Wilma Gunn, on behalf of Scottish H.A.R.T., calls on the Scottish Parliament to introduce the necessary legislation to ensure that provision is made to offer screening for cardiomyopathy and all heart disorders a) to all 16-year-olds and over embarking on taking part in strenuous competitive sports and; b) to all families with a history of cardiac problems.

WILMA BRYDON GUNN,
Founder and National Chairman,
Scottish H.A.R.T.
Petition by Mark Russell calling for the Scottish Parliament to express its deep concern that despite health being a devolved matter the regulation of Health Professionals has been reserved by the Westminster Parliament.
PETITION BY MARK RUSSELL

to

THE SCOTTISH PARLIAMENT

CONCERNING THE REGISTRATION AND REGULATION OF
HEALTH PROFESSIONALS IN SCOTLAND

The petitioner respectfully requests that the Scottish Parliament expresses its deep concern that despite Health being a devolved matter the regulation of Health Professionals has been reserved by the Westminster Parliament.

Health is a devolved matter to the Scottish Parliament. Therefore the responsibility of providing Scotland’s population with quality, safe and effective healthcare lies entirely with the Scottish legislature.

However, the Westminster Parliament has reserved regulation of healthcare professionals, which involves professional qualifications, eligibility to practice and control over standards of professional competence and conduct (G2 of Schedule 5 to the Scotland Act). Health professionals are defined for this purpose as: doctors, dentists, chiropodists and podiatrists, opticians, pharmacists, nurses, physiotherapists, clinical scientists, dieticians, operating department practitioners, orthoptists, paramedics, orthotists and prosthetists, biomedical scientists, radiographers, speech and language therapists, paramedics and art therapists.

Two exceptions are specified to the reservation. The Parliament does have competence to legislate about what vocational training and experience is necessary for doctors before they can provide general medical services in the NHS (Scotland) Act 1978. The Parliament can also legislate to regulate the provision of general dental services in the NHS (Scotland) Act so far as that relates to vocational training and disciplinary proceedings (section 25 of the NHS (Scotland) Act).

The Health Professions Council (HPC) is a new independent, UK-wide regulatory body responsible for setting and maintaining standards of professional training, performance and conduct of the 12 healthcare professions that it regulates.

The HPC was created by a piece of legislation called the health professions order 2001—a Statutory Instrument No 2, which came into force on 12 February 2002.

Contained within this legislation was the power to protect the titles of the regulated professions. It was envisaged that protection of the titles would offer some safeguards to the public when making choices from the available competencies. For example, prior to the Act, any person could legally call himself or herself a chiropodist or podiatrist or physiotherapist, without having gained any qualifications in that discipline whatsoever.
The primary objective of the HPC is to secure effective regulation of all practitioners who practice in their respective fields under the banner of the protected title.

Those practitioners who were already in practice but had no formal or recognised qualifications could apply to be ‘grand-parented’ onto the new register and it was initially envisaged that some form of test of competence by applied to those persons, which would assure the public and the professions of their suitability to undertake safe and effective practice. This process however has become notoriously lax and there is no examination or test of competence to ensure safe and effective standards.

Grand-parented practitioners, with no formal training or qualifications, now have the same legal basis for employment within Scotland’s NHS as a graduate practitioner. There is a clear and potential danger to the health and welfare of Scotland’s population.

The Scottish Parliament may have the responsibility of providing healthcare to its population but it is powerless to regulate and uphold standards to those people it employs in its National Health Service.

That is an anomaly, I respectfully submit, should be addressed without delay.

Petitioner:
Dr Jim Johnston  
Clerk to the Public Petitions Committee  
The Scottish Parliament  
EDINBURGH  
EH99 1SP  
1 December 2005

Dear Dr Johnston

Petition PE802 – Regulation of Health Professionals

I refer to the above and to the two submissions made on behalf of the Health Professions Council and by the Minister of Health at the Scottish Executive.

The basis of the petition was that I considered that people in Scotland could be at risk from grand-parented podiatry practitioners following enactment of the legislation of the Health Professions Order by the HPC. The reason for this claim was that I considered the process of self-declaration by applicants insufficient to determine and guarantee some level of safe and effective clinical competency demanded by the Statutory Orders.

I am grateful to the Chief Executive of the HPC and to the Minister for Health & Community Care who outline in great detail the responsibilities and duties of the regulatory body and the relationship between that body and the Scottish Executive. However I am not convinced of the veracity of the process, which I still consider defective, as it relied, entirely, on the honesty and integrity of the individual applicant when completing the registration documentation. It is still my position that there are insufficient mechanisms to check and establish the accuracy of the applicant’s details and claims. Just because a practitioner has not had a claim on their professional indemnity insurance for a period of three years does not, in my opinion, act as a robust measurement of their clinical skills.

To use a comparison, gas or electrical fitters are not awarded safety certification without their competency being examined by an independent and robust examination process, which is repeated on a regular basis. Why should health be of a lesser standard?

Cont/...
I attach three cases which can be viewed on the HPC website under their Fitness to Practise Hearings. Two of these registrants (Soons & Carter) have now been removed from the register following allegations that "entry in the register relating [to you] has been incorrectly made in that your application for registration did not meet the requirements for registration". The other Fitness to Practise Hearing, concerning a grand-parented practitioner in Scotland (McCabe) is still to be heard however I draw your attention to the nature of the allegations, which, if founded, are of a serious nature.

Already, Fitness to Practise Hearing cases against ‘grand-parented’ practitioners are becoming disproportionate compared to those charged against state registered practitioners under the previous regulatory body – the Committee for Professions Supplementary to Medicine.

Although there is a review of non-medical regulation currently underway, and although it is anticipated that there will be changes to the regulatory environment, these processes are again driven by the Westminster Parliament. After careful consideration of all the issues and of the submissions made by the HPC and the Scottish Executive I strongly urge the Scottish Parliament, who have devolved responsibility for the provision of Health to seek additional powers and establish a independent and robust regulatory regime for health professionals who practise in Scotland.

Yours sincerely

Mr Mark Russell

enc.

Petition PE802
Richard Hough
Assistant Clerk to the Public Petitions Committee
The Scottish Parliament
TG.01
Parliamentary Headquarters
Edinburgh
EH99 1SP

2 August 2005

Dear Mr Hough

Scottish Parliament Public Petitions Committee – Consideration PE802

Thank you for your letter of 14 July 2005 concerning the above matter. Having read the correspondence relating to this matter there appear to be two main issues of concern to the Petitioner.

Regarding the matter that regulation of Health Professionals has been reserved by the Westminster Parliament the Society believes that this is a matter that should be resolved by the Scottish and Westminster Parliaments. We would not wish to comment further, other than to say that the Society would expect to see any introduction of statutory regulation of psychologists provide high quality public protection through a consistent approach across all four home nations.

Regarding the matter of standards and, in particular, concerns expressed by the petitioner about standards applied by the Health Professions Council (HPC) we are, again, unable to comment in very much detail. The consultation document ‘Enhancing public protection: Proposals for the statutory regulation of applied psychologists’ recently circulated by the Department of Health contained only very limited information on standards and the grandparenting process that HPC proposed to apply in the case of applied psychologists. The Society has indicated in its response to the consultation that it does not have confidence in the proposed regulatory model as likely to provide sufficient public protection. The Society is currently engaged in discussions with civil servants at the Department of Health about taking forward the matter of regulation of psychologists and two of the key questions that the Society will be asking of any proposals are whether they protect the public better than the status quo and if they maintain or enhance current professional standards.

A copy of the Society’s response to the Department of Health consultation is enclosed for information. I hope that this is helpful.

Yours sincerely

Graham Powell
President
Public Petitions Committee – a template for public petitions

Should you wish to submit a public petition for consideration by the Public Petitions Committee please complete the template below. Please refer to the Guidance on submission of public petitions for advice on issues of admissibility before completing the template. You may also seek advice from the Clerk to the Committee whose contact details can be found at the end of this form.

Details of principal petitioner:
Please enter the name of person and organisation raising the petition, including a contact address where correspondence should be sent to, email address and phone number if available.

| Name: James Kelly |
| The Kelly Campaign |

Text of petition:
The petition should clearly state what action the petitioner wishes the Parliament to take in no more than 5 lines of text, e.g.

The petitioner requests that the Scottish Parliament considers and debates the implications of the proposed Agenda for Change legislation for Speech and Language Therapy Services and service users within the NHS.

The petitioner requests that the Scottish Parliament....... Petition by James Kelly calling on the Scottish Parliament to consider and debate the need for an independent body to be set up within Scotland to investigate claims of medical negligence.

Additional information:
Any additional information in relation to your petition, including reasons why the action requested is necessary, should not be included here. However, it may be appended to the petition and will be made available to the Public Petitions Committee prior to its consideration of your petition. Please note that you should limit the amount of any additional information which you may wish to provide in support of your petition to no more than 4 sides of A4.
Action taken to resolve issues of concern before submitting the petition:
Before submitting a petition to the Parliament, petitioners are expected to have made an attempt to resolve their issues of concern by, for example, making representations to the Scottish Executive or seeking the assistance of locally elected representatives, such as councillors, MSPs and MPs. Please enter details of those approached below and append copies of relevant correspondence, which will be made available to the Public Petitions Committee prior to its consideration of your petition.

| ALLAN WILSON MSP | HUGH HENDERSON MSP |
| SHONA ROBISON MSP | MR. BLAIR MP |
| C. ROSS JAMIESON MSP | ANDY KIRK MSP |
| C. ROSS JAMIESON MSP | MALCOLM CHISHOLM MSP |

Request to speak:
Petitioners may request to appear before the Public Petitions Committee in support of their petition, although it should be noted that requests to speak will only be granted if the Convener considers that a brief statement from the petitioner would be useful in facilitating the Committee’s consideration of the petition. Due to the large volume of petitions being considered the Committee will usually only hear presentations on up to 4 new petitions at each meeting.

Please indicate below whether you wish to request to make a brief statement before the Committee when it comes to consider your petition.

Yes / No

*Delete as appropriate

Signature of principal petitioner:
When satisfied that your petition meets all the criteria outlined in the Guidance on submission of public petitions, the principal petitioner should sign and date the form in the box below. Other signatures gathered should be appended to this form.

Signature

Date ..............

Please note that any additional information, copies of relevant correspondence and additional signatures should be appended to this form and submitted to:

The Clerk to the Public Petitions Committee,
The Scottish Parliament,
Edinburgh
EH99 1SP
Tel: 0131 348 5186   Fax: 0131 348 5088
e-mail: petitions@scottish.parliament.uk
Thank you for your letter of 4 October 2005 on Petition PE 866 from Mr James Kelly, calling on the Scottish Parliament to consider the need for an independent body to investigate claims of medical negligence.

Specifically the Committee were considering the role of Citizens Advice Scotland (CAS). CAS have now developed a framework which I have agreed which will see local Citizens Advice Bureaux deliver an independent advice service to NHS Scotland. This will mean that there will be a ‘one stop shop’ for advice which covers health issues, benefit issues, housing issues and all the other issues that CAS covers.

On the issue of medical negligence, perhaps the most relevant body in relation to NHS Scotland would be the Scottish Public Services Ombudsman (SPSO). This body employs investigators who are not medically trained but who have access to specialist medical advice if they require it either in-house or externally. The body itself is independent of both the NHS and of Ministers and is therefore able to report in a wholly impartial way. The SPSO may examine ‘in relation to a health service body or an independent provider, any action taken by or on behalf of the body or provider’ or ‘in relation to a family health service provider, any action taken by or on behalf of the provider in connection with any family health services provided by that provider,’ (Scottish Public Services Ombudsman Act 2002).

As you will see the powers of the Ombudsman are very broad in scope and include medical negligence. I consider that the establishment of a further body would simply duplicate existing arrangements.

I hope these comments are helpful.

ANDY KERR
Our Ref: JSAC/lhl

Mr Richard Hough
Public Petitions Committee
TG.01
Parliamentary Headquarters
EDINBURGH
EH99 1SP

Dear Mr Hough

CONSIDERATION PE866: TO CONSIDER THE NEED FOR AN INDEPENDENT BODY TO BE SET UP WITHIN SCOTLAND TO INVESTIGATE CLAIMS OF MEDICAL NEGLIGENCE

I refer to a letter dated 30 September 2005 from Dr James Johnston requesting comments on Consideration PE866 on medical negligence. I am pleased to enclose the comments of the Royal College of Physicians of Edinburgh.

Please note that these comments have already been sent to you by e-mail.

Yours sincerely

John S A Collins MD FRCP Edin
Secretary
The College promotes the highest standards of practice in internal medicine and related specialties wherever its Fellows, Collegiate Members and Members practise.
COMMENTS ON

THE SCOTTISH PARLIAMENT: PUBLIC PETITIONS COMMITTEE

CONSIDERATION PE866: TO CONSIDER THE NEED FOR AN INDEPENDENT BODY TO BE SET UP WITHIN SCOTLAND TO INVESTIGATE CLAIMS OF MEDICAL NEGLIGENCE

The Royal College of Physicians of Edinburgh is pleased to respond to the petition by Mr James Kelly that an independent body is established to investigate claims of medical negligence in Scotland. It is clear that Mr Kelly has addressed his concerns to a significant number of doctors, NHS officers and MSPs without getting a satisfactory response from his perspective, and he appears to be highly sceptical that current systems are fair to the victims of alleged medical negligence. This breakdown of trust is not helpful and his petition deserves very careful consideration.

The College has comments in relation to whether the purpose of the new body would be to confirm or refute fault and/or to establish remedies, including censure and compensation. The College will address these different aspects in turn:

1 **Investigation of Fault and Censure (where appropriate)**

*NHS Complaints Procedures:*

At present in Scotland there is a national and well established mechanism in the NHS for patients and others to raise complaints at local level about the quality of clinical care. The NHS Complaints procedure has a local focus with a right of appeal to the independent Public Services Ombudsman. Complaints about the standard of clinical care are allowed in addition to service complaints. This in no way underestimates the challenges for many complainants when pursuing a complaint which may become a claim of medical negligence. However, the adversarial atmosphere inherent in such systems is unhelpful to all and discourages openness and learning. This is fed by concern about the funding of large compensation payments.

*Loss of Local Health Councils:*

The Local Health Councils which previously could act as advocates for patients and their families have been disbanded, and the newly established Scottish Health Council has no such advocacy remit. The Scottish Health Council is available to ensure that the NHS in Scotland becomes patient focused and develops effective mechanisms to involve patients and the public in planning, service delivery and quality control. There is therefore a need to support individual patients who have cause to question the standards of care provided in Scotland. The College understands that this may be
possible through Citizens Advice Scotland, and the College would welcome the provision of such a service.

**General Medical Council:**

Patients also have the right of direct complaint to the General Medical Council. The GMC procedures are well documented on their website. Each case is assessed individually and the GMC will make a judgement based on the evidence provided. It should be remembered that all committees and panels include lay members, and that 40% of the GMC Board are lay members. The GMC itself is under scrutiny by the umbrella body, the Council for Healthcare Regulatory Excellence, which is accountable to the UK Parliament. This independent body has a duty to protect patients and has the power to refer decisions of regulators for review to the High Court under certain circumstances. Over half its members are lay and independent of any of the regulators.

Claims of medical negligence can be complex and difficult to evidence. It is therefore important to achieve a balance of independent lay views with informed medical expertise to ensure that decisions are fair to both patients and practitioners. The College understands that the petitioner, in discussions with the Petitions Committee, cited the criticism of the GMC by Dame Janet Smith in her reports into the case of Harold Shipman. The GMC has made significant changes to try to improve its procedures and is clear of its responsibility to protect patients.

**The Role of the Scottish Judicial System:**

The courts remain a means of testing fault and awarding damages, although expensive, slow and beyond the means of many patients and their families. It is also possible to seek a judicial review of a decision by the Public Sector Ombudsman.

**National Patient Safety Agency:**

In England and Wales, the National Patients Safety Agency (NPSA), through its National Clinical Assessment Service, supports the NHS to investigate doctors and dentists with potential performance problems. The aim is to investigate problems in a constructive and open manner and to identify and rectify problems early for the benefit of patients and the profession. This should address problems before they become so significant that referral to the GMC is required. However, the NPSA cannot accept referrals from patients. It may be beneficial and cost effective for Scotland to collaborate with the NPSA to provide the same investigatory systems across the UK; indeed this appears likely to happen.

2 **Compensation for victims of medical negligence**

There are many perverse incentives in the current ‘fault-based’ systems as society become more litigious generally. Employers and practitioners are discouraged from admitting liability in the absence of thorough investigation. This can be time
consuming and frustrating to patients who can suffer undue delay (often measured in years) when they are at their most vulnerable, and with the burden of proof on the plaintiff, no guarantee of success. Employers are tempted to settle financially (with no admission of liability) to avoid protracted legal cases and, in accepting such settlements, patients are bound to silence.

A ‘no fault’ system of compensation for the victims of medical accident (whether negligence is proved or not) would be beneficial. This would certainly address undue delay and loss to patients as a result of damage sustained through accident or negligence. It would also bring the additional benefit of a non adversarial system and protect patient trust in doctors generally.

There are examples of ‘no fault’ systems in many other countries and, indeed, the option was ruled out in England in favour of a mediation pilot. The College understands that the Royal College of Surgeons of Edinburgh is providing additional information on this point. This College is concerned about the funding of such a system, and whether budgets would be diverted from patient care to support the required new investigatory procedures and fund any resulting successful claims.

Conclusions

In summary, there are a number of systems through which allegations of medical negligence can be investigated. It may be that the NHS Complaints system needs attention to ensure it works well for patients. Patients would benefit from specialised support to pursue their complaints.

The GMC has improved its procedures and is under the scrutiny of the Council for Healthcare Regulatory Excellence. It will not always be the appropriate investigatory body and a system akin to that operated by the NPSA may benefit Scotland, if NHS Boards were required to utilise their independent investigatory services.

Creating a ‘no fault’ compensation system would serve to support patients for their loss and may reduce the adversarial atmosphere of many local NHS complaints procedures, but may not be cost effective.

The College is not convinced there would be benefit in establishing a completely independent body to investigate medical negligence. It would replicate the roles of several existing investigatory bodies, would undoubtedly be costly to administer and may be no quicker at reaching conclusions.

All College responses are published on the College website www.rcpe.ac.uk.

Further copies of this response are available from Lesley Lockhart (tel: 0131 225 7324 ext 608 or email: l.lockhart@rcpe.ac.uk)

[11 November 2005]
RESPONSE BY
THE ROYAL COLLEGE OF SURGEONS OF EDINBURGH TO
SCOTTISH PARLIAMENT PUBLIC PETITION COMMITTEE
CONSIDERATION PE866

THE CASE FOR AN INDEPENDENT REVIEW BODY TO
ADJUDICATE MEDICAL LIABILITY COMPENSATION IN CASES OF
MEDICAL NEGLIGENCE

The Royal College of Surgeons of Edinburgh is pleased to have the opportunity to comment on the petition before the Scottish Parliament from Mr James Kelly that an independent body be established in Scotland to investigate and adjudicate on cases of medical negligence. This petition offers Scotland the opportunity to debate this important issue, where changes from the present adversarial system of awarding compensation could benefit many Scottish patients.

Background

The NHS in the UK is currently facing a £2.8bn bill for medical negligence claims and GPs are now 13 times more likely to be sued than they were 10 years ago. Payouts for medical accidents in Scottish hospitals have tripled in five years to almost £10 million in 2004, compared to around £3.5m in 1999. Legal procedures mean that the average case takes six years to settle from the time a complaint is lodged and only around 10% of victims receive compensation.

All are agreed that prevention of medical misadventure must be actively pursued. The National Patient Safety Agency (NPSA) has begun to made inroads into this in England and Wales, with some of their recommendations being endorsed by QIS in Scotland. Yet medical mistakes remain common. It is estimated that 800 medical mistakes are committed in hospitals in the UK every day. More than 15,000 cases of patients seeking compensation are currently at some stage in the legal process.

The Mulcahy Report (2000) on the NHS Mediation Pilot reported that a 70% sample of claimants were totally or very dissatisfied with the claims process, even where compensation was awarded. Data collected by the British Medical Association (BMA) have demonstrated that plaintiffs feel that health authorities, trusts and solicitors are overly defensive in their management of medical negligence cases.

Experience elsewhere

Compensation programs that do not rely on negligence determinations are popularly referred to as “no-fault” systems. In fault-based models, which are
based on tort law, the claimant must prove four elements: duty, injury, causation, and negligence. No-fault systems eliminate the requirement of proving negligence.

Several no-fault systems in medicine operate internationally. Collectively, Denmark, Sweden, Finland, and New Zealand have accumulated nearly 80 years of experience in operating administrative schemes that replace medical malpractice litigation. Medical no-fault schemes were introduced in New Zealand in 1974 (as part of its universal scheme), and in Sweden in 1975.

The health care systems in these countries rely on public payment and provision of services. New Zealand’s scheme, for example, draws from general taxation revenue, while Sweden’s draws on premiums charged to regional councils and doctors.

**New Zealand**

In 1974 New Zealand abolished tort law remedies for all personal accident injuries and replaced it with a no-fault compensation scheme administered by the state. The scheme was based on five principles from the 1967 Woodhouse Royal Commission Report. They are:

1. community responsibility (the community collectively bore a basic responsibility for the social costs of accidents);

2. comprehensive entitlement (equity required giving assistance to all those disabled by accidents, irrespective of cause, time, or location);

3. complete rehabilitation (accident victims should recover in the shortest possible time);

4. real compensation (compensation should reflect real loss); and

5. administrative efficiency (collecting funds and paying benefits should be conducted as efficiently as possible).

Benefits are provided without proof of “fault”. The common law right to sue for damages for personal injury (except for punitive or exemplary damages) was abolished. The Accident Compensation Commission (ACC) administers the system.

The system now has six accounts: Employers; Earners; Non-Earners; Motor Vehicle; Subsequent Work Injury; Medical Misadventure. When initially set up, the primary focus was on providing compensation and promoting rehabilitation. Increasing costs have led to concerns that the behavioural
assumptions underlying the scheme are inadequate. As a result the scheme has been continually reviewed.

In 1979 a New Zealand Cabinet Committee recommended that:

(1) claimants should meet part of the cost of the first two visits to the doctor and (2) lump-sum awards for minor injuries, pain and suffering, and loss of enjoyment of life be abolished except for serious cosmetic disfigurement.

Employer pressure in 1992 led the government to set up another review committee. The Accident Rehabilitation and Compensation Insurance Act 1992 was aimed at controlling premium costs its objective being: "to establish an insurance-based scheme to rehabilitate and compensate in an equitable and financially affordable manner those persons who suffer personal injury".

Despite considerable discussion of the scheme, there have been virtually no empirical studies of its impact by independent researchers. Most studies have been internal.

**Sweden**

The key element of Swedish compensation model is the concept of avoidability. System designers recognized that compensating all injuries arising from medical care would be prohibitively expensive. Thus, only subsets of medical injuries are eligible for compensation.

In brief, adjudicators ask 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 query is "no," the claimant receives compensation.

Patients who believe they have been injured as a result of medical care are encouraged to apply for compensation using forms available in all clinics and hospitals. Doctors and other health care personnel are actively involved in approximately 60 to 80% of claims, alerting patients to the possibility that a medical injury has occurred, referring patients to social workers for assistance, and helping them to lodge claims.

**A system like this undoubtedly encourages the reporting of adverse medical events openly and transparently, in contrast to a tort system.**

Once a claim is made, the treating doctor prepares and files a written report about the injury. An adjuster makes an initial determination of eligibility and then forwards the case for final determination to one or more specialists who are retained by the system to help judge compensability. Approximately 40% of claims receive compensation. Patients who are dissatisfied with the outcome may pursue a two-step appeals process consisting of review of the determination by a claims panel followed by an arbitration procedure.
Successful claims are paid in a uniform manner using a fixed benefits schedule and include compensation for both economic and non-economic losses. But before patients are eligible for compensation, they must have spent at least 10 days in the hospital or used more than 30 sick days. This "disability threshold" eliminates the minor claims.

The Patient Insurance Compensation Fund, from which all claims are paid, has undergone several reforms since it was created in 1975. One example is legislation enacted to restrict fund expenditures. The legislation replaces the scheme's injury thresholds with thresholds linked to the level of damages awarded in compensable claims (those insured claims where a "deductible" applies). Another reform imposed an upper limit on damages ("cap") of 200 times the base sum for each "loss events." The "base sum" is a unit amount that allows funds that are redistributed by Sweden's various social insurance programs to be adjusted annually for inflation and changing certain medical eligibility criteria narrowed categories of compensable injury. For example, wound infections had been compensated from the outset of the program. But, adjusters have become strict about the type of infections that are eligible, specifying that infections caused by a patient's own bacteria do not meet avoidability criteria and will not be compensated. In effect, this removes "dirty" wound infections from consideration.

Efforts to control costs through eligibility and benefit reductions have been made possible by the interconnectedness of social insurance schemes in Sweden. Because medical injury compensation now plays a "fill-up" function in relation to compensation provided through other schemes, benefit reductions in these other schemes requires increased outlays from the Patient Insurance Compensation fund unless commensurate changes are introduced.

PROPOSALS

1. Prevention
This College believes that there must be greater emphasis on the prevention of medical mistakes. In England and Wales the National Patient Safety Agency (NSPA) is an agency of the NHS, established with the specific aim of increasing the safety of all patients coming into contact with the NHS. It provides valuable guidelines, protocols and directives. Yet these have no statutory authority within NHS Scotland, although some of them have been endorsed by NHS Quality Improvement Scotland (QIS). This College believes that all recommendations of NPSA, an agency devoted to increasing patient safety, should be made available to all NHS workers in Scotland, and improved patient safety should have the same high profile as in England and Wales.

2. No fault compensation.
This College is concerned about the social injustices of the present system and wishes to see adequate arrangements to provide compensation and support to those who suffer personal injury through medical mishap according to need and not according to cause.
The prospect of the patient who has suffered as a result of medical misadventure receiving appropriate compensation remains uncertain and, when achieved, may involve many years of stressful legal action, with its associated expense. For patients not eligible for legal aid, the risk of serious financial loss if the action is unsuccessful, often causes them to abandon compensation and not proceed with their claim.

The Chief Medical Officer for England in a report in 2003 recommended that a no fault system should not be pursued, a decision made largely on financial grounds. His recommendation that a mediation system should form the basis of resolution of medical negligence has confirmed the perpetuation the current adversarial system throughout the UK. A mediation system had also been proposed by the working party report “Encouraging Resolution” produced in 2002 by the Royal Society of Edinburgh.

It is agreed that a no-fault system would be costly, and that the cost of compensating all injuries arising from medical care would be prohibitively expensive. Yet for selected subsets of medical injuries, as in Sweden, such a system would result in more patients receiving compensation than at present. This College would be pleased to enter into further dialogue with the Scottish Executive about such a system, on the clear understanding that the funding of a no-fault compensation scheme would not divert funds from patient care in Scotland.

A system of no fault compensation would have the potential to relieve the patient of the necessity of proving fault, and would base compensation principally upon the injured person’s needs. Both victims of medical negligence and doctors accused of making mistakes could benefit from a "non-adversarial" scheme.

November 2005
Dear Dr Johnson,

Scottish Parliament Public Petitions Committee - Consideration PE866

Thank you for inviting the BMA to comment on Petition PE866 by James Kelly calling on the Scottish Parliament to consider and debate the need for an independent body to be set up within Scotland to investigate claims of medical negligence.

The Committee may be interested to know that the NHS Redress Bill (England and Wales) is currently under consideration at Westminster. This Bill is intended to reform the current clinical negligence system, enabling patients to receive redress without having to go through the legal system. Under the proposals in this Bill, the NHS redress scheme will be operated by the NHS Litigation Authority and will seek to ensure that patients receive a more consistent, speedy and appropriate response to clinical negligence. The BMA welcomes the objectives of this Bill.

Modern healthcare is highly complex. Adverse incidents are potentially as likely to arise from known but unpredictable complications during treatment as from clinical negligence where a health care professional has fallen below the professional standard required of them. Where clinical negligence does occur, adverse incidents or near misses are frequently the result of a chain of events rather than a single isolated poor decision. Problems are all the more likely because of the continued failure of the NHS to create a climate where organisations, doctors and other health professionals can all genuinely learn from experience and prevent avoidable harm to patients. There is a definite advantage to alternative dispute resolution and mediation if that is acceptable to the patient. However, the NHS must also ensure that care systems are set up so that if they do fail, they do so in a safe way i.e. without harm befalling the patient.

At present, patients injured as a result of an adverse event can only receive compensation if the injury is attributed to negligence on the part of those caring for them and even then, only after a prolonged legal process, often involving action in courts. Not only must the Pursuer (Claimant) show that the clinician is liable but they must also demonstrate a causative link between the failure of the doctor and the harm that befalls the patient. The BMA would like to see the introduction of a less confrontational process for dealing with adverse events under a system that provides compensation and support to those who suffer personal injury given according to need and not according to cause. For doctors however, there continues to be a risk that under such a process, the Claimant may feel that although he/she has received compensation, the doctor has not been held individually accountable and the patient could still make a formal complaint to the General Medical Council.

Scottish Secretary: Bill O'Neill, BSc PRCP
Chief Executive/Secretary: Tony Bourne


0870 60 60 828

Scotland National Office

9 November 2005
A system of no fault compensation would offer a choice to the individual. Currently around 40% of medical negligence claims are settled out of court and only 1% reach a Proof Hearing. Instead of a few individuals who are able to establish that the adverse event they experienced was a result of clinical negligence being awarded large sums in compensation, all patients suffering adverse events during their medical care would be compensated reasonably for the damage they endured and, where appropriate, dependents compensated for financial loss.

We would not intend such a scheme to protect professional staff if errors have been made and the route through the courts would always be open for patients wishing to prove professional negligence.

In conclusion, the Association would welcome further debate on how a new system would work and, as part of that discussion, it may be appropriate to consider the role and function of an independent body within that structure.

In our view, changing the system to introduce a less adversarial scheme for dealing with adverse events would benefit patients, doctors and the wider NHS for the following reasons:

- From a patient’s viewpoint, it would enable all those suffering adverse events to receive speedy compensation without having to prove clinical negligence.
- From the doctor’s viewpoint it would avoid the immense stress and time away from providing clinical care defending allegations of clinical negligence from patients, with little justification or hope of success, often pursued with legal aid.
- From the NHS viewpoint, it would stop very significant and disproportionate amounts of money being absorbed in legal costs that could be better spent providing patients who have experienced an adverse incident with reasonable compensation.

Yours sincerely,

Gail Grant
Senior Public Affairs Officer (Scotland)
Dear Dr Johnston

Response to the Public Petitions Committee Consideration PE866

Thank you for your letter of 30 September 2005 from the Petition’s Committee, asking Citizens Advice Scotland to comment on the establishment of an independent body to investigate claims of medical negligence. Since the petition calls for a change to existing process, and the Independent Advice and Support Service will be a new activity, Citizens Advice Scotland does not feel it is appropriate for us to comment at this time on this matter. Although a number of Citizens Advice Bureau have for sometime assisted clients with raising a range of concerns and complaints about NHS services we do not feel that we have established enough evidence to be able to give an opinion.

However one matter that does appear to require clarification is what the role of the new Independent Advice and Support Service will be. In essence we will provide independent support and assistance for patients in dealing with complaints through the existing processes.

I have included an appendix giving a brief description of the Independent Advice and Support Service, explaining how it will support users of the NHS. We hope that this will help to clarify what the service will and will not be able...
to do to help patients who have concerns or wish to complain about NHS services.

Yours sincerely

Jacqueline Burman

Health Project Development Officer
APPENDIX

Citizens Advice Bureaux across Scotland will deliver the new Independent Advice and Support Service to users of the NHS

The service has two components:

- To provide advice and support service to patients\(^1\) wishing to make a complaint or raise concerns about NHS services;
- To provide information and advice to patients on a variety of issues that impact on their health and well-being in order to maintain or improve these.

It is intended that the service will help people to understand how they can raise issues of concern or make complaints about NHS services using the NHS Complaints Procedure (as detailed in ‘Can I Help You?’). The service will help people to understand what the NHS Complaints Procedure is designed to do and to determine whether using the NHS Complaints procedure is appropriate to get the outcome that they wish.

The service will clarify to patients how they can complain about any aspect of treatment or care:

- Delivered by NHS staff and services in Scotland,
- Or paid for by the NHS but delivered in a private facility.

The service will clarify the things that can’t be complained about using the NHS Complaints procedure, these are:

- private healthcare,
- an incident that is subject to a legal action for clinical negligence, or
- care services (funded & provided by local authorities).

The service will give advice on how the patient can proceed if s/he wishes to pursue these issues through other procedures.

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\(^1\) Patients where used means patients, carers, service users, their families, representatives, etc.
Supporting the patient to make a complaint

If a person does wish to raise a complaint but feels that s/he would be unable to do this without support, the service will help that person to do so.

In addition, the service will provide assistance in a number of ways including:

- directing patients to specific sources to obtain information they require e.g. giving out leaflets, supplying details of telephone help lines, websites, etc;
- exploring the options available to a patient to resolve an issue, and supplying a self-help pack;
- contacting third parties by telephone when authorised by the patient or assisting patients to compile letters;
- accompanying a patient to meetings or assisting them when reviewing personal files; and
- contacting specialist support or independent advocacy services if the patient requires additional support.

Taking the matter further

Following Local Resolution stage, if the outcome does not satisfy the complainant, the service will discuss the implications of available options and assist the person to decide on the most appropriate next step to take. This could be to ask the Scottish Public Service Ombudsman to investigate, or to raise the matter with a regulatory body or to seek advice from a solicitor. If the person feels s/he needs further support, this will be given.

The limits of the service

The service will not in anyway be involved in investigating complaints, or give clinical/legal advice, as this is beyond the scope of the service. The service will provide information and where appropriate refer patients onto specialist organisations that do provide advice and support in these areas. Complainants would be advised that if they are seeking legal advice to start a claim for negligence whilst in the process of pursuing a complaint about NHS
services that the investigation into the complaint by the NHS will immediately cease.

In some cases during the process of supporting someone to raise a concern or make a complaint it might become apparent that the person requires the services of another organisation such as an advocate or counselling service. In this case the service would advise the patient and if agreed refer to that service. In some cases this may mean bureau working with the patient and the advocate or other party together to reach a satisfactory outcome. Two examples of how the service could assist clients are given below.

**Case studies**

Case 1.
A person contacted a bureau to make a complaint about her brother’s treatment. The bureau discussed the issues with the person and realised that the case was not a complaint that could be taken through the NHS complaints procedure but was within the remit of the Mental Welfare Commission as it was concerned with appealing against being detained. In this case the bureau contacted the Mental Welfare Commission and arranged for the sister to meet them to discuss how they could assist her with her brother’s case.

Case 2.
A daughter visited a Citizens Advice Bureau (CAB) because her mother had died and she was worried that the care her mother had received from her GP had been inadequate. She wanted to know if her mother had been diagnosed earlier whether anything could have been done to alter the outcome.

The adviser explained what the daughter could and couldn’t expect from the NHS complaints procedure, found out what she hoped to achieve by using the procedure, and then clarified the details to ensure that the complaint was within time limits.

The daughter was unsure of the exact details of her mother’s care during the early stages and the adviser suggested that before making a formal complaint
the daughter could ask to see her mother's medical records to get more information, explaining how this could be done.

After viewing the records, the daughter was still concerned that the GP had not referred her mother for a number of tests, despite unexplained symptoms. The adviser was also concerned that the daughter was still grieving the death of her mother and asked her if she was aware of bereavement counselling services and discussed if she would like details of how to contact the local organisation or whether she wished the adviser to do so on her behalf. It was agreed that the adviser should make the contact with the counselling service. After a period of time the daughter returned to the bureau to seek further help to get an explanation about what happened to her mother but she didn't want to make a formal complaint. The adviser explained that her letter should ask specific questions to clarify the areas she was uncertain about. The practice responded outlining the action that had been taken by the GP, and gave details of the investigations and tests results. The practice expressed their hope that the details about the diagnosis and treatment were now clear to the daughter and also offered a meeting if she still wanted to discuss any points.

Following this reply the bureau advised the daughter that if she wanted an independent opinion on the case she could contact the charity, Action for Victims of Medical Accidents (AvMA) who have clinicians that will look at a case and see if clinical negligence was a possibility. The daughter felt that this would be useful and contacted the organisation to discuss her mother's case. The discussion with the specialist identified that the circumstances were not unusual and it appeared that everything expected had been done. The daughter was reassured with this outcome and decided not to take the matter any further.
JAM/em

11 November 2005

Dr James Johnston
Clerk to the Public Petitions Committee
The Scottish Parliament
Public Petitions Committee
TG.01
Parliamentary Headquarters
EDINBURGH
EH99 1SP

Dear Dr Johnston

Please find enclosed the response from the Royal College of Physicians & Surgeons of Glasgow as requested. An electronic version has also been sent.

Kinds regards.

Yours sincerely

Dr James A Miller
CHIEF EXECUTIVE

Enc
Public Petitions Committee
Petition Number PE866
Response from Royal College of Physicians and Surgeons of Glasgow

Introduction
The Royal College of Physicians and Surgeons of Glasgow is pleased to comment on the petition from James Kelly, on behalf of the Helen Kelly Campaign. The petition calls on the Scottish Parliament to consider and debate the need for an independent body to be set up within Scotland to investigate claims of medical negligence. In preparing this response further research was undertaken by reviewing the Helen Kelly Campaign web-site (www.helenkelly.org) and the record of the meeting between the petitioner and the Scottish Executive’s Public Petitions Committee on 21st September 2005 (www.scottish.parliament.uk/business/committees/petitions), petition number PE866. In this response the College makes neither comment on the specific case from which the petition arose nor the wider aims of the subsequent campaign.

Medical Negligence
The term ‘medical negligence’ has a specific meaning within tort law and there are 3 main tests, which need to be satisfied to determine whether a doctor has been negligent.

➢ Did a duty of care exist?
➢ Was that duty of care breached?
➢ Did the breaching result in harm?

This issue is inextricably linked with determining the standard of care provided by a medical practitioner. These have been described in case law in England (Bolam Vs Friern Hospital)\(^1\) and in Scotland (Hunter v Hanley)\(^2\). Whilst there has been some debate as to whether these two cases present a different burden of proof they are generally regarded as the being the same i.e. the standard of care which can reasonably be expected from an ordinary practitioner with the skill in question.

Medical negligence is therefore a specific term in law and is applied where the appropriate tests can be satisfied. There are already systems in place, which deal with

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\(^1\) Bolam V Freim Hospital Management Committee (1957) 1 WLR 582
\(^2\) Hunter Vs Hanley (1955) SLT 213
such circumstances through the courts and through the medical professions’ governing body. What is less clear cut is where something has gone wrong and no individual is at fault. This scenario is one in which patients and their carers feel ‘cheated’. When something goes wrong it is has become the norm to establish who is to blame and often there is “no one” to blame.

The case for an independent body to determine whether a doctor has been “negligent”, from a lay perspective, may appear to be a compelling one, in order to allay any fears of professionals maintaining their self-interest. However, this issue has been addressed by the medical profession’s governing body (General Medical Council) through ensuring lay representation on the committees investigating such complaints. This was in part a response to the outcome of Dame Janet Smith’s investigation into Harold Shipman. Decision reached by such committees through the GMC processes, are also subject to review.

**Expert Opinion**
Its is the view of the College that where there has been any question raised over the conduct of a medical practitioner, the opinion of other medical practitioner(s) must be sought. The two issues of expert comment and independent investigation are not mutually exclusive. This balance between lay and expert opinion has been recognised by professions and as a result they have taken steps to ensure lay representation on the bodies charged with investigating such claims. At a local level non-executive trustees on NHS boards are often used in this capacity in reviewing complaints. There is also the opportunity to have the outcome of complaints reviewed by an independent reviewer. Within the courts, expert opinion does not stand in isolation. In the Bolitho case (Bolitho V City of Hackney Health Authority 1997)\(^3\) there were competing bodies of expert evidence and the Judge in this appeal case determined that expert option must also stand up to logical analysis. Therefore current systems have been enhanced to reflect the need for both medical and non-medical expertise in arriving at final conclusions.

**Current Systems**
A number of systems already exist to deal with complaints / accusations of negligence etc. These include local NHS Boards’ complaint procedures, the ombudsman’s office,

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\(^3\) Bolitho V City of Hackney Health Authority (1997) All ER 770
the GMC and ultimately the courts. The common theme running through these is an adversarial relationship between the complainant and the individual / institution against whom a complaint is made. The recent loss of local health councils has resulted in one fewer advocacy system to which patients and their carers had access. It is possible that Citizen’s Advice Scotland may take over this role but this is not something that appears to be well known or publicised. It is therefore suggested that there is a need to build on the solid foundation already in existence rather than creating new systems.

Financial Gain
Complainants often remark that they are not interested in any financial gain but to achieve a better understanding of what happened and to receive an apology. There is however a perception of an emerging culture of litigation amongst the general public and there is a danger that individuals who have been disadvantaged financially by the outcome of a clinical incident may be 'lost' within a system dealing with speculative claims. The issues of a no-fault compensation system were discussed widely, drawing on significant international experience, within a Department of Health consultation and was ruled out by the Chief Medical Officer at the Department of Health in England (DOH 2003). The rationale for this decision should be reviewed as part of this process.

Potential Solution
There would appear to be strong support for a system which lies somewhere between the complaints systems adopted by NHS Boards and redress to the courts. The College endorses the recommendations of the Royal Society of Edinburgh’s report “Encouraging Resolution Mediating Public / Health Services disputes in Scotland”. This report identifies the need for a process of mediation to assist in answering complaints from patients about health services which have not been resolved at an earlier stage and suggests ways these could be settled without recourse to the courts.

Achieving a satisfactory resolution for both sides is a challenging task and one it has been suggested could be achieved through mediation. It should however be noted that

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4 Department of Health ‘Making Amends: A consultation paper setting out proposals for reforming the approach to Clinical Negligence in the NHS. DOH 2003
5 Royal Society of Edinburgh ‘Encouraging Resolution Mediating Public / Health Services disputes in Scotland’ RSE 2002
even where mediation has been successful and where compensation has been awarded, claimants remain dissatisfied with the process (Mulcahy 2000\(^6\)).

There also exist with the NHS in England and Wales some examples of different approach to clinical dispute resolution. To this end the College recommends that an analysis of the effectiveness of such systems be undertaken to identify best practice in achieving a satisfactory outcome.

**Conclusions**

- RCP SG recognises that a number of systems currently exist for patients and carers to seek resolution to a clinical incident. These are often adversarial and should be reviewed to minimise this effect.
- RCP SG insists that in all cases where the practice of a medical practitioner is brought into question the expert opinion of other practitioner(s) must be sought.
- RCP SG recognises that any formal review process requires a balance of medical and non-medical expertise and that these are not mutually exclusive.
- RCP SG endorses the view that systems of mediation maybe the most appropriate means by which resolution can be achieved.
- RCP SG is aware of a number of different systems both within the UK and internationally dealing with clinical negligence and these should be reviewed in advance of any proposed changes. Elements of best practice can then be incorporated into any system adopted.
- RCP SG also recognises that experience shows that resolution does not always achieve satisfaction amongst complainants.

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Dr. James Johnston,
Clerk, Public Petitions Committee,
The Scottish Parliament,
EDINBURGH
EH99 1SP
By e-mail

Dear Dr. Johnston,

CONSIDERATION OF PETITION PE866

Further to your letter of 30th September and my e-mail of today's date, I have now consulted with relevant colleagues and can offer the following comments on Petition PE866.

Someone who has been the victim of a medical accident has a number of avenues which can be explored on the occurrence of an adverse event. These include complaints under the Health Authority's internal complaints procedure, which itself may include a referral to an external individual specialist; a complaint to the Scottish Public Services Ombudsman; a Fatal Accident Inquiry if a death has resulted; a complaint to the relevant professional regulatory body such as the General Medical Council and the Nursing & Midwifery Council; and of course a claim for damages for personal injury.

A claimant seeking damages for personal injury arising out of alleged medical negligence faces the following issues:-

1. **Legal Issues** - The onus will be on the claimant to raise his or her case in time – generally within the three year limitation period. Difficulties can arise for a claimant because of issues of awareness and whether any claim is sufficiently serious to justify bringing legal proceedings.

   The onus will be on the claimant to prove facts on a balance of probabilities. That is not easy when the claimant is, for example, unconscious or very unwell at the material time. The claimant will have the right to recover medical records. However, these seldom tell the complete story. There is no obligation on any civil witness, such as a nurse or a doctor, to provide a statement to a claimant's solicitor in advance of a Court Hearing.
On the basis of the facts which the claimant has been able to establish, the onus is on the claimant to prove that the doctor or nurse was negligent. That is difficult where there has been an exercise of clinical discretion. In such circumstances the test for negligence remains as set out in the case of Hunter v. Hanley 1955 S.C. 200 when Lord President Clyde said

"To establish liability by a doctor where deviation from normal practice is alleged, three facts require to be established. First of all it must be proved that there is a usual and normal practice; secondly it must be proved that the defender has not adopted that practice; and thirdly (and this is of crucial importance) it must be established that the course the doctor adopted is one which no professional man of ordinary skill would have taken if he had been acting with ordinary care. There is clearly a heavy onus on a pursuer to establish these three facts, and without all three his case will fail."

The test is better known in England as the "Bolam Test", following the decision of McNair J. in the case of Bolam v. Friern Hospital Management Committee [1957] 1 W.L.R. 582. The test as articulated in Bolam is simply a re-articulation of the test in Hunter v. Hanley.

In order to satisfy the negligence test, it is necessary for the claimant to prove what the standard procedure was in relation to their treatment and care and that there was a departure from that standard procedure. Only a doctor practising within the particular speciality concerned can provide appropriate evidence as to the standard procedure. This is the model that is followed generally throughout the globe. It is simply not possible to exclude doctors from the evidential process.

A ground of action may also arise once the grounds of reasonable care have been explored, if the particular doctor has acted in a way which is illogical, even if slavishly following standard procedure (please see the decision in the case of Bolitho (deceased) v. City & Hackney HA 1998 [A.C.] 323).

Practitioners have not experienced difficulties in identifying suitable, individual experts who will provide objective reports on the actions of the treating clinicians. The charity "Action Against Medical Accidents" (AVMA) can assist member solicitor firms in identifying appropriate specialists. The public may have once believed one could not get one doctor to speak up against another. That is not the reality now. The medical profession is fully aware of the need for transparency and accountability in order to maintain public confidence.

The onus also remains on the claimant to establish that it was the negligent act or omission that caused that loss, injury or damage which they have sustained. The claimant will require to prove that, but for that negligent treatment, the outcome would have been different and that, had reasonable treatment been provided, the outcome would have been different.

The damages awarded to the pursuer are intended to compensate for the difference in outcome between what has in fact happened and what would probably have happened had reasonable treatment been provided. In almost every clinical negligence case, medical opinion will again be required on these causation questions. If the dye was cast before the negligence occurred, there may be no loss whatsoever.

The onus is finally on the claimant to establish the quantification of loss they have suffered. This is approached in Scotland by looking at a number of heads of claim: in particular, an award for what is known in Scotland as "solatium", for the pain, suffering and inconvenience suffered; an award for wage loss, both past and future; an award for loss of employability on the labour market; an award for loss of pension rights; an award for services provided to the injured person and services which the family have lost as a result of the injury; and finally other costs including nursing care and house adaptations. Again, expert medical opinion is almost always necessary to explain to the Court the nature of the injuries and the future prognosis.
The legal remedies available to the victim are not mutually exclusive. There can be a Fatal Accident Inquiry, a complaint to the General Dental Council or the General Medical Council and the party can also take an action for civil damages.

Even if there is no loss and no competent civil claim for damages, complaints to the Health Authority, the Scottish Public Services Ombudsman and the General Medical Council can still be made.

2. Access to Justice - Many who are the victims of medical accidents are children, the elderly or people on benefits. Such claimants can only fund the investigation of their cases with the help of legal aid. The investigation of their case under the Legal Aid legislation has to be carried out under the Advice & Assistance Scheme.

A survey carried out on behalf of the Law Society of Scotland demonstrates that the cost of time for a solicitor is substantially more than legal aid rates. Whilst legal aid rates remain at a low level, the vast majority of large Scottish practices will not participate in legal aid work.

The Society would be very interested to know the sort of independent body Mr. Kelly envisages being set up – how many members, what qualifications etc.? Medical negligence cases are always very difficult because, by necessity, lay persons do not have the specialist knowledge necessarily required to pass judgement on the medical treatment provided. It, therefore, does seem that, of necessity, any body set up would require to incorporate relevant members of the medical profession.

I trust the foregoing is of assistance. If you have any further queries, please do not hesitate to contact me.

Yours sincerely,

Michael P. Clancy
Director
### Details of principal petitioner:

**Brian McAlorum**

### Text of petition:

The petitioner requests that the Scottish Parliament reviews the criteria and funding mechanisms for national specialist services provided to NHS Scotland by individual health boards as currently they are neither transparent nor effective as witnessed by the centre for integrative care at Glasgow Homoeopathic Hospital.

### Action taken to resolve issues of concern before submitting the petition:
• PQs S2W – 10157 - 8; 8663 – 7. All of which failed to receive a satisfactory reply.
• Letters by many MSPs and patients to Health Minister and NHSGG. None of which have received a satisfactory reply. 3 attached as examples.
• Letters from many patients to non-Greater Glasgow Health Boards. Only NHS Lanarkshire has confirmed that they value the service, pay for it as part of a block payment, but say that its future is a matter for NHSGG to decide!
• Addressed NHSGG Board in July & October. See website for minutes http://www.show.scot.nhs.uk/gghb
• Letter from NHSGG to other West of Scotland Boards asking for their thoughts on the service. We have been unable to secure a copy of this.
• 18000 signature petition to NHSGG in July.
• Patient attendance at MSP surgeries, including First Minister.

Request to speak:
All petitioners are given the opportunity to present their petition before the Public Petitions Committee. The Convener will then make a decision based on a number of factors including the content of the petition and the written information provided by the petitioner as to whether a brief statement from the petitioner would be useful in facilitating the Committee’s consideration of a petition.

Please indicate below whether you wish to request to make a brief statement before the Committee when it comes to consider your petition.

Yes

Signature of principal petitioner:
When satisfied that your petition meets all the criteria outlined in the Guidance on submission of public petitions, the principal petitioner should sign and date the form in the box below. Other signatures gathered should be appended to this form.

Signature

Date 24/11/2014

Please note that any additional information, copies of relevant correspondence and additional signatures should be appended to this form and submitted to:

The Clerk to the Public Petitions Committee,
The Scottish Parliament,
Edinburgh
EH99 1SP
Tel: 0131 348 5186 Fax: 0131 348 5088
e-mail: petitions@scottish.parliament.uk
Dear Michael,

Thank you for your further letter of 22 September 2005 about petition PE791 from Brian McAlorum, which calls for the Scottish Parliament to review the criteria and funding mechanisms for national specialist services provided to NHSScotland by individual health boards. The Public Petitions Committee has specifically asked whether the Executive has any plans to review the criteria and funding mechanisms for national specialist services.

In my earlier letter, I explained that any service designated as a national service will be one which is highly specialised, of low, and therefore unpredictable, volume, and the cost of treating each case will be high. Applications for designation are overseen by the National Services Advisory Group (NSAG), to which the National Services Division (NSD) of NHS National Services Scotland acts as secretary. On behalf of NSAG, NSD issues a letter each year to NHSScotland setting out the criteria for designation. These criteria are therefore well known, and are kept under constant review by NSAG so that they are set out as precisely as possible. In considering applications, NSAG aims to ensure that the criteria for designation are fully met, so that the highest possible standard of care that can be delivered within available resources to all Scottish residents requiring treatment or investigation of a very specialised nature, or for a very uncommon condition. The Regional Planning Groups are represented on NSAG so that if applications are thought not to meet the criteria, consideration can also be given as to whether a regional planning approach would be more appropriate. If NSAG decides that a bid meets the designation criteria, it is then referred to a meeting of the NHS Board Chief Executives for consideration, especially of any financial implications. Bids which are approved by the Chief Executives then come to me for a final decision on designation.

The funding of these bids comes from the total resources allocated to NHSScotland, and is achieved by a process of what is called 'top-slicing'. The cost of each service is calculated rigorously by
NSD, and complete approval of a bid is the trigger for the Health Department to write to every NHS Board indicating that its general allocation is being reduced by the amount of its contribution to the new national service. The effect is that the whole of NHSScotland shares the cost, and the risk, related to the service in question. Decisions are therefore taken by the system as a whole, in a completely open manner.

I hope it will be clear from this description of the process that the system we have in place is well-established, well-understood and is based on clear and well-publicised criteria. That being so, the Executive has no plans at present to review the criteria and funding mechanisms for national specialist services.

ANDY KERR
Dear Dr Johnston,

Thank you for your letters of 29 July and 26 September about Petition PE791 in which you call for a review of the criteria and funding mechanisms for national specialist services provided to NHS Scotland by individual NHS boards.

As the Minister for Health and Community Care explained in his response to Michael McMahon, “Any service designated as a national service will be highly specialised, low volume or unpredictable and high cost. In the case of the Homeopathic Hospital the pattern of referral will be uniform and interventions will be relatively inexpensive. In these instances NHS Boards are able to plan for and fund the level of service they require. Services with unpredictable referral patterns, however, present significant planning issues in terms of the appropriate design of clinical services and can present a financial risk to NHS Boards. Hence the criteria for designation are restricted to low volume and high cost services. For these reasons it would be inappropriate to designate the Homeopathic Hospital as a national service.”

There is nothing further I can add to the Ministers response. However, I understand that you have again written to Mr Kerr to ask whether the Executive has any plans to review these criteria.

I hope this is helpful.

HARRY BURNS
Public Petitions Committee – a template for public petitions

Should you wish to submit a public petition for consideration by the Public Petitions Committee please complete the template below. Please refer to the Guidance on submission of public petitions for advice on issues of admissibility before completing the template. You may also seek advice from the Clerk to the Committee whose contact details can be found at the end of this form.

Details of principal petitioner:
Please enter the name of person and organisation raising the petition, including a contact address where correspondence should be sent to, email address and phone number if available

Mark Mulholland

Text of petition:
The petition should clearly state what action the petitioner wishes the Parliament to take in no more than 5 lines of text, e.g.

The petitioner requests that the Scottish Parliament considers and debates the implications of the proposed Agenda for Change legislation for Speech and Language Therapy Services and service users within the NHS

The petitioner requests that the Scottish Parliament considers and debates the Permitted Development Rights enjoyed by Network Rail in respect of the erection of 96-foot GSM-R communication masts in residential areas. The petitioner proposes that all such masts require planning consent before erection.
Additional information:

Any additional information in relation to your petition, including reasons why the action requested is necessary, should not be included here. However, it may be appended to the petition and will be made available to the Public Petitions Committee prior to its consideration of your petition. Please note that you should limit the amount of any additional information which you may wish to provide in support of your petition to no more than 4 sides of A4.

Action taken to resolve issues of concern before submitting the petition:

Before submitting a petition to the Parliament, petitioners are expected to have made an attempt to resolve their issues of concern by, for example, making representations to the Scottish Executive or seeking the assistance of locally elected representatives, such as councillors, MSPs and MPs. Please enter details of those approached below and append copies of relevant correspondence, which will be made available to the Public Petitions Committee prior to its consideration of your petition.

Our group, Parents and Residents Against Masts (PRAM) has, since August 2004, approached many public officials and the contact has been via meetings, telephone conversations and correspondence. A summary of those personnel approached is as follows:

Janis Hughes – MSP (meetings and correspondence)
Robert Brown – MSP (meetings and correspondence)
Bill Aitken – MSP (telephone conversations and correspondence)
Nicola Sturgeon – MSP (meeting and correspondence)
Thomas McAvoy – MP (meeting and conversations)
Councillor Gretel Ross – South Lanarkshire Council – (meetings)
Councillor Russell Clearie - South Lanarkshire Council – (meetings)
Michael Docherty – Chief Executive – South Lanarkshire Council – (meeting and correspondence)
Ron McAuley – Route Director Scotland for Network Rail - (meetings and correspondence)
Iain Coucher – Depute Chief Executive – Network Rail – (correspondence)

All other MSP’s have been contacted by our team on at least 4 occasions which has lead to extensive email correspondence with many MSP’s on the subject. We are aware the matter has already been raised at ministerial level within Scottish Parliament.

Request to speak:

All petitioners are given the opportunity to present their petition before the Public Petitions Committee. The Convener will then make a decision based on a number of factors including the content of the petition and the written information provided by the petitioner as to whether a brief statement from the petitioner would be useful in facilitating the Committee’s consideration of a petition.

Please indicate below whether you wish to request to make a brief statement before the Committee when it comes to consider your petition.

Yes

*Delete as appropriate

Signature of principal petitioner:

When satisfied that your petition meets all the criteria outlined in the Guidance on submission of public petitions, the principal petitioner should sign and date the form in the box below. Other
Signature...

Date ... 19/01/05

Please note that any additional information, copies of relevant correspondence and additional signatures should be appended to this form and submitted to:

The Clerk to the Public Petitions Committee,
The Scottish Parliament,
Edinburgh
EH99 1SP
Tel: 0131 348 5186     Fax: 0131 348 5088
e-mail: petitions@scottish.parliament.uk
SCOTTISH PARLIAMENT PUBLIC PETITIONS COMMITTEE – CONSIDERATION PE811

Thank you for your letter of 22 September about the Committee’s consideration of petition PE811 concerning the permitted development rights available to Network Rail and the radio communications masts erected under these rights.

With regard to the Committee’s discussion of 8 September, I should point out that Network Rail’s permitted development rights under Class 34 of Schedule 1 to the Town and Country Planning (General Permitted Development) (Scotland) Order 1992 (the GPDO) apply on their operational land. A mast erected on other land would require planning permission.

The issue was raised of how these masts would fit in with the proposals for the modernisation of the planning system. At present, such masts do not require an application for planning permission and therefore the proposals for changing development management procedures and development planning procedures would not affect them. However, as part of the process of modernising planning we are reviewing the permitted development rights contained in the GPDO as a whole, a possibility I mentioned in my letter of 11 April. This review will include Class 34 relating to railway undertakers. The extent to which new planning application procedures, and statutory requirements on consultation, will apply to these masts will depend on any changes made to the permitted development rights as a result of the review.

Your discussion also mentioned concern about planning authorities not engaging with Network Rail when consulted about their rollout programme. In response to concerns about this raised by Network Rail, the Executive wrote to planning authorities on 27 August 2004, explaining the need to engage with Network Rail on this issue in order to identify particularly sensitive sites. I understand that Network Rail have written to all planning authorities in Scotland about their plans and, where their
proposals change, they will contact planning authorities again about such changes. They have also advised that where it has been more than a year since they notified the planning authority and no work has been begun in their area, they will notify the planning authority again. The Executive will issue a further reminder to planning authorities regarding any further approaches made to them by Network Rail and asking planning authorities to consider contacting Network Rail regarding any approaches which they may have previously disregarded.

I wrote to Network Rail in April this year about this issue. The response from John Armit, Chief Executive, agreed that in addition to the notification of planning authorities and households within 100 metres of a mast site, all relevant MPs, MSPs (list and constituency) and local authority councillors would be notified of mast proposals in their area. He further reassured me that Network Rail would seek flexible approaches to solutions on the ground in the more controversial cases, subject to the need to ensure there are no gaps in the coverage of the system and to the cost constraints on the project. I attach an annex with more details of Network Rail’s procedures.

As far as Network Rail’s plans for rollout in Scotland are concerned, at present they are still working in Strathclyde where they aim to have rollout completed by February 2006. The pilot routes (from Helensburgh to Drumgelloch and Glasgow Central to Kilmarnock) are currently being tested. Related works on communication masts, although not part of the main GSM-R project, are also ongoing between Carstairs and Carluke. The next phase will be Kilmarnock to Gretna which is scheduled to begin this month with completion expected in April 2006, subject to contract agreement.

I hope this information is of assistance.

Yours sincerely

MALCOLM CHISHOLM
SCOTTISH PARLIAMENT PUBLIC PETITIONS COMMITTEE – CONSIDERATION PE811

NETWORK RAIL PROCEDURES

Through the introduction of a traffic lighting exercise and project interrogation each site is scrutinised corporately by Network Rail (NR) to ensure that the chosen location is the best operationally and will have minimal impact on any residences that might be in the area. NR advise that the introduction of improved project management processes and enhanced notification has lead to a downturn in the number of sensitive sites and reaction to projects development.

Site Location:

Sites are chosen by NR following a careful and detailed selection process involving:

• Three-dimensional computer modelling of the railway terrain to identify potential sites.
• Followed by surveys of every site to see if the proposed sites are feasible and that the NR planning guidelines (e.g. avoiding housing as far as possible) had been adhered to.
• Second computer prediction to confirm the location will provide adequate coverage for train communication.
• A final, more detailed, site survey is then carried out at every site.

Criteria

There is an extensive list of further criteria set by NR that must be adhered to, after the initial mapping exercise has been completed. This includes:

• Ensuring that the site is within a reasonable distance of a railway access point, to ensure the safety of workers tasked with its future maintenance. They must also be placed a safe distance away from overhead lines, and any other electrical equipment that could interfere with the structure.

• The strip of railway land has to be large enough to accommodate the structure and supporting cabinet, whilst ensuring that all conducting parts of the site are at least 3.5m from the nearest rail.

• NR must also avoid sites that could interfere with any flight paths and make sure that the structure does not obscure drivers (road and rail) view of signals and levels crossings.

• Ideally, NR also place sites next to existing power supplies to avoid the need to install new infrastructure, thus ensuring that they do not disturb any existing buried services.

Notification Procedures for System roll out

Although Network Rail is not statutorily required to undertake public consultations in connection with the implementation of the GSM-R project, local authority planning departments are supplied with details of the project and exact mast locations within their boundaries, well in advance of the
roll-out of the project. NR will also re-notify those planning departments where a year has passed since the original notification without the work having been begun.

NR is happy to engage with local authorities and any comments/advice received at that stage is considered.

NR will advise all MSPs, MPs and Councillors in whose areas of responsibility the mast is to be erected. This now applies to all masts, not just those designated by NR as “sensitive” sites.

NR will also notify residents living within 100-metres of the proposed mast. Notification will take place a minimum of 4-weeks prior to works commencing. 6- weeks where practical.

While NR do not notify community councils as a matter of course, they would do so if requested by the local authority planning department.