RCGP Position Statement on the Recommendations of the Mid Staffordshire NHS Foundation Trust public inquiry report

Overview

The RCGP has been giving close consideration to the findings of the final Mid Staffordshire NHS Foundation Trust public inquiry report. This paper sets out our views on a number of key recommendations, including those that relate explicitly to general practice and GPs.

We believe strongly that the findings of the report highlight the need for patient care and compassion to be restored to the heart of everything the NHS does. Over time healthcare delivery in the NHS has become more technical, more specialised, more performance managed and less patient-centred and holistic. A ‘generalist’, whole-person approach to care should be at the heart of a change in culture throughout the NHS. As part of this, health professionals must be able to raise concerns on behalf of their patients without fear of recrimination. This paper should be read alongside the College’s press release issued following publication of the report.

Whilst some of the report’s recommendations refer specifically to parts of the NHS structure in England (e.g. sections on commissioning), action is needed across England, Wales, Scotland and Northern Ireland on a number of issues which cut across national borders – particularly the need for greater support for whistle blowers and action to ensure the ban on ‘gagging clauses’ is effectively enforced.

Summary of RCGP Position:

- As generalists, GPs are well placed to develop an understanding of how their patients have experienced care outside of general practice, and RCGP supports the need for systems to collate feedback to those working in primary care on patient experiences and concerns. Careful thought is needed on how to achieve this effectively.

- Whilst GPs can play a supportive role in monitoring standards of care, lead responsibility for monitoring and checking the quality of service provision should lie with the service providers, regulators and commissioners.

- The RCGP recognises that there may be a case for introducing a duty of candour as a means of more effectively embedding the principles of openness, transparency and candour in the NHS. However, any introduction of new statutory duties must align with existing duties (including professional duties placed on all doctors and upheld by the GMC) to be effective. Simple, clear and enforceable duties need to be understood by all those who work in the NHS.

- Urgent measures are needed to improve the support available to NHS ‘whistle blowers’, and the Government should pursue a discussion with medical defence organisations, trade unions and Royal Colleges to explore this issue. The Government should also put in place a clear plan of action to enforce a ban on ‘gagging clauses’ in NHS contracts.
RCGP Position on Specific Recommendations:

**Effective Complaints Handling: Learning and information from complaints**

**Recommendation 120**

The report recommends that commissioners should have as near to real-time access to all complaints and information on their outcomes as possible. It suggests that commissioners should be required by the NHS Commissioning Board to support and oversee the role of GPs in this area, and be given the resources to do so.

- The RCGP supports measures which improve complaint handling processes in a way that benefits patients. Any workload implications for GPs will need to be considered in more detail.

- It is unclear whether the intention of the recommendation is for commissioners to have oversight of complaints received by GPs regarding secondary care, complaints regarding their general practice surgery and GPs, or both. The RCGP would welcome clarification on the nature of complaints that the report recommends commissioners will be expected to have oversight of.

- Should this recommendation be accepted by the Government, systems, support and resources would be needed to enable real-time sharing of complaint information and their outcomes. RCGP feel that further exploration of the evidence is needed to ensure that any system introduced would be adequate to flag up patterns that could be indicative of potential harm to patients.

**Effective complaints handling: Commissioning for standards**

**GP responsibility for monitoring delivery of standards and quality**

**Recommendation 123**

The report argues that GPs should play an important role in undertaking monitoring on behalf of their patients who receive acute hospital and other specialist services. It highlights five aspects of this role which we have addressed in turn:

**i)** ‘[GPs] have a role as an independent, professionally qualified check on the quality of service, in particular in relation to an assessment of outcomes.’

- As generalists, GPs are well placed to develop an understanding of how their patients have experienced care outside of general practice, and the RCGP supports developing systems in primary care where individual experiences can be fed back and collated to ensure effective feedback from the sector

- This recommendation opens up questions about capacity within general practice and the need to ensure the right mechanisms for communication between service providers and GPs are in place. GPs can play a supportive role – although lead responsibility for monitoring and checking the quality of service provision must continue to lie with the services themselves, regulators and commissioners.

**ii)** ‘[GPs] need to have internal systems enabling them to be aware of patterns of concern, so that they do not merely treat each case on its individual merits.’
• The RCGP supports the development of better systems to ensure patterns of concern are flagged up. Further work is needed to scope out how this would work in practice, bearing in mind the need to aggregate cases together to a level that enables consideration of any trends to be meaningful. GP organisations will need to work with the DH, the NHS Commissioning Board and the CQC and others to explore the feasibility of systems to highlight patterns of concern.

iii) ‘[GPs] have a responsibility to all their patients to keep themselves informed of the standard of service available at various providers in order to make patients’ choice a reality.’

• This recommendation does not specify whether it is targeted at commissioners, who have a role in monitoring services quality, or individual GPs who will mainly rely on quality assurance mechanisms and contracting requirements to ensure that local services are suitable for their patients. While practices will be able to pick up some lapses in care and quality, clarity is needed on what access to information GPs (and patients) would have to assess the quality of provider services. In any case, a consistently poor quality service should not be one that a patient should be able to choose.

iv) ‘A GP’s duty to a patient does not end on referral to hospital, but is a continuing relationship.’

• A strong relationship of trust between a patient and their GP, developed and maintained over time, can be a powerful driver for the delivery of safe and effective care, and this of course should not end when a patient is referred to hospital. Supporting and enhancing continuity of care features strongly in recent RCGP reports on Medical Generalism and Integration of Care, as well as the College’s 2022 vision for the future of general practice1. We agree that there is a role for GPs to act on major concerns brought to the GP during or after hospital care. Better joint working between GPs and hospital specialist teams2 – e.g. more structured discharge planning – is also needed to deliver on this recommendation.

• In our view this recommendation cannot, however, be about GPs taking direct responsibility for patients in hospitals – GPs cannot be held responsible for the quality of care that patients receive from another provider such as a hospital, and ultimately hospital directors should remain responsible for ensuring their services are of high quality.

v) ‘[GPs] will need to take this continuing partnership with their patients seriously if they are to be successful commissioners of services. They should exploit to the full this new role in ensuring their patients get safe and effective care.

• The RCGP agrees that a strong partnership between GPs and their patients will be important if GPs are to be successful commissioners of services. The RCGP will continue to work with CCGs and the NHS Commissioning Board to support commissioners in this area.

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1 RCGP report on Medical Generalism (June 2012); RCGP report on Integration of Care (June 2012); and RCGP 2022 Vision [Consultation Version Sept 2012 – final version expected to be published in May 2013].
2 See Teams without Walls: The value of medical innovation and leadership. Report of a Working Party of the Royal College of Physicians, the Royal College of General Practitioners and the Royal College of Paediatrics and Child Health
• In taking forward the report’s recommendations relating to CCGs, it will be important to establish clear roles and responsibilities in terms of monitoring the safety and quality of NHS services. Whilst recognising (as above) that GPs have an important role to play, in RCGP’s view primary responsibility for systematically checking whether services are meeting national standards should continue to rest with the Care Quality Commission (CQC) in England and equivalent bodies in Wales, Scotland and Northern Ireland.

Public accountability of commissioners and public engagement

Recommendation 135

RCGP agree that commissioners “should be accountable to their public for the scope and quality of services they commission”. Lay presence on CCG Boards, transparency in decision making processes and ensuring that CCGs develop a recognisable identity serving as a familiar point of reference for the community are correctly identified as potential means to achieve this. We do feel, however, that two of the report’s suggestions in this area – setting up a CCG “membership system” and conducting regular surveys – may not be practical or appropriate, particularly given the budgetary constraints under which CCGs will operate.

Care should also be taken to ensure that activities in this area do not clash or duplicate the existing systems through which CCGs will engage with local people through local HealthWatch organisations. The report’s recommendation that CCGs “create and consult with patient forums and local representative groups,” for example, may lead to multiple groups and forums being created, causing unnecessary duplication and inadvertently diluting patient engagement.

Medical training and education: Medical training

Recommendation 155

The Francis report makes recommendations that the GMC “should set out a standard requirement for routine visits to each local education provider” and that “the Royal Colleges should be enlisted to support such visits and to provide the relevant specialist expertise where required… All healthcare organisations must be required to release healthcare professionals to support the visits programme”.

• General practice has led the way in setting standards for trainers and since 2006 has been the highest rated specialty in terms of training experience3.

• Systems for visiting local education providers already operate in a number of areas, so changes implied by this recommendation need clarification. The implications of releasing staff are quite different for the small teams that characterise general practice, and further consideration will be needed if GP practices are to be included within the list of organisations that are to be required to release staff to support the visits programme, in particular regarding how this would be financed.

• The RCGP supports the promotion of good practice on raising and acting on concerns as part of GP training. From August 2013 the RCGP curriculum will be updated to include explicit references to GMC guidance on raising and acting on concerns.

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Recommendation 160

The report recommends that “proactive steps need to be taken to encourage openness on the part of trainees and to protect them from any adverse consequences in relation to raising concerns.”

- The RCGP strongly agrees with this recommendation and we will be raising this in discussions with the Committee of General Practice Education Directors.

Openness, transparency and candour
Recommendations 173 – 184

Recommendation 173

- The report highlights the need for a change in culture throughout the NHS to embed the principles of openness, transparency and candour. RCGP supports the promotion of these principles and believes they are essential to the delivery of safe and effective patient care. With this in mind, there may be a case for introducing a statutory duty of candour as a means of more effectively embedding these principles in the NHS.

- The Government must carefully consider how a new statutory duty would achieve this in addition to the existing duties on both individuals and providers – including the GMC’s Good Medical Practice, the NHS Constitution and the NHS code of conduct for managers – already in place. Any new duty should be closely aligned with this existing framework to ensure it is clear, consistent and understandable to all health professionals and organisations.

- RCGP supports the introduction of a statutory duty of candour for all organisations involved in the commissioning and provision of care in the NHS. As part of fulfilling this, such organisations should be expected to put in place appropriate mechanisms (including within employment contracts) and systems to ensure that staff are open, transparent and candid with them.

- However, in our view further consideration is needed of whether the potential benefits of introducing a statutory duty of candour on individuals that can be enforced through the courts will outweigh the possible perverse incentives to which it could give rise. The application of such a duty to individuals might provide an added deterrent to the withholding of information. However, there could also be significant unintended consequences, including:
  - It might encourage individuals to focus their actions on protecting themselves against the risk of litigation rather than working together as part of a team to put the care and support of patients first.
  - If duties were placed on both organisations and individuals, it might result in different parties involved ‘passing the buck’ between each other if the duty has not been complied with.
  - Such a duty might, therefore, encourage an ethos driven not by what is best for patients but by legal considerations – which might serve to create a barrier to the sort of cultural change towards more patient focused care described in the Francis report.
Recommendation 181

- “The provision of information in compliance with this [Duty of candour] requirement should not itself be evidence or an admission of any civil or criminal liability…”

- The RCGP agree that candour is key to changing culture. However, further clarification is needed on what the legal status of any information disclosed in compliance with the duty of candour would be and how any rules in relation to civil or criminal liability would work in practice.

Responsibility for, and effectiveness of, health standards

Recommendation 28

The report says that breach of fundamental standards: “…. Should result in regulatory consequences attributable to an organisation in the case of system failure and to individual accountability where individual professionals are responsible. Where serious harm or death has resulted to a patient as a result of the breach of the fundamental standards, criminal liability should follow and failure to disclose breaches of these standards to the affected patient (or concerned relative) and regulator should also attract regulatory consequences.”

- Where there is evidence of professional negligence or of contravention of the criminal law, individuals must of course be subject to the relevant processes and sanctions. However, the RCGP is concerned that the introduction of a specific new form of offence in cases where fundamental standards are breached could have a counterproductive effect by discouraging a more open and transparent culture.

- If individual medical professionals are required to report suspicions they have about a mistake being made to their employer, complying with their duty of candour, this could in some circumstances expose them to possible prosecution for breach of the fundamental standards. To avoid giving rise to conflicting incentives, disclosures made under the duty of candour should be explicitly excluded from any framework for legal action against an individual for a breach of fundamental standards.

Restrictive contractual clauses

Recommendation 179

The report proposes that “‘Gagging clauses’ or non disparagement clauses should be prohibited in the policies and contracts of all healthcare organisations, regulators and commissioners”.

- Enforce a ban on gagging clauses: Careful thought is needed as to how effective action can be taken to stop the use of ‘gagging clauses’ in the NHS. Whilst we understand that both the Secretary of State and the Chief Executive of the NHS in England have written to NHS Trusts instructing them not to use gagging clauses, it is clear that their use has persisted in recent years and there is an issue of enforcement which must be dealt with⁴. The Government should, in its response to the report, outline a plan of action to enforce a ban on such clauses.

⁴ ‘NHS spent £15m gagging whistleblowers’. The Daily Telegraph, 22nd February 2013
• **Review the legal framework:** The Government should launch a review of the Public Interest Disclosure Act 1998 to ensure that it adequately protects whistle blowers in the NHS in practice. We are concerned that the Enterprise and Regulatory Reform Bill currently before Parliament may, in attempting to close a loophole allowing individuals to gain protection under PIDA when concerns have been raised about their personal employment contract may have unintended consequences that weaken protection for genuine whistle blowers in the NHS.

• **Access to support for whistle blowers:** The financial, emotional and professional consequences for whistle blowers who aren’t able to access proper means of support are often great. Anecdotally there are examples of whistle blowers not being eligible for support either from a trade union (if the issue is not strictly an ‘employment’ matter) or from a medical defence organisations (if the issue is not strictly a ‘clinical’ matter). Often when someone does blow the whistle the facts are disputed and the individual is then subject of retaliatory complaints and/or disciplinary action, so it is highly likely that a lack of access to outside support is discouraging people from coming forward.

Action is needed to ensure all those who ‘blow the whistle’ on an issue relating to patient care are able to access appropriate support, including legal cover. As a starting point the Government should pursue discussions with the medical defence organisations, trade unions and Royal Colleges to explore how this issue can be resolved.

**Common information practices, shared data and electronic records**

**Recommendation 244**

The report states that: “There is a need for all to accept common information practices, and to feed performance information into shared databases for monitoring purposes… Patients need to be granted user friendly, real time and retrospective access to read their records, and a facility to enter comments. They should be enabled to have a copy of records in a form useable by them, if they wish to have one. If possible, the summary care record should be made accessible in this way”.

• The NHS Commissioning Board has set a target of 2015 for all GP practices in England to offer patients online access to their records and transactional services. RCGP – working with a wide group of stakeholders – has accepted an invitation from Government to lead a programme of work in this area, including the development of guidance for GPs. As part of this work, in March 2013 published ‘Patient Online: The Road Map’ which provides practical guidance and support for GPs.

• The development of patient online access to records presents significant opportunities for both patients and GPs. It will also have major implications for the way patients access primary care services and how GPs work, and implementation must be thought through carefully.

• The RCGP’s work in this area therefore addresses at least some aspects of the report’s recommendation from the point of view of general practice. Some aspects of the recommendation – such as the facility for patients to enter comments in their records – will need further consideration and scoping.

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5 This document is available online here: [http://www.rcgp.org.uk/patientonline](http://www.rcgp.org.uk/patientonline)