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

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

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

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

In the general comments section, I include some information about my office and its current role within the NHS complaints process. The answers to the following questions should be seen in the light of those general comments. It should also be noted that the SPSO does not provide for financial compensation for injury or have direct experience of claims. Given this, I have not answered all the questions but have provided answers to those where I feel our experience as a complaints handling body may offer some assistance.

I responded in detail to Margaret Mitchell's consultation on possible apology legislation. I attach that response. [21]

My predecessor, Alice Brown, the first Scottish Public Services Ombudsman, was an enthusiastic advocate of the power of an apology. I have continued the SPSO's commitment to encouraging and supporting apologies. In the proposed Apology Bill consultation response you will see that I support the argument for carefully worded legislation to encourage a cultural shift. The fear of litigation and the sense that to apologise is somehow wrong are, sadly, still issues in public services as a whole.

A great deal can, however, be done without litigation. When things go wrong, staff need to feel supported to acknowledge errors, to explain where there is uncertainty and to involve patients and their families in the process of understanding what happened and why. An apology may well be a critical and central part of this process. It is, though, only fully effective if it is sincere and if it is part of a wider culture that supports open and honest conversations between the professional, the patient and those people who are important to the patient – their friends and family. Above all, an apology cannot be a "one-off" isolated point, it needs to be part of an

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[19] http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/No-faultCompensation/Volume-II-report
[20] http://www.spso.org.uk/files/2011_March_SPSO%20Guidance%20on%20Apology.pdf
[21] http://www.spso.org.uk/files/webfm/Media%20Centre/Inquiries%20and%20Consultations/2012/12%2009%2027%20SPSO%20response%20to%20proposed%20Apologies%20Bill.pdf

ongoing conversation that is about acknowledging what went wrong and making changes to prevent a recurrence. It should not be seen as something that an individual needs to demand but something that is freely given as part of the normal process of providing care.

This needs to be part of a culture that sees health care as collaborative and the patient and family as part of the decision-making process both in making decisions about care and in making decisions when things go wrong.

It should be acknowledged that this is not necessarily a cultural shift that needs imposed on the NHS. There are already many within the NHS working towards this. So, while barriers remain, it is a goal to which we should aspire.

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

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

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

Yes ☐ No ☐

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

I would broadly support the criteria put forward by the Review Group. I think that in order for a system to be fully accessible it needs to be able to interact easily with other systems. The individual sees their experience as a whole and any new scheme should not require them to take a concern about communication through one

route and a concern about a clinical outcome through a wholly different route. I return to this in my general comments below.

I would also recommend that the scheme should have access to appropriate specialist advice, as I do. The approach we take to complaints is inquisitorial rather than adversarial . Members of the public who come to us do not need lawyers to put their arguments together or clinical experts to justify their view of the treatment received. What we do is talk to the complainant to see what is concerning them and we then take that complaint forward and gather evidence. In the end, I have to satisfy myself that I have enough evidence to make a decision. I do not decide whose side of the argument has been best put or who has had the most persuasive clinical advice but, on the basis of the evidence I have obtained, I establish what happened and what should have happened. I also ensure that my decision, even when based on complex clinical advice, is clear to the person who made the complaint. This allows them to challenge any errors that may have been made and also provides them, hopefully, with the confidence that the correct decision has been made.

In order to be fair, I would argue that given the inherent power imbalance between the NHS and the public, a similar approach is taken and the scheme has access to their own independent advisers when assessing a claim. This does not mean specialist advice and support should not be available to individuals. In particular, we have found that access to independent support and advocacy can be very powerful, particularly for the vulnerable.

I note the criteria that people involved should feel the scheme to be equitable. This is clearly a desirable aspiration. However, decisions about this are usually made on the basis of outcomes. It is my frequent experience that if someone is happy with my decision, they consider me to be fair and impartial; if that are not, they consider that I am biased. I would suggest that clear routes are built in to allow people to interact with the scheme so they have a sense of ownership in the process. It may be appropriate to involve some sort of user or patient input in the creation of the scheme and, in particular, to say how they want to interact with the process.

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

Desirable

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

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

Yes ☐ **No** ☐

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

These desirable outcomes should be seen as essential. I think that any scheme which fails on these points would be considered to be a lost opportunity.

On the point directly relating to the complaints system, I would go further and say not only should the scheme not prevent patients from seeking other forms of non-financial redress, it should work alongside the complaints system and patients should be able to seek "redress" and receive a single response. The point is made in the review group documentation that patients saw the failing as part of a broader context. They should not lose this context by being required to artificially separate their concerns into financial and non-financial. The ideal would be they would be able to bring their concerns to one place - these should be dealt with and, if financial redress is appropriate or sought, a response should be provided alongside the response to any non-financial issues. This does not mean that only one organisation or scheme is involved but that any requirement to co-ordinate or co-operate should be on those organisations and schemes and not on the individual with the concerns.

Wider issues

- The scheme contributes to:
  - organisational, local and national learning
  - patient safety
  - quality improvement
- Lessons learned can be used to influence organisational risk management in the future
- The scheme encourages and supports safe disclosure of adverse events
- The scheme does not put barriers in place for referral to regulators of any cases which raise grounds for concern about professional misconduct or fitness to practise.

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

This question flows very naturally from the one above and my answer builds upon the one I have already made. We have worked a great deal to ensure that, as far as possible, learning from complaints is shared. We publish all investigation reports and almost all of our decisions are also reported. We have regular contact with health boards, and regulators. It is notable that the Patient Rights (Scotland) Act 2011 also seeks to reinforce learning from all feedback.

Throughout my response to this consultation, I am aware of the benefits we would all gain from a move to a culture of openness and partnership rather than one which is defensive and seeks to protect resource and reputation above all other factors. A no-fault compensation scheme may well help by reducing the fear of litigation which certainly helps to drive a culture of defensiveness.

5. When considered the Review Group's suggested essential principles and criteria against other schemes and the Swedish model came out on top. Based on this the Review Group offered:

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

Question 5: Based on the background information on the system in operation in Sweden given in Annex A would you support the approach suggested in Recommendation 1?

Yes ☐ **No** ☐

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

On questions 5 to 12, please see my answer to question 1.

> **Recommendation 2 -** that eligibility for compensation should not be based on the 'avoidability' test as used in Sweden, but rather on a clear description of which injuries are **not** eligible for compensation under the no-fault scheme.

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

Yes ☐ **No** ☐

If not, why not?

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

6. The Review Group was of the view that any recommended changes to a no-fault system should cover all healthcare professionals including those not directly employed by the National Health Service. The group believed that fairness dictated that all patients whether treated by the NHS or privately should have access to an improved system if possible. If this proved impossible, the group nonetheless believed that there were benefits that could be obtained by a move to no-fault for NHS patients. The group's preference was that **all** patients should be covered by the no-fault scheme and offered:

> **Recommendation 3 -** that the no-fault scheme should cover all medical treatment injuries that occur in Scotland; (injuries can be caused, for example, by the treatment itself or by a failure to treat, as well as by faulty equipment, in which case there may be third party liability)

Recommendation 4 - that the scheme should extend to all registered healthcare professionals in Scotland, and not simply to those employed by NHSScotland.

(As explained in the Cabinet Secretary's foreword we acknowledge that further work is needed to help in our understanding of the volume, level and cost of compensation claims handled by the Medical Defence Unions and private healthcare providers. We will seek to explore this further with the relevant stakeholders during the consultation period.)

Question 7: Do you support the view that, if introduced, a no-fault scheme should cover all clinical treatment injuries (e.g. private healthcare and independent contractors) and all registered healthcare professionals and not just those directly employed by NHSScotland?

Yes ☐ No ☐

If not, why not?

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

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

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

7. The Review Group did not favour the use of a tariff system for compensation, as it felt that this would not address individual needs and it was unlikely that people would buy into a system where compensation was based on a tariff. The group therefore offered:

Recommendation 5 - that any compensation awarded should be based on need rather than on a tariff based system;

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

Yes ☐ No ☐

If not, why not?

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

8. The Review Group was satisfied that a no-fault scheme established as they describe would be fully compatible with the requirements of the European Convention of Human Rights, based in particular on the need – as in Sweden and New Zealand – to build in appropriate appeals mechanisms, with an ultimate right to appeal to the courts on a point of fact or law. In addition, retention of the right to litigate will ensure that those for whom the no-fault system is felt to be inappropriate will still be able to raise claims using this route. The group recommended:

> **Recommendation 6 -** that claimants who fail under the no-fault scheme should retain the right to litigate, based on an improved litigation system
>
> **Recommendation 7 -** that a claimant who fails in litigation should have a residual right to claim under the no-fault scheme
>
> **Recommendation 8 -** that, should a claimant be successful under the no-fault scheme, any financial award made should be deducted from any award subsequently made as a result of litigation
>
> **Recommendation 9 -** that appeal from the adjudication of the no-fault scheme should be available to a court of law on a point of law or fact.

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

Yes ☐ **No** ☐

If no, why not?

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

Yes ☐ **No** ☐

If yes, what are your concerns?

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

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

10. It is proposed that the suggested improvements will be taken forward as part of the forthcoming consultation on the Courts Reform Bill later this year by the Scottish Government Justice Directorate. In particular the Scottish Civil Courts Review[22] recommended that pre-action protocols should be made compulsory and it is considered that this would assist in resolving many of the areas identified by the Review Group In addition, Sheriff Principle Taylor's Review of Expenses and Funding of Civil Litigation in Scotland[23], which is due to report at the end the year will consider a range of issues.

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

Yes ☐ No ☐

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

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

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

Yes ☐ No ☐

12.1 What are your views on the Review Group's suggestion that the future care component of any compensation in such cases could be provided in the form of a guarantee of delivery of services (both medical and social care) to meet the needs of the child, instead of by way of a monetary sum?

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

General Comments

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

The Scottish Public Services Ombudsman (SPSO) is the independent body that investigates complaints from members of the public about devolved public services in Scotland. There is clearly a relationship between complaints and the claims process. The background documentation to this consultation makes reference to us and our work in this context. In this section, I do not wish to repeat this but to highlight two points which I think are particularly relevant 1) our role in terms of compensation and 2) the need to ensure any new scheme fits alongside current process and does not lead to problems seen elsewhere when the landscape becomes cluttered.[24]

Compensation

One point which is not clear in the documents is that the reasons why compensation is not part of the complaints process are complex. Compensation is not dealt with through the complaints process but this does not mean there is never a financial outcome sought or that one is never provided. While it happens rarely, individuals do come to us who would like compensation for a loss or injury. We explain that we do not provide compensation (we have developed a leaflet for the public setting out our role in relation to compensation). In my experience, it is exceptional that an individual or family who wish to complain about the NHS withdraw a complaint when we explain that we do not provide compensation. The most common outcomes sought are for an apology which will implicitly include an acknowledgement that the person coming to us is right and something has gone wrong, and for reassurance that the problem will not happen again.

I am aware that we can be and sometimes are used to obtain information that may then be used in a claim process. This is, in part, because the way claims and complaints are so clearly separated and there is a perception that the NHS will not provide answers to questions once the claims process has begun. Again, I have to say this is a minority of cases, although it is a trend which I think is growing.

There are circumstances where I would recommend a financial payment be made by the NHS. This usually only happens when an individual has had to pay for private care which should have been funded by the NHS.

It may not be fully appreciated, however, that there is no specific restriction in the legislation that created this office that prevents me from making other types of financial redress in NHS cases. Indeed the legislation for this office makes no specific mentions of recommendations. It is simply an accepted part of the role of an ombudsman that, in ensuring justice between the citizen and the state, we will make recommendations and that they should, in some way, seek to redress the loss, injustice or hardship caused by any problems we have identified. My office has produced guidance which shows how we will approach such decisions. The NHS in

[24] The Sinclair review pointed out the problems that can occur when the complaints handling landscape becomes cluttered. http://www.scotland.gov.uk/Topics/Government/PublicServiceReform/IndependentReviewofReg/ActionGroups/ReporttoMinisters

Scotland has said they will not make payments in terms of compensation unless legally liable and it is not the role of my office to establish negligence. We also are aware of the difficulties in making clear and consistent assessments of injury and loss when the issue is personal injury and distress. Causation can be a further issue. It is usually easier to demonstrate there has been a failing than to say what the outcome of that failing has been. Given this, I do not make recommendations for financial payments to compensate for any injury or loss or distress suffered when I uphold a complaint against the NHS.

It is not, however, inevitable that the complaints process does not provide for compensation. Ombudsmen in England, Wales and Northern Ireland have provided and continue to provide financial remedies on occasion. The amounts can be significant. For example, I am aware the Parliamentary and Health Service Ombudsman has made recommendations for sums in large figures and will use the guidelines used by the judiciary in calculating appropriate compensation. This recent Welsh Ombudsman report includes a figure for a financial payment following a complaint[25].

I am not opposed in principle to the idea that financial redress as a remedy could be made by the Ombudsman on health complaints. It should be noted, however, that Ombudsman recommendations are not legally enforceable and rely on the NHS body accepting the failing and agreeing with the amount. There are indications that NHS Scotland would likely challenge any such recommendation given their position that they will only provide compensation when legally liable. I am aware that one UK Ombudsman is currently awaiting the outcome of a court challenge to such a recommendation by an NHS body which disputes their right to make such recommendations. Challenge is not itself a sufficient reason for not having financial redress available from the Ombudsman in health matters. I cannot speak for any future Ombudsman but given the settled practice of this office any change here would only likely be undertaken following a consultation with interested parties, including Parliament, since in my view this would represent a major change in the operation of the SPSO. It is though important to note that the clear line between a claim and a complaint is one that has developed through time and is not inevitable.

Responding to concerns holistically

My second point is about the importance of recognising the whole of the complainant's journey. In the background research to this consultation, there was much that I recognised - the importance of validation for those pursuing an issue, often on behalf of a loved one; the wish to ensure that no one else is affected by a problem an individual or family have endured; and, perhaps most significantly for this consultation, that it is not a single, clinical error that leads to a claim but a complex picture which usually includes communication problems. It is important that whatever scheme is developed we do not lose sight of the ability to look holistically at the full circumstances surrounding the concerns being raised and that we do not require

[25] http://www.ombudsman-wales.org.uk/en/investigations/public-interest-reports-listed-by-subject/case-201102690.aspx

anyone to have to access more than one system to ensure their experience of NHS care can be looked at in the round.

As well as making decisions on individual complaints, we also have a duty to help support the improvement of complaints handling and have considerable expertise about what can happen when complaints processes go wrong. It is our experience that individuals can feel frustrated and find it difficult to navigate complex systems which have more than one route for pursuing the same concern, sometimes with different possible outcomes. At times, we see issues where individuals tend to see the NHS as one service and although their care journey may involve a GP, a pharmacy and a hospital, they may be confused that in order to complain about their care, they may need to make three separate complaints. The welcome move towards greater integration of health and social care is already leading to complexity in complaints processes[26]. Part of the problem is that flexibility in the provision of care is not reflected by flexibility in the way complaints are handled. Any introduction of a new scheme should be designed to be as easy to access as possible and to sit alongside existing processes. It should not be the case that you need to access two procedures: the complaints and no-fault compensation scheme to get the full answer. Both may need to be involved and may have separate roles but I would argue that they should at least be able to work together or to cross refer issues and that flexibility rather than barriers be built in.

Ideally, the introduction of a no-fault scheme could mean that no one should have to go through two systems to ensure communication is better in the future and that any loss is compensated for in relation to the same clinical incident. This does not mean two separate processes may not be involved but that they should be able to work together seamlessly for the benefit, initially of the individual but in the long term, this seamless working should also help to ensure that it is easier to share lessons learned from any problems.

We are grateful for your response. Thank you.

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[26] See our response to the recent consultation – http://www.spso.org.uk/files/webfm/Media%20Centre/Inquiries%20and%20Consultations/2012/12.09.11%20SG%20integration%20of%20adult%20health%20and%20social%20care%20all%20docs.pdf