you agree that eligibility should be structured around the notion of "avoidability"?

Yes ☑ No ☐

If you disagree please briefly explain why:

Again there would need to be clear equity across Health Boards.

Question 4 - Do you support the proposal that the non-retrospective scheme should be restricted to harm which has been or is likely to be, experienced by the person for a continuous period of at least 6 months?

Yes☐ No ☐

If no, please briefly explain why:

Unsure.

6 months may be unworkable in some cases, or acute harm could occur over a shorter period of time and require support. There needs to be an element of flexibility, although the majority of issues could likely be confined to 6 months.

7. In the first instance it is proposed that the Redress Scheme would be restricted to payment of compensation **where the harm has been or is likely to be, experienced by the person for a continuous period of at least 6 months** and is as a result of **clinical treatment administered by directly employed NHS staff in Scotland.** The scheme will **not be retrospective** (i.e. will cover clinical events that occur after the date of introduction). It will, take account of health and social care integration and therefore clinical treatment provided as part of an integrated service.

8. The No-fault Review Group also recommended that the scheme should cover all medical treatment injuries that occur in Scotland and should extend to all registered healthcare professionals in Scotland, and not simply to those employed by NHSScotland. However, in response to the earlier consultation a good deal of concern was expressed about the cost and complexity of introducing a scheme which extended beyond the NHS. Therefore, it is proposed that in the first instance the scheme be limited to clinical treatment provided by directly employed NHS staff in Scotland (independent contractors – GPs, dentists, opticians and pharmacists – would be excluded along with private providers) with options to extend, if considered appropriate, at a later date.

Question 5 - Do you support the proposal that the proposed non-retrospective scheme should in the first instance be restricted to clinical treatment provided by directly employed NHS Staff in Scotland?

Yes ☐ No ☑

If no, please briefly explain why:

This proposal excludes from the scheme huge swathes of NHS practice. In a number of cases it may be difficult to clearly separate primary and secondary care responsibilities.

Complexity should not be the guiding principle. Ethics and the moral stance should be the starting point with complexity worked through from there.

If the scheme is limited there should be a provisional indication as to when other healthcare providers might be covered.

9. Currently around 70% of all awards made under the current CNORIS system are under £100,000. We are proposing that the No-blame redress scheme will handle claims up to £100,000.

10. The cap of £100,000 on the level of award payable under the scheme (including cost of care packages and damage for loss of earnings) will effectively exclude the most severe and complex cases (e.g. brain damaged children) and those cases where continuing care is appropriate. These cases would continue to be handled through the legal system. (Please also see proposals in relation to continuing care costs explained at Item 6 in the Consultation paper.)

11. The Breach of Duty of Care principles would continue to be applied to claims being handled through the legal system. However, these claims will benefit from the introduction and compulsory use of a Pre-action Protocol currently being developed by The Personal Injury Committee of the Scottish Justice Council. The protocol will be used within the existing Clinical Negligence and Other Risks Indemnity Scheme (CNORIS) and will allow for speedier and more transparent outcomes in clinical negligence legal claims.

Question 6 - Do you support a cap of £100,000 on the level of award under the proposed scheme?

Yes ☐ No □

If no, please briefly explain why:

Unsure.

It would appear that, in reality, the consequence could exceed £100,000 very easily. This must be reflected in the awards bearing.

The amount would need to be reviewed on a regular basis with a timescale for review laid out.

12. The No-fault Review Group recommended that any compensation awarded under the new scheme should be based on need rather than on a tariff based system. We are proposing that the level of compensation for injuries sustained will be based on existing principles including case precedent and the Judicial College Guidelines (formerly the Judicial Studies Board Guidelines). Compensation for patrimonial loss (e.g. past and future wage loss, care and accommodation costs etc.) will require to be assessed on an individual basis often with regard to expert opinion.

Question 7 - Do you agree that levels of award should be based on the Judicial College Guidelines with patrimonial loss assessed on an individual basis?

Yes ☑ No □

If you disagree please briefly explain why:

If the Redress Scheme is administered by the Central Legal Office, (CLO) this could act against the wider policy intention of removing the blame culture, given the legal focus of the CLO. It may be preferable for the scheme to be administered by claims handlers/social workers who are not solicitors but are instead trained to review claims in accordance with similar arrangements that operate, for example, in Criminal Injuries Compensation.

13. As it stands current legislation does not allow Ministers to introduce a redress scheme which makes provision for payment of sums which Health Boards etc. have no legal liability (actual or potential) to pay. A provisional slot has therefore been identified for the introduction of a bill for Primary legislation for a „No-Blame Redress Scheme" in early 2017.

The primary legislation and process will be developed, in a manner which would allow the eligibility criteria, cap and scope to be amended at a later date through secondary legislation, if appropriate once the scheme has been established and fully tested.

Question 8 - Do you agree that the primary legislation should be flexible enough to allow the eligibility criteria and scope of the scheme to be extended at a later date?

Yes ☑ No ☐

If you disagree please briefly explain why:

As long as the process that is introduced works and does not lose public confidence in a poorly thought out process.

14. The original No-fault Review Group's recommendations included recommendations that: claimants who fail under the no fault scheme should retain the right to litigate, based on an improved litigation system; claimants who fail in litigation should have a residual right to claim under the no fault scheme; 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; and 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.

15. The proposed No-blame scheme will be compliant with the European Convention of Human Rights and patients will retain the right to go to Court should they wish. The legislation will, however, protect against „double dipping" i.e. if a patient accepts an award offered under the new No-Blame Scheme they would not then be able to use that to raise a legal claim for negligence. (Please see Item 8 in the consultation document in relation to consideration of an appeal process.)

Question 9 - Do you agree that the legislation should protect against "double dipping"?

Yes ☑ No ☐

If you disagree please briefly explain why:

However, why permit a person who chooses to litigate rather than access the scheme to then have redress to the scheme should litigation fail – won't this encourage people to litigate first and then use the scheme as a fall back and/or as an attempt to top up the financial compensation? Is it likely that someone who fails to get what they want when litigating will have more success under the scheme? This runs the risk of prolonging the agony for the litigant/scheme user with all the dangers that this, in itself, carries. If this route is permitted should there be a recommendation included that deducts any financial award recommended by the scheme from what has already been gained by litigation?

Litigation may also have a negative impact on the Duty of Candour. This will be of particular concern if the CLO is managing the process.

16. The rising costs of continuing care is an area of concern. Some respondents to the previous consultation on the Review Group's recommendations called for the repeal of S2 (4) of the Law Reform (Personal Injuries) Act 1948, which stipulates that personal injury defendants must disregard NHS care when paying compensation. This means public bodies like the NHS have to fund private care. Repealing this section would allow personal injury defendants to buy NHS and local authority care packages rather than pay for private care.

17. In cases where continuing care is appropriate it is proposed that an independent assessment of the individual care package requirements would be undertaken in each case and a guarantee of treatment and care by the NHS or local authority provided. In circumstances where the package of care or elements of it cannot be provided by the NHS or Local Authority, the relevant NHS Board will be responsible for commissioning these services from alternative providers.

Question 10 - Would you support the repeal of Section 2(4) of the Law Reform (Personal Injuries) Act 1948 in relation to continuing care costs providing, as proposed, the care package is independently assessed and quality care guaranteed in each case?

Yes ☑ No ☐

If no please briefly explain why:

As long as the quality of care does not fall in the hope of saving money.

18 In order to maximise existing expertise the No-blame scheme proposed would:
 essentially be a „fast track" element of the existing NHS compensation scheme the Clinical Negligence and Other Risks Scheme (CNORIS). This would be administered by the Central Legal Office with **independent medical expert input** as appropriate.
 in the main continue to be funded through Boards" contributions calculated as at present based on claims history and Boards would retain their existing delegated limits. The current scheme excess of £25,000 would also be retained;
 be managed by NHS National Services Scotland, (which currently manages CNORIS).

Question 11 - Would you support the development of a "fast track" element of CNORIS, utilising existing expertise with **independent medical expert input**?

Yes ☑ No ☐

If no, please briefly explain why:

As long as the quality/equity of decision making does not suffer in the pursuit of saving time.

19. The No-blame Scheme will be compliant with the European Convention of Human Rights (ECHR) and allow a right of appeal against the decision of the scheme administrator thereby enjoying an adequate level of independence and impartiality and with sufficient „equality of arms". We will explore the creation of an independent appeal panel and how this would fit into the wider courts and tribunals landscape.

Question 12 - Do you agree that the creation of an independent appeal panel combined with independent medical input in consideration of the claim and award would provide the appropriate level of independence?

Yes ☑ No ☐

If you disagree please briefly explain why:

Recommendation 9 says that appeals will be allowed on points of law or fact and it is very important that this is the case to ensure that the appeal process does not end up functioning in exactly the same way as the scheme and provide claimants with the ability to "double dip". Also, should appeals also be allowed if there is an error in process?

Question 12.1 – Do you agree that the independent appeal panel will meet the patient's right to appeal?

Yes ☑ No ☐

If no, please briefly explain why:

We are grateful for your response. Thank you.