Written evidence submitted by the Royal College of Physicians and Surgeons of Glasgow (SIB0007)

The Royal College of Physicians and Surgeons of Glasgow was founded in 1599 to improve quality and practice of Medicine.

Based in Glasgow, the College has 14,000 Fellows and Members who work as senior clinicians throughout the United Kingdom and across the world. Unlike our sister Royal Colleges, we have a multidisciplinary membership. This submission mainly affects the Faculties of Medicine, Surgery and Dentistry. The College believes whilst recognising that devolved administrations exist with differing powers, the regulation of the practice of medicine in its widest sense and the delivery of health and social care should have similar philosophies and practical procedures throughout the four nations and Crown Dependencies of the United Kingdom.

The practice of medicine is now complex and relies on multiple systems to be in place and is dependent on multiple practitioners. Mistakes rarely happen as a result of one individual's error. The College's view is that practitioners should be able to discuss their mistakes in an open non-confrontational way which allows them to reflect on their actions to prevent or mitigate the effect of further incidents. This is currently the situation for practitioners in their training (e portfolio) and principals (appraisal). However these are not legally privileged documents. Recent cases have caused practitioners to feel that they will not be supported if they are open in these forms of review (Bawa-Garba and Sellu).

In terms of health care providers (NHS Trusts and Boards) and commissioners, there is limited review in the forms of Serious Untoward incidents (SUI). There is no practical mechanism for NHS Trusts and Boards to be held accountable (Corporate Homicide prosecutions are rare in the NHS) and there is no regulator for non-medically qualified managers. There appears to be little mechanisms where system review and SUI review can be linked to fitness to practice.

The current Health and Social Care environment has multiple regulators and interested parties.

It is not clear what formal lines of communication exist to coordinate the work of these organisations, despite the fact that they can adjudicate independently and without considering the breadth of issues.

Such organisations involved in this sphere include:

Educational and Training Bodies

- Health Education England and the relevant bodies in the devolved nations
- Royal College training Committees
- General Medical Council, General Dental Council, Nursing and Midwifery Council and other Health related professional bodies

Regulatory Bodies

- General Medical Council
- Medical Practitioners' tribunal Service
- General Dental Council

- Nursing and Midwifery Council
- Allied Health Professionals Regulators
- Professional Standards Authority

Quality Regulators

- Care Quality Commission and its equivalents in the devolved nations

Complaints Procedures

- Health Care Providers complaints procedures
- Parliamentary Commissioner (Ombudsmen) enquiries

Legal Action

- HM Courts throughout the United Kingdom in each Jurisdiction
- Use of Gross Negligence Manslaughter, Culpable Homicide and Corporate Manslaughter charges

Public Enquiry

- Set up by Parliament or Government minister eg Mid Staffordshire, Morecombe Bay

Currently there are a range of significant reviews undertaking investigations in this area:

- Professor Sir Norman Williams' Review into Gross Negligence Manslaughter in Healthcare at the request of the Secretary of State for Health and Social Care

- Dame Claire Marx's Review of Gross negligence Manslaughter and Culpable Homicide at the request of the General Medical Council

- Duty of Candour at the request of the Professional Standards Authority

The College believes there is considerable confusion and lack of clarity. We consider important principles need to be maintained:

- Individual practitioners should be responsible for their personal care.
- Delivers and Commissioners of health and social care should be responsible for their actions
- Individual Practitioners should not take the blame for systemic failures. The College believes there is a strong argument to be made that gross negligence manslaughter (culpable homicide in Scotland) should not be an offence. Sir Ian Kennedy QC (Br Med J 2018;360:k1376) has stated that "we need to rethink the role of the criminal law and medical manslaughter. Does it have any place in how we deal with things going wrong... because medical manslaughter means you can pick someone, blame them and imagine you have solved the problem. And what you have done is exacerbated it.
- Non-Medically qualified managers should be regulated.
- Any new system needs to enhance not duplicate systems.
- HM Courts should be used as a last resort.

The College gives the following answers to specific questions arranged by the Committee:

General issues

Will the HSSIB command the confidence of patients and their families and healthcare professionals?

The College believes the current environment is confusing and has duplicity. Without a history of working in this area, it is difficult to believe that the public and the professions will have confidence in this Body. At present, professionals lack confidence in the regulatory bodies such as the GMC and the GDC. They currently spend approximately 60 % of their budget on fitness to practice cases.

Should the HSSIB's remit extend to private healthcare?

Yes. There is a need to regulate private health care. This has been demonstrated in the Paterson case, where private deliverer of health care did not consider they had a responsibility for patients using their service.

Can patients and the public be confident that 'safe space' investigations will remedy the deficiencies of existing NHS complaints mechanisms?

The College considers that while "safe space" investigations may have merits, it will not protect staff or patients or their relatives enough to allow them to be completely open and safe. Trainee doctors following recent cases are not happy to be open and candid because the evidence they present may be used against them in fitness to practice proceedings.

It will also be necessary to have systems in place to control vexatious complainers.

Are there any deficiencies in the drafting of the Bill that would prevent it from achieving the Government's objectives?

The College has no comment on the drafting of the Bill.

Establishment and powers

Will the establishment of the HSSIB add to confusion about the responsibilities of the various bodies currently dealing with complaints and safety concerns in healthcare?

While this issue is important, the College believes that confusion could be increased with the development of this body. It would recommend widening the powers of existing bodies and also giving clarity to the existing bodies' roles and functions.

It will be important to learn from previous work in this area, including the unsatisfactory launch of the National Patient Safety Agency when it was founded in 2002.

Would the draft Bill equip the HSSIB with adequate powers to achieve the Government's objective of improving patient safety, or the ability of the Secretary of State to secure the improvement of the safety of the NHS? Does it go too far in any respect?

The College does not believe this organisation will improve patient safety.

The Government must first look at the results of the current ongoing reviews in this area and avoid duplication with existing authorities and organisations.

Would it be appropriate to model the powers and status of the HSSIB more closely on similar bodies which investigate safety incidents in the aviation, rail or maritime industries?

Yes.

The principle of using other models of reporting incidents has merits on reporting health investigations. The College believes systemic failures are as important as personal failures. Currently inadequate staffing, lack of breaks and sleep are important issues.

Does the draft Bill ensure that the HSSIB is sufficiently independent of both the NHS and the Government?

Independence of both NHS and Government is important and indeed vital to any organisation looking at potential errors. However any organisation needs to be responsible to a body. Currently the General Medical Council considers it supports the patients' interest but fails to recognise it needs to support the NHS in general and training doctors in particular.

Safe space

Is a legally protected 'safe space' necessary to successfully undertake NHS investigations?

The College supports the principle of providing a "safe space" in which to hold safety investigations.

However, as described this is not a legally protected space as it is still open for courts to ask for information.

Will creating a 'safe space' for safety investigations "encourage patients, families, NHS staff and other participants in an HSSIB investigation to speak freely for the purposes of promoting learning and improving safety"?

The College does not consider that there is enough protection for the public or NHS staff. It also considers that it may protect the vexatious complainant. It asks the question whether it would protect the staff or relatives of those in the Bristol Children's Cardiac Surgery and the Mid Staffordshire events.

Would the draft Bill adequately protect from disclosure information given to the HSSIB?

No. There is not enough protection.

Accreditation

Will the public have confidence in trusts carrying out their own 'safe space' investigations, and will this build public confidence in the NHS safety investigations system more generally?

It is quite clear the public require independent investigations.

NHS Trusts and Boards may be seen by some to have conflicts of interest and should not lead to safety investigations. Accreditation will not be effective or seen as independent by the public or the professions.

Are the accreditation provisions in the draft Bill satisfactory?

No

Will the HSSIB be able to maintain standards of investigation?

Unclear

Reporting

Will the HSSIB be able to effect change and ensure its recommendations are acted upon?

Unsure. The College does believe this body will be effective. It is clear there will be duplication of effort between bodies.

Would there be adequate safeguards for people referred to in HSSIB reports?

Without legal privilege there will not be adequate safeguards. Equally there needs to be clear control of vexatious complainers.

In summary, as the Bill stands, the College would have difficulty supporting it. It would recommend looking at the three reviews' reports before proceeding. There is a danger of duplication of function between various bodies and no improvement of service

Dr Richard Hull FRCP Glasgow
Honorary Secretary
Royal College of Physicians and Surgeons of Glasgow
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