RESPONSE TO

SCOTTISH GOVERNMENT CONSULTATION

‘Proposals for a ‘No-Blame’ Redress Scheme for Harm Resulting from Clinical Treatment’

June 2016

Introduction

Action against Medical Accidents (AvMA) is the UK charity for patient safety and justice. AvMA has over 30 years of experience of supporting and advising people who have been affected by medical accidents (lapses in patient safety) and working with all stakeholders to improve patient safety and the systems for support and redress for those affected.

Summary of AvMA's response

AvMA welcomes the intentions of Scottish Government to create a fairer way of compensating people and aligning this effort with other processes for improving patient safety. If carefully designed and implemented well the proposed redress scheme will be a radical improvement offering fair redress to many more people in Scotland and developing a learning culture. However, the proposals currently lack sufficient detail and we have serious concerns about some of them. If the proposals are not improved, they could end up being a retrograde step.

We welcome the innovative proposal to adopt an avoidability test for determining eligibility. It is only fair that people whose harm could have been avoided if they had simply received a reasonable level of care should receive redress. However, 'reasonable care' needs to be better defined as does the consideration of causation. The new test needs to be significantly easier to meet than the test for medical negligence.

We strongly object to the proposal to repeal Section 2(4) of the Law Reform (Personal injuries) Act to take away people's choice to use private providers where necessary for continuing care needs. This has nothing to do with the redress scheme as such and should be the subject of a much wider discussion with stakeholders and a full consultation in its own right. The redress scheme should not be contingent on restricting the choice of people and continuing care needs.

We are disappointed that there is no mention in the consultation document about how patients would be empowered in the process. As essential component to a fairer redress scheme is access to specialist independent medico-legal advice.

The independence of the redress scheme will be crucial for public confidence and the success of the scheme. We do not believe basing it with the Central Legal Office is appropriate.

Lastly the changes, if they are to reap their potential to be a radical improvement in compensating people fairly and learning lessons to improve patient safety , will require a large investment in personnel and appropriate skills and expertise, and a change in culture. This challenge should not be underestimated.

We look forward to working with Scottish Government and others to improve the proposals in the interest of fairness and patient safety.

Our response to the specific questions asked in the consultation document are set out below.

ANSWERS TO CONSULTATION QUESTIONS

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

Response

Yes. We agree that there should be an integrated approach which would contribute to learning for patient safety as well as provide appropriate redress for patients. With this in mind we propose that included in the scheme should be a requirement to provide the patient with a 'patient safety letter' at the conclusion of the process which sets out the learning and actions arising and analyses the approach to investigations and the application of the Duty of Candour. However, we would stress that this whole initiative will require a significant amount of training for staff involved in investigation, and investment in more specialist staff with the required skills in investigations. Most incidents and complaints investigations do not currently consider eligibility for compensation and the 'avoidability' test is new and complex for staff to understand. A key lesson from the Welsh 'Putting Things Right' scheme is that there needs to be investment in training and specialist staff.

We take it that consideration of eligibility will be automatically included in investigations of incidents. However, it is important that the scheme allows for patients to make their case for/apply for redress and not for this simply to be about cases already identified by staff as meeting the criteria. Patients will need access to specialist and independent advisers to explain the scheme to them and help them make their own case for eligibility, and it is essential that provision for this should be built into the scheme.

2. Do you agree with the broad principles for the scheme?

Response

Yes. We agree with the broad principles of the proposed scheme and welcome this as a radical and innovative approach which has the potential to create a fairer system and enhance patient safety. However, the devil will be in the detail, of which there is relatively little in the consultation document. There are elements about the proposals as currently outlined about which we have strong concerns. We would welcome involvement in further developing these plans and further consultation on the final proposals.

3. Do you agree that eligibility should be structured around the notion of 'avoidability'?

Response

Yes. We agree that eligibility should be structured about the notion of 'avoidability'. We believe that this has several important advantages over the legal test of negligence which is used in litigation.

- It is more aligned with patient safety, i.e. establishing whether the harm could have been avoided and how processes can be integrated.
- It avoids the necessity to point a finger of negligence or blame at individual clinicians. It should consider whether the organisation / system could have avoided the harm.
- Unlike litigation, it does not encourage a defensive denial culture. In litigation defendants first ask themselves whether it is possible to defend a case – not whether someone deserves redress / compensation.

We agree that the test should be whether the harm would have been avoided by the use of 'reasonable care'. This should mean that more people will receive redress. It can only be right that people should receive redress if the harm would have been avoided by 'reasonable care'. However, more detail is needed on the definition of "reasonable care" to ensure that is genuinely an easier test for a person deserving redress to meet, and is focussed more on whether the organisation could have avoided the harm for example by following good practice guidelines, having sufficient qualified staff and the right patient safety culture etc.

The use of the avoidability test should represent a radical departure from the use of breach of duty (negligence) and causation used in legal cases. The difference between the harm probably having been avoidable had the organisation provided reasonable care and having to prove 'causation' has to be very carefully thought through and articulated to avoid would be deserving recipients of redress losing out due to over legalistic assessments of causation. Again, we stress that it is essential that patients/their families have access to independent legal advice and support to empower them in the process.

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

Response

No. We think that it would be difficult to accurately assess whether someone will experience harm for a continuous period of 6 months. The principle should be that if avoidable harm has been caused, the person receives the appropriate redress. The lower the harm and its impact, the lower the size of the redress will be. Also, if this is to be integrated with the normal approach to adverse events and patient safety, it makes sense to include all such incidents. If this restriction was put in place it would have the effect of excluding cases where the patient dies within six months of having been harmed, which would clearly be unfair.

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

Response

No. We do accept that the scheme should initially be restricted to treatment provided by NHS Boards as opposed to primary care providers as well. However, the term 'directly employed NHS staff' is inappropriate.

Firstly, to bring the scheme into line with other processes with which it is supposed to be integrated, the focus should not necessarily be on individual staff. It is perfectly possible that the harm may have been avoidable had the *organisation* provided reasonable care. Patient safety incidents are most often the result of systems failures rather than individual clinicians' mistakes.

Secondly, many staff providing treatment in NHS Health Boards are locums/agency staff who are not directly employed. Consideration should also be given as to whether patients harmed in services which are commissioned by the NHS should have access to the scheme.

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

Response

Not initially. We can see that for pragmatic reasons Scottish Government needs to set the cap somewhere. We think that there is an argument for a trial/pilot period with a much lower cap. Our concern is that this is a radical new approach which takes time to bed down. We would not like to see people losing out whilst that happens. Once the scheme has bedded down and is seen to be working fairly the cap could be extended.

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

Response

Partially agree. The most important thing is that people are compensated fairly based on their needs. The Judicial College Guidelines can be used as a guide but are not sufficiently comprehensive to cover every form of harm. We note that the consultation document says that compensation for patrimonial loss will be required to be assessed individually. However, we are concerned that it is stated this will only 'often' be the case.

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

Response

Partially agree. We agree that there should be some flexibility to extend the eligibility and scope at a later stage should be built in. However blanket flexibility for ministers to bring in changes that would dramatically change the nature and scope of the scheme without due process would be dangerous. There should be a requirement for there to be consultation on changes and parliament to consider changes to the regulations.

9. Do you agree that the legislation should protect against 'double dipping'?

Response

Partially agree. We agree that if a patient accepts an award under the scheme they should not be able to use that to raise a legal claim for negligence over the same harm for which they have been compensated under the scheme. In other words there should be protection from 'double compensation'. However, it is vital that the right of the patient to make a claim over greater harm which comes to light after they have accepted an offer of redress, and their right to make a claim over different aspects of the incident than those dealt with by the scheme remains.

We believe an essential part of that process must be to provide independent legal advice to the patient in order to help them make an informed choice as to whether to accept an award.

We do strongly believe that any information about a patient's treatment must be shared with them unconditionally.

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

Response

No. We believe that this is a huge issue which affects people who would not be eligible for the redress scheme in any case. We think it is inappropriate for such an important issue to be tagged on to the end of a consultation about the redress scheme. It would need thorough engagement with stakeholders to consider all the implications and a full consultation in its own right.

The object of litigation is to put the injured party back into as near a position as possible were it not for the negligent harm. The ability to purchase private care is sometimes a necessity, and the injured party should enjoy some choice.

We note that the question assumes that needs are independently assessed and 'guaranteed'. However, we do not see how care packages could be 'guaranteed' if they remain subject to the decision making of and resources available to local authorities and the NHS.

If the legislation was repealed in the way proposed it would impact negatively not only on people affected by clinical harm but all people affected by personal injury. If the repeal was restricted to clinical cases it would put injured patients in a worse position than other personal injury victims. This would be unacceptable.

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

Response

No. We do not believe that the Central Legal Office would be the most appropriate body to administer the scheme. This would lack independence and therefore public confidence. It would also be asking the Central Legal Office to administer two completely different approaches at the same time. We would favour an independent body administering the scheme. If this is not possible, it will be imperative to separate out the other functions of the CLO from administration of the redress scheme and create a separate board with independent members to oversee the redress scheme.

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

Response

No – not on their own. We agree that an independent appeal panel with access to independent medical expert input would be essential but much more detail on how this would work in practice is needed. We believe the patients would need to be provided access to independent specialist advice to enable them to make their case and inform the considerations of the panel and its experts. The administration of the scheme itself would also need to be sufficiently independent.

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

Response

No. Careful consideration will need to be given to the arrangements for the appeal panel and governance overall to ensure robust independence and patient confidence. There is insufficient detail at present about how the panel would work.

We believe that the patient/family should ultimately have the right to take their appeal to a court, as was recommended by the expert group which advised Scottish Government on no-fault compensation.

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

Response

We note that the definition of "harm" provided at the end of the document is lacking in several respects. It is not clear if this is deliberate or not. For example it does not include "death", "failure to treat" or decreased life expectancy. We believe these are crucial elements which the redress scheme should be able to provide redress for.