



Mid-Staffordshire NHS FT public inquiry: the RCS view

What happened at Mid-Staffordshire NHS Foundation Trust was truly shocking. The catalogue of neglect, squalid bedside humiliation and unnecessary deaths are beyond comprehension to those of us who came into the NHS to care for patients and make them better. We are profoundly sorry for what those patients and their families went through and that they bore such abysmal treatment at the hands of healthcare staff.

Robert Francis QC has carried out a forensic examination of the systemic problems which could have given rise to such neglect. We support many of his proposals which apply across the NHS and we have set out additional ideas for how we can try to prevent such problems from ever occurring again. We are fast approaching the 65th anniversary of the NHS. Over the coming weeks and months there will be much debate about how to improve this much-valued public institution and the RCS will comment on proposals as they emerge. Initially, we believe there are six ways in which the healthcare system could be materially improved so that good clinical treatment is everyone's priority, to be delivered in hospitals with open, caring environments.

1. 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 and central Government: 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.**

This is why we agree with the Inquiry's view that we need a patient centred culture. Patients must be the first priority in all of what the NHS does. This may sound like common sense to the general public – because it should be – but all too often the NHS has prioritised finance above care, self-interest ahead of patient-interest, and put defensiveness before transparency. Cultural change will not happen overnight, but we must examine every aspect of the NHS and ask whether this is really putting patients first.

We therefore call for:

- Lay or patient representation to be included or sought at all levels of the NHS – especially on NHS trust boards – and specifically in developing fundamental standards and quality assurance of care.

- Hospitals to make clear to patients the name of the consultant in charge of their care so they know who they can turn to if necessary.
- The same standards of care, seven days a week. It cannot be right that over weekends and bank holidays, patients may receive a lower standard of care than during the week. However government and healthcare professionals will need to consider what extra resources will be required to fulfil this aspiration.
- A review to be established with the support of NHS representatives, to look at how best to improve the representation of patient safety and dignity issues on trust boards. This should, for example, involve an independent medical and nursing representative – not otherwise involved in the trust’s management – specifically appointed to advise the board and when necessary raise concerns about the treatment of patients in the trust.
- Healthwatch to have a consistent local structure supported by transparent funding from local authorities. We agree with the patient charity National Voices that the Inquiry’s report was strong on candour but weak on patient voice and experience. The Government should therefore commit to reviewing 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. The College’s Patient Liaison Group was established in 1999 and provides a formal mechanism by which patients are represented within the College. It has repeatedly highlighted the ambiguity within certain job titles which can be misleading to patients, particularly with regards to distinguishing between medical and non-medical qualifications. We will explore who should carry out such a review but it should have the support of the royal colleges and other relevant professional bodies.
- We have also asked the College’s Patient Liaison Group to report back to the College on what more can be done to improve the surgeon-patient relationship.

2. Establish clear standards in the NHS

We agree with the Inquiry’s recommendation that there need to be clear standards – minimum-level, day-to-day, and aspirational – for organisations and professionals to comply with and to improve patient care. Like the Inquiry, we believe that the medical royal colleges and other professional bodies should now be given a far greater role in the setting of standards and the way in which they are embedded and overseen in the NHS. This view was recently endorsed by the NHS Commissioning Board Medical Director¹. The College already sets service, clinical, and professional standards (see below for more information on the role of the RCS and surgeons in the broader NHS) but there needs to be a clear message from Government about the importance of involving us in the NHS.

¹ On Tuesday 5 March Sir Bruce Keogh told the Health Select Committee that previously the royal colleges have been relegated into commenting on, rather than involved in, the delivery of the NHS. Sir Bruce said we now need to better involve the royal colleges.

It is important to involve professional bodies not just for their expertise: doing so will assure the public and the medical profession that standards are supported by the clinical evidence. Similarly, involving the public in standard-setting is essential to provide confidence that standards are ultimately aimed at improving patient care.

- We wish to see a clearer role for the College in helping to set standards, and we would welcome a public statement of support from the Government and the NHS Commissioning Board to encourage commissioners and other relevant organisations to involve professional bodies, such as the Royal College of Surgeons, in standard setting. The NHS Commissioning Board and the Department of Health should develop a plan to set out how the NHS can better involve the royal colleges and other medical professional bodies in the development, setting, and monitoring of standards and review how this can be appropriately resourced.
- When a regulator undertakes a review of a surgical service they need to fully involve the College and Specialty Associations to ensure they are using appropriate expertise to understand the clinical aspects of the service and its outcomes.

3. Improve openness and transparency in the NHS

Trust and openness between staff lies at the heart of all good healthcare. As the body responsible for setting surgical standards we know that raising concerns early, before they become a serious patient safety threat, combined with a strong relationship between clinicians and managers, is vital to patient safety. Staff have a duty to raise concerns, but their employers also have a duty to listen. For this reason, we believe it is completely unacceptable for NHS trusts to impose ‘gagging clauses’ on staff and we welcome the Secretary of State’s recent announcement that NHS trusts will no longer be able to silence staff when it comes to issues of patient safety. We are concerned that coercion and harassment remains a serious problem in some trusts; this must be tackled and stopped if there is to be a real change in the culture of the health service.

The route to greater transparency within the NHS also lies in far better use of data. The RCS is now preparing for the publication of surgeons’ results later this year and we welcome the report’s commitment to the publication of proper outcome data which is publically funded. The surgical profession believes that the publication of credible and meaningful data will improve patient outcomes through greater scrutiny, identifying and managing poor performance, and ultimately empowering patients with robust information

- We are working closely with the NHS Commissioning Board and the Surgical Specialty Associations on a new national proposal to support the collection and publication of consultant-level outcomes from national clinical audit data, the gold-standard for proper outcome data. We would welcome discussions about how the data collection and analysis can be funded and developed, and we will review with the Specialty Associations what further audits can be carried out. It

is essential that any future audits are led and supported by the relevant professional body to ensure the methodology, collection and interpretation of the data is robust. Consideration also needs to be given to how best to help the public access and interpret such data.

- We acknowledge the need to ensure that any relevant information we hold is proactively shared with regulatory bodies and vice-versa. We would welcome the development of a memorandum of understanding with the GMC (and any other relevant bodies) to formalise such arrangements.
- We remain to be convinced that a statutory duty of candour will improve transparency and patient safety. Any legislative proposal must not dissuade reporting of any kind, deter clinicians from undertaking complex medical cases, or discourage innovation. We would welcome the opportunity to shape proposals with all interested parties.

4. Clarify the roles of different bodies in the system

The Inquiry's report provides the opportunity for the Government and the NHS to be clear about who does what in the system. Who is ultimately responsible when things go wrong? Which organisation(s) are in charge of correcting serious problems with patient care? What role do commissioners play in all of this? In particular we would like to see:

- A clear statement from the NHS Commissioning Board about the role of commissioners in improving and monitoring quality. As the report makes clear, commissioners presently have a weak role in this area and it varies across the country.
- A joint statement from the GMC and Health Education England, and also CQC and Monitor, setting out their different areas of work, agreeing responsibilities, and making clear what information the organisations will share. Otherwise there is a risk of overlap.

5. Establish regulation and training of healthcare support workers and managers

We need an improved regulatory system for managers and healthcare support workers to share best practice and to ensure any leaders, managers or healthcare assistants that are 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 healthcare support workers who we believe should become regulated, such as surgical care practitioners and healthcare assistants. Although the Inquiry said 'there was a failure of the NHS system at every level', a recent poll suggests more than half the public blame NHS managers for the disaster of poor care at the Mid Staffordshire NHS Foundation Trust². It is clear that managers in particular need to earn the trust of the public.

² <http://www.hsj.co.uk/5055127.article>

- We welcome the proposals to introduce registration of healthcare support workers and managers, and improve training and support for both sets of professionals. It is of serious concern to us that healthcare assistants in particular have so little training. We would like to see plans to move to systems of regulation where there is a regular assurance of performance against agreed frameworks. However, regulation must be proportionate and not distract staff from the central job of caring for patients.
- We also strongly agree with the proposals³ to introduce a common code of ethics, standards and conduct for senior board-level leaders and for serious non-compliance with these codes to render such persons liable to be found not to be fit and proper persons to hold such positions elsewhere.
- Where managerial staff are practising clinicians, dual regulation should be avoided in line with Professional Standards Authority guidelines.

6. Improve the quality assurance of education and training

Education and training of healthcare professionals is fundamental to the delivery of high quality care and patient safety. For doctors' training in specialties such as surgery the balance between training and service is very important. It is vital that the new education and training system recognises and supports weighting given to training in specialties such as surgery as this leads to the development and refinement of clinical judgement and technical skills which are essential for patient safety. Key to developing these skills is the recognition of the importance of supporting the relationship between individual consultants and surgeons in training by maximising the time available to train and develop their clinical skills.

Training must be incentivised throughout the service, making the most of training opportunities and ensuring sufficient time is available and that trainees and trainers are supported by the senior hospital management team. Time also needs to be available for activities for the benefit of the wider NHS.

The College already has a key role with our sister colleges in setting the standards for training programmes and assuring trainees meet these standards in order to complete their training. Quality assuring training providers not just individuals is therefore vital to ultimately improving patient care.

- We would like to see royal colleges working with the GMC to take part in routine visits to local education providers, as the Inquiry has recommended. This needs appropriate resources, and needs to be more than just administrative support; the GMC and other regulators need to involve the medical professions in the site visit team.
- To help enable this, we would welcome a clear message from the Department of Health about the importance of trusts releasing staff to use their expertise in a visits programme.

³ Recommendations 215 and 218

What we will do

The majority of the Inquiry's recommendations are aimed at Government, non-Departmental public bodies, providers and commissioners. Nevertheless, all parts of the system must play their part in improving the quality of patient care including surgeons. We have therefore decided to take the following actions and we will review progress against this regularly.

Action	Timescale
➔ We will meet with the GMC and CQC to discuss what further information the organisations can share.	ASAP.
➔ We are supporting the publication of individual surgeon-level data from the identified national clinical audits. We are reviewing with the Surgical Specialty Associations what additional audits should be carried out.	Publication to start June 2013.
➔ We will review our Invited Review Mechanism model contract and assess how we can share appropriate information to make our reviews more transparent without compromising patient and professional confidentiality.	Decision by summer 2013.
➔ We are reviewing the support we can offer trusts to peer review training and service delivery standards.	On-going.
➔ We are reviewing the potential for the College to accredit training providers and programmes to deliver excellence in training.	On-going.
➔ With the establishment of Health Education England and the Local Education and Training Boards we will review the information we systematically share.	Summer 2013.
➔ We have asked the College's Patient Liaison Group to report back to the College on what more can be done to improve the surgeon-patient relationship.	PLG to report back by late Spring 2013 with College response in Autumn 2013.
➔ We will explain the findings of the Inquiry to our members and highlight what work the College will do to support them.	Ongoing.
➔ We are continuing to encourage surgeons to take up leadership roles in commissioning and provider organisations.	Ongoing.

The role of the RCS and surgeons in the broader NHS

The problems at Mid-Staffordshire NHS Foundation Trust show what happens when medical professionals and patients are isolated from the management of the Trust. The RCS believes it is important for the royal colleges and the medical and nursing professions more broadly, to be fully engaged in the NHS. This view isn't motivated by self-interest but a desire to use our expertise to improve professional, clinical, and commissioning standards for patient care. Clinician involvement is also vital for reassuring the public that clinical, rather than financial, reasons are at the heart of decisions about their care.

What role do we currently play?

The Royal College of Surgeons is a professional body covering England, Wales and Northern Ireland. The Royal College of Surgeons of England is committed to enabling surgeons to achieve and maintain the highest standards of surgical practice and patient care. We established our own independent Patient Liaison Group in 1999 to formally represent patients within the College. We already provide support for trainee and consultant surgeons, and support for improving surgery throughout the NHS.

In education and training we:

- Set the curriculum with our sister colleges for surgeons in training and set examinations;
- Provide educational courses and practical workshops for surgeons at all stages of their career;
- Examine trainees to ensure the highest professional standards;
- Assure the quality of training programmes and education courses;
- Share intelligence to national bodies such as Health Education England about the surgical workforce to aid planning;

To support the broader NHS we:

- Work with the Surgical Specialty Associations to publish professional, clinical, and service standards used by frontline professionals, providers, commissioners, and the broader NHS;
- Encourage surgeons to engage in local decision-making processes. For example, we recently published *Reshaping Surgical Services* which outlined the principles that any reconfiguration of services should consider;
- Offer an Invited Review Mechanism to support NHS trusts in resolving concerns about the clinical performance of an individual surgeon or surgical unit;
- Run a programme of work designed to improve patient safety. This has included establishing the Clinical Board for Surgical Safety;
- Promote and support surgical research in the UK;
- Support audit and evaluation of clinical effectiveness;
- Act as an advisory body to the Government, non-Departmental public bodies like NICE, and the NHS.