Written evidence submitted by The Royal College of Physicians of Edinburgh (PNS0011)

Introduction

The Royal College of Physicians of Edinburgh 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 14,000 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.

The College is pleased to provide the comments below in response to the call for views; these are based on the collated views of a number of College Fellows.

Maternity care and leadership

While other Medical Royal Colleges and other organisations may be able to provide more detailed information in this area, Fellows are aware that there is a formal review of all child deaths under 18 years of age in England in addition to a possible inquest. Families are kept abreast or at least should be kept abreast of this and the final conclusions and, most importantly, any learnings that may result from the death.

Fellows consider that the medical examiner in local trusts is useful in crystalising the potential cause of deaths. COVID across all situations has had a direct impact on progress and implementation of policy and wider distribution. More information may be required in terms of understanding what additional funding, if any, might be available.

It may also be too early to comment on the effectiveness of these recommendations.

Training of staff in health and social care

Fellows consider this is a huge area which remains to be addressed comprehensively and requires to be made equitable – for example doctors do have some study leave days and a budget whereas other health care workers may not, thus producing a significant inequity for training.

Fellows who provided comments were not yet aware of the introduction of the unified National entry level qualification for leadership. Such a qualification was considered important and this 'unification' of the qualification across health and social care was welcome given the need to do more to share goals and targets.

All trusts do have a basic induction programme to educate in the computer systems; structures within the trust; systems and details about the organisation however more time should be provided during the process to allow HCPS to become adequately integrated in the trust.

"Mandatory" training exists in all trusts but the value of this needs urgent review as all is not necessary. It is fully funded but again lacks allocated time in job plans.

Leadership programs have been developed and offered in many trusts to all staff – these are fully resourced and paid for. The challenge for many staff is getting the time to attend such courses. The courses in leadership are of great value and indeed may enhance the overall trust's ability to

improve quality of care and efficiency. However, it may be too early to assess the impact of those who have attended leadership courses.

COVID had a significant impact in the delivery of much training for staff but also provided an opportunity for staff training remotely but in the evenings and during “free non worktime”. The impact of this should be researched and assessed as to whether it is seen as acceptable. It potentially offers more flexibility which could be incorporated into rotas in the future.

Culture of safety, and whistleblowing

Fellows consider that many HCPs are unaware of the process of whistleblowing, which presents a huge concern. Some would remain reluctant and afraid to whistle blow as there are still occasions where it leads to dismissal and there can be a feeling that systems are based on rhetoric and not actions. Recently highlighted cases in the National Press have only supported this belief that whistleblowing can damage one’s career and not lead to important reviews of services for the benefit of patient safety.

The culture of safety and whistleblowing is certainly taken seriously by many trusts and executives are acutely aware of issues raised to the Freedom to Speak up Guardian. However, there are some issues that do not make it that far, for example where staff raise things with their line manager and get inadequate responses or attention. This can lead to a feeling of "why bother" that still exists in some people's eyes. We are a long way from all who raise issues through whatever route feeling that their issue has been listened to considered and replied to and whistleblowing remains an exception due to fear.

Concerns remained that there is still a drive towards targets (which tend to be set nationally) at the expense of patient safety. An example of this is the concept of “reverse boarding” – this is where patients are placed in the corridor of a ward without the approval of the responsible consultant to reduce the A/E targets from breaching. From a management perspective this is a decision by them with no extra staff provided on wards to monitor these patients and the consultant takes on the extra responsibility and risk, even if concerns are highlighted. This situation worsens over the winter period. Information on whether this reduces the risk to patients in being moved from one congested area to another is not known but requires a detailed review.

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