Health & Social Care Committee Inquiry into leadership, performance and patient safety in the NHS.

About the Royal College of Physicians of Edinburgh

The Royal College of Physicians of Edinburgh (the "College") is a professional membership organisation which sets clinical standards and aims to improve and maintain the quality of health and patient care. We do this by improving accessibility to the profession, developing collaborative partnerships, encouraging innovation and delivering outstanding education, training, quality improvement, and assessment opportunities.

Founded in 1681, we support and educate doctors in the hospital sector throughout Scotland, the UK and around the world with over 14,500 Fellows and Members in over 90 countries, covering 54 medical specialties and interests. We enable a worldwide community of physicians and their teams to advance the health of our global population for the long-term benefit of society.

- How effectively does NHS leadership encourage a culture in which staff feel confident raising patient safety concerns, and what more could be done to support this?

Fellows stated that while the situation had improved over the years, it remained suboptimal and challenges remain for staff in raising safety concerns in a "supposed" no blame environment. Some Fellows highlighted tensions between clinicians and management in risk and gave the example of the use of "reverse boarding" which is demanded by managers to reduce the congestion in Accident and Emergency and can mean putting patients in the corridors of wards. The consultant has no say in this but has to cover the risk.

Fellows consider that there needs to be better "listening" by management and overt evidence of actions being taken when issues are raised.

- What has been the impact of the 2019 Kark Review on leadership in the NHS as it relates to patient safety?

Fellows indicated that the results of the Kirk review, as they relate to a "current fit and proper persons test" that is designed to ensure that senior staff who are responsible for quality and safety of care are fit and proper to be in their roles, are not especially evident currently in the NHS. They suspect that many clinicians are unaware of the document or its implementation and consider that the process needs to be more visible and transparent to all healthcare workers.

- What progress has been made to date on recommendations from the 2022 Messenger Review?

The College considers that the Messenger Review is a welcome addition to the NHS leadership and management programme in delivering high quality safe patient care in the NHS. The

Messenger Review clearly identified the important role and responsibilities of medical leadership in particular. However some Fellows indicated that they consider that the Review is not widely known by healthcare workers and there is little evidence of its implementation.

Our Fellows consider that the main issue is that health systems require investment in effective management and, if anything, the NHS continues to be under-managed in comparison to other sectors. At present, busy clinical professionals may often have to take on this deficit in these leaderships roles and this further exaggerates the workforce crisis and prevents reform. Indeed, the cumulative effects of this could exacerbate the workforce crisis and hold up much-needed reforms in the NHS.

The same policies continue with new more challenging activity targets and efficiency savings, all the while staff shortages increase in all health and social care sectors.

For this review to make a difference, funding, support and resourcing is essential to deliver on the recommendations. For this to be successful there needs to be the right leadership culture and behaviours in the NHS.

The College would welcome a focus on revisiting the Messenger Review recommendations and delivering these in the NHS and on boosting the status of medical leadership.

- How effectively have leadership recommendations from previous reviews of patient safety crises been implemented?

  Fellows indicated that there is much variation in this and again suggested that the main limitations remain resources and staffing in addition to the time to train/retrain and reflect.

- How could better regulation of health service managers and application of agreed professional standards support improvements in patient safety?

  Some Fellows indicated that managers should be under the same scrutiny as health care workers and regulated by a body similar to the GMC (but not by the GMC) to ensure accountability.

- How effectively do NHS leadership structures provide a supportive and fair approach to whistleblowers, and how could this be improved?

  Fellows believe that a huge amount of work is still required to listen and protect whistleblowers. Some Fellows believe that there remains too great a culture of suppression of those who try to voice concerns.

- How could investigations into whistleblowing complaints be improved?

Fellows suggested that a well-defined external structure should be considered for whistleblowers to speak to and thus not fear internal issues.

- How effectively does the NHS complaints system prevent patient safety incidents from escalating and what would be the impact of proposed measures to improve patient safety, such as Martha's Rule?

The complaints system tends to occur after incidents and therefore is not preventative. The NHS still requires much work to learn from these – again many of the issues arrive from a system under immense strain with overworked staff, staff shortages and poor resources. Martha's Rule is a welcome addition but without a complete overhaul and significant investment it will only have a limited effect.

- What can the NHS learn from the leadership culture in other safety-critical sectors e.g. aviation, nuclear?

Fellows stated that much has been learned already from other sectors with the introduction of the WHO surgical check chart, and the use of simulation to review incidents and learn from these events. Staff training is essential, and the newer methods and resources supplied to education departments has been a welcome addition.

The challenge in comparing the NHS to other systems is in part related to the changing face of modern healthcare. For example, all of these factors exist:

- more work 'around the clock'
- older and sicker patients attending the hospital with complex needs and multimorbidity.
- Increase in complex interventions and new technology which increase risk
- An explosion of evidence and hence more time needed to train and keep up to date
- A need for more time for prescribing and monitoring of potentially dangerous drugs
- increased specialism and super-specialism
- patients want information and involvement
- increasing workforce pressures and staff shortages