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INFECTED BLOOD INQUIRY

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REPORT OF THE EXPERT GROUP ON FINANCIAL AND OTHER SUPPORT

MARCH 2003

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CONTENTS

FOREWORD
Lord Ross, Chair of the Expert Group on Financial and Other Support

		PAGE
1.	**INTRODUCTION**	
•	ORIGINS OF THE GROUP	1
•	DEVELOPMENTS AFFECTING PEOPLE INFECTED WITH THE HCV OR HIV FROM BLOOD TREATMENT	
•	TERMS OF REFERENCE	
•	EVIDENCE CONSIDERED	2
		4
2.	**SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS**	
•	CONCLUSIONS	5
•	RECOMMENDATIONS	8
3.	**THE CONTEXT**	
•	DEFINITIONS	11
•	THE CLINICAL NEGLIGENCE SYSTEM IN SCOTLAND	12
•	THE REVIEW OF CLINICAL NEGLIGENCE BY THE DEPARTMENT OF HEALTH, ENGLAND	14
•	THE COMPENSATION SCHEME IN OPERATION IN THE REPUBLIC OF IRELAND	15
•	EX-GRATIA SCHEMES IN OPERATION IN THE UK AND IN OTHER JURISDICTIONS	
•	NO-FAULT COMPENSATION	16
•	SEARCH FOR A GENERAL PRINCIPLE ON PROVISION OF FINANCIAL AND OTHER SUPPORT	17
4.	**THE SITUATION OF PEOPLE WHO HAVE BEEN INFECTED WITH HIV OR HCV AS A RESULT OF RECEIVING BLOOD, BLOOD PRODUCTS OR TISSUE TRANSFER FROM THE NHS IN SCOTLAND**	
•	BACKGROUND	19
•	CONCLUSIONS ON HEPATITIS C	
•	ESTIMATIONS OF COST	20
•	RECOMMENDATIONS ON HEPATITIS C	21
•	THE GROUP'S REACTION TO THE SCOTTISH EXECUTIVE'S RESPONSE TO THE PRELIMINARY REPORT	22
5.	**THE SCOTTISH LEGAL AID SYSTEM IN RESPECT OF CLINICAL NEGLIGENCE CASES**	
•	CLINICAL NEGLIGENCE CASES	25
•	THE SCOTTISH LEGAL AID BOARD PROPOSALS FOR REFORM	26
•	RECOMMENDATIONS ON LEGAL AID SYSTEM	27

6. OTHER AREAS CONSIDERED FOR REFORM **PAGE**

- PRIORITY TREATMENT FOR PEOPLE WHO HAVE BEEN HARMED BY NHS TREATMENT IN SCOTLAND 28
- REVERSING THE BURDEN OF PROOF 29
- RETROSPECTIVE EX-GRATIA PAYMENTS LINKED TO 'DEFECTIVE PRODUCT/DEFECTIVE PRACTICE' CONCEPT 30

7. SUGGESTIONS FOR REFORM OF THE CURRENT DISPUTE RESOLUTION SYSTEMS

- INTRODUCTION 32
- ADVOCACY
- THE NHS COMPLAINTS PROCEDURE 33
- QUALITY AND PATIENT SAFETY ISSUES
- MEDIATION IN HEALTH SERVICE DISPUTES 34
- PRE-LITIGATION MEASURES 35
- IMPROVING ACCESS TO LITIGATION PROCESS
- THE LITIGATION PROCESS 36
- SETTLEMENT ISSUES 38
- RECOMMENDATIONS ON DISPUTE RESOLUTION SYSTEMS 38

ANNEXES

ANNEX A
MEMBERSHIP OF THE EXPERT GROUP 40

ANNEX B
LIST OF EVIDENCE CONSIDERED 41

ANNEX C
DATA ON THE CLINICAL NEGLIGENCE SYSTEM 44

ANNEX D
THE LITERATURE REVIEW COMMISSIONED BY THE DEPARTMENT OF HEALTH IN ENGLAND 53

ANNEX E
THE MORI SURVEY COMMISSIONED BY THE DEPARTMENT OF HEALTH IN ENGLAND 55

ANNEX F
EX GRATIA OR NO-FAULT COMPENSATION IN THE UK AND IN OTHER COUNTRIES 57

ANNEX G
RECOMMENDATIONS MADE IN OUR PRELIMINARY REPORT 62

ANNEX H
LETTER OF 29 JANUARY 2003 FROM THE MINISTER FOR HEALTH AND COMMUNITY CARE TO LORD ROSS 64

ANNEX I
THE AIMS AND WORK OF AVMA 65

ANNEX J
CONCLUSIONS NOTED FROM THE CIVIL JUSTICE COUNCIL FORUM ON CLINICAL NEGLIGENCE 68

FOREWORD

When the Group was set up, it was directed to make any preliminary recommendations by the end of July 2002, and to forward any final recommendations by the end of December 2002.

In the event, its preliminary recommendations were not submitted to the Minister for Health and Community Care until November 2002. Given the complexity of the issues raised by its Remit, this was not surprising. The delay in submitting its final Report with recommendations is largely due to the fact that when the Minister was giving evidence to the Health and Community Care Committee following on the presentation of the Group's preliminary report, he raised certain questions relating to devolved and reserved powers. The Group requested clarification of this matter, and this was provided by the Minister on 10 January 2003. Further elaboration was supplied by the Minister when he appeared before the Health and Community Care Committee on 20 January 2003. The issues raised by the Minister have not yet been resolved, but the Group does not consider that it should further delay the completion of its report and recommendations. The Group for its part does not believe that there are any sound legal objections to what it has proposed.

The Group is conscious that it has not succeeded in discovering a general principle covering all cases where it would be appropriate for financial and other support to be provided for people who had been harmed by NHS treatment in Scotland in circumstances where there was unlikely to be liability on the part of NHS Scotland, and believes that when cases arise in the future they can only be dealt with on an ad hoc basis.

The Group believes that its recommendations go a long way towards meeting the terms of its remit, and is satisfied that they merit careful consideration by the Scottish Executive. It is disappointed that the Minister has not as yet agreed to implement its recommendations in relation to Hepatitis C, and hopes that he will give the matter further consideration. The Group also believes that its other recommendations, if implemented, should improve the current dispute and compensation mechanisms in Scotland.

The Group wishes to express its warm thanks to its special advisers, Peter Beaton, Chris Naldrett, Ross Scott and Bob Stock, and to its secretariat headed by the indefatigable Moira Milligen who, with Kate McLaughlin, has ensured that the Group was provided with all the information and papers it required.

Donald M Ross

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1. INTRODUCTION

ORIGINS OF THE GROUP

1.1 The establishment of the Expert Group has its origins in discussions around the situation of patients who have been infected with the Hepatitis C virus (HCV) via blood. In the 1980s, people were infected with HCV as the result of NHS treatment, blood transfusion or treatment with blood products, (principally blood clotting factors supplied to haemophiliacs but also other products such as immunoglobulin). It is estimated that 14,000 people in the UK may have contracted HCV from blood or blood products. Many of them will have been very ill at the time of treatment and possibly 60% may have died from causes other than HCV infection. Some people also contracted HIV (human immunodeficiency virus) in exactly the same way as those with HCV.

1.2 At the time the patients were infected, HCV and HIV had not been identified and there was no test available to screen for them in blood donations. The Government therefore took the view that the NHS was not negligent. This patient group was not offered any compensation because of the general principle, which was a fundamental part of Government policy, that 'the NHS did not pay compensation when it had not been negligent'.

DEVELOPMENTS AFFECTING PEOPLE INFECTED WITH HCV OR HIV FROM BLOOD TREATMENT

1.3 The UK government offered financial support via the Macfarlane and Eileen Trusts to people who contracted HIV from blood and blood products provided by the NHS. This support was a mixture of one-off compensation payments and ongoing financial support – made either to the persons affected or, in cases where that person was deceased, to their dependants. The rationale for making these payments was largely based on the presumption made at the time that HIV would inevitably and swiftly progress to death. No equivalent payments were made to people who contracted HCV from blood and blood products provided by the NHS. However, in 2001 a number of people who claimed to have been infected in this way raised an action in the English High Court under the Consumer Protection Act 1987 (CPA). The resultant judgement by Mr Justice Burton established that blood contaminated with HCV was a 'defective product' for the purposes of the Act and the English blood services were therefore liable to pay compensation. The Scottish Executive decided that NHSScotland would make payments to persons whose circumstances were analogous to those who were eligible for awards under the High Court judgement.

1.4 Many people who contracted HCV from blood and blood products provided by the NHS were unable to take advantage of this judgement however. This was partly because CPA did not come into force until 1 March 1988 and it did not apply at the time when they were infected. The time bar provisions linked to CPA excluded many others. In particular, liability under CPA ceases 10 years from the date when the person was treated with the defective product. Some people did not discover that they had the virus until after they were already time-barred by this provision.

The Consumer Protection Act 1987 (CPA)

1.5 The CPA implemented the Product Safety Directive. This strict liability legislation meant that negligence was no longer the only issue where the NHS might have a legal duty to pay compensation. It was therefore necessary to modify the principle about when the NHS does not pay. In Scotland, the modification quoted in the remit of our Group was adopted as follows:

> 'The NHS does not pay compensation when it has no legal liability for the harm suffered by the patient.'

The Recommendations of the Health & Community Care Committee of the Scottish Parliament

1.6 Having considered a petition calling for compensation for 'HCV in blood' patients, the Health and Community Care Committee of the Scottish Parliament recommended ex gratia financial and other appropriate practical support should be made available for this group of patients. The Health and Community Care Committee recommended 'financial and other appropriate practical support' rather than compensation, partly because they felt that the term 'compensation' is linked to the concept of fault and partly because they felt that money was only one of the things that patients needed to help them lead a reasonable life. They recommended that the level of financial assistance should be determined on the basis of need, having regard to the physical or psychological loss individually suffered, and should include redress for practical difficulties such as the inability to obtain an affordable mortgage

1.7 The Committee's recommendation was based on the following principles:

- HCV patients were morally entitled to the same compensation as HIV patients;
- HCV patients were morally entitled to similar support to that given in the support package provided for people who had contracted vCJD from food;
- the unfairness of some people being able to benefit from the CPA judgement but not others.

1.8 The Scottish Executive did not agree with this recommendation. It felt that it was a deviation from the principle that the 'NHS does not pay when it has no legal liability for the harm suffered by the patient' and that it would be essential for any new compensation system to be judged against agreed and published criteria and that these criteria would need to be transparent, equitable and universally applicable. Furthermore, any new system that deviated from the principle should balance the needs of the total patient population against those of any group being provided with financial support.

1.9 The Health and Community Care Committee also recommended the establishment of an Expert Group to look at the current compensation system and propose alternatives. The Executive agreed to the establishment of such a group and that it would examine situations where people have been harmed but the NHS is not at fault. It also agreed that the situation of 'HCV/HIV in blood' patients should form part of its wider considerations.

1.10 A list of Members of the Expert Group is attached at Annex A.

TERMS OF REFERENCE

1.11 The terms of reference of our Group as given by the Minister for Health and Community Care and agreed by the Health and Community Care Committee of the Scottish Parliament are:

- To consider circumstances in which a system of financial and other support might be available to people who have been harmed by NHS treatment in Scotland in circumstances where there is unlikely to be liability on the part of NHSScotland and to apply general principles which are consistent, equitable and transparent for all.

- The situation of patients who have contracted HIV and/or Hepatitis C from blood transfusion or treatment with blood products should form part of the wider considerations.

- Preliminary recommendations should be made by the end of July 2002 and should include whether the current system should be changed and, if so, what changes should be made and whether any of these changes should be applied retrospectively.

- Consideration should also be given to the current dispute and compensation mechanisms in Scotland for dealing with negligence and fault-based compensation to determine if there is room for improvement. Any recommendations should be brought forward by the end of December 2002.

Notes

In considering the above –

1. The group should note the existing approach that "*the NHS does not pay compensation when it has no legal liability for the harm suffered by the patient*" and consider whether this is appropriate.

2. Any recommendations should be based on achieving a workable balance between the following tests:

   Any alternative arrangements should:

   a) not inhibit innovation and creativity in NHSScotland

   b) be consistent with efficient health service operation

   c) represent a fair deal for <u>all</u> patients.

3. The group should take into consideration the findings of the Review of Clinical Negligence by the Department of Health in England – taking due account of any factors that are likely to affect their applicability to the Scottish situation. It should also look at the approach to medical compensation adopted in the Republic of Ireland.

4. The group should take into consideration the findings of the Review of Mediation in the Health Service in Scotland by the Royal Society of Edinburgh, and the Scottish Executive Report on the Evaluation of the NHS Complaints system.

1.12 We noted in discussions that our consideration of what constituted 'NHS treatment in Scotland' should not be confined to hospital treatment and should include all aspects of the NHS including primary care and dentistry.

1.13 We are aware that our remit cannot be changed as the Minister for Health and Community Care had agreed it with the Health and Community Care Committee of the Scottish Parliament but we consider it is acceptable for us to agree a common interpretation of it. Some members had difficulty with the phrase in the first element of the remit 'where there is unlikely to be liability on the part of NHSScotland' and suggested that this might usefully be interpreted as 'where liability on the part of NHSScotland was unknown'.

1.14 Our Preliminary Report, published in November 2002, concentrated on patients harmed by NHS treatment where there is unlikely to be any liability on the part of NHSScotland. This report ratifies the findings in the Preliminary Report and concentrates on reviewing current compensation methods. These include the NHS complaints procedure, and the current clinical negligence system in Scotland. The Report recommends areas where we think improvements can be made.

EVIDENCE CONSIDERED

1.15 We considered a wide range of oral and written evidence for this report. A full list of the evidence considered is at Annex B.

2. SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

No-Fault Compensation

2.1 Chapter 3 and Annexes B, D-F set out the evidence considered on no-fault compensation systems in this country and in other jurisdictions. We conclude that no-fault compensation may have advantages, including: speed; ease of access; reduction in legal costs; and reduction of stress on the part of claimants and health professionals. However, there are also disadvantages in that it tends not to encourage improvements of quality of care as a result of lessons learned. Furthermore, in both the Swedish and New Zealand schemes, because the issue of fault has not been entirely eliminated, we feel the end result is a bureaucratic system which tries to tackle the complex issues of negligence and causation without the benefit of legal expertise. We feel that these are major disadvantages.

2.2 We concluded in the Preliminary Report that the issue of no-fault compensation was so extensive and complex that we could not make meaningful preliminary recommendations on it by the end of July 2002 and decided to consider no-fault further in the second part of our work. Following further consideration of the evidence, we conclude that we do not wish to recommend the introduction of a general no-fault compensation scheme. This Report concentrates on recommending improvements which could be made to the current systems for resolving health service disputes.

People who have contracted HIV or HCV as a result of receiving blood, blood products or tissue transfer from NHSScotland

2.3 We considered the arrangements already in place to provide financial support for those infected with HIV through blood, blood products or tissue transfer via the Macfarlane and Eileen Trusts and are impressed by the principles underlying these schemes.

2.4 We conclude that the fact that people who contracted HIV as a result of receiving blood, blood products or tissue transfer from the NHS received compensation whilst people who contracted Hepatitis C virus (HCV) in exactly the same way did not, is inequitable. We are of the view that this inequity should be addressed by introducing new arrangements

The Scottish Legal Aid System

2.5 We noted from the evidence submitted by the Scottish Legal Aid Board (SLAB), that the process of applications for increases in Advice and Assistance and submission of accounts by Solicitors, is to be revised and improved.

Other areas considered for reform

2.6

- *Priority Treatment for People who have been harmed by NHS Treatment*

We considered evidence on a scheme for priority treatment for war pensioners operating within the UK and on a scheme in the Republic of Ireland that allows priority treatment for patients who contracted Hepatitis C from infected blood and blood products. We conclude

that priorities for treatment should be assessed on the basis of clinical need only without regard to whether any previous NHS treatment was the cause of the harm.

- *Reversing the Burden of Proof*

In our Preliminary Report, we briefly considered the concept of reversing the burden of proof so that the onus of proof rests on the NHS rather than the claimant and decided to give it further consideration in the second part of our work. Following further discussion of this subject in Chapter 6, we conclude that although some Members were in favour of the idea of reversing the burden of proof, we do not wish to recommend this in this Report.

- *Retrospective ex gratia payments linked to 'Defective Product' concept*

We considered the merits of introducing a scheme which would enable ex gratia payments to be made to patients who had been harmed before 1 March 1988 (the date the Consumer Protection Act (CPA) came into force) linked to defective products and practices as a result of NHS treatment in Scotland. We do not wish to make any recommendations on this proposal.

- *Advocacy*

In this context we refer to advocacy by people other than advocates, solicitor-advocates or solicitors. We noted that the Scottish Executive has supported initiatives to promote the successful development of advocacy services. However, we believe there is still a gap in the provision of more specialised advocacy services. We believe the establishment of a Scottish Branch of Action for Victims of Medical Accidents (AVMA), discussed in Chapter 7, would help to fill this gap.

- *The NHS Complaints Procedure*

In Chapter 7, we set out our views that there are a number of ways to improve the early handling of complaints and claims. These include better training for complaints/claims handling staff; more accessible information for complainants and claimants on clinical issues; more emphasis on face to face or telephone contact to clarify points not clearly expressed; increased support or advocacy for complainants and claimants in the early stages to prevent complaints escalating. We conclude that the Scottish Executive's review of the NHS complaints procedure should address these areas of difficulty.

We were disappointed to note that the remit of the Working Group on the NHS complaints procedure did not include consideration of NHS Trusts and Boards' power to award compensation. We are aware that NHS Trusts and Boards currently have the power to make ex-gratia payments but this power is not used in many cases. We would like to see the use of this power encouraged in respect of ex-gratia payments for 'lesser injuries' including time off work, pain and suffering.

- *Quality and Patient Safety Issues*

We are aware that much work is currently being done by the Scottish Executive towards achieving a better integration and co-ordination of national organisations with an interest in clinical quality and we welcome the establishment of the new special health board, NHS

Quality Improvement Scotland, from January 2003. We note that one of the functions of the new special health board is patient safety and it is expected to manage a service agreement with the NPSA (National Patient Safety Agency).

We conclude that the Scottish Executive should continue to build on the current work on improving patient safety and learning the lessons from things that go wrong.

- *Mediation in Health Service Disputes*

We considered the evidence in the Report 'Encouraging Resolution, Mediating Patient/Health Services Disputes in Scotland' published by the Royal Society of Edinburgh in February. While we believe that mediation has certain advantages, we conclude that it needs to be thoroughly researched before we can fully recommend it.

- *Pre-litigation measures*

We noted that negotiated settlements are taking place already within Central Legal Office and we believe that prior exchange of factual evidence should be encouraged.

- Improving Access to the Litigation Process

We considered the evidence in Chapter 7 to the effect that claimants in Scotland experience difficulty in finding legal/medical experts to pursue their claims. We consider that the establishment of a Scottish branch of AVMA would assist with these difficulties. We also considered evidence from practising Solicitors who outlined the difficulties they encountered in relation to pursuing clinical negligence cases. We understand that Solicitors very seldom get fully paid at Legal Advice and Assistance rates on the investigation of a clinical negligence case, nor do they receive their actual charge out rate for fee paying work so they are unable to obtain sufficient cover for the work that has been done. We conclude therefore that the Scottish Executive, in conjunction with the Law Society and the Scottish Legal Aid Board, should consider increasing the level of fees to solicitors in civil business to enable them to pursue clinical negligence cases, and the level of expenditure for payment of outlays.

- The Litigation Process

Following consideration of evidence on the current litigation process, we conclude that the Coulsfield reforms will eliminate unnecessary delay and expense in routine cases but we consider that a process of judicial case management should be considered for complex clinical negligence cases.

- Settlement Issues

Having considered the evidence in the Consultation Paper by the Lord Chancellor's Department: 'Damages for Future Loss: Giving Courts the Power to Order Periodical Payments for Future Loss and Care Costs in Personal Injury Cases', we conclude that the Scottish Executive should continue to encourage the Central Legal Office to offer structured settlements and to consult publicly on the issues involved with the giving of a power to award periodical payments and structured settlements against the will of the parties.

RECOMMENDATIONS

(Recommendations 1-3 were included in our Preliminary Report and have subsequently been partially modified but otherwise ratified for inclusion in this Report.)

Recommendation 1

The Scottish Executive should agree to make compensation payments as a matter of urgency to all people who can demonstrate, on the balance of probabilities, that they received blood, blood products or tissue from the NHS in Scotland before the dates when they were made HCV-safe and who were subsequently found to be infected with Hepatitis C virus, as follows:

A an initial lump sum of £10,000 to cover inevitable anxiety, stress and social disadvantage;

B an additional lump sum of £40,000 to those who develop chronic hepatitis C to cover pain and suffering;

C in addition, those who subsequently suffer serious deterioration in physical condition because of their Hepatitis C infection e.g. cirrhosis, liver cancer or other similar serious condition(s), should be entitled to full compensation. This compensation should be calculated on the same basis as common law damages taking account of the payments made under A and B above;

D where people who would have been beneficiaries of these arrangements are deceased and their death was not due to the Hepatitis C virus, the above payments should pass to their Executors. Where their death was due to the Hepatitis C virus, the compensation should be paid to their Executor and relatives in the same way as relatives are entitled at common law in terms of the Damages (Scotland) Act 1976 and in addition same sex partners – both to be assessed on the same basis as common law damages.

E people who receive any payment under legal liability arising from alleged negligence or breach of statutory duty, from the Scottish Ministers, or any of the constituent authorities of the NHS in Scotland, in respect of having been infected with Hepatitis C should not qualify for these arrangements;

F people who are already in receipt of payments linked to HIV infection from the Macfarlane Trust, Macfarlane Trust Special Payments Trust, Eileen Trust or the associated government Scheme of Payments should have these payments taken into account when compensation is assessed for the purposes of C;

G people who have become infected with Hepatitis C as a result of the virus being transmitted from a person infected by blood, blood products or tissue from the NHS in Scotland shall be entitled to compensation on a similar basis to those who have been infected directly in this manner.

Recommendation 2

The Scottish Executive should consider how it could fund and develop other mechanisms for supporting people who suffer from HCV including services delivered by voluntary organisations. In particular, additional support in the following areas should be considered:

(a) Access to understandable information on HCV

(b) Counselling Services

(c) Access to information on benefits available

(d) Advice and assistance in securing appropriate and adequate assurance and insurance

(e) Setting up a pro-active publicity campaign spearheaded by the Health Education Board for Scotland.

(f) Improved access to palliative care and symptom management services when appropriate.

Recommendation 3

The Scottish Executive should invite SLAB to consider the following:

(a) Proceeding with the development of the template on Advice and Assistance as soon as possible;

(b) Including in the template provision for meeting/negotiation with the defender;

(c) Including in the template provision for class actions as well as individual clinical negligence cases;

(d) Updating the guidelines to the profession;

(e) Introducing an 'interests of justice' test for civil legal aid applications in clinical negligence cases;

(f) Proceeding towards the making of staged payments.

Recommendation 4

We make the following recommendations in relation to the current dispute resolution procedures:

(a) That the Scottish Executive should consider including the following in their revision of the NHS complaints procedure: better training for complaints/claims handling staff; more accessible information for complainants and claimants in clinical cases; more emphasis on face to face or telephone contact to clarify points not clearly expressed; increased support or advocacy for complainants and claimants in the early stages to prevent complaints escalating and to enable complaints to be dealt with appropriately.

(b) The Scottish Executive should consider encouraging NHS Trusts and Boards to use their power to make ex-gratia payments under the NHS complaints procedure in respect of 'lesser injuries'.

(c) We endorse the recommendation made by the Royal Society of Edinburgh in their Report 'Encouraging Resolution - Mediating patient/health service disputes in Scotland', that the Scottish Executive should, in conjunction with the National Health Service Scotland Central Legal Office (CLO), undertake a fully researched mediation project mirroring that being undertaken by the National Health Service Litigation Authority (NHSLA) in England.

(d) The Scottish Executive should consider making initial funding available for AVMA to open a Scottish branch.

(e) The Scottish Executive should invite the Law Society and the Scottish Legal Aid Board to consider increasing the level of fees to solicitors in civil business to enable them to pursue clinical negligence cases and also to enable increased expenditure to be available for payment of outlays in relation to reports, eg medical reports.

(f) The Scottish Executive should draw the attention of the Lord President of the Court of Session to the need for implementation of judicial management procedures for complex clinical negligence cases.

(g) The Scottish Executive should encourage the Central Legal Office to continue and develop its practice of offering structured settlements early in the negotiating process.

3. THE CONTEXT

DEFINITIONS

3.1 We consider it advisable to set down broad definitions for certain words or phrases referred to in this Report in order to set the context for some of our considerations. These are as follows:

- *Negligence*

Negligence is a 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.

- *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.

- *Standard of Proof*

In civil actions, apart from exceptional cases, the onus of proof is on the pursuer, and the onus may be discharged on a balance of probabilities.

- *Professional Negligence*

A medical practitioner, like others exercising professional skills, must display and apply reasonable care and a reasonable standard of professional competence. 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)*

- *Statutory Liability*

Statutes may impose a standard more exacting than that of taking reasonable care. A statute may impose absolute liability, independently of negligence, and the defender will be liable, even if they have taken all reasonable care to prevent the harm complained of, provided it is proved that there was a breach of the statutory duty, and that the breach caused the harm.

- *Damages*

Damages are a sum of money paid as compensation for loss, injury or damage resulting from an act or omission of the defender which is in breach of a duty owed. The award of damages is intended to put the injured party as nearly as may be in as good a position as they were in before the loss occurred.

- *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.

- *Ex gratia*

Anything *ex gratia* is done without recognising any legal obligation to do so. An *ex gratia* payment is one made without any admission of liability under contract or negligence or otherwise, and in the context of this Report represents compensation to cover hardship.

- *Provisional Damages*

Provisional damages for personal injuries may be awarded where there is admitted or proved to be a chance that at some definite or indefinite time in the future, the injured person will, as a result of the act or omission which gave rise to the cause of action, develop some serious disease or suffer some serious deterioration in their physical or mental condition. In such circumstances, provisional damages are assessed on the assumption that the injured person will not develop some serious disease or suffer some serious deterioration in their condition. Future damages may then be awarded if they do develop the disease or suffer the deterioration.

THE CLINICAL NEGLIGENCE SYSTEM IN SCOTLAND

3.2 Clinical negligence claims against Independent Family Health Service providers, eg most GPs and dentists and private healthcare practitioners, are handled by defence organisations. These organisations regard their claim handling business as commercially sensitive and therefore data on this is not available for us to consider.

3.3 Our focus has had to be on the secondary care sector within NHSScotland where the Central Legal Office (CLO) (a Division of the Common Services Agency) deals with all claims for clinical negligence and for which data is readily available.

3.4 We considered data covering a 5 year period and based on cases settled in each year. This data is set out in Annex C. In summary, the data reports that over the last 5 years the total cost of settlements has risen from £3.6m to £7.0m but in an uneven pattern. Adding CLO fees increases the figures to £4.0m to £7.7m with the apportionment between awards, expenses and CLO fees remaining relatively steady at 79%, 12% and 9% respectively on average.

3.5 NHS Trusts and Boards' 'provisions' for clinical negligence continue to rise but the rate of increase over the last 3 years has fallen from 53% to 6% (latter based on un-audited figures). Provisions are estimates of future settlement costs arising from past events. The level of provision is determined by NHS Trusts/Boards from best estimates of likely settlement values of claims being processed or known (some claims may take more than 6 years to settle) and the future value of structured settlements.

3.6 The number of claims lodged against NHS Trusts and submitted to CLO has remained level at approximately 500 per year. On average about 70% will be dismissed or abandoned by the pursuer leaving some 150 cases per annum that result in a compensation award. Approximately 40% of those claims will be settled for less than £5,000. A further 17% will settle for between £5,000 and £10,000. At the other end, just 5% of claims will account for 65% of expenditure. On average that is nine >£100,000 cases costing £3.3m in total.

3.7 Of the average 150 cases, legal proceedings will be commenced in approximately 60 (40%) cases with only 10 actually being heard in Court (average 43% in the Sheriff Court and 57% in the Court of Session). More generally, approximately 56% of all claims for which an award is paid will be settled within 3 years whilst 17% will take more than 5 years. Most of the latter are birth injury cases.

3.8 Finally, to put the claim numbers and costs into perspective, £10m is 0.2% of NHSS resources and, in 2000/01, the NHSS dealt with 785,000 inpatients, 400,000 day cases and 1,500,000 A&E cases – a total of 2.6 million cases.

Comparisons with England

3.9 Generally, for NHS costs and activity, Scotland will be 10% of those for England. In the case of medical accidents, however, taking 1999/00 for example (and it is reasonably typical) the comparative figures are:

- Claims received: England 10,000[1]– Scotland 500 (5%)
- Claims being processed: England 23,000– Scotland 1,500 (6.5%)
- Settlements: England £386m – Scotland £3.7m (this figure is lower than average but has no material effect on comparisons between Scotland and England) 1.0%
- Provisions: England £2.6 billion – Scotland £38 million (1.5%) (figures exclude incidents 'occurred but not reported')

3.10 It is not possible to state with authority why the cost of clinical negligence in Scotland is proportionally so much less than in England and other parts of the UK. However, possible reasons might be:

- CLO is the sole handler of clinical negligence claims and has considerable skill/experience in defending them.
- Staff to patient ratio is different in Scotland.
- Pursuers' access to legal aid more limited in Scotland. (See Chapter 5)
- Limited number of specialist solicitors in Scotland (see Chapter 7).

3.11 The fact that the number of claims has remained level needs to be seen against a background of initiatives, through the clinical governance agenda, aimed at improving clinical standards (eg Clinical Standards Board for Scotland – now NHS Quality Improvement Scotland), and risk management arrangements (eg Clinical Negligence and Other Risks Scheme).

[1] Reference: NAO Report, 'Handling Clinical Negligence Claims in England' published 3 May 2001

Conclusions On The Clinical Negligence System In Scotland

3.12 Given the data in Annex C, it would be difficult to reduce or peg the settlement levels that we are currently seeing. Similarly, there appears to be little scope to reduce legal defence costs significantly. Adopting a policy to enforce structured settlements would have short-term financial benefits to NHSScotland and offer increased financial security for those receiving the award. Evidence considered on Structured Settlements is set out in Annex C and is discussed further in Chapter 7.

THE REVIEW OF CLINICAL NEGLIGENCE BY THE DEPARTMENT OF HEALTH, ENGLAND

3.13 In July 2001, Alan Milburn was given the go ahead for the Department of Health to produce a White Paper on reform of the clinical negligence system in England. The drivers behind the initiative were the need to stem spiralling bills in England and to improve 'the claims system that is acknowledged as distressing to patients and NHS staff alike'.

3.14 The first of these drivers is substantially absent in Scotland. The cost of Clinical Negligence in Scotland is only a fraction of that in England with claims in 1999-2000 totalling £3.7m compared to £386m paid out in England.

3.15 The first step to the White Paper was the establishment of an Expert Advisory Group under the chairmanship of the English CMO. Its tasks were to:

(i) review the current legal framework, procedures and operational arrangements for dealing with clinical negligence claims;

(ii) assess potential reforms against a number of laid down aspirations, eg reducing costs, being fair and transparent, dealing with complaints and concerns quickly;

(iii) recommend package of measures to address concerns.

3.16 Despite the emphasis on clinical negligence, the Group's detailed remit was very broad and included consideration of the 'merits and disadvantages of different types of no-fault compensation and of fixed tariffs'.

3.17 The Group was expected to report in January 2002 but has not done so. At the time of finalising this Report, we understand that it is "under active consideration". We have not therefore been able to take into account any findings of that Group.

3.18 We also considered evidence from the MORI Survey commissioned by the English Advisory Committee on the Review of Clinical Negligence. The results of the MORI Survey are summarised in Annex E.

THE COMPENSATION SCHEME IN OPERATION IN THE REPUBLIC OF IRELAND

3.19 We considered evidence on the compensation system in the Republic of Ireland for persons infected with HCV through administration of infected blood and blood products, including the Annual Report of the Hepatitis C Compensation Tribunal, the Report of the Consultative Council on Hepatitis C – March 2002 and the conclusions of the Report of the Tribunal of Enquiry into the Blood Transfusion Service Board.

3.20 The Irish Government established the Hepatitis C Compensation Tribunal on 16 December 1995 as a non-statutory scheme of compensation. This followed the publication of a Report in January 1995 by an Expert Group into the contamination of the Anti-D blood product in Ireland. [Anti-D is a blood product routinely administered to some pregnant women to prevent death or serious illness of the baby from Rh Haemolytic Disease.]

3.21 The initial contamination arose as a result of plasma being accepted by the Irish Blood Transfusion Service Board (BTSB) from a patient who was infected with HCV virus undergoing therapeutic plasma exchange. In a separate, subsequent, incident, BTSB manufactured and distributed Anti-D from plasma obtained from another patient infected with HCV.

3.22 Consequently, supplies of Anti-D Immunoglobulin manufactured from the plasma obtained from these patients were contaminated with the virus. Recipients of the contaminated Anti-D subsequently donated blood – causing further contamination of blood supplies.

3.23 A further Report in March 1997 (the sworn judicial inquiry into the contamination of the Anti-D product) concluded that the contamination of the Anti-D supply should have been avoided and was due to wrongful practices on the part of BTSB. Following publication of the Report, the Tribunal was placed on a statutory footing with effect from 1 November 1997 by means of the Hepatitis C Compensation Tribunal Act 1997 and related Statutory Instruments.

3.24 We concluded from the evidence that the priority treatment provisions operating in the Irish scheme were interesting and are discussed further in Chapter 6. The scheme itself, however, is fault based and therefore not directly relevant for our consideration of no-fault compensation.

EX GRATIA SCHEMES IN OPERATION IN THE UK AND IN OTHER JURISDICTIONS

3.25 We considered the provisions of some existing schemes that provide assistance, including the Macfarlane and Eileen Trusts, the vCJD scheme, the Criminal Injuries Compensation Act, the Pneumoconiosis etc (Workers' Compensation) Act 1979, the Vaccine Damage Payments Act 1979 and the compensation scheme in operation in the Republic of Ireland for persons infected with HCV through administration of infected blood and blood products. The evidence we considered on these schemes is set out in more detail in Annex F. We noted that all of these compensation schemes retain some test of causation or some limit on compensation.

NO-FAULT COMPENSATION

3.26 There has been extensive research and literature on the subject of no-fault compensation, commencing with the Pearson Commission, established in 1973 to consider the current compensation system for all forms of personal injury. The Commission received 865 written submissions from 766 organisations and individuals between 1973-78. They also held 225 meetings in the UK and 252 overseas. The Pearson Commission recommended that a no-fault scheme for medical accidents should not be introduced at present (1978) but that the schemes in New Zealand and Sweden should be studied further.

3.27 Two Private Members Bills were brought to the Westminster Parliament in 1991 by Harriet Harman MP and Rosie Barnes MP, in an attempt to introduce no-fault compensation for medical injury. Both Bills failed. They did not define 'medical accident' or eligibility for compensation satisfactorily and also lacked procedural frameworks to ensure professional accountability. The Government of the day responded by saying that it had no intention of interfering with the right of the citizen to bring an action in tort.

3.28 We considered evidence on the no-fault compensation systems in operation in the UK, New Zealand, Virginia, Florida and Sweden. (Annexes B and D-F refer.) We concluded that on the face of it, the Swedish scheme's figures showed a significant saving. However, these figures need careful interpretation as there may be other reasons for this, eg other social insurance programmes meeting medical expenses and wage losses due to medical injury.

CONCLUSIONS ON NO-FAULT COMPENSATION

3.29 A no-fault-based compensation system may have advantages, including speed and reduction in legal costs and stress on complainants and health professionals. However, there are also major difficulties with no fault compensation as it ignores the important issues of accountability and quality of care. Whilst no system should focus only on fault, if there is fault, it is essential that it be identified to enable lessons to be learned, quality of care improved and dangerous practices avoided.

3.30 In the Preliminary Report we concluded that no-fault compensation was too extensive and complex a subject for us to be able to make any meaningful recommendations at that stage. We endorse this view and conclude that this Report should concentrate on recommending improvements which could be made to the current systems for resolving health service disputes, including the NHS complaints procedure and the current clinical negligence system.

3.31 In our further review of the evidence on no-fault, we conclude that the main problems with no fault systems have been identified as follows:

(a) The scope of coverage

The test for compensation under such a scheme should be medical causation rather than negligence. However, in the no-fault schemes we have studied, particularly in the New Zealand one, the injured patient has to establish fault, ie negligence and causation, to establish eligibility. The operation of the Swedish and New Zealand no-fault systems show that establishing causation under these schemes is not a straightforward process. A broad range of possible injuries can be causally connected

with medical interventions. Thus, it is very difficult to set out the exact parameters of a no-fault scheme.

(b) Cost

We considered the second main disadvantage of no-fault compensation is that it would cost substantially more than the current clinical negligence system. Data produced by Professor Michael Jones in his discussion paper[2] on No-Fault Compensation which the Group considered, estimates the cost of introducing a no-fault compensation scheme for England and Wales to be between £973.5 million and £1.25 billion.

(c) Accountability and Deterrence

The third major problem with no-fault compensation which we identified is that it places emphasis on compensation and does not discourage or discipline clinical misconduct. We believe that eliminating liability may reduce incentives to deliver high quality care. No-fault systems pay out in cases where there has been fault on the part of health professionals – with no feedback to the health professionals.

3.32 For these reasons, we conclude that we do not wish to recommend the introduction of a general no-fault system in Scotland. We have, however, recommended the introduction of a no-fault scheme to meet particular ad hoc circumstances. Chapter 4 sets out further details.

SEARCH FOR A GENERAL PRINCIPLE ON PROVISION OF FINANCIAL AND OTHER SUPPORT

3.33 In the first part of the Group's Terms of Reference, we were invited to consider circumstances in which a system of financial and other support might be available to people who had been harmed by NHS treatment in Scotland in circumstances where there was unlikely to be liability on the part of NHSScotland, and to apply general principles which are consistent, equitable and transparent for all. If we had decided to recommend the introduction of a general no-fault system in Scotland, this would have been a complete answer to the first part of the remit, since anyone harmed by NHS in Scotland would be compensated whether there was fault or not, provided that the test of causation was satisfied, and such a system could be regarded as fair to all.

3.34 We did not, however, feel able to recommend the introduction of a no-fault scheme in Scotland. Linked to that conclusion, we found the existing principle that "the NHS does not pay compensation when it has no legal liability for the harm suffered by the patient" to be generally sound, although we also felt that special circumstances do arise from time to time where it is legitimate to make an exception. Our thinking on this is explained in the following paragraphs.

3.35 Ex gratia schemes already exist to provide assistance in various circumstances, and these have been listed in paragraph 3.24. The Group has recommended the introduction of compensation payments for the benefit of people who can demonstrate, on the balance of

[2] 'A No-Fault Compensation Scheme for Medical Accidents' – A Discussion Paper by Professor Michael A Jones, Professor of Common Law, University of Liverpool.

probabilities, that they have received blood, blood products or tissue from the NHS in Scotland before the dates when they were made HCV safe, and who were subsequently found to be infected with HCV. We recognise that all these constitute exceptions to the general rule that the NHS does not pay compensation when it has no legal liability for the harm suffered by the patient.

3.36 We asked ourselves whether there is any general principle covering all these schemes which could be applied to particular situations not yet identified but which might arise in the future. However, we have not succeeded in discovering such a principle. The existing schemes were all adopted for a particular purpose only, and all that can be said is that they appear to be fair in all the circumstances, and to cover situations where there was felt to be a moral obligation on the part of the State to make payments to persons who had been harmed. These are the considerations which have led to the Group's recommendation for compensation payments to HCV patients. Beyond that, we have been unable to identify any general principle applicable to such schemes and to other situations that might arise in the future, but it may be that, from their very nature, all such cases can only be dealt with on an ad hoc basis.

4. THE SITUATION OF PEOPLE WHO HAVE BEEN INFECTED WITH HIV OR HCV AS A RESULT OF RECEIVING BLOOD, BLOOD PRODUCTS OR TISSUE TRANSFER FROM THE NHS IN SCOTLAND

BACKGROUND

4.1 We were asked to consider as part of wider considerations 'the situation of patients who have contracted HIV and/or HCV from blood transfusion or treatment with blood products'. The background is set out in Chapter 1 and Annex F.

4.2 Presently people who have contracted HIV through receiving blood, blood products or tissue from the NHS benefit from the arrangements via the Macfarlane and Eileen Trusts, whereas people who contracted HCV under exactly similar circumstances do not. We believe that infection with HCV brings about adverse effects for the people involved similar to those experienced by people infected with HIV. Furthermore, the way in which people were infected with HCV was exactly the same as those who became infected by HIV. We feel that this represents an inequity that should be addressed by introducing new arrangements.

4.3 We considered evidence on a scheme which might operate on broadly similar principles to that of the Macfarlane and Eileen Trusts. This would mean recommending that each person who could demonstrate that they were infected with HCV as a result of receiving blood, blood products or tissue from the NHSScotland , would receive a lump sum payment. We also considered evidence from the publication by the Scottish Executive entitled 'Hepatitis C: Essential Information for Professionals' which suggests that:

- around 20% of those infected with Hepatitis C will clear the virus at the acute stage.

Of the 80% who do not:

- around 20% may never develop physical symptoms;
- 60% will develop long-term symptoms of liver damage – with the potential to progress to cirrhosis, liver cancer or liver failure.

CONCLUSIONS ON HEPATITIS C

4.4 We conclude that we should have regard to the loss suffered by the individual in recommending new arrangements for Hepatitis C sufferers. Furthermore, we conclude that the support arrangements for people suffering from the disease should be improved.

4.5 We considered that our recommendations below are consistent with our remit. We gave consideration to whether our recommendations would represent a 'fair deal for all patients' as indicated in Note 2(c) of our remit. The proposed arrangements address an inequity between two groups of patients who were harmed by exactly the same set of circumstances (i.e. the inadvertent provision of blood, blood product or tissue contaminated with a virus). We therefore feel that the recommendation does satisfy this test.

4.6 We appreciate that spending resources of this nature inevitably means that money is being used which would otherwise be spent on health care in general. However, we feel the circumstances justify the introduction of these new arrangements for Hepatitis C sufferers.

ESTIMATIONS OF COST

4.7 We believe funding the proposed compensation payments is likely to cost between £62m and £89m maximum. This would comprise £2.5m in awards made at £10,000, £49.4m in awards made at £50,000 (£40,000 plus £10,000), and between £10m and £37m in awards that are assessed on the basis of Common Law Damages. The cost would be spread over a number of years due to the time it is likely to take for people to become aware of their condition and for the condition to progress to a relevant trigger point.

4.8 We received advice from our advisers who drew on information contained in a Paper by Dr Kate Soldan, an epidemiologist at the Department of Health's Public Health Laboratory Service Communicable Disease Surveillance Centre. She had written a previous paper dealing with HCV infection in England. The estimates which our advisers made of the cost of providing the sums described in our first Recommendation involved numerous assumptions made by Dr Soldan. The estimate was that 3,498 (or in round figures 3,500) people in Scotland had been infected by blood transfusion and tissue transfer. Of these, 1,886 were considered likely to be deceased by 1995 leaving 1,612 survivors. Because of their age and state of health, no more than 50% of the survivors should be assumed to be alive today. That means in round figures 800 survivors, and 2,700 deceased. As regards haemophiliacs, we were advised that a total of 500 were likely to have been infected as the result of receiving blood products, 135 of whom are likely to be deceased, leaving 365 still alive. . These figures were used as the basis for our estimated costs and are summarised below:

	Surviving	**Deceased**
Blood and Tissue Patients	800	2,700
Haemophiliacs	365	135
Total	**1,165**	**2,835**

Total estimated number of individuals infected via blood, blood products or tissue: 2,835 plus 1,165 = 4,000

4.9 In calculating lump sum payments, we had regard to figures paid by the Macfarlane Trust to HIV patients. We concluded that where patients had died, their Executors and dependants would succeed to any claim. We then had to consider what proportion of infected persons would be likely to claim. We had regard to information from England regarding the operation of the Macfarlane Trust. We also bore in mind that people who have been infected with HCV via blood transfusion, are often unaware of their infection, and may never become aware, particularly if other unassociated medical conditions supervene, and it has been a long time since the date of likely infection. In the event, having regard to all the considerations placed before us, we decided to apply a take-up figure of 31%.

4.10 On the basis of material before us, including the Scottish Executive publication *Hepatitis C: Essential Information for Professionals*, we concluded that 20% of the 4,000 infected patients would be likely to clear the virus within 2 to 6 months. We decided that

such patients should each receive a sum of £10,000 for anxiety, stress and social disadvantage only. The remaining 80% of the 4,000 infected patients who had developed chronic HCV should each receive an additional sum of £40,000 (ie a total of £50,000). We also concluded that 16% of the 4,000 infected patients would be likely to suffer serious deterioration, eg cirrhosis, liver cancer, or other similar conditions. They should receive compensation calculated on the same basis as common law damages. Accepting a take-up of 31%, as explained above, we thus arrived at a total of £62m or £89m depending on differing estimates of the outlay on payments calculated on the basis of common law damages. We regard our figures, and particularly the figure of £89m, as representing the worst case scenario.

RECOMMENDATIONS ON HEPATITIS C

4.11 In addition to the abovementioned compensation we believe it is important that the affected individuals receive additional support in other areas. We therefore also recommend the following:

The Scottish Executive should agree to make compensation payments as a matter of urgency to all people who can demonstrate, on the balance of probabilities, that they received blood, blood products or tissue from the NHS in Scotland before the dates when they were made HCV-safe and who were subsequently found to be infected with Hepatitis C virus, as follows:

A an initial lump sum of £10,000 to cover inevitable anxiety, stress and social disadvantage;

B an additional lump sum of £40,000 to those who develop chronic Hepatitis C to cover pain and suffering;

C in addition, those who subsequently suffer serious deterioration in physical condition because of their Hepatitis C infection e.g. cirrhosis, liver cancer or other similar serious condition(s), should be entitled to full compensation. This compensation should be calculated on the same basis as common law damages, taking account of the payments made under A and B above;

D where people who would have been beneficiaries of these arrangements are deceased and their death was not due to the Hepatitis C virus, the above payments should pass to their Executors. Where their death was due to the Hepatitis C virus, compensation should be paid to their Executor and relatives in the same way as relatives are entitled at common law in terms of the Damages (Scotland) Act 1976, and in addition same sex partners – both to be assessed on the same basis as common law damages.

E people who receive any payment under legal liability arising from alleged negligence or breach of statutory duty, from the Scottish Ministers, or any of the constituent authorities of the NHS in Scotland, in respect of having been infected with Hepatitis C should not qualify for these arrangements;

F people who are already in receipt of payments linked to HIV infection from the Macfarlane Trust, Macfarlane Trust Special Payments Trust, Eileen Trust or the associated government Scheme of Payments should have these payments taken into account when compensation is assessed for the purposes of C;

G people who have become infected with Hepatitis C as a result of the virus being transmitted from a person infected by blood, blood products or tissue from the NHS in Scotland shall be entitled to compensation on a similar basis to those who have been infected directly in this manner.

4.12 We further recommend:

The Scottish Executive should consider how it could fund and develop other mechanisms for supporting people who suffer from HCV including services delivered by voluntary organisations. In particular, additional support in the following areas should be considered:

(a) Access to understandable information on HCV

(b) Counselling Services

(c) Access to information on benefits available

(d) Advice and assistance in securing appropriate and adequate assurance and insurance

(e) Setting up a pro-active publicity campaign spearheaded by the Health Education Board for Scotland

(f) Improved access to palliative care and symptom management services when appropriate.

THE GROUP'S REACTION TO THE SCOTTISH EXECUTIVE'S RESPONSE TO THE PRELIMINARY REPORT

4.13 The recommendations made in our Preliminary Report, which was published on 6 November 2002, are contained in Annex G. In response to our Report, the Minister for Health and Community Care intimated that the recommendations contained in paragraph 4.8 of the Preliminary Report required careful consideration from both financial, medical and legal perspectives. He also stated he was investigating the possibility of providing some form of ongoing financial support to those experiencing serious long-term harm and hardship. We were disappointed that the Minister had not accepted our preliminary recommendations on Hepatitis C in full.

4.14 On 11 December 2002, Lord Ross and Mr Philip Dolan gave evidence to the Health and Community Care Committee in support of our Preliminary Report. The Minister also gave evidence. The Minister stated to the Committee that he was prepared to be flexible about who might qualify for payments, but that he did not intend to make the £10,000 payments to all Hepatitis C sufferers. He also indicated that implementing our proposals in full would take too much money from the health budget, and that he could not contemplate making more than £10 million available for each of three years.

4.15 The Minister also indicated that problems arose in relation to devolved and reserved powers. Following on our meeting of 19 December 2002, we sought clarification from the Minister on this matter. By letter dated 10 January 2003, the Minister stated that a question might arise as to whether the ex gratia payments proposed could be reserved on the grounds that they provided assistance for social security purposes, and that another issue was the

effect such payments might have on existing social security entitlements. As a result, we decided that we could not finalise our Report by the end of December.

4.16 On 20 January 2003, the Minister again appeared before the Health and Community Care Committee and described his latest thinking on the matter. He stated that he now proposed the payment of £20,000 to everyone who contracted Hepatitis C from blood products and who was still alive. He also later stated in his evidence that this payment should be made to "everyone who has the virus" and wrote to us in those terms. A copy of the Minister's letter is contained in Annex H. He further proposed payments of £25,000 to those at the cirrhosis, cancer of the liver or more advanced stage of the illness. In relation to our Category A, this was included with Category B. He also indicated that his advice was that a liver biopsy would be required to determine whether an individual had developed chronic Hepatitis C, and that it was not acceptable to require people to undergo such a procedure.

4.17 The Minister's latest proposals are welcome insofar as payments are proposed for some people who have contracted Hepatitis C from blood products. However, we are disappointed that our recommendations are not to be implemented fully. On the assumption, as now appears, that payments of £20,000 are to be made to those who have the Hepatitis C virus, it is clear that some of those described in our Category A will not receive any payment. Those excluded by the Minister will include those who have had the virus and have subsequently cleared it and particularly individuals who have had the virus and its consequences for some time and where it has been cleared as a result of treatment. We consider it unjust that such people should be excluded from the £20,000 payment.

4.18 We have concerns regarding the Minister's response to our Categories B, C and D. We still feel that additional payments should be made to those who develop chronic Hepatitis C (our Category B.) We understand that there are tests other than liver biopsy which could establish chronic Hepatitis C on the balance of probabilities (the normal civil law test).

4.19 We welcome the fact that some additional financial provision is to be made to those covered by our Category C but we are concerned that such additional payments are to be restricted to £25,000. We remain of the view that the additional payments for them should be calculated on the same basis as common law damages.

4.20 While we appreciate the Minister's desire to focus on people who are alive, we also believe it is manifestly unjust that no payments are proposed for those covered by our Category D (people who are deceased). This, in particular, can only serve to increase the worry and frustration of those who are alive because they might not survive to qualify for such a payment. For those who have died, it can only add a feeling of unfairness to the grief of the relatives, especially when the delay which cuts off compensation is no fault of the deceased. If the Minister is concerned about the category of relatives being too wide, he could of course restrict it to payments to immediate relatives and dependants, eg spouses/partners and children.

4.21 There has been much discussion about a cohort of current identified sufferers. While it is clear that the needs of these people are of the utmost urgency, we believe that all in the categories we have listed should be compensated as soon as possible.

4.22 We continue to believe that there is a moral obligation to provide compensation for people who have contracted Hepatitis C through receiving blood products from the NHS in Scotland, and that it is wrong that such people should be treated less favourably than people who have contracted HIV under similar circumstances. We do not consider that justice will be done unless our Recommendation is implemented in full, or at least to a greater extent than is presently proposed by the Minister.

4.23 We have considered paragraph F1 Schedule 5 of the Scotland Act 1998 and do not consider that the compensation payments we are recommending can fall within the definition of benefits as defined in paragraph F1. Our intention always was to provide for compensation and we have therefore made this more explicit. On reconsideration, it also appears to us more appropriate to recommend that compensation be made direct rather than through the mechanism of a discretionary trust.

4.24 When the Minister appeared before the Health and Community Care Committee on 20 January 2003, he spoke among other things about the question of whether what was being proposed would be within the powers of the Scottish Parliament. He indicated that discussions had been taking place at official and ministerial level with the Westminster Government about the vires issue. At one stage he gave the impression that that issue was under the control of the Westminster Government. We believe that the question of whether the Scottish Executive has power to do what has been proposed by the Minister in response to our Report is a devolution issue within the meaning of the Scotland Act 1998 (1998 Chapter 46) (see Schedule 6 to the Act, paragraph 1c)). In terms of paragraph 34 of Schedule 6, the Lord Advocate has power to refer any devolution issue which is not the subject of judicial proceedings to the Judicial Committee of the Privy Council. The Lord Advocate is a member of the Scottish Executive, and accordingly at any time it would be open to the Scottish Executive to instruct The Lord Advocate to refer this issue to the Judicial Committee. If the Westminster Government is disputing the vires of what is being proposed by way of compensation for the people who have contracted Hepatitis C from blood products, we recommend that the Scottish Executive should take immediate steps to have the issue referred to the Judicial Committee by the Lord Advocate.

5. THE SCOTTISH LEGAL AID SYSTEM IN RESPECT OF CLINICAL NEGLIGENCE CASES

CLINICAL NEGLIGENCE CASES

5.1 The Scottish Legal Aid Board's (SLAB) civil legal aid system contains no separate classification for clinical negligence; it is subsumed within a far larger reparation category. Detailed information on civil legal aid applications, grants and costs is not therefore available. However, a broad analysis done by SLAB estimates that in 2000-2001 the number of civil legal aid applications relating to clinical negligence was around 310; the number of applications granted was around 160.

5.2 A small sample of final accounts received for cases granted in the last three years showed varying costs, ranging from £50 to more than £12,000. Using the average cost of the sample, and the estimated number of grants in 2000-2001 as indicators, SLAB estimate the gross cost (including VAT) to the public purse as being around £450,000 per year. The net cost to the public purse would, however, be lower as a result of being offset by any financial contributions from applicants and award of expenses or damages in successful cases.

5.3 SLAB's analysis showed greater activity as regards advice and assistance with around 1,400 intimations for 2000-2001. By June 2001, 664 accounts were submitted for intimations received in 1999-2000. Payments ranged from £0 to £1,600. The total sum was just over £170,000. The total cost to the public purse will increase once all accounts are submitted, but not all intimations result in an account. The costs of some cases are wholly covered by financial contributions from applicants. Also, if a case is resolved under advice and assistance and a financial award is made, it is, as in civil legal aid, used to cover the costs.

5.4 We noted from the evidence submitted by the Scottish Legal Aid Board (SLAB) on access to legal aid in Scotland that SLAB's role is very much an administrative one. SLAB is working towards a more strategic approach on how legal aid is delivered in accordance with the recommendations of the Justice 1 Committee of the Scottish Parliament.

5.5 In England, there is a contractual basis for clinical negligence cases whereby cases are considered on the basis of wider public interest and special case units have been established. Scotland operates the system of Advice and Assistance. In clinical negligence cases, a lot of preliminary evidence is necessary and this means that solicitors could be applying for increases several times.

5.6 After initial interview with the client, noting his precognition, and coming to the view that there may be a case of clinical negligence the solicitor will intimate the claim and, if liability is not admitted, may then seek to obtain the client's medical records, with a view to submitting them to an expert for an opinion.

5.7 Increases are often sought for a particular procedure which solicitors are sometimes recommended to adopt in such cases; this involves going through the medical records with the client and then submitting them to a 'collator' to ensure that they are complete and in order before they are presented to the expert.

5.8 The Board does not grant increases to follow this procedure invariably in every case. In any case in which an increase is sought for either of these purposes, it needs to be justified

by reference to the circumstances of the individual case. If the Board is not satisfied that one or other or both steps are necessary for a cost-effective approach to dealing with the matter, then the increase will be curtailed accordingly.

THE SCOTTISH LEGAL AID BOARD PROPOSALS FOR REFORM

5.9 The Scottish Legal Aid Board (SLAB) is aware that some of the processes in Advice and Assistance require to be updated and is developing a template to enable the submission of applications for increases and accounts by Solicitors electronically to simplify and speed up the process. It is also considering moving towards staged payments and interim re-imbursement for Advice and Assistance where there is no indication that repayment will be made.

5.10 In England, the whole process for applying for legal aid is simpler as an automatic increase is available in the form of a limited certificate. It would not be possible to introduce a limited legal aid certificate in Scotland under the Legal Aid (Scotland) Act 1986. However, some of the reforms being considered by SLAB, particularly those relating to Advice and Assistance, should simplify the process considerably in Scotland.

5.11 SLAB has provided guidelines for the profession on the requirements for certain cases. However, there is limited guidance available on obtaining legal aid for pursuing class actions. This is particularly relevant for the work of our Group in relation to Hepatitis C sufferers whose actions failed.

5.12 Civil legal aid will not be granted until SLAB is satisfied on probable cause, reasonableness, and financial eligibility. In clinical negligence cases it may be difficult for an applicant to obtain the expert evidence required to demonstrate probable cause. In criminal cases, the test applied by SLAB is whether it is in the interests of justice that legal aid be granted. For example, in a case of major injury there may be a disqualification from legal aid on purely, and in some cases marginal, financial grounds. The injured person is then left with the prospect of placing their financial security (and that of their family) at risk by having to fund the cost themselves with the attendant risk of a large award of expenses against them if they lose. An interests of justice provision would allow a balance to be struck between the importance of the matter to the injured person (and their family, NHS and society) on the one hand and the financial test on the other.

Conclusions On Legal Aid System

5.13 We conclude that it is desirable that the legal aid system should be able to deal with class actions as well as individual clinical negligence cases.

5.14 We would like to be involved in the development of the revised guidelines but realise that this may not be possible as this Group's work is now concluded.

5.15 We conclude that it would be easier for applicants to obtain legal aid in clinical negligence cases if the 'interests of justice' test were adopted and SLAB should consider the introduction of such a test in clinical negligence cases.

5.16 In our Preliminary Report, we agreed to look further at issues relating to access to legal aid and the development of specialist legal/medical experts. These issues are considered further in Chapter 7.

RECOMMENDATIONS ON LEGAL AID SYSTEM

5.17 Having considered a presentation from the Director of Legal Services at SLAB and the evidence submitted, we recommend that the Scottish Executive should invite SLAB to consider the following:

(a)	proceeding with the development of the template on Advice and Assistance as soon as possible;
(b)	including in the template provision for meeting/negotiation with the defender;
(c)	including in the template provision for class actions as well as individual clinical negligence cases;
(d)	updating the guidelines to the profession;
(e)	introducing an 'interests of justice test' for civil legal aid applications in clinical negligence cases;
(f)	proceeding towards the making of staged payments.

6. OTHER AREAS CONSIDERED FOR REFORM

6.1 In this chapter, we consider the following:

- Priority Treatment for People who have been harmed by NHS Treatment.
- Reversing the Burden of Proof.
- Retrospective ex gratia payments linked to 'Defective Product Concept'.

PRIORITY TREATMENT FOR PEOPLE WHO HAVE BEEN HARMED BY NHS TREATMENT IN SCOTLAND

6.2 We considered evidence on 2 existing schemes – priority treatment for war pensioners in the UK and for HCV patients in the Republic of Ireland.

Priority Treatment for War Pensioners

6.3 In 1953, hospitals run by the Ministry of Pensions for the treatment of war pensioners were transferred to the NHS. The Government gave an undertaking that there would be priority examination and treatment for war pensioners[3] in NHS hospitals for the condition for which the war pensioners received a pension or gratuity. Priority is not given for unrelated conditions. The Transfer of Functions (Ministry of Pensions) Order 1953 passed the financial and administrative responsibility for the provision of medical and surgical services for war pensioners to Health Departments. In Scotland, funding was transferred to NHS Boards to cover the cost of providing these services.

6.4 Priority in out-patient services provided and funded by the NHS Board of residence include:

> supply and repair of artificial limbs, nursing equipment, hospital treatment expenses, dental treatment, eye tests, hearing aids, chiropody, skilled nursing care, orthotic devices, elastic hosiery, wigs and other aids and appliances considered medically necessary for their condition.

The Compensation Scheme in Operation in the Republic of Ireland for HCV Patients

6.5 The Irish government provides ring fenced funding to ensure priority treatment for people who have contracted HCV from blood transfusion or blood product that includes:

- each specialist HCV Unit to have a Specialist Liver Consultant or Hepatologist and a nurse/counsellor

[3] A war pensioner was previously classed as someone who has a pension or receives a gratuity for disablement caused by armed service during the 1914-18 and 1939-45 wars and services since 1945. With effect from 29 July 1996 the term 'War Pensioner' also includes those people who were injured or disabled as a result of service in the Armed Forces of the Crown either before 4 August 1914 or between 1 October 1921 and 2 September 1939.

- no patient to wait more than an hour for their scheduled appointment with a clinician
- no patient to wait more than two weeks for an appointment
- each Unit to have a designated ward area for testing, treatment or biopsy
- no patient to wait more than one month for an appointment for counselling
- minimum of five days hospital admission for anti viral therapy if patient requests it

6.6 The ring-fenced expenditure associated with providing this priority treatment has risen from 8.34m euros in 1998 to 13.01m euros in 2002 – giving a total to date of 51.65m euros (£32.89m).

Discussion

6.7 We considered whether 'priority treatment should be given to people harmed by NHS treatment where there is unlikely to be liability on the part of the NHSScotland'. Such a scheme could be considered to have the advantage of being in line with the principles of fairness and equity as it could be said that the NHS was prepared to make every effort to minimise the adverse effect of any harm it had caused. However, if treatment were prioritised for all patients harmed by NHS treatment, this would include people who had consented to the risk. We felt that this was undesirable and it would be preferable for any such scheme to be restricted to circumstances where neither the patient nor the health service were aware of the risk involved.

6.8 Furthermore, such a scheme would be resisted by those patients not covered by the scheme but who felt that their clinical need was greater than those receiving the priority treatment.

Conclusion On Priority Treatment

6.9 We recognise that a scheme of priority treatment could be said to be advantageous for a limited group such as war pensioners. However, we do not consider such a scheme would be equitable in the wider context of patients harmed by NHS treatment. We conclude that any prioritisation of treatment should be based on clinical need rather than the fact that injury occurred through NHS treatment. We therefore do not wish to make a recommendation to introduce priority treatment for those harmed by NHS treatment. However, we remain concerned about the need for treatment for people harmed in this way. We feel it is important that the Scottish Executive ensures that resources are made available to provide for treatment and monitors the position.

REVERSING THE BURDEN OF PROOF

6.10 Clinical negligence differs from other personal injury litigation in the parties' greater reliance on expert medical evidence for issues of causation and liability. Causation is more difficult to establish than in other personal injury cases because the effects of the allegedly negligent treatment must be distinguished from those of the patient's underlying condition which gave rise to the need for treatment.

6.11 It has been widely recognised that patients as a group appear to be unusually disadvantaged when attempting to obtain compensation for harm resulting from clinical interventions. The defending NHS professional has ready access to professional advice, expertise and information about the event as well as having first hand knowledge and understanding of what happened. The aggrieved patient, on the other hand, may find it difficult to obtain access to the relevant information and expert legal, medical advice and support.

6.12 We considered the proposal that 'the burden of proof which currently rests with the claimant, should be transferred to NHSScotland'. We also considered evidence prepared by Russell Levy, a partner in the Solicitors firm of Leigh, Day &Co which formed part of a submission to the English Review Group on Clinical Negligence by the Association of Personal Injury Lawyers.

6.13 We recognise that reversing the burden of proof may have certain advantages. It could lead to a less adversarial process as healthcare providers would have an increased interest in seeking to establish what happened at the earliest opportunity. It would also undoubtedly redress the imbalance as the benefit of any doubt would be transferred to the patient.

6.14 However, there are certain disadvantages associated with this proposal. One of the most significant of these is that the patient would still have to prove that they were harmed by the NHS to initiate the claim and to proving fault in clinical negligence. If the test used for taking a claim forward was defined as 'unexpected injury or death' then the problem of dealing with cases that are foreseeable still remains as does that where there is implied consent. Furthermore, in our view, reversing the burden of proof would, in all probability, create a big increase in claims which could in turn place an unmanageable burden on the NHS, especially if the definition of fault was left open.

Conclusion On Reversing The Burden Of Proof

6.15 We conclude that the real problem is that there is an 'inequality of arms' between the claimant and the defender in clinical negligence cases. We consider that this 'inequality of arms' could be addressed in other ways, for example by improving access to medical and legal experts, the extension of the NHS complaints procedure to award ex gratia payments in cases where the claim is in respect of a 'lesser' injury and researching the use of mediation. Recommendations on these issues are included in Chapter 7. A number of Members were in favour of the idea of reversing the burden of proof, but we decided not to recommend this proposal.

RETROSPECTIVE EX GRATIA PAYMENTS LINKED TO 'DEFECTIVE PRODUCT/PRACTICE' CONCEPT

6.16 We considered the pros, cons and potential challenges of introducing a scheme which enables ex gratia payments to be made to patients who had been harmed before 1 March 1988 by a defective product as a result of NHS treatment in Scotland – in circumstances where it is likely that responsibility for the defect rested with NHSScotland.

6.17 Such a scheme would enable payments to people who were infected with HCV as a result of receiving blood transfusions or being treated with blood products, whose infection

occurred before the Consumer Protection Act 1987 (CPA) came into force. However, payments would not be provided for those infected after March 1988 who were unable to take legal action under the CPA because of time-bar considerations. That group would remain a disaffected group with a very clear moral argument that they are being treated unfairly.

6.18 We considered whether the scheme would be less arbitrary if it were extended to include defective 'practices' as well as defective products and if it was not restricted to harm incurred prior to March 1988. Such a scheme could also be restricted to cover harm resulting from defective products and practices that were unknown to both the patient and the health service at the time the treatment was administered. It might also allow for other forms of support and not be restricted to financial compensation.

6.19 An obvious difficulty in terms of defining defective practice is that clinical practice changes constantly: thus, a practice which would have been regarded as perfectly normal in the 1950s (such as removing tonsils at an early stage to prevent later problems) can often be frowned upon some years later. In our view, including defective practice as a ground for compensation would run the risk of leading to excessively conservative medicine, with clinicians reluctant to change practice as soon as might otherwise be desirable.

6.20 We also felt that there was likely to be great difficulty in defining the scope of such a scheme in a way that would enable it to be administered effectively, that would not raise issues about the retrospective application of legislation and that would not give rise to an open-ended and potentially very large contingent liability which may adversely affect future spending on health services in Scotland.

Conclusion On 'Defective Product/Practice' Concept

6.21 Having considered these issues very carefully, we conclude that we do not wish to make a recommendation in favour of such a scheme.

7. SUGGESTIONS FOR REFORM OF THE CURRENT DISPUTE RESOLUTION SYSTEMS

INTRODUCTION

7.1 Improving responsiveness to patients and promoting patient safety have become key priority areas in the health service. We believe that the provision of understandable information and involvement of the patient is at the heart of patient-centred health care. Further, patient care should relate back to quality standards, as patient safety is paramount. A common denominator in the evidence we have scrutinised is that patients wish to be reassured that the adverse incident which has led to their suffering, injury or harm, will not recur. The system has to build in a mechanism for ensuring that lessons are learned from clinical injuries and are fed back into the system to improve the standards of clinical care and patient safety.

7.2 In this Chapter, we consider how the current systems of dispute resolution including the NHS complaints procedure and the clinical negligence system can be improved to ensure that staff and patients can be confident the incident can be investigated in a supportive, honest and open environment. We believe this is currently not happening. Evidence considered has shown that the patient feels 'up against the system'. The system is reported to be far from patient-centred, lacking in independence and lessons are not being learned.

ADVOCACY

7.3 In this context we refer to advocacy by people other than advocates, solicitor-advocates or solicitors. Independent advocacy for patients is recognised increasingly as a valuable tool in ensuring that people are supported and enabled to make informed choices about their care. It helps people to have access to the information they need, to understand the options available to them and to make their wishes and views known. We note that the Scottish Executive has issued good practice guidance and guidance for commissioners (NHS Boards and local authorities) to support the requirement on them to ensure that independent integrated advocacy is available to all those who need it.

7.4 In April 2002, two new bodies were established to ensure that commissioners, providers and users of advocacy are provided with the infrastructure, guidance and support necessary to promote the successful development of advocacy services; the Advocacy Safeguards Agency and the Scottish Independent Advocacy Alliance were set up, funded by the Scottish Executive Health Department.

7.5 We are of the view that these initiatives should be supported but we believe there is still a gap in the provision of more specialised advocacy services in particular, access to advocacy which can assist with advice on clinical issues. We believe the establishment of a Scottish branch of AVMA, discussed in paragraph 7.21, would help to fill this gap.

THE NHS COMPLAINTS PROCEDURE

The Findings of the Independent Evaluation of the NHS Complaints Procedure

7.6 The current NHS complaints procedure, established in April 1996, is under review by the Scottish Executive. The Report of the UK-wide evaluation of the NHS complaints procedure, issued by the Scottish Executive in September 2001, identified a high level of dissatisfaction with the handling of patient complaints. Only 33% of complainants believed their complaint was handled well at local resolution and 25% at independent review.

7.7 The main causes of patient dissatisfaction included time taken to reach conclusion, bias, stress, lack of information/support and lack of independence.

The Scottish Executive's Proposals for Reform

7.8 In response to the Evaluation Report, the Scottish Executive set up a Working Group of practitioners and NHS staff to develop proposals to deliver the commitment in *Our National Health: A plan for action, a plan for change* 'to ensure that a system that is credible, easy to use, demonstrably independent and effective is created'. The Scottish Executive is currently undertaking a consultation exercise on these proposals.

7.9 We suggest that there are a number of ways to improve the early handling of complaints/claims including: better training for complaints/claims handling staff; more accessible information for complainants and claimants, especially about clinical issues; more emphasis on face-to-face or telephone contact to clarify points not clearly expressed; increased support or advocacy for complainants and claimants in the early stages to prevent complaints escalating. We conclude that the Scottish Executive's review of the NHS complaints procedure should address these areas of difficulty.

7.10 We found the remit of the Working Group on the NHS complaints procedure to be rather narrow and it did not include awarding compensation. We are aware that NHS Trusts and Boards currently have the power to make ex-gratia payments but this power is not used in many cases. We conclude that the Scottish Executive should be asked to consider encouraging and supporting NHS trusts and boards to use their existing powers within the NHS complaints procedure to make ex-gratia payments for 'lesser injuries' such as time off work and pain and suffering.

7.11 We are of the view that there should be some mechanism for giving advice as to what further action, if any, could be taken where the NHS complaints process has been exhausted and where complainants are contemplating initiating a claim. It is particularly relevant given that 60% of settlement payments are for less than £10,000. We consider that this would be an issue which the Scottish branch of AVMA would address.

QUALITY AND PATIENT SAFETY ISSUES

7.12 We are aware that much is currently being done by the Scottish Executive to fulfil the commitment in the Health Plan to work with relevant interests to achieve better integration and co-ordination of those national organisations and professional bodies with an interest in quality. The establishment of a new special health board, NHS Quality Improvement Scotland in January 2003 will build on and integrate the work of the existing national clinical

effectiveness organisations and is an important step towards giving clinical effectiveness and quality issues the clarity required by front line service providers.

7.13 Clinical Governance already provides the framework in NHSScotland to learn from incident reporting and deliver safer services as a result of the learning. We conclude that the Scottish Executive should continue to build on the current work on improving patient safety. We note that the Scottish Executive has recently issued a consultation paper on how to improve patient safety in Scotland 'Learning form Experience'. The consultation paper identifies the necessary steps to improve safety for patients in Scotland. These include linking with the work of the new National Patient Safety Agency and providing education which supports staff to work together to identify, learn from and solve these problems.

7.14 We welcome the establishment of the NHS Quality Improvement Scotland and the work being done on clinical effectiveness and patient safety in conjunction with the National Patient Safety Agency. We hope that these developments will avoid mistakes being repeated, encourage learning from them and ensure that the lessons are communicated across NHSScotland.

MEDIATION IN HEALTH SERVICE DISPUTES

7.15 We considered the evidence in the Report on 'Encouraging Resolution, Mediating Patient/Health Service Disputes in Scotland' published by the Royal Society of Edinburgh in February 2002. The Report makes recommendations covering wide-ranging policy areas throughout the Scottish Executive, including the legal process; culture and education; funding; complaints procedures, service provision and setting and maintaining standards. The Scottish Executive has undertaken to consider the recommendations in the Royal Society's Report further in the light of the review of the NHS complaints procedure, the work of our Expert Group and the outcome of the pilot studies currently being undertaken by the NHSLA in England.

7.16 We believe that mediation may have certain advantages, including the promotion of early settlement, particularly in small claims; it can allow non-pecuniary issues to be addressed and it provides a forum for venting feelings. Further, there are no 'closed doors' as parties are free to leave the process whenever they wish and resort to other resolution processes including litigation. However, it is still quite an expensive process and if the outcome is not accepted then there has been additional cost and delays without resolution. Furthermore, mediation is not always acceptable to patients, as some do not feel that they have 'equality of arms'. The complainant is immediately at a disadvantage, as he/she does not have the clinical knowledge of the health professional.

7.17 We conclude that mediation may have certain benefits but it needs to be thoroughly researched before we can fully recommend it. We therefore wish to endorse the recommendation made by the Royal Society of Edinburgh in their report 'Encouraging Resolution: Mediating Patient/Health Service Disputes in Scotland' that the Scottish Executive should, in conjunction with the National Health Service Scotland Central Legal Office, undertake a fully researched mediation project mirroring that being undertaken by the National Health Service Litigation Authority in England.

PRE-LITIGATION MEASURES

7.18 We note that negotiated settlements are taking place already within Central Legal Office (CLO). When CLO receive a claim letter, they will investigate the facts of the case. If it is concluded that it is a valid claim and liability can be admitted then settlement will be negotiated. However, not all cases can be resolved by negotiation at an early stage, and therefore some cases will always go into court before a settlement can be negotiated. Negotiated settlements can never entirely replace court proceedings since it is the right of any individual to seek to secure performance of their legal rights by using formal legal processes. Nevertheless, we feel that since most claims and litigation conclude through settlement, steps should be taken to encourage early disclosure and early negotiation leading to early settlement whether before or after the raising of formal proceedings.

IMPROVING ACCESS TO THE LITIGATION PROCESS

7.19 Lawyers in Scotland who are active in reparation or damages practices (of whom there are many) should be able to act in clinical negligence cases ideally following appropriate specialist training. Notwithstanding this, a view has been expressed that people in Scotland experience difficulty in finding a solicitor to pursue their case. Reasons for this include the criteria for receiving legal aid being stricter in Scotland than in England, and that the ability to recover legal costs is more restrictive in Scotland. Both act as a disincentive for lawyers to take on clinical negligence cases. Unlike England, Scotland has been unable to establish an extensive pool of lawyers experienced in clinical negligence.

7.20 Another possible difficulty for claimants in Scotland is in finding medical experts to assist with the claim. This may be due in part to the fact that Scotland has a relatively close knit medical community and, therefore, consultants and others may be reluctant to place themselves in a position of having to judge and give an opinion on the actions of colleagues. In England, Action for Victims of Medical Accidents (AVMA) has been instrumental in developing a panel of medical experts and the setting up of a Scottish branch of AVMA might facilitate a similar development in Scotland. This matter has been discussed at the Scottish Academy of Royal Colleges and Faculties who would be willing to look at ways of providing information, particularly in relation to small specialties or problematic cases. It would also be possible to look at liaison between the medical organisations in Scotland and any new legal system for these individuals, which might be set up.

Establishment of a branch of Action for Victims of Medical Accidents (AVMA) in Scotland

7.21 We considered evidence from the then Chief Executive of AVMA, who as a member of our Group declared his interest, on the aims and the work of his organisation. A copy of the evidence submitted is at Annex I. We noted that AVMA had identified that clinical negligence was a discrete area of the law that required specialist lawyers to handle it. AVMA have addressed this in 2 ways. Firstly, AVMA provided a resource service for all lawyers dealing with clinical negligence as well as running courses and conferences to improve their skills. Secondly, AVMA has built up a panel of Solicitors to whom they could confidently refer their clients. AVMA is a registered charity and receive some donations from clients and the public.

7.22 We are of the view that the Scottish Executive should consider making initial funding available for establishing a Scottish branch of AVMA which would go some way towards improving access to medical/legal experts for claimants.

7.23 We also considered evidence from practising Solicitors who outlined the difficulties they encountered in relation to pursuing clinical negligence cases. We agree with the view expressed that in realistic terms it is impossible to run a clinical negligence case without legal aid. Even were liability to be admitted (which is extremely rare) the funding of the experts, the court fees, counsel etc. is beyond the pocket of the ordinary person. For those people who want to get preliminary advice and a medical report, the Solicitors have estimated that it will cost about £1000 or more. We understand that the Solicitors very seldom get fully paid at Legal Advice and Assistance rates on the investigation of a clinical negligence case, nor do they receive their actual charge out rate for fee paying work so they are unable to get sufficient cover for the work that has been done.

7.24 We therefore conclude that the Scottish Executive, in conjunction with the Law Society and the Scottish Legal Aid Board should consider increasing the level of fees to solicitors in civil business to enable them to pursue clinical negligence cases and to enable increased availability and level of expenditure for payment of outlays, eg medical reports.

THE LITIGATION PROCESS

7.25 We had before us evidence on the current Court of Session procedures for dealing with clinical negligence cases and conclude that there are some areas where improvements should be considered. The whole process is based on written pleadings. The pleadings are intended to give notice of each party's case. Shortcomings in the pleadings system have been the subject of judicial criticism.[4] The pleadings often do not meet the objective as a result of failings of either party, eg by the pursuer failing to properly focus the case or the defender not making appropriate admissions. The procedures for meeting any criticism of either party's pleadings are cumbersome requiring a formal legal debate before a Judge to be arranged even on a minor matter. That in turn involves considerable delay.

7.26 The system also often allows each party to change their case late in the day leading to postponements of the hearing of the case, which when ultimately arranged, may open up further potential arguments on the pleadings. Delays as long as five and six years for resolution of complex clinical negligence cases are not uncommon and there have been cases which have taken as long as ten years (see paragraph 3-7). It is also well recognised that in any event many cases which do settle, do so only shortly before the hearing of the case.

7.27 New rules for the reform of the Court of Session procedure and based on the proposals by Lord Coulsfield, have been drafted to come into force in April 2003. They are intended to apply to all personal injury cases including clinical negligence cases and will provide for brief pleadings. Also, the hearing is to be set at the earliest about thirteen months from the commencement of proceedings. Within that period a time-table is set for recovery of documents, valuation of claims and pre-trial meetings, etc. If there is a default by either party in that time-table then the matter is to be brought before the Court.

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[4] (see for example David Cook -v- UIE Shipbuilding Scotland Limited 1999 SCLR 156 Lord Morison and also in the Review of Business in the Outer House in the Court of Session Lord Cullen December 1995 and Report by Working Party on Court of Session Procedure Lord Coulsfield 2000).

7.28 It is questionable whether this procedure is appropriate for clinical negligence cases which are complex in fact and law, for example on legal causation, and involve the instruction and availability of consultants many of whom are leading experts in their field. Indeed, in the example of the cerebral palsy case considered by us, it was agreed that such a case would not be appropriate for the new procedures. We understand that Lord Coulsfield himself, at a meeting before lawyers to discuss the rules, conceded that while a clinical negligence case may start under the new rules any motion to have it taken out of these new rules and proceed under the existing procedure would be likely to be granted.

7.29 It seems therefore that complex clinical negligence cases will remain under the existing procedures.

7.30 We were therefore concerned that for example, in the cerebral palsy case which we had considered, a family should have to wait years for resolution of the case not to mention members of the medical profession having potential criticism hanging over them during that time. We conclude that a party to a clinical negligence case should be able to apply to the court for the case to be removed from the Coulsfield Rules and proceed under judicially managed procedures. The court could also have the power of its own accord to remove such a case. Judicial management would give the Judge wide powers to progress the case including orders for:

- Exchange of information relating to such questions as causation, negligence and damages;
- The production of expert reports and/or obtaining of additional expert reports or clarification of any such reports;
- Affidavits to be produced from witnesses;
- Tailoring the time-table to the needs of the case;
- In general taking such steps as he or she thought necessary to narrow the areas of dispute.

Judicial management would also involve a Judge staying with the case in question. Judges might also be allocated with particular expertise in clinical negligence cases.

7.31 The cases dealt with by CLO are few in number (see paragraphs 3.6 and 3.7). There would be no disproportionate allocation of judicial time to such cases having regard to the savings to be gained by avoiding the time and resources allocated to existing procedures for Judges, court administration, inconvenience to witnesses, and funding of the case by pursuers and defenders.

SETTLEMENT ISSUES

Crown Indemnity

7.32 We considered a proposal to remove Crown Indemnity and revert to the pre-existing system of funding compensation. However, we decided that this would not result in any savings for the NHS and that this would be a backward step for patients.

Structured Settlements

7.33 We considered the Consultation Paper from the Lord Chancellor's Department 'Damages for Future Loss: Giving the Courts the Power to Order Periodical Payments for Future Loss and Care Costs in Personal Injury Cases'. The current law under the Damages Act 1996 allows for periodical payment awards to be made only if the parties agree. However, following recommendations in the Lord Chancellor's Department's Paper, we believe that the Government is likely to seek to legislate in England and Wales to empower the court to impose a settlement by way of periodical payments. In Scotland, we understand that some structured settlements are entered into on an annuity basis and the Scottish Executive Justice Department is currently deciding whether to consult on arrangements similar to that being contemplated in England and Wales.

7.34 We conclude that in certain cases, particularly those where the future losses are likely to be substantial, it would be at least appropriate and probably desirable for some part of the future losses to be settled by the provision of a structured settlement or periodical payment scheme of some kind. At present, we do not feel able to support the proposal that the court should be given a power to award periodical payment settlements and structured arrangements against the will of the parties. However, we would support moves by the Scottish Executive to consult publicly on the issues involved with the giving of such a power and in particular issues relating to the conditions in which this would be exercised and any rights of review or variation in relation to any periodical payment or structured settlement. Meantime, we would wish to encourage the Central Legal Office to continue and develop its practice of offering structured settlement or periodical payment as early as possible in the negotiation process.

RECOMMENDATIONS ON DISPUTE RESOLUTION SYSTEMS

7.35 We wish to make the following recommendations to improve the current dispute resolution systems:

(a) That the Scottish Executive should consider including the following in their revision of the NHS complaints procedure better training for complaints/claims handling staff: more accessible information for complainants and claimants on clinical issues; more emphasis on face to face or telephone contact to clarify points not clearly expressed; increased support or advocacy for complainants and claimants in the early stages to prevent complaints escalating and to enable complaints to be dealt with appropriately.

(b) That the Scottish Executive should consider encouraging NHS Trusts and Boards to use their existing powers within the NHS complaints procedure to make ex-gratia payments for 'lesser injuries'.

(c) We endorse the recommendation made by the Royal Society of Edinburgh in their Report 'Encouraging Resolution: mediating patient/health service disputes in Scotland', that the Scottish Executive should, in conjunction with the National Health Service Scotland Central Legal Office (CLO), undertake a fully researched mediation project mirroring that being undertaken by the National Health Service Litigation Authority (NHSLA) in England.

(d) That the Scottish Executive consider making initial funding available for AVMA to open a Scottish branch.

(e) That the Scottish Executive consider, in conjunction with the Law Society and the Scottish Legal Aid Board, increasing the level of fees to solicitors in civil business to enable them to pursue clinical negligence cases and enable increased expenditure to be available for payment of outlays in relation to reports in particular medical reports.

(f) The Scottish Executive should draw the attention of the Lord President of the Court of Session to the need for implementation of judicial management procedures for complex clinical negligence cases.

(g) The Scottish Executive should encourage the Central Legal Office to continue and develop its practice of offering structured settlements early in the negotiating process.

ANNEX A

MEMBERS OF THE EXPERT GROUP ON FINANCIAL AND OTHER SUPPORT

Lord Ross, Chair
Former Vice-President, Royal Society of Edinburgh and Chair of the Mediation Group

Pat Dawson
Head of Policy, Royal College of Nursing, Scotland

Philip Dolan, Chairman
Scottish Haemophilia Group Forum

GRO-A Edinburgh

Dr John Garner
Chairman, BMA, Scotland

Maureen Henderson
Director of Nursing, South Glasgow University Hospitals NHS Trust

Ranald Macdonald
Legal Adviser, National Health Service Scotland Central Legal Office

Fiona Mackenzie
Chief Executive, Forth Valley NHS Board

Professor Sheila McLean
Director, Institute of Law and Ethics in Medicine, Glasgow University

Sheila McGoran
Chief Officer, Lanarkshire Health Council

Frank Maguire
Solicitor Advocate, Thompsons, Glasgow

Arnold Simanowitz
Former Chief Executive, Action for Victims of Medical Accidents, Croydon

Dr Charles Swainson
Medical Director, Lothian University Hospitals NHS Trust

Dr Sue Whyte
Former Chair of the Scottish Academy of Royal Colleges and Faculties and Chair of the Scottish Joint Consultants Committee (SJCC)

Special Advisers

Peter Beaton) Scottish Executive Justice Department
Chris Naldrett) Scottish Executive Health Department
Ross Scott) Scottish Executive Health Department
Bob Stock) Scottish Executive Health Department

Secretariat
Moira Milligen, Scottish Executive Health Department
Kate McLaughlin, Scottish Executive Health Department.

ANNEX B

LIST OF EVIDENCE CONSIDERED

Access to Legal Aid in Scotland -presentation by the Director of Legal Services, the Scottish Legal Aid Board

Access to Solicitors – Evidence from Drummond Miller WS, Anderson Strathern WS, and Brodies.

The Annual Report of the Hepatitis C Compensation Tribunal 2000. (published by the Government of the Republic of Ireland)

Annual Report 2000/2001: The Scottish Legal Aid Board

Corporate Plan 2002/03: The Scottish Legal Aid Board

Clinical Negligence: How do patients see the issues and options for Reform? (Presentation – Arnold Simanowitz, Chief Executive, of Action for Victims of Medical Accidents and Member of the Expert Group.)

Consultation Paper by the Scottish Executive: 'Learning from Experience.

Context of the System as it exists at present [The NHS Complaints Procedure, Handling Clinical Negligence and other claims. Dispute Resolution – Scottish Executive policy, The Current System of Redress. (Presentation – Pam Whittle, Scottish Executive.]

Court of Session Procedures – Presentation by Frank Maguire, Thompsons Solicitors and Member of the Expert Group on Financial and Other Support.

Defining 'Medical Misadventure' Lessons from New Zealand' (Paper) (Ken Oliphant)

Evidence was also heard from a number of people who suffer from Hepatitis C.

Guidelines on Reparation Cases: The Scottish Legal Aid Board

'Hepatitis C: Essential Information for Professionals' Guidance produced by the Scottish Executive, August 2002

'Hepatitis C and Heat Treatment of Blood Products for Haemophiliacs in the mid-1980s" (Paper) (SE Health Department)

Hepatitis C Compensation Tribunal (Annual Report 2000).

'Learning from Experience' How to Improve Safety for Patients in Scotland. A Scottish Executive Consultation Paper.

Literature Review – Evaluating Policy Alternatives for Patient Compensation (Paul Fenn, Alistair Gray, Neil Rickmann, Stephen Dixon. Commissioned by the Department of Health, England, Review of the Clinical Negligence System.)

Lord Chancellor's Department's Consultation paper – Damages for Future Loss: Giving the Courts the Power to Order Periodical Payments for Future Loss and Care Costs in Personal Injury Cases. Evidence on the difficulties encountered when pursuing clinical negligence cases from the following firms of Solicitors – Drummond Miller WS, Anderson Strathern WS and Brodies.

No Fault Compensation Schemes and Other Support Arrangements within the UK [Macfarlane and Eileen Trusts, vCJD Scheme and Compensation, The Criminal Injuries Compensation Scheme (CICS), Pneumoconiosis Act 1979, CICA cases, Tariff of Injuries, Vaccine Damage Payments Scheme, the Scheme in Operation in the Republic of Ireland, Operating CICS.] (A discussion paper prepared by the Secretariat.)

The MORI Survey - (Paul Fenn, Alistair Gray, Neil Rickmann.-Commissioned by the English Advisory Committee on the Clinical Negligence System

No Fault Systems in Operation in Other Countries (A No-Fault Compensation Scheme for Medical Accidents. Discussion paper by Michael A Jones, Professor of Common Law, University of Liverpool.)

Origins of the Expert Group and the Interface with HCV in Blood Issues (Presentation – Bob Stock, Health Planning and Quality, Scottish Executive.

Perspectives on Clinical Negligence Litigation in Scotland - presentation by Ranald MacDonald, Legal Adviser, Scottish Health Service, Central Legal Office and Member of the Group and Chris Naldrett, Finance Policy, Scottish Executive and Adviser to the Expert Group.

Priority Treatment for People who have been harmed by NHS Treatment [Discussion paper prepared by the Secretariat for the Expert Group. Existing Schemes: priority treatment for war pensioners, costs of the scheme, travel expenses for war pensioners, the compensation scheme in operation in the Republic of Ireland for Hep C patients.]

Structured Settlements and Periodical Payments – Paper prepared for the Group by Peter Beaton, Head of Civil and International Justice Division, Justice Department.

The Report of the Health & Community Care Committee on Hepatitis C 'Hepatitis C Heat Treatment of Blood Products for Haemophiliacs in the mid 1980s

The Report of the Royal Society of Edinburgh - 'Encouraging Resolution Mediating Patient/Health Service Disputes in Scotland'.

The Report of the Tribunal of Inquiry into the Blood Transfusion Services Board (published by the Government of the Republic of Ireland)

The Scotland Act 1998, Schedule 5 Reserved Matters, Part II Specific Reservations Head F – Social Security F1, and Schedule 6 – Devolution Issues Part I Preliminary and Part V general

The Work of Action for Victims of Medical Accidents (AVMA) – Paper by The Chief Executive, Arnold Simanowitz.

'A Quality and Standards Board for Health in Scotland' – Scottish Executive Consultation Paper.

Report on the Civil Justice Council Forum on Clinical Negligence – Paper by Peter Beaton, Head of Civil and International Justice Division, Justice Department and Conclusions.

Retrospective Ex Gratia Payments linked to 'Defective Product Concept' [Discussion Paper prepared by Bob Stock, Health Planning and Quality, Scottish Executive.]

Reversing the Burden of Proof [Discussion paper submitted by Russell Levy, a partner in Solicitors Leigh, Day & Co, which formed part of a submission to the English Review Group on Clinical Negligence by the Association of Personal Injury Lawyers.]

Review of Health Services available for persons who contracted Hepatitis C through the administration within the state of blood or blood products. (Consultative Council on Hepatitis C – March 2002.)

Scheme of Payments For Those Infected with HIV Through Blood or Tissue Transfer: The Scottish Office Home & Health Department April 1992

The Swedish Patient Insurance System – 8 Years of Experience (Paper) (Carl Oldretz, Skandia Insurance Co, Stockholm Sweden.)

ANNEX C

DATA ON THE CLINICAL NEGLIGENCE SYSTEM

This Annex provides statistical data on the Clinical Negligence System under the following headings:

- Summary of Settlement Costs and Claim Numbers
- Award/Expenses Payments Analysis
- Summary of Annual Provisions and Contingent Liability Figures
- Claim Submission and Processing Times
- Analysis of Cases 'Referred to Court'

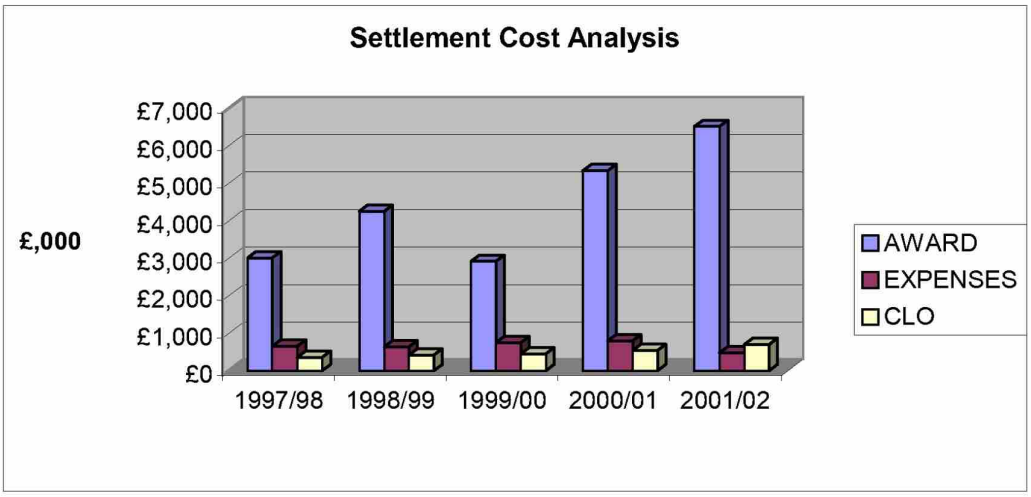
Furthermore, an Explanatory Note on Structured Settlements is provided at the end of the Annex.

SUMMARY OF SETTLEMENT COSTS

Data

	£,000		
YEAR	AWARD	EXPENSES	CLO
1997/98	£3,013	£648	£357
1998/99	£4,248	£630	£414
1999/00	£2,916	£747	£444
2000/01	£5,335	£797	£540
2001/02	£6,513	£471	£700

£,000		
Claim Total	Cases	Average
£3,661	149	£24,570
£4,878	147	£33,184
£3,663	139	£26,353
£6,132	177	£34,644
£6,984	165	£42,327



Notes:

1. The data reports on actually settled cases and not the number of cases processed each year. (CLO fees/expenses exclude non-clinical negligence cases.)

2. Claimants' expenses are not settled at the same time as CLO expenses, therefore annual figures are not prepared on a comparable basis.

3. The relationship between the three cost elements remains relatively constant over the 5-year period and average 79% for Awards, 12% for Legal Costs and 9% for CLO fees and expenses.

4. The value of Awards has increased at a relatively low level but the totals are such that one or two large settlements, i.e. £1m+ would have a marked and possibly distorting effect.

5. The above figures are on a cash basis and therefore differ slightly to those reported in SEHD summarised accounts that detail the Income & Expenditure position. However, it will be seen that differences in accounting methods equal out over the period covered. 2001/02 I&E figure has still to be audited.

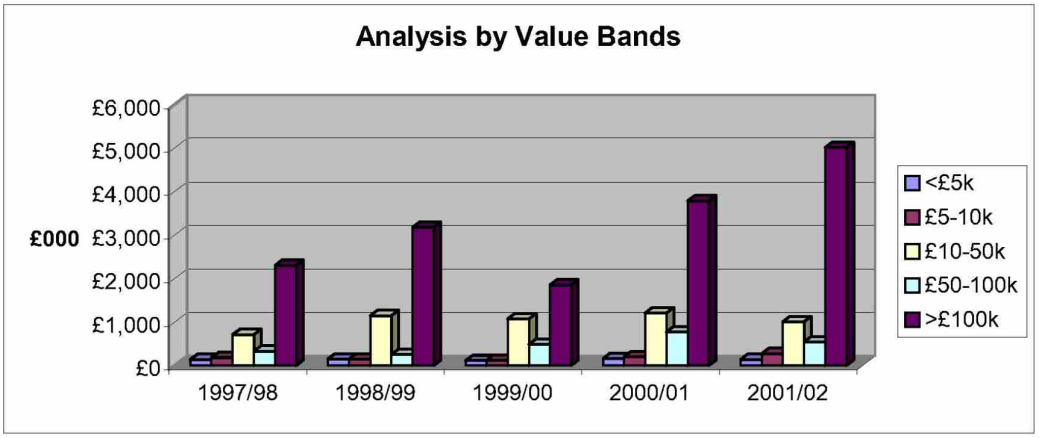
	I&E	*Cash*	*Difference*
1997/98	£4.1m	£3.7m	-£0.4m
1998/99	£4.4m	£4.9m	+£0.5m
1999/00	£3.5m	£3.7m	+£0.2m
2000/01	£6.5m	£6.1m	-£0.4m

PAYMENTS ANALYSIS

Data: Cost of Awards & Expenses (£000).

	<£5k	£5-10k	£10-50k	£50-100k	>£100k
1997/98	£139	£180	£710	£328	£2,304
1998/99	£151	£147	£1,146	£259	£3,176
1999/00	£113	£122	£1,074	£492	£1,860
2000/01	£157	£201	£1,214	£774	£3,786
2001/02	£142	£275	£1,012	£539	£5,016
Average	£140	£185	£1,031	£478	£3,228

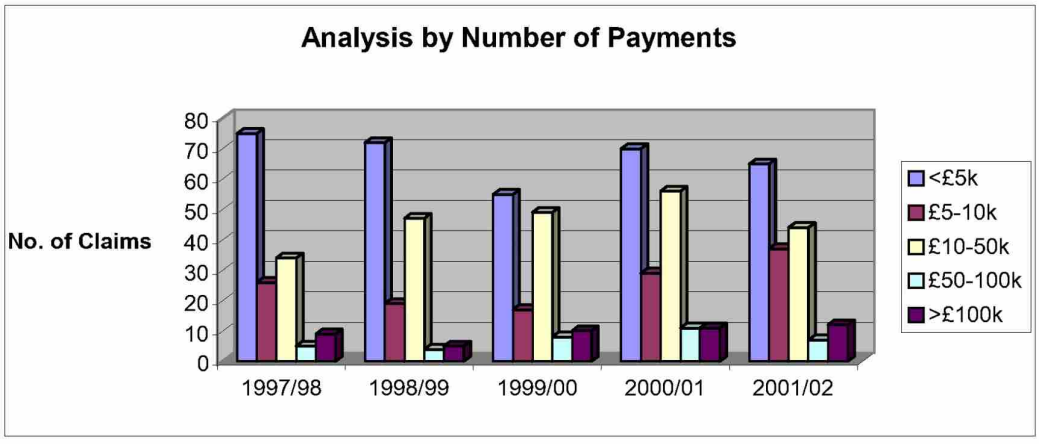
Totals
£3,661
£4,879
£3,661
£6,132
£6,984
£5,063



Data: Number of Settlements

	<£5k	£5-10k	£10-50k	£50-100k	>£100k
1997/98	75	26	34	5	9
1998/99	72	19	47	4	5
1999/00	55	17	49	8	10
2000/01	70	29	56	11	11
2001/02	65	37	44	7	12

Totals
149
147
139
177
165

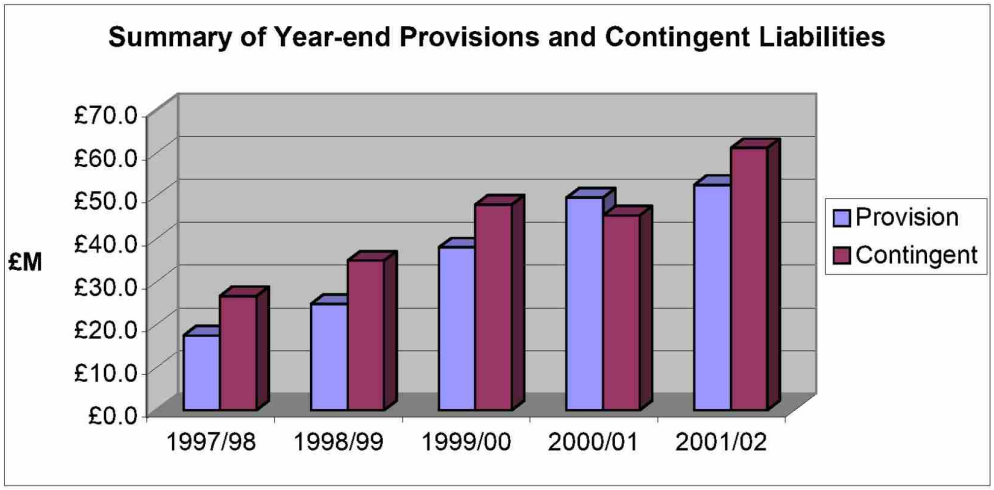


In summary: 60% of settlements account for only 7% of expenditure
30% of settlements account for 20% of expenditure
10% of settlements account for 63% of expenditure

YEAR END PROVISIONS & CONTINGENT LIABILITY

Data: £M

	Provision	Contingent
1997/98	£17.4	£26.6
1998/99	£24.8	£34.9
1999/00	£38.0	£48.0
2000/01	£49.6	£45.4
2001/02	£52.6	£61.2



Notes

1. 'Provision' is the gross estimate of claims expected to settle at any time in the future, i.e. not necessarily in the current accounting year.

2. The net position, i.e. taking account of expected receipts from SEHD financial risk pool, will appear on the Trust's Income & Expenditure A/C and represents cash 'tied up'.

3. 'Contingent liability' is simply a Note to the Accounts and does not represent cash 'tied up.'

4. Rises in the provision figure do not automatically point to a rise in claims or negligent incidents. Reasons for increases include:

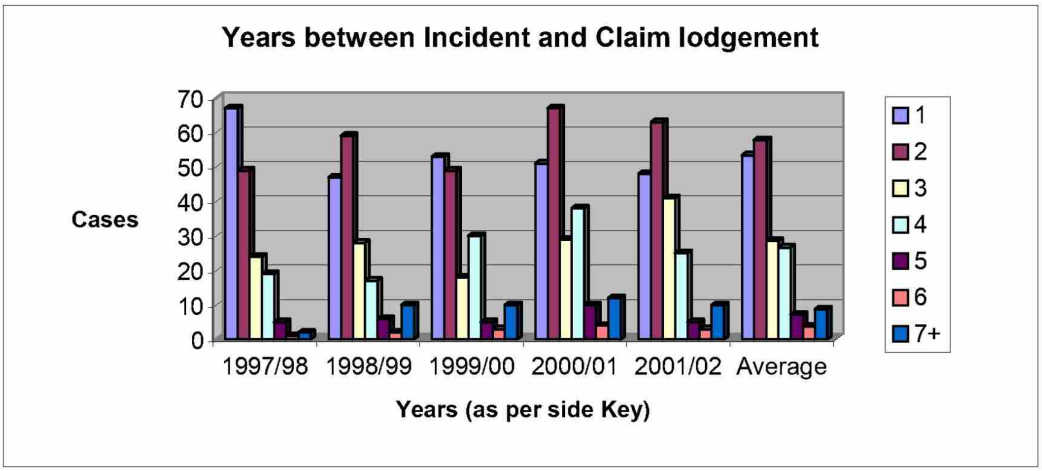
* Revision of estimated settlement cost
* Delay in settling claims already on the books
* Addition of high cost claim(s)

5. The rise from 1997/98 through to 1999/00 is, in part, accounted for by a change in the method used by NHS Trusts/Boards to calculate provisions.

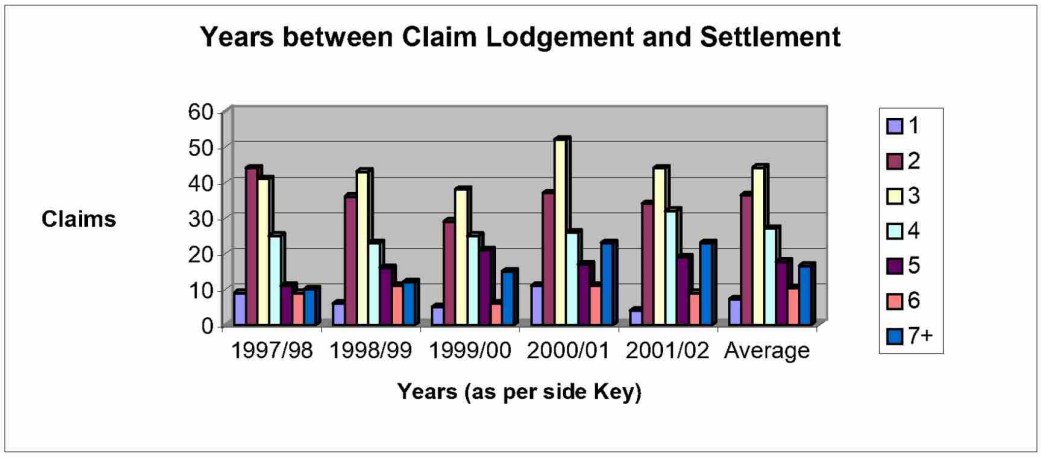
6. The figures for 2001/02 are currently provisional.

CLAIM SUBMISSION AND PROCESSING TIMES

	1	2	3	4	5	6	7+	Total
1997/98	67	49	24	19	5	1	2	167
1998/99	47	59	28	17	6	2	10	169
1999/00	53	49	18	30	5	3	10	168
2000/01	51	67	29	38	10	4	12	211
2001/02	48	63	41	25	5	3	10	195
Average	53	58	29	27	7	4	9	182



	1	2	3	4	5	6	7+	
1997/98	9	44	41	25	11	9	10	149
1998/99	6	36	43	23	16	11	12	147
1999/00	5	29	38	25	21	6	15	139
2000/01	11	37	52	26	17	11	23	177
2001/02	4	34	44	32	19	9	23	165
Average	7	36	44	27	18	10	17	155



Notes: see next page.

Notes:

1. Data analysis for Years between Incident and Lodgement of Claim based on case throughput and not cases settled. However, this has no significant effect on the trend analysis which, on average, shows:

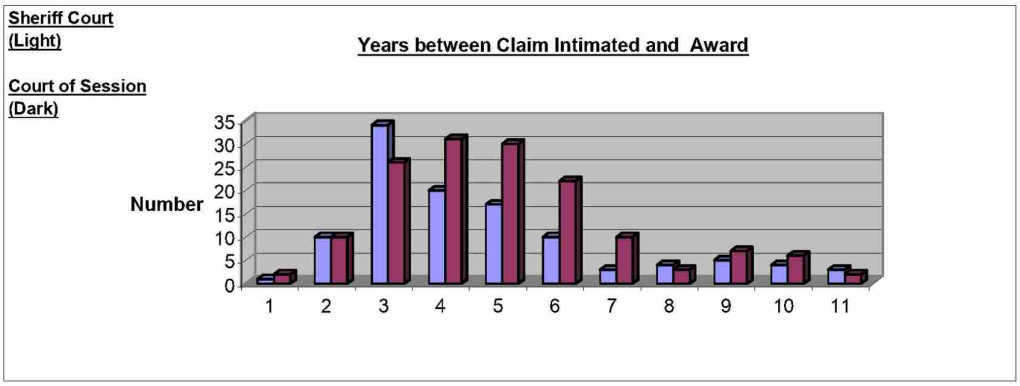
- In 60% of cases, the claim was lodged with CLO within 2 years of the incident
- In 7% of cases, the claim was lodged with CLO 5+ years after the incident

2. Data analysis for Years between Claim Lodgement (with CLO) and Settlement based on settled cases, e.g. of the 139 cases that settled in 1999/00, 38 settled 3 years after the claim was lodged with CLO. The data shows that, on average:

- 56% of claims that resulted in an award settled within 3 years of claim lodgement with CLO
- 50% of those cases settled in the third year, i.e. Year 3 is the modal year
- 17% of claims that resulted in an award settled more than 5 years after claim lodgement with CLO

CLINICAL NEGLIGENCE: CLAIMS & PAYMENT DATA - CASES REFERRED TO COURT

Year	Cases Settled	Referred to Court	%	Court Type	Number of Cases	%	Years since claim intimated to CLO										
							0	1	2	3	4	5	6	7	8	9	10+
1998/99	147	54	37	Sheriff	21	39	0	1	8	5	4	2	0	1	0	0	0
				Session	33	61	0	4	5	9	4	6	1	1	3	0	0
1999/00	139	59	42	Sheriff	20	34	0	2	4	2	4	2	2	0	2	1	1
				Session	39	66	0	2	9	9	11	3	1	1	1	2	0
2000/01	177	79	45	Sheriff	43	54	1	6	12	6	5	4	0	2	3	2	2
				Session	36	46	2	1	5	5	7	7	4	1	2	1	1
2001/02	165	68	41	Sheriff	27	40	0	1	10	7	4	2	1	1	0	1	0
				Session	41	60	0	3	7	8	8	6	4	0	1	3	1
TOTALS	628	260	41	Sheriff	111	43	1	10	34	20	17	10	3	4	5	4	3
				Session	149	57	2	10	26	31	30	22	10	3	7	6	2
				Combined	260	100	3	20	60	51	47	32	13	7	12	10	5



Notes:

1. 'Referred to Court' is the number of cases for which legal proceedings commenced.

2. 'Settled Cases' are those where compensation has been awarded/paid.

3. Numbers in 'Referred to Court' and' Cases Settled' columns are not directly linked, e.g. the 79 cases that were referred to court in 2000/01 do not form part of the 174 cases settled in that year. The figures are aligned simply to show the general percentage of settled cases that are likely to be referred to court.

4. A Proof date will be fixed in approximately 1/3rd of referred cases but in practice only 10, on average, will actually be heard in court.

5. In summary the data/Table show that:

- 32% of cases referred to court settled within 2 years
- 51% of cases referred to court settled within 3 years
- 70% of cases referred to court settled within 4 years
- 82% of cases referred to court settled within 5 years
- 18% of cases took more than 6 years to settle

STRUCTURED SETTLEMENTS

1. Awards for damages in personal injury cases traditionally comprise a single lump sum payment. The 'future loss' element of the award is calculated so that, if prudently invested, the sum will provide an income stream to meet the continuing care needs for the expected remainder of the Pursuer's life. The amount of the lump sum is agreed by the court either as a result of a hearing or an out-of-court agreement.

2. Structured settlements on the other hand allow for part of the damages to be paid in the form of an annual tax-free installment for the duration of the Pursuer's life. NHS Trust and Boards are under instruction to consider/offer a structured settlement in all cases expected to settle above £250,000 (exclusive of costs).

3. There are two types of structured settlement:

- **Annuity-backed structured settlement** - At the point of settlement the health body purchases an annuity, i.e. a guarantee from an insurance company to pay an annual stream of income for the remainder of the Pursuer's life;

- **Self-funded structured settlement** - The health body gives an undertaking to make the stream of future payments out of normal revenue funding.

4. The benefit of a structured settlement for the Pursuer is that they will receive an income stream guaranteed for life and usually index-linked to the Retail Price Index. Additionally, provided that the required Value for Money Report accords with Inland Revenue rules, the payments are free from all taxes. A further advantage for the Pursuer is that the projected settlement can be tailored to their individual needs.

5. For the NHS, a self-funded structured settlement should offer better value for money than a lump sum settlement because it avoids paying the profit element of an insurance-backed annuity. Additionally, because the damages no longer need to he paid out in one lump sum, the cash flow demands will be spread more evenly over time. The NHS may also be able to negotiate a discount on the lump sum comparator in recognition of the tax and other advantages to the Pursuer. Finally, the NHS is assured that payments will last only as long as the named recipient lives and that, if the life expectancy is not achieved, there is no residual cash benefit to other parties.

ANNEX D

THE LITERATURE REVIEW COMMISSIONED BY THE DEPARTMENT OF HEALTH IN ENGLAND

1. The Chief Medical Officer's Advisory Group in England on the Review of the clinical negligence system commissioned a literature review from a team of researchers at Nottingham University. The Literature Review was commissioned on the basis that a necessary part of any reform process is understanding how systems (and reforms) have worked elsewhere. For example, the apparent cheapness of 'no fault' schemes in New Zealand and Sweden have been questioned by some academics. The Nottingham University team therefore undertook a brief literature review of the work done by economists in this area. Time constraints meant that they could not consider the work of others in this field, eg lawyers, sociologists, medics. The main questions addressed in the Literature Review revolved around American Clinical negligence reform and the New Zealand and Swedish no-fault schemes as these were the dominant jurisdictions in the Literature search.

Results of the Review

2. We considered the results of the Literature Review which attempted to discover what evidence exists in relation to the impact of both existing and proposed alternatives in delivering the 2 objectives of compensation and deterrence.

- In Section 3 of the Literature Review, the researchers examine the evidence on the costs and effectiveness of alternative patient compensation schemes. Section 3.1 examines the extent to which the evidence suggests that systems based on negligence perform valuable functions by considering the following issues:

  - The costs of running a negligence system.

  - Is the negligence system a high-cost lottery which compensates only on (relatively) random basis? Evidence suggests this is not an accurate criticism[5].

  - Does the negligence system provide deterrence? Evidence on analysis of US automobile compensation[6] (some States have negligence and others have no-fault) concludes that fatal accidents are 5-9% more likely under no-fault.

  - Does the negligence system lead to defensive medicine? The researchers find that evidence is mixed. Early evidence[7] (in New York State) found significant links between several obstetric procedures and previous claims experience. Subsequent work[8] fails to find any link between clinicians' previous claims history and the treatment by several obstetrics procedures. These are all US studies and the results might not be easily imported into the UK.

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[5] UK Fenn and Rickmann 1999.
[6] Cummins et al 2001.
[7] Localio et al (1993).
[8] Sloan et al 1997.

- Are there any net benefits in running a negligence system? Available evidence suggests that a positive net benefit is plausible[9].

- Section 3.2 examines the evidence on the following no-fault schemes:

  - Sweden and Finland operate non-tort schemes in conjunction with generous and comprehensive social insurance schemes. The Swedish scheme separates investigations into patient claims through the Patient Compensation Insurance (PCI) from those into physician activity which are dealt with by the Medical Responsibility Board (MRB). On the face of it, evidence shows that the Swedish system's figures show a significant saving[10] but these figures need careful interpretation as there are other reasons for this, eg other social insurance programmes meet medical expenses and wage losses due to medical injury.

  - The New Zealand system. In 1972, New Zealand moved to a no-fault system of compensation for accidents – the Accident Compensation Scheme (ACS). Evidence showed that this system provided a reasonable screen for causation, provided compensation in particular to events that would be unlikely to receive tort awards but may not provide much deterrence[11].

  - Utah and Colorado

    In 1992, Utah and Colorado instituted research programmes into their handling of medical negligence claims as a response to the level of tort litigation. Two studies[12] sampled medical records from Utah and Colorado for 1992. These were reviewed to detect the number of compensable events according to the Swedish avoidability criterion. The authors suggest that these studies demonstrate 2 points:

    (1) a no-fault scheme can be constructed to compensate more individuals at no more costs than under a tort-based scheme and;

    (2) it is possible to quantify the extent of the trade-off between patient access and overall cost that such schemes imply.

Conclusion

3. We concluded that the evidence from the Literature Review highlighted legitimate doubts about the ability of schemes like those in operation in New Zealand and Sweden to provide suitable deterrence.

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[9] Weiler et al.
[10] Danzon 2001.
[11] Paterson 2001.
[12] Stoddart et al 1997 and Stoddart and Brennan 2001.

ANNEX E

THE MORI SURVEY COMMISSIONED BY THE DEPARTMENT OF HEALTH IN ENGLAND

1. The MORI Survey was commissioned by the English Advisory Committee on the Review of Clinical Negligence. The Survey was carried out during the period 26 October 2001-16 November 2001 to obtain some quantitative information on the frequency and severity of any illness, injury or impairment that a population sample perceived themselves to have experienced as a result of any medical treatment or care they had received.

2. A questionnaire was designed to provide data on the incidence of such adverse events and where they occurred to assess where they happened, their severity in terms of health and employment, the response considered most appropriate, whether a legal claim was pursued, and the amount of compensation considered acceptable. In addition, demographic information was obtained on respondents' age, sex, region, level of qualification/education, social class and household income.. The following provides a summary of the main results.

Results

3. The questionnaire was administered in face to face interviews to a randomly selected sample of adults – 3638 men and 4568 women, giving a total sample size of 8,206. In total, 4.8% (395) of the sample believed that over the last 3 years they had suffered some illness, injury or impairment that in their view was caused by their medical treatment or care.

4. There was no evidence of significant differences in this response by sex, and although there was regional variation, the differences were not statistically significant. There was clear evidence that the proportion responding positively declined with increasing age and was inversely associated with social grade. Also there was some evidence of a lower positive response rate in higher income groups.

Location of Reported Incidents

5. The largest single category of events 55% (216) occurred in NHS hospitals, followed by General Practitioners 25% (99).

Impact on Health and Work

6. 55% of those reporting some event claimed that it was insignificant, emotional only or minor and temporary but 28% reported a temporary or permanent major disability and almost 30% claimed that the event had had a permanent impact on their health.

7. Responses to impact on work were similar with 55% stating impact was not relevant, non-existent or minor; 35% reported having to take at least 1 month off work because of the event and around 25% stated that they had to take at least 1 year off work.

8. 47% of reported events that happened in an NHS hospital could be classified as relatively minor in terms of their impact on health, but this rose to 69% for events that were related to GP care.

Responses that respondents considered most appropriate to the event that occurred

9. The most common response considered appropriate was an apology or explanation (34%) followed by an inquiry into the causes (23%) or support in coping with the consequences (16%). 11% thought that financial compensation was the most appropriate response. The figures show some correlation between the severity of the event and the response considered most appropriate – as the severity of increases, the proportion of respondents considering an apology or explanation the most appropriate response falls from 45% to 15%, while the proportion expressing a preference for support in dealing with the consequences rises from 5% to 35%. The proportion of those considering financial compensation the most appropriate response rises with the severity of the event but not significantly (no more than up to 15%).

Respondents who pursued a legal claim for financial compensation

10. 11.4% stated that they had pursued a legal claim for financial compensation. Of the remainder, the main reasons given for not pursuing a claim were that the respondent did not want financial compensation (36.7%) or that it had not occurred to them (19.5%). There is some correlation between the proportion stating that financial compensation was most appropriate and the severity of the event, but in no instance did the proportion who sought financial compensation via a legal claim rise above 15%.

Amount of compensation

11. 60% stated that they did not want financial compensation. 26% volunteered a figure, the mean amount that these respondents were willing to accept was £41,700.

Conclusion

12. We noted that the survey showed that a relatively low proportion of those experiencing an illness, injury or disability as a result of their medical care considered financial compensation to be an appropriate response.

ANNEX F

EX GRATIA OR 'NO-FAULT' COMPENSATION SCHEMES IN THE UK AND OTHER COUNTRIES

1. We use 'no-fault' to refer to compensation which is obtained without the need to proceed against the person responsible for the harm.

2. We have had no-fault schemes in operation in Britain since the 1897 Workmen's Compensation Act. We consider the provisions of some of these schemes below.

The Macfarlane and Eileen Trusts

3. The Macfarlane Trust was established in 1988 to assist people throughout the UK who contracted HIV from contaminated blood products in the late 1970s and early 1980s. The support offered was a mixture of one-off compensation payments and ongoing financial support. When it was established, the Trust had 1,240 haemophiliac registrants; 808 of whom have since died. The expenditure to date is £68 million in one-off compensation payments, plus £27 million in ongoing payments. These ongoing payments are a mixture of regular monthly payments and one-off grants for a wide range of needs, eg travel, education, special equipment, gaps in the statutory benefits system.

Payments made to dependants

4. Dependants are eligible for support until the age at which they cease full-time employment.

5. All registrants receive £255 per month, plus an extra £50 per month if they are on income support and £61 if they are receiving disability living allowance. A review 2-3 years ago showed that 70% of registrants are largely dependent on income from the Trust plus state benefits. In 1992 the Trust was augmented by the Special Payments Scheme. This paid out £0.7m in ex gratia compensation to 12 non-haemophiliacs who contracted HIV because of blood, blood products or tissue transfer. In 1993 this was augmented by the Eileen Trust, which provided ex gratia ongoing payments to this non-haemophiliac group and has paid out £0.5m.

6. We noted that the establishment of the Macfarlane and Eileen Trusts was an exception to the principle that the NHS does not pay compensation when it has no legal liability. The rationale for this exception was largely linked to the presumption made at the time that HIV would inevitably and swiftly progress to death.

vCJD Scheme

7. The scheme will provide for payments to be made in respect of 250 cases of vCJD up to a maximum of £55 million. If numbers exceed 250 cases, the scheme will be reviewed. The scheme makes compensation for the experience of vCJD for the patient; the experience of vCJD for the patient's immediate family and/or carers; costs incurred by the patient and family as a direct result of the patient's suffering from

vCJD and future losses caused to the patient's dependants as a result of his/her death from vCJD.

8. In April 2001, regulations came into force ensuring that payment of compensation to vCJD victims or their families would not be taken into account for the purposes of calculating income-related social security benefits nor be subject to 'claw-back' under the social security recovery scheme.

The Criminal Injuries Compensation Authority

9. The Criminal Injuries Compensation Authority administers the criminal injuries compensation scheme which operates throughout England, Scotland and Wales. They pay compensation to people who have been victims of a violent crime or those injured trying to apprehend criminals or prevent a crime. Since 1 April 1996, the level of compensation has been determined according to a scale, or tariff, set by Parliament.

10. The scheme reflects the basic elements of common law claims for personal injury and wrongful death, but the size of awards paid in recognition of victims' injuries — and not linked to their financial loss — is fixed according to the tariff.

11. When applicants have also suffered financial loss, through loss of earnings or earnings capacity, cost of medical or other care, or because they were dependent on someone who was murdered, they may apply for additional compensation. The Authority decides the amount of money they are entitled to by looking at all the available information on their financial circumstances before and since the crime occurred.

12. We noted that this is an example of a scheme where the definition is in very general terms and which is then left to develop by interpretation. It is also an example of a scheme where there is an attempt to give some kind of figure for pain and suffering on a tariff basis.

Pneumoconiosis etc (Workers' Compensation) Act 1979

13. This scheme was set up to pay compensation to people who are unable to recover damages from their employers as they are no longer in business. Diseases covered in the Act include pneumoconiosis; diffuse mesotheliona (asbestos-related cancer); diffuse pleural thickening (asbestos-related); primary carcinoma of the lung (only if accompanied by asbestosis or diffuse pleural thickening – this qualification is intended to distinguish asbestos-related lung cancer from that caused by other factors and byssinosis (associated with cotton dust exposure).

14. As well as being designed as a cushion for cases which cannot be successful in a civil sense because no employer is in business, the scheme very much 'piggy backs' on the qualifications of Industrial Disablement Benefit and uses that as a base to give payments in accordance with league tables.

Vaccine Damage Payments Act 1979

15. The Vaccine Damage Payments Act 1979 which came into force on 22 March 1979, introduced a scheme of payments for those severely disabled as a result of vaccination. Where the Secretary of State is satisfied that a person has been severely disabled and that, on the balance of probabilities, this is as a result of vaccination against any of the diseases specified in the Act and associated regulations, a tax-free one-off lump sum is payable [currently £100,000]. Severe disablement is assessed as being disablement to the extent of 80% or more.

16. The payment is not compensation but is designed to ease the present and future burdens of those suffering from vaccine damage and their families. A payment under the scheme does not prejudice the right of the disabled person to pursue a claim for damages through the courts.

The Scheme in Operation in the Republic of Ireland for Compensation for Hepatitis C Patients

17. We considered details of the Compensation Tribunal set up in the Republic of Ireland to compensate patients who were diagnosed Hepatitis C positive resulting from receiving a blood transfusion, blood product or Anti-D (within the State), and noted that it was essentially a fault-based system. Nonetheless, it provided an insight into how a compensation system was operating. We found the 'other support arrangements' associated with the scheme very interesting. These are discussed further in Chapter 6.

NO-FAULT COMPENSATION SCHEMES IN OPERATION IN OTHER JURISDICTIONS

18. We considered evidence on no-fault schemes in New Zealand and Sweden which are very different in scope. The New Zealand Scheme is a general scheme and provides compensation for personal injury by any type of accident – road, domestic, work, medical etc). A person who has an entitlement under the Scheme is barred from raising a tort action. The Swedish Scheme is specifically for medical accidents and the patient remains entitled to bring a tort claim.

The New Zealand Scheme

19. The scheme provides statutory entitlements for all persons who suffer personal injury by accident 'Personal Injury by accident' includes the death of a claimant, physical injuries, eg a strain, mental injury suffered as a consequence of physical injuries or mental injury caused by certain criminal acts. Claimants seeking compensation for medical accidents must have suffered "personal injury caused by medical misadventure" which is defined as "personal injury caused by medical error or medical mishap".

'Medical Error'

Medical 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 medical malpractice claim under tort law. Non-negligent errors constitute medical misadventure *only* if they fall within the definition of 'medical mishap'.

'Medical Mishap'

Medical mishap, however, is very narrowly defined and is, therefore, highly restrictive in its application. It is defined as an "adverse consequence of treatment when, (a) the treatment given to a claimant, is given properly, and is given by or at the direction of a registered health professional; and (b) the adverse consequence is suffered by the claimant; and (c) the adverse consequence is 'severe'[13]; and (d) the likelihood that treatment of the kind that was given would have the adverse consequence is 'rare'[14].

Claimants not successful in claiming 'medical mishap', must establish 'medical error' which effectively requires proof of negligence on the part of the registered health professional. The result is that in the majority of cases in which claimants seek compensation for 'medical misadventure', proceedings are likely to turn into actions to prove medical negligence or malpractice.

20. The Accident Compensation Corporation ('the ACC') and registered insurers are responsible for administering the scheme. A potential claimant simply lodges his/her claim with the appropriate insurer. The receiving insurer then has to investigate the claim and determine whether or not the claimant is actually covered and, if so, decide what statutory entitlements the claimant should receive. The insurer has two months to investigate the claim and inform the claimant of its decision. The insurer is also under an obligation to inform the claimant about review and appeal rights. Should the claimant, therefore, disagree with the decision of the insurer, he/she can apply for a review of the decision.

21. Currently, employers and earners pay premiums. Income from tax on petrol sales and motor vehicle annual relicensing fees is also paid to the ACC. The premiums paid, as well as the injury costs, are then assigned to one of six accounts. The scheme used to be run as a "pay-as-you-go" scheme with enough money being raised each year to cover the cost of all claims paid in that year irrespective of when the injuries happened or how long their effects were expected to last. In 1998, however, the Government announced its decision to move the basis of the ACC premium collection towards a fully funded approach.[15] Premiums would be set at a

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[13] An adverse consequence is 'severe' if it results in the claimant dying; or being hospitalised as an inpatient for more than 14 days; or suffering significant disability lasting more than 28 days in total.

[14] An adverse consequence is 'rare' if the probability is that the adverse consequence would not occur in more than 1% of cases in which treatment is given. A medical mishap will not be 'rare', however, if the risk was known to the insured before the treatment was commenced.

[15] Reported in the ACC, Annual Report 1998 at 11.

level to cover current costs and to establish reserves sufficient to fund all previous accidents. Consequently, premiums for both employers and earners include a full-funding surcharge aimed at building up reserves over the next 10 to 15 years to meet the liability for the future cost of current claims.

The Swedish Scheme

22. While the system in New Zealand is comprehensive, the Swedish system applies only to injuries sustained in the medical care environment. It has been in place since 1 January 1975, though conditions may be revised from time to time. It came into being following discussions among politicians, medical professionals and insurers in order to indemnify so-called 'therapeutic injuries'.

23. Being based on employers' no-fault compensation principles, there is no dedicated legislation. Instead, the system exists by common agreement among parties. Though it was set up to provide more objective grounds of compensation than those provided by civil law, claimants retain the right to claim in the courts. In principle, civil damages will be paid only if the victim can prove negligence or intent on the part of the person causing injury.

24. The financial structure of the system is based on insurance, which is compulsory for health care providers. County Councils (who bear most of the cost of health care insurance) made a public pledge to accept liability for and to compensate certain injuries in connection with health or medical treatment. The scheme was not designed to compensate for general misfortune and/or accident *per se*; nor for sickness nor disability benefit. These are covered by other legislation. Under the Swedish system, liability is borne by the health care providers, who will have paid premiums to a consortium of insurers. Premiums correspond to actual indemnity and administrative costs, because awards reflect civil awards. From the literature it appears that the system is cost-effective.

25. The Swedish system is based on the principle of 'avoidability'. Adjudicators investigate whether (1) an injury resulted from treatment, (2) the treatment in question was medically justified, and (3) the outcome was unavoidable. If the answer to the first query is yes, and the answer to either the second or third queries is no, the claimant receives compensation. But before a patient is eligible for compensation, they must have spent at least 10 days in the hospital or endured more than 30 sick days. This threshold eliminates minor claims.

26. However, the Swedish system is still not without some of the difficulties encountered anywhere in the world, regardless of the compensation system in place. An example is iatrogenic injury in which it may be impossible to tell whether an infection was caused by the patients' own bacteria or by hospital bacteria, which even the strictest hygiene may be unable to prevent. For these reasons, a policy was needed to make the scheme more comprehensive and to compensate some unavoidable complications rising from medically indicated treatments, while not indemnifying *every* treatment or infection. A Schedule was therefore drawn up which set out those circumstances under which compensation is *not* to be paid. All other circumstances are covered, if they fit within the criteria already mentioned and the provisions of the scheme.

ANNEX G

RECOMMENDATIONS MADE IN OUR PRELIMINARY REPORT.

4.8 We recommend the following:

The Scottish Executive should establish and fund a discretionary Trust as a matter of urgency that will make ex gratia payments to all people who can demonstrate, on the balance of probabilities, that they received blood, blood products or tissue from the NHS in Scotland and were subsequently found to be infected with Hepatitis C virus, as follows:

A an initial lump sum of £10,000 to cover inevitable anxiety, stress and social disadvantage;

B an additional lump sum of £40,000 to those who develop chronic Hepatitis C;

C in addition, those who subsequently suffer serious deterioration in physical condition because of their Hepatitis C infection e.g. cirrhosis, liver cancer or other similar serious condition(s), should be entitled to additional financial support (on an ongoing basis if necessary) as may be assessed appropriate by the Trust. This financial support should be calculated on the same basis as common law damages, taking account of the payments made under A and B above;

D where people who would have been beneficiaries of these arrangements are deceased and their death was not due to the Hepatitis C virus, the above payments should pass to their Executors. Where their death was due to the Hepatitis C virus, the Trust should provide for payments to be made to dependant children, spouses, partners or parents, as appropriate.

E people who receive any payment under legal liability arising from alleged negligence or breach of statutory duty, from the Scottish Ministers, or any of the constituent authorities of the NHS in Scotland, in respect of having been infected with Hepatitis C should not qualify for these arrangements;

F people who are already in receipt of payments linked to HIV infection from the Macfarlane Trust, Macfarlane Trust Special Payments Trust, Eileen Trust or the associated government Scheme of Payments should have these payments taken into account when additional financial support is assessed for the purposes of C;

G people who have become infected with Hepatitis C as a result of the virus being transmitted from a person infected by blood, blood products or tissue from the NHS in Scotland shall be dealt with by the Trust on a similar basis to those who have been infected directly in this manner.

We further recommend:

The Scottish Executive should consider how it could fund and develop other mechanisms for supporting people who suffer from HCV. In particular, additional support in the following areas should be considered:

- Access to understandable information on HCV
- Counselling Services
- Access to information on benefits available
- Assistance with assurance and insurance
- Setting up a pro-active publicity campaign spearheaded by the Health Education Board for Scotland.

5.7 Having considered a presentation from the Director of Legal Services at SLAB and the evidence submitted, we recommend that the Scottish Executive should invite SLAB to consider the following:

- proceeding with the development of the template on Advice and Assistance as soon as possible;
- including in the template provision for meeting/negotiation with the defender;
- including in the template provision for class actions as well as individual clinical negligence cases;
- updating the guidelines to the profession;
- introducing an 'interests of justice test' for civil legal aid applications in clinical negligence cases;
- proceeding towards the making of staged payments.

ANNEX H

SCOTTISH EXECUTIVE

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January 2003

EXPERT GROUP ON FINANCIAL AND OTHER SUPPORT

Further to my letter of 10 January, I am writing to inform you of the outcome of the discussion on Hepatitis C at the meeting of the Health and Community Care Committee on 29 January.

As you are aware, I announced my intention to establish a scheme to make ex-gratia payments to those who are suffering harm, at the meeting of the Committee on 11 December 2002. Following further consideration of the complex issues involved, I am now in a position to inform you in more detail of the type of scheme which the Executive would like to implement.

I believe that an initial lump sum of £20,000 should be paid to those who have Hepatitis C as a result of receiving blood, blood products or tissue from the NHS in Scotland. In addition, a further £25,000 should be paid to those who suffer serious deterioration in their physical condition because of their Hepatitis C infection, eg cirrhosis, liver cancer or other similar serious condition(s).

I appreciate that these proposals do not fully implement the recommendations of the Expert Group but I hope you will agree that given the current constraints on the NHS, they are a significant step forward and to a large extent reflect the principles of the Group's recommendations.

We are still awaiting a view from the UK Government on the 'devolved and reserved powers' issue which I hope will be resolved shortly.

MALCOLM CHISHOLM

ANNEX I

THE AIMS AND WORK OF AVMA (ACTION FOR VICTIMS OF MEDICAL ACCIDENTS)

ORIGINS OF AVMA

AVMA is a registered charity established in 1982.

The impetus for the founding of the charity was a TV play, Minor Complications, shown on the BBC in 1980. The play was based on a true story of a woman who suffered a medical accident. During a laparoscopic sterilisation her bowel was punctured. The doctors initially would not acknowledge that there had been an accident and she nearly died.

The play then dealt with her attempts to find out what had happened and to secure compensation. She came up against a wall of silence on the part of the medical profession and sheer incompetence on the part of the legal profession.

Following the screening of the play there was such a large response from members of the public who had also suffered medical accidents that the playwright, Peter Ransley, realised that he had stumbled on a serious social problem. He was surprised to find that there was no help for victims from the NHS and no independent organisation to help them. He therefore decided to set up AVMA.

Aims

From the outset the aim of the organisation was twofold. On the one hand to work to try and ensure that avoidable accidents did not happen (the political campaigning side), and on the other to help those who had suffered to secure redress (the personal help).

AVMA's work

AVMA provides personal help for victims which is divided into legal and non-legal work and is carried out by the casework department. Because they deal with medical accidents the caseworkers must have a medical background. Over the years the department has included nurses, midwives and doctors. They also need to have legal training. Some of the caseworkers have had law degrees and have even had a dual qualification but most have received their legal training once they joined AVMA.

Because of severely limited resources and the number of patients dealt with, most of the advice has been given by correspondence. The caseworkers analyse and help the patient to understand what has gone wrong. They then advise what action can be taken. Where they identify the possibility of legal action they refer clients to one of AVMA's panel solicitors.

Legal work

Although AVMA's main work is not about compensation it is the work that has been done in the legal arena that has been the key to the improvement of the situation for victims and indeed for the raising of the profile and advances made in patient safety in the health service. AVMA identified that clinical negligence was a discrete area of the law, which required specialist lawyers to handle it. This was addressed in two ways: - firstly by providing a resource service for all lawyers dealing with clinical negligence as well as running courses and conferences to improve their skills particularly their skills in understanding medical issues; secondly by building up a panel of solicitors in whom AVMA had confidence to refer their clients. The key to this was the fact that the caseworkers monitor the conduct of the cases by the panel solicitors who are required to report on progress every six months.

Resources

AVMA's problem has always been resources. To date, AVMA has dealt directly with 40,000 patients and indirectly with more than double that number through the solicitors who belong to their resource service. With adequate funding AVMA would have been able to do much more including action on the campaigning front. AVMA started with a small grant from the Greater London Council. Subsequently it was supported by the King's Fund for a short period and for a period of five years by a grant from the Department of Health in England (DoH). We have recently received a new grant from the DOH to provide second tier advice to the pilot of the Independent Advocacy and Advice Service that will be dealing with the complaints side of the abolished Community Health Councils. They have also recently received a grant from the Community Fund to establish a fully functioning help line.

They have received some donations from clients and the public but AVMA's cause is not an obviously popular one (like children, animals or cancer for example) and it has not been possible to raise much in this way. This has meant that they have had to raise funds themselves.

This has been done by charging lawyers for the services they provide for them and by running conferences and courses for lawyers. When AVMA held its first conference in 1989 it was something novel and attracted some 120 delegates. Since then clinical negligence has become a popular subject for conferences but AVMA's annual conference remains pre-eminent with the 2002 conference being attended by 430 delegates.

Staffing

When the organisation was set up they had funding for one worker, the Chief Officer. As further funds were secured they engaged and trained specialists to deal with further aspects of the work in the different departments.

The organisation is in the process of restructuring but to give an idea of the resources required the essential staff dealing with the casework and legal work is as follows: -

Casework Manager
5 caseworkers
Lawyers' Service Manager
Legal Worker
Medical Support Worker
Risk Assessment Manager

Campaigning

It is the work that AVMA do with patients that informs their campaigning role. This has enabled them to advise healthcare workers and government of the requirements of victims and what is needed to improve both the lot of victims and patient safety. They have had success not only in raising the profile of medical accidents but in educating healthcarers and creating the conditions for government initiatives such as the National Patient Safety Agency, an inspectorate in the form of the Commission for Health Audit and Inspection and other initiatives such as the revalidation of doctors.

ANNEX J

CONCLUSIONS NOTED FROM THE CIVIL JUSTICE COUNCIL FORUM ON CLINICAL NEGLIGENCE

1. The system is not "broke", and requires tweaking rather than complete reform. The costs of the system is not disproportionate overall.

2. The system would benefit from a small claims scheme for lower value, lower complexity cases (more outside the courts rather than in).

3. There was some support for specialised (or ticketed) judges, although many were persuaded by Lord Justice May's practicality argument.

4. There was a need for additional judicial training to improve (inter alia) consistency.

5. There was strong support for Government's proposals to introduce periodic payments.

6. There was some support for a presumption of periodic payments, although the general feel was against this. There was however strong support for formal consideration at an early stage (CMCs) and forceful judicial direction where considered appropriate.

7. Reviewability should be retained in Government's proposals (there was no big objection).

8. There was a balance in favour of bringing together the complaints and claims procedures (to run in parallel rather than being combined).

9. There was near unanimous support for rehabilitation, although a recognition that implementation would currently be very difficult (the insurers relationship with claimants has nearly broken down over costs, and insurers are also facing significant shortfalls in investments).

10. There was support for ADR, in particular mediation, but it was considered too expensive in the main for small cases.

11. Consideration of a de minimis limit for CRU