Weds 5 March 2014

Royal College of Surgeons

Briefing

Briefing ahead of debate on the Francis Inquiry

What happened at Mid-Staffordshire NHS Foundation Trust was shameful. The catalogue of neglect and unnecessary deaths are beyond comprehension to those of us who came into the NHS to care for patients and make them better. During the last twelve months a number of initiatives have been introduced which will improve patient safety in England. In particular we welcome:

- Progress towards greater openness and transparency in the health service, including in the implementation of a new statutory duty of candour.
- The publication of surgeons' outcomes data. England now leads the world in transparency around surgeons' clinical outcomes. Patients can access their surgeons' outcomes for particular procedures or operations such as a hip replacement or surgery for obesity.
- Improvements made to the Care Quality Commission's inspection model, particularly the greater use of clinical and patient experts.
- The Government's proposal to introduce a named consultant in charge of someone's care across a hospital stay.
- NHS England's recent proposals to help reduce never events. While they represent a small proportion of all care in the NHS, preventable mistakes are still happening. We support the taskforce's plans to standardise practices in operating departments, improve support for surgical safety training, and harmonise reporting and the publication of data.

Despite these improvements there is still more work to be done. This briefing outlines what further actions we believe are necessary following Robert Francis QC's seminal report.

Put patients at the centre of care

This public inquiry came about because of the campaigning of Cure the NHS. They were initially ignored several times. But without their persistent pressure on everyone in the system and in Government, some of the problems at Mid-Staffordshire NHS Foundation Trust may have continued. This is an important lesson for all of the NHS: patients' concerns and their experiences must be acted on, not ignored. Managers, clinicians, staff and politicians must never assume they have a monopoly on expertise.

While progress is being made to create, in Robert Francis QC's words, a 'patient centred culture', **we believe a number of initiatives still need to happen including:**

- Lay or patient representation at all levels of the NHS, especially on NHS trust boards.

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- A review of the implementation of Healthwatch after their first year with a view to improving their level of independence, support and funding if necessary.
- The creation of job titles across the NHS that are clear and meaningful to patients. Our Patient Liaison Group – a formal mechanism by which patients are represented within the College – has repeatedly highlighted how certain job titles can be misleading to patients, particularly whether they indicate if someone has medical qualifications.

Provide seven-day services in the NHS

It is unacceptable that mortality and complication rates are significantly higher for patients admitted at the weekend. The RCS backs NHS England's recent standards for seven day care, some of which echo the standards created by the Academy of Medical Royal Colleges.

To provide seven day services, the NHS needs to centralise services onto fewer sites to ensure there is sufficient consultant cover and availability of services. In other words, we will need to reconfigure some services. Given the sensitivities around moving services, a debate will need to be had with the public about how the NHS can deliver seven day care. To aid NHS planning, we also believe **the Government or NHS England should commission in-depth financial modelling of the anticipated cost of seven-day services.** This does not exist at present.

Clarify the role of commissioners

It remains unclear what role commissioners play in improving and monitoring quality, and how this differs to the Care Quality Commission. We believe **NHS England should set out a clear statement about what role their organisation and CCGs will play in safeguarding patient care.**

Duty of candour

In November the Government asked our President, Professor Norman Williams, and Sir David Dalton, Chief Executive of Salford Royal NHS Foundation Trust, to assess whether a duty of candour on organisations should cover moderate harm, as well as death or serious injury. The review has the aim of improving the reporting of patient safety incidents. We have collected written and oral evidence on this issue and the findings and recommendations will be published very shortly.

Regulate healthcare support workers and managers

We welcome the recent review by Camilla Cavendish which made a number of recommendations on how the training and support of healthcare assistants can be improved. However, **we also need an improved regulatory system for both managers, and healthcare support workers and assistants** to ensure anyone found not to be fit and proper persons are prevented from holding such positions in the future. Regulation is also important for improving the status and support for both professions. Within surgery, nurses and operating department practitioners are currently regulated but there are a number of workers who we believe should become regulated, including surgical care practitioners and healthcare assistants.

What is the RCS currently doing to improve patient safety?

Since the publication of the Francis report we have been actively working with the regulators, the CQC and GMC to provide independent expert advice on quality assurance of NHS services. Our Invited Review Mechanism, a service the College provides to a Trust that wants independent advice on any surgical concerns, has been significantly strengthened. We continue to engage our Patient Liaison Group across all of our work and are currently working with them on initiatives to improve patient safety. The profession is also working with NHS England to publish additional surgeon-level outcomes data by 2020.

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