**Scottish Government**

**Consultation on a Patient Safety Commissioner role for Scotland**

**A response by the Association of Personal Injury Lawyers**

**May 2021**

**Introduction**

When serious failures occur, they have devastating consequences for individuals. Many incidents could have been avoided if lessons had been learned. In 2020, Thinktank IPPR produced a report; Better Than Cure, examining the need for an injury prevention policy[[1]](#footnote-1). It found that public health was a priority amongst the public and that it is time for a renewed focus on injury prevention generally. The report recommended that Government should treat injury prevention as a public health priority and introduce a high-level cross sector injury prevention strategy[[2]](#footnote-2). Part of their cross-sector recommendation is to introduce a new role of injury prevention commissioner. Whilst the IPPR proposals are overarching recommendations the importance of not having piece-meal reform is an important one. APIL urges the Scottish Government to approach Westminster about the need for a wider, cross sector safety strategy.

The full extent of patient harm in Scotland is unclear due to the lack of available patient safety and adverse events data. Scottish health boards collect this data separately which makes it difficult to establish how prevalent the patient safety issues are. In England, this data is collected by one body, NHS England, this ensures transparency and accessibility. It is concerning that this data is not collected centrally by one organisation in Scotland. The UK generally has a long way to go on the issue of patient safety. The need to significantly improve levels of patient safety is not a new concept. It is important that patients and their families have confidence in the system when things do go wrong. When something goes wrong trust is lost, relationships between healthcare professionals and patients fail and clinicians can become defensive, resulting in a reluctance to recognise error. This often results in a failure to apologise and provide a form of explanation. The system is complex and as a result, learning from mistakes and implementing change to ensure incidents do not happen again is often either slow or never implemented. Families often approach our members as a last resort because they feel they are not being listened to, answers are not being given and their concerns have been dismissed.

A consistent theme in high profile inquires such as the Cumberlege review is the healthcare system’s failure to listen. Baroness Cumberlege’s recommendation for a Patient Safety Commissioner (Commissioner) aims to strengthen advocacy for patients. The recommendation is an important one but the remit is too narrow. Although the patient safety areas within the First Do No Harm report are important, there are other areas of patient safety which also require immediate focus which go to the root of patient safety issues. In our members’ experience, they are rarely approached about defective medical devices and products. Instead, they are approached by patients and/or their families who want to understand what happened to them, why it happened and to ensure that it does not happen again to others. It is important that solutions are found for the system as a whole and not a niche group of litigants. In order to drive real change the role should be system wide to ensure there is a true advocate for *all* patients. In addition, the Commissioner must be independent of the NHS and political influence and have statutory powers to enforce the duty of candour. This will also enable them to hold the Government and the NHS accountable for failings in patient care and be a champion for those affected by adverse effects and avoidable harm.

The culture within the healthcare profession and hospitals is also problematic. The IPPR report specifically highlights that the NHS is not optimised for patient safety due to the hierarchical system which is not open to learning and has an atmosphere of fear[[3]](#footnote-3). APIL believes the Commissioner should focus on changing the culture of the medical profession to benefit public safety. The dismissive and defensive attitude is specifically mentioned in numerous patient safety reviews, including the recent Ockenden and Cumberlege reviews, yet nothing seems to be done to change this. The culture and attitude impact reporting of issues due to fear of speaking out against health boards and colleagues. Many healthcare professionals *want* to report bad practice or safety issues however there are barriers which prevent them from doing so. They often have to approach lawyers instructed by patients and their families confidentially out of fear of jeopardising their reputation and career within the medical profession. This clearly contributes to poor practices being ignored, despite causing avoidable harm to patients. APIL suggests that a safe whistleblowing structure is required to create a safe, accessible way for healthcare professionals to report issues without the consequence of being suspended. This culture and fear of recrimination should also be addressed through medical/professional development training. There is also a serious lack of learning from mistakes which are reported. Investigations which do take place into reported issues are poor because they are conducted by people within the NHS. This results in the failure to identify issues and deal with them accordingly to protect the public from adverse events.

**Q1. Do you agree that the Patient Safety Commissioner role should first focus on medicines and medical devices, as set out in the Cumberlege Review?**

No. Although issues with medicines and medical devices are important, there is a systemic failure in the healthcare sector to listen when things go wrong. In our members’ view, cases involving surgical mesh or other devices are generally dealt with satisfactorily.They are more often contacted by patients who are concerned by a particular medical practitioner’s actions or as a result of systems failures which have occurred within a particular health board. The Commissioner role suggested in this consultation excludes incidents arising from other underlying issues such as a lack of staff training and/or the serious shortfall in staff which contributes to substandard care and treatment resulting in avoidable harm. For example, maternity units that do not have sufficient midwives and overstretched psychiatric and mental health services create serious patient safety issues which should be prioritised and dealt with. The Commissioner’s role would also exclude reviewing actions of healthcare practitioners directly, therefore too narrow in scope.

It is important that reform does not compound an already disjointed and complex system. There is a real opportunity for the Scottish government to provide a voice to harmed patients and make a positive difference.

**Q2. If the role were to expand in the future, which specific aspects of patient safety do you feel the Patient Safety Commissioner should focus on?**

APIL reiterates that the role of the Commissioner should be broader from the outset to include wider patient safety issues. In addition, the Commissioner’s role should be extended to consider information disclosure including whether a patient has received sufficient information on treatment and options to make an informed decision.

APIL believes that an independent body should also be created to investigate adverse events in Scotland. Currently, there is no independence in investigations into adverse events as a result of treatment or care. Those who investigate the reported events are within the NHS, which results in issues being ignored and therefore not dealt with. This leads to the same issues arising time and time again because reports do not seem to be shared with other health boards.

Often the investigation reports are very general and fail to conclude whether the outcome could have been altered or not. Our members find that independent reports are much clearer in whether the outcome could have been avoided. An independent body would ensure a thorough investigation into adverse events and better highlight issues to be dealt with.

An example of failing to report the real cause of incidents, which results in a further adverse event, is highlighted in the following case study:

*Case study*

*A young female patient committed suicide whilst sectioned in a mental institution by strangling herself on her bed. The health board was previously in front of a fatal accident enquiry regarding an identical case where it was stated that the bed should be destroyed. The health board failed to destroy the bed and continued to purchase more of the same bed – one of which this patient used to commit suicide. The report was detailed in highlighting her symptoms and treatment/medication, however the report failed to highlight that the bed was the cause of the suicide. The health board was fined £100,000 recently following a prosecution.*

These reports following investigations do not seem to be shared across health boards. Our members also report that it is often difficult for their clients to obtain the report in relation to the issue which they raised. If it is difficult for the patient and/or their family to obtain the report, it suggests that the health boards are reluctant to share them. If hospitals are emphasising that they are learning from their mistakes and implementing change to ensure that events do not happen again, then these reports and follow-up actions should be shared with other hospitals in Scotland as well as being accessible to patients who have raised the concern. APIL hopes that the Commissioner would co-ordinate this process, making investigation reports more widely accessible to hospitals and patients which will have a wider positive impact on health services, enabling them to learn from the mistakes of other hospitals and implement change and recommendations. It must be mandatory for health boards to implement the Commissioner’s recommendations to improve safety. The Commissioner should be recognised as independent and health boards must follow the recommendations rather than ignore or fail to implement them.

**Q3. Do you believe that the Patient Safety Commissioner should be independent of the Scottish Government?**

In light of Baroness Cumberlege’s recommendation, the Commissioner must be independent of the Scottish Government. The Commissioner must be free of political influence to hold the Government and its agencies accountable and make real change to improve healthcare services for the public. The examples given within the consultation document, namely the Children and Young People’s Commissioner who reports to the Scottish Parliament and the Scottish Veterans Commissioner who is accountable to the veteran’s community are inappropriate suggestions. These suggestions are inappropriate because the Children and Young People’s Commissioner is not independent of political influence and being accountable to a community like the Veterans Commissioner is not enough to enforce real change.

**Q4. Do you believe that the Patient Safety Commissioner should be independent of the NHS?**

In light of Baroness Cumberlege’s recommendation, it is crucial that the Commissioner is independent of the NHS. Adverse event investigations undertaken by the NHS are inadequate in concluding whether the adverse event could have been avoided. The investigation reports produced fail to acknowledge the real reason for the adverse events because the body undertaking the investigations are not independent, which results in failing to act on serious patient safety issues.

In order for patients and their families to have confidence in the system and know that their concerns will be dealt with, it is vital that the Commissioner is independent of the NHS and is not funded by the NHS. This will ensure that the NHS is held to account for their failings rather than the health board coming to their desired conclusion. It is crucial that the Commissioner has the power to make real change and ensure that their recommendations are implemented to protect the public from avoidable harm and adverse events.

**Q5. Who should the Patient Safety Commissioner be accountable to?**

APIL believes that the Commissioner should be accountable to Parliament in a general way rather than being accountable to the Scottish Government or any political party. We suggest they should be accountable in the same way as a Chairman would be accountable to a Public Inquiry.

**Q6. How much do you know about existing policies and organisations already in place (listed in table 1 on page 11) to support patients’ voices to be heard within the healthcare system?**

APIL’s Scottish members are quite aware of the existing policies and organisations already in place. They were however unaware of Care Opinion. On inspection of the website and looking into the organisation, our members think this organisation appears to be useful for patients to share their experiences and stories. Perhaps more advertising and signposting to the Care Opinion’s website is required. This is something that our members could signpost their clients to.

**Q7. In your view, despite the existing ways patients can make their voices heard (listed in table 1 on page 11), why do you think people still feel that this is not happening?**

APIL does not think that the existing organisations are effective because they are unable to make real change. Patients and their families often feel that lessons have not been learnt from what has happened to them. Research conducted by *Farrell et al.[[4]](#footnote-4)* which was reported in the Scottish Government’s No Fault Compensation Review Group Report and Recommendations[[5]](#footnote-5), found that when an error occurs, patients expect a genuine and meaningful apology and explanation and want to ensure that steps are taken to prevent the error from recurring[[6]](#footnote-6). The research demonstrates that this is the primary aim for most patients rather than a financial award[[7]](#footnote-7) yet rarely do patients receive such an apology. In light of this, Scotland needs an organisation to ensure that recommendations are implemented to make real change to enhance patient safety and achieve the primary aim of the patient and/or their family. The Commissioner could ensure that this aim can be achieved by holding the Government, its agencies and the NHS to account for failings.

**Q8. In your view, what should the main functions of the Patient Safety Commissioner be?**

The Commissioner should have the independence to drive change and the power to enforce that change. This includes proactively assessing and collating data from other organisations and reviewing individual cases to establish adverse event trends. These trends may highlight a clear patient safety issue which the Commissioner should then investigate. The Commissioner should also improve communication between health boards and build on learning from mistakes in a bid to achieve greater uniformity/consistency across all of Scotland’s health boards. Similarly, the Commissioner should aim to improve transparency by ensuring information is adequately and timeously communicated to patients.It is important that the Commissioner’s function does not duplicate the general reactive function of the Scottish Public Services Ombudsman and the Health Improvement Scotland.

**Q9. What skills and expertise do you think the Patient Safety Commissioner needs to carry out their role?**

In order to carry out their role successfully, the Commissioner should be aware of how the NHS operates. APIL suggests that a doctor, midwife or nurse who no longer works within the NHS should be the Commissioner. This is because they would require inside and up-to-date knowledge on processes however would need to be independent of the NHS. This would also ensure that the Commissioner understands and has experienced the pressures which come with working within the healthcare profession, especially within a hospital setting. In light of our view that the Commissioner should be proactively assessing data to establish trends, the Commissioner, or their team, must have experience in analysing data.

Some legal knowledge would also be useful within the supporting team; however, we do not think it is strictly necessary for the Commissioner themselves to have legal knowledge. The most important part of patient safety issues is assessing whether the adverse event could have been avoided. This requires knowledge and experience in healthcare processes rather than legal knowledge. APIL suggests that having a well-defined legal structure will allow those within the team as well as the Commissioner to learn about the legal aspects of the role required.

**Q10. What support do you think the Patient Safety Commissioner would need?**

The Commissioner needs a supporting team who have analytical experience in order to assess data and establish trends of adverse effects to investigate. It would also be beneficial if the supporting team had some legal knowledge, although a well-defined and easy to follow legal structure should be available to assist the Commissioner with driving and enforcing change.

**Q11. Do you think that the Patient Safety Commissioner role should be established in law?**

In light of Baroness Cumberlege’s recommendation, it is fundamental that the Commissioner’s role is established in law. It is crucial that the Commissioner has the power to compel people to talk to them and provide documents and information required to ensure a thorough investigation takes place. Without this power, healthcare professionals and health boards may be reluctant to participate in investigations and the Commissioner would be unsuccessful in improving patient safety. APIL suggests it should be an offence to fail to assist the Commissioner in an investigation into patient safety matters.

APIL does not agree with the suggestion within the consultation document that the Commissioner could be established by adding the role into an existing organisation. The Commissioner must be established in law and be wholly independent so that it is able to achieve the aims it is set out to achieve, effectively.

**Impact Assessments**

The introduction of a Commissioner should not negatively affect protected characteristics. The Commissioner’s work should be beneficial and accessible to all. People are disproportionately affected by adverse events as a result of their ethnicity, disability or sex within healthcare services. For example, the IPPR report[[8]](#footnote-8) outlines that the rate of maternal death in pregnancy is much higher among black and Asian women – 15 and 40 deaths out of 100,000 compared to 8 deaths of white women. It also states that access to healthcare is affected by endemic structural racism which results in symptoms and signs being dismissed more often in black and Asian women[[9]](#footnote-9). With regard to sex, the First Do No Harm report clearly demonstrates that women are regularly dismissed for having ‘women’s issues’ and are not taken seriously by healthcare professionals when disclosing adverse effects of treatment[[10]](#footnote-10). The Commissioner should explore the issues with regard to protected characteristics and ensure that those who are disproportionately affected by healthcare services are better protected from adverse events. This should ultimately benefit those that are disproportionately affected. The Commissioner’s role should also help protect the rights of a child in relation to maternity cases and ultimately improve access to safe healthcare for all within society.

There are serial safety issues which specifically affect island communities in Scotland. The Commissioner should proactively assess the specific problems which island communities face to ensure that safe healthcare is accessible. The Applecross community for example have been forced to raise money and build a permanent helipad to ensure that those within the community and those who visit the area are better able to access urgent hospital care. Having a permanent helipad would create access to urgent care for an isolated community who would otherwise be at least two hours away from a hospital[[11]](#footnote-11). The Commissioner’s work should benefit island communities by giving better access to healthcare.

**About APIL**

The Association of Personal Injury Lawyers (APIL) is a not-for-profit organisation which has worked for 30 years to help injured people gain the access to justice they need, and to which they are entitled. We have more than 3,000 members who are committed to supporting the association’s aims, and all are signed up to APIL’s code of conduct and consumer charter. Membership comprises mostly solicitors, along with barristers, legal executives, paralegals and some academics.

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1. Lesley Rankin & Henry Parkes Better Than Cure Injury Prevention Policy (Institute for Public Policy Research (IPPR) August 2020) [↑](#footnote-ref-1)
2. Ibid. p 4 [↑](#footnote-ref-2)
3. IPPR (n 1) p 25 [↑](#footnote-ref-3)
4. Dr Anne Maree Farrell, Ms Sarah Devaney & Ms Amber Dar ‘No Fault Compensation Schemes for Medical Injury: A Review’ (Manchester University 28 January 2010) [↑](#footnote-ref-4)
5. Prof Sheila A.M. McLean - No Fault Compensation Review Group Report and Recommendations vol 1 (commissioned by The Scottish Government 15 February 2011) < [https://www.webarchive.org.uk/wayback/archive/20170105042808/http://www.gov.scot/Topics/Health/Policy/No-Fault-Compensation/ReviewGroupVol1](https://www.webarchive.org.uk/wayback/archive/20170105042808/http%3A/www.gov.scot/Topics/Health/Policy/No-Fault-Compensation/ReviewGroupVol1) > [↑](#footnote-ref-5)
6. *Ibid.* p 5 [↑](#footnote-ref-6)
7. *Ibid.*  [↑](#footnote-ref-7)
8. IPPR (n 1) p 23 [↑](#footnote-ref-8)
9. L Anekwe ‘Ethnic disparities in maternal care’ (British Medical Journal 2020) < [Ethnic disparities in maternal care | The BMJ](https://www.bmj.com/content/368/bmj.m442) > [↑](#footnote-ref-9)
10. First Do No Harm – The report of the Independent Medicines and Medical Devices Safety Review (OCL 8 July 2020) < <https://www.immdsreview.org.uk/downloads/IMMDSReview_Web.pdf> > p 17 - 18 [↑](#footnote-ref-10)
11. Help Appeal ‘New helipad in memory of teen Bethany Walker nears completion’ 18 March 2021 < <https://helpappeal.org.uk/new-helipad-in-memory-of-teen-bethany-walker-underway/> > [↑](#footnote-ref-11)