Learning from invited reviews

2014–2021

Contents

Foreword

By Adam de Belder

Medical director for invited reviews

The RCP's Invited Reviews service was created in its current guise by Dr Peter Belfield to provide an independent service dedicated to improving patient care. I joined the team initially as an expert reviewer for the British Cardiac Society (BCS), and subsequently as deputy medical director. Following Dr Belfield's retirement, I was appointed as medical director for invited reviews in August 2021.

The work of the Invited Reviews service is varied and challenging, as you would expect when local mechanisms of resolution have failed, but there is no doubt that our methodology of case record review and service review has demonstrated a direct and positive impact on patient care and provides a supportive framework for change.

Medicine has moved from an era of gratitude to one of expectation when it comes to healthcare delivery. Inevitably, this has put some individuals and teams under great pressure to provide expected levels of care at an appropriate professional standard and in a timely manner. Additionally, the COVID-19 pandemic has stretched the service to its limits, which has led to many services falling below the standards expected. As the RCP Invited Reviews service exists to provide support to struggling individuals and teams, it is likely that referrals to the service will increase. We are in a good position, with an experienced team, to deal with whatever problems we are presented with. We have good relations with the specialist societies who help us put together bespoke clinical teams for specific reviews, and a professional set of case review managers using proven quality assurance methodology.

This document – *Learning from invited reviews* – brings together our experiences across multiple specialties, identifying common themes and crystallising some of our generic findings, which we hope will prove useful to all in clinical leadership roles.

Key learning from invited reviews

Service design

Concerns relating to service design often concentrate on two issues:

> whether the service reflects best practice in that specialty area

> the sustainability of the service.

Find out more here.

Patient safety

Patient safety issues highlighted across the reviews varied widely. Often healthcare organisations were aware of potential patient safety concerns and had already taken steps to improve care. Find out more here.

Consultant oversight of inpatient care

This was not always clearly visible from patient records, where there was sometimes inadequate documentation to establish which clinician and clinical team was taking ownership and responsibility for patient care. This reflects the complexity of emergency care pathways, with many patients undergoing multiple ward moves and being referred from one clinician and team to another without a clearly articulated and documented plan. Find out more here.

Patient experience and communication

Evidence of communication with patients and their families was often stronger when patients were on an end-of-life care pathway and weaker at earlier stages of care. Some reviews identified a lack of evidence that patients had been counselled adequately regarding 'aggressive' or 'risky' treatments. Find out more here.

Clinical record keeping

Common omissions in clinical records included documentation of conversations with patients and their families regarding treatment options and evidence of their involvement in the management plan. Find out more here.

Clinical governance

Many organisations have well-established clinical governance processes, but these systems tend to operate in 'silos' within specialty professional groups, which undermines the sharing of learning across multi-professional teams. Find out more here.

Leadership and culture

A recurring concern has been that organisations have not allocated adequate time for individuals to deliver clinical leadership roles within job plans. Find out more here.

Workforce

Physicians frequently communicated to review teams that there was a need to increase consultant numbers. More often, however, the way physicians organised their working patterns and practices held the key to addressing many of the pressures faced by the service. Find out more here.

Teamworking

Issues arising from clinical record reviews with respect to teamworking tended to focus on a lack of evidence of multidisciplinary team collaboration and discussion regarding a patient's care, including nurse/doctor communication and the involvement of allied health professionals. Find out more here.
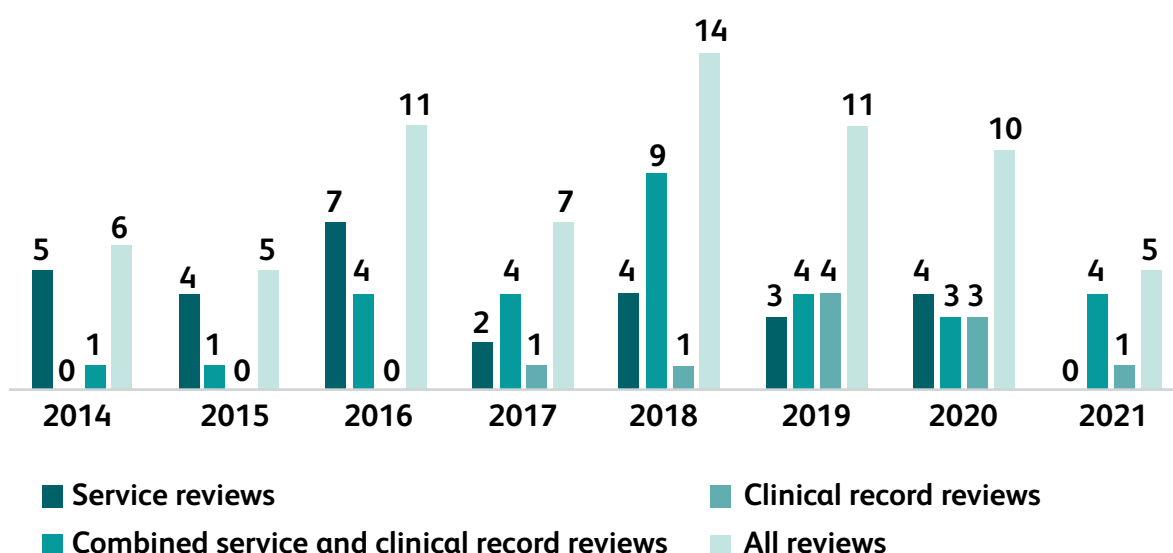
Invited reviews activity

A snapshot of activity January 2014 to June 2021

> We completed 69 reviews, across 48 different NHS organisations and 19 specialties.

> A total of 451 patient medical records were reviewed by specialist clinical reviewers.

> 1,090 recommendations were made across these reviews.

> For 55 of the reviews, NHS organisations had conducted internal reviews before making a request to the RCP.
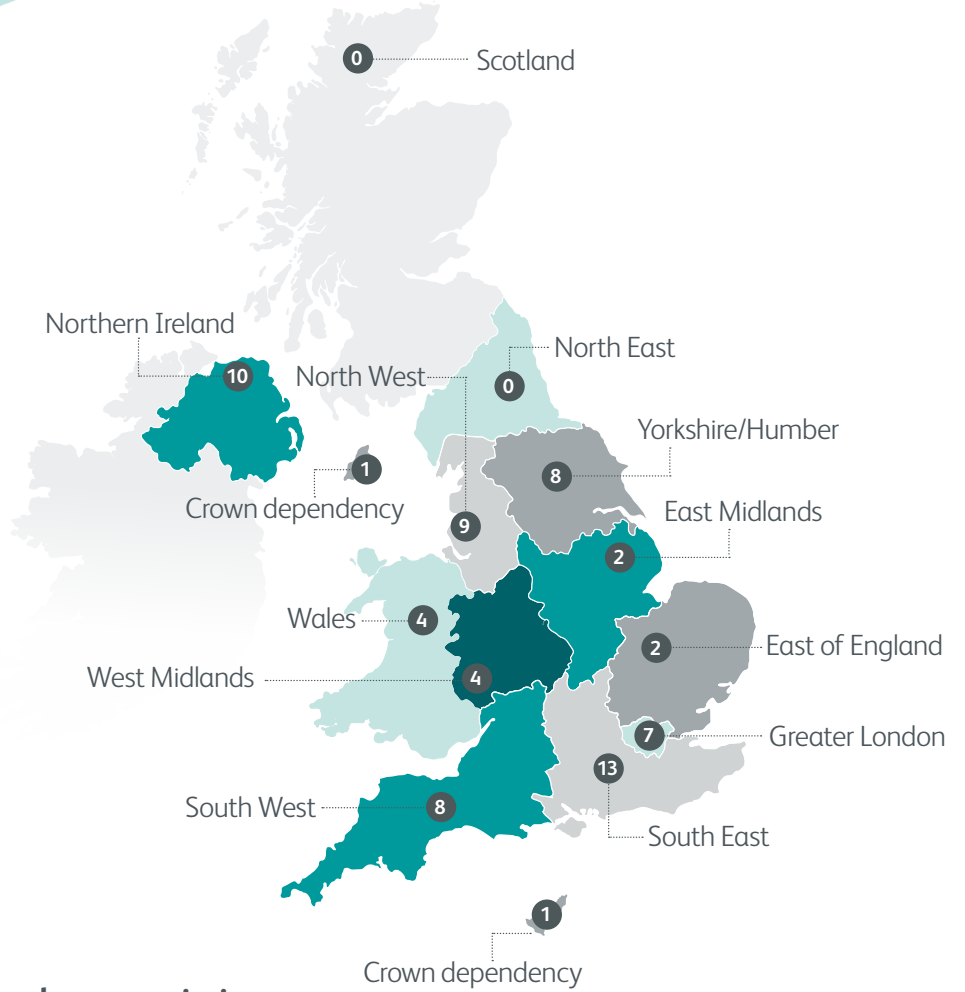
The biggest area of growth has been requests for clinical record reviews, either as a standalone record review or as part of a service review.

Activity has been increasing (allowing for the COVID-19 pandemic) and repeat business is a contributing factor to this. The RCP sees this as a reflection of the quality of the product we deliver and its ability to bring about change. Reviews have been adapted and refined in the light of the COVID-19 pandemic to enable a safe structure offering the same high-quality service.

Number of invited reviews 2014 to June 2021

Bar chart showing number of invited reviews by year:

Year	Service reviews	Combined service and clinical record reviews	Clinical record reviews	All reviews
2014	5	0	1	6
2015	4	1	0	5
2016	7	4	0	11
2017	2	4	1	7
2018	4	9	1	14
2019	3	4	4	11
2020	4	3	3	10
2021	0	4	1	5

Legend: ■ Service reviews ■ Clinical record reviews ■ Combined service and clinical record reviews ■ All reviews

Geographical spread of reviews

- 0 Scotland
- Northern Ireland 10
- North East 0
- North West 1
- Yorkshire/Humber 8
- 9
- East Midlands 2
- Crown dependency
- Wales 4
- West Midlands 4
- East of England 2
- Greater London 7
- South East 13
- South West 8
- Crown dependency 1

Reviews by commissioner

- NHS trust and CCG 1
- Other 4
- NHS foundation trust 30
- Health and social care trust 10
- Health board 4
- NHS trust 20

Invited review process

Stage 1. Responding to the request for an invited review
Invited reviews can only be requested by a medical director (MD) or chief executive officer (CEO) to ensure appropriate engagement from the board of the organisation and to optimise the implementation of any changes recommended in the final invited review report.

1.

Stage 2. Clear and coherent terms of reference
The medical director for invited reviews works closely with the healthcare organisation to discuss and agree appropriate terms of reference for the review.

2.

Stage 3. Expert and experienced review teams
The RCP works with the relevant specialty society to appoint reviewers with the appropriate specialist expertise and seniority to undertake the review.

Stage 4. Review visits tailored to the organisation
The visit takes place, remotely and/or in person.

3.

4.

Stage 6. Effective quality assurance
Draft reports are quality assured by members of the invited reviews governance group, the specialist society, lay reviewers and, if necessary, legal advisers.

Stage 5. Drafting impactful reports
A report is drafted with assistance from the clinical reviewers.

6.

5.

Stage 7. Accuracy by fact checking
The draft report is sent to the MD/CEO of the healthcare organisation for correction of matters of fact.

Stage 8. Report issued
The final report is issued to the healthcare organisation with a framework and timetable of recommendations.

7.

8.

Stage 9. Closing the loop
The RCP follows up with healthcare organisations 6 months after the issue of the final report. If recommendations are made to address potential patient safety concerns the RCP will follow up earlier.

9.

1. Responding to the request for an invited review

What is an invited review?

The invited reviews service was formed in 1998 and offers consultancy services to healthcare organisations that may require independent and external advice. Reviews provide an opportunity for healthcare organisations to deal with issues and concerns at an early stage.

Why organisations request a review

The NHS is staffed by incredibly hardworking, tenacious and talented clinicians, managers, administrators and support staff. RCP review teams frequently meet individuals who go above and beyond to deliver high-quality patient care, often in the context of increasing patient acuity, rising activity, staff and bed shortages and financial constraints. The dedication to patient care demonstrated by many staff is a recurring positive feature across the reviews.

Our thematic analysis revealed the top three most common reasons for a request:

13% (36) To conduct a clinical record review

11% (32) Concerns regarding clinical practice

11% (31) Concerns over the delivery of care

Other common reasons for an invited review request included:

> Concerns over patient safety – **10%** (29)
> Increased mortality rates or to consider a single patient death – **8%** (22)
> Teamworking – **8%** (22)
> Clinical governance – **7%** (21)
> Patient/family complaint/concerns – **6%** (17)
> Workload issues – **6%** (16)
> Service design – **5%** (15)

This analysis shows that reviews are requested against a backdrop of other actions taken to investigate the issue or explore solutions.

Of the 69 requests for an invited review, 49% of the organisations had conducted an internal and/or external review first. A fifth (20%) had discussed the issues with a regulator, such as the Care Quality Commission (CQC), the National Clinical Assessment Service* or another organisation, such as the Parliamentary and Health Service Ombudsman. In five instances restrictions had been placed on a physician's practice and in one case restrictions had been imposed on a service.

* The National Clinical Assessment Service is now part of NHS Resolution and is known as Practitioner Performance Advice.

Types of invited reviews

The RCP can offer the following reviews. In some circumstances, these can be combined to help address the terms of reference for the review. For example, a clinical record review (CRR) may form part of a service review (SR), looking at index and/or a random selection of cases to give the review team a better understanding of pathways.
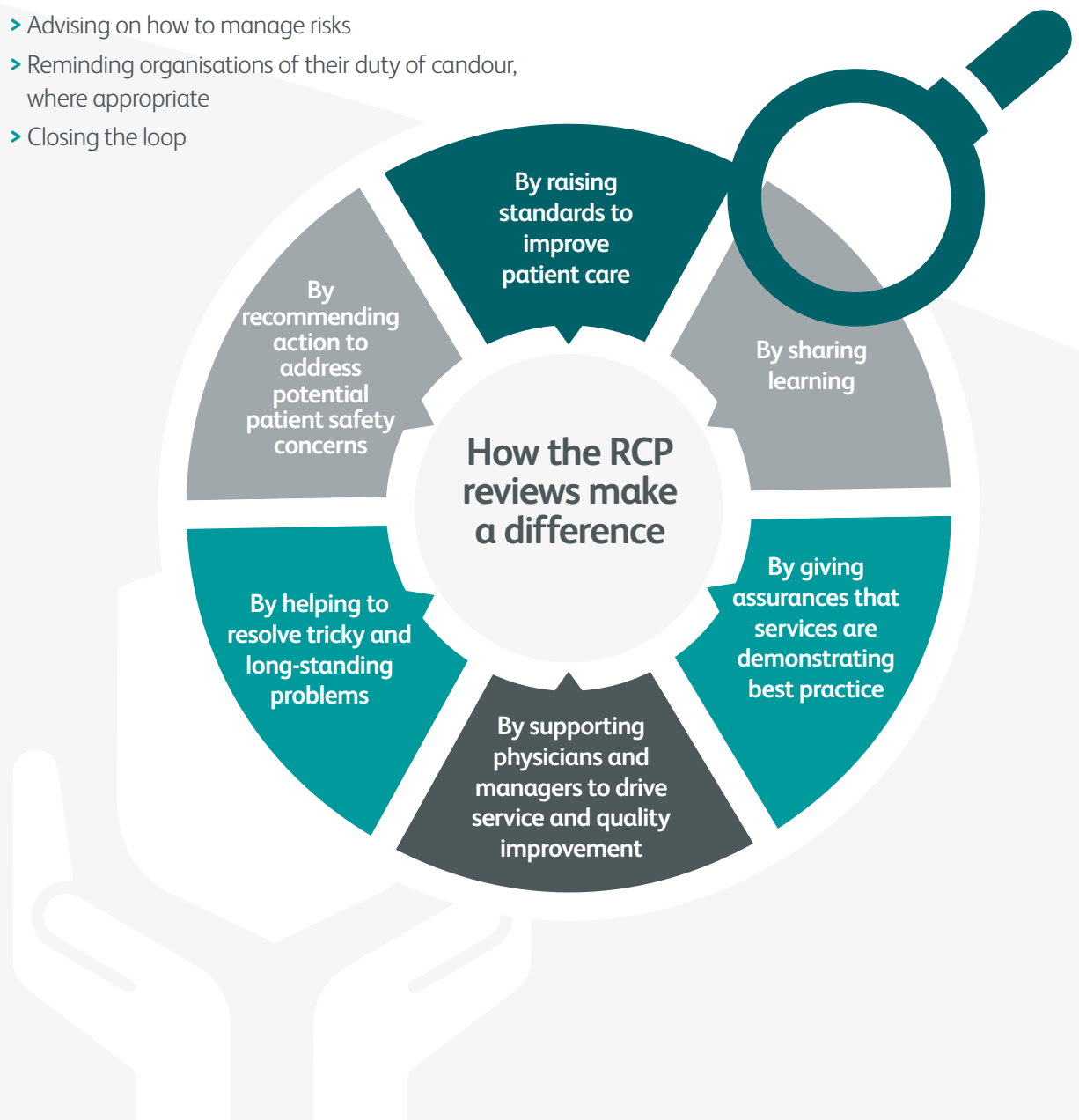
Invited reviews

Single clinical record review
Independent expert opinion on the management of a specific case/complaint/serious incident

Multiple clinical records review
Reviewing a series of cases due to specific concerns or providing assurance of a pathway(s)

Service review
Looking at pathways, team working, leadership, planning, governance and workforce

Individual review
Identifying whether there is a case to answer regarding potential unsatisfactory clinical practice of an individual consultant physician

How do invited reviews make a difference?

Underpinning all invited reviews is the objective of supporting quality improvement. The following are key to achieving this objective (and are discussed further in Section 5):

Our thematic analysis revealed the top three most common reasons for a request:

> Encouraging sharing of learning from reviews

> Advising on how to manage risks

> Reminding organisations of their duty of candour, where appropriate

> Closing the loop

By raising standards to improve patient care

By sharing learning

By recommending action to address potential patient safety concerns

How the RCP reviews make a difference

By giving assurances that services are demonstrating best practice

By helping to resolve tricky and long-standing problems

By supporting physicians and managers to drive service and quality improvement

2. Clear and coherent terms of reference

Once the RCP has developed an understanding of the reasons underpinning a request for a review, it works with the healthcare organisation to draft and agree terms of reference. As a patient-centred and clinically led organisation, the RCP is well placed to advise healthcare organisations on the clinical management of patients under the care of physicians.

The most common terms of reference across all reviews are set out in Table 1.

Table 1. Most common terms of reference	Percentage and (number) of reviews to which term of reference applies
Clinical management (quality/safety/mortality)	12% (42)
Clinical record review	11% (40)
Clinical governance/incident reporting	10% (36)
Care pathway / service design	10% (36)
Any new areas of concern	10% (35)
Compliance with national/specialty/RCP guidelines	10% (35)
Teamworking within a department	9% (30)
Sustainability and future of the service	5% (18)
Workforce, staffing and skillmix	4% (14)
Relationships with other departments	3% (9)
Patient experience or patient/family complaint	3% (9)

3. Expert and experienced review teams

The composition of the invited review team will vary depending on the terms of reference and the nature of the issues to be reviewed, but will normally comprise the medical director (MD), a deputy MD and/or an invited review clinical lead (chair of the review), two relevant specialists, a lay reviewer and a review manager. The review team are required to declare any potential conflicts of interest they may have. The review team's names and workplace, as well as any potential conflicts of interest, are shared with the requesting healthcare organisation in advance of the review visit. The RCP works closely and collaboratively with specialist societies and associations in appointing clinicians with the relevant medical expertise and knowledge and will take care to ensure, where possible, that they come from similar-sized organisations.

4. Review visits tailored to the organisation

Clinical record reviews

Requests for clinical record reviews have been the area of greatest growth for the RCP review service. Such reviews rely on having a team of specialist clinical reviewers who work in a structured way to reach judgements, first independently and then as a group, to agree overall gradings on the care provided to the patient.

The number of cases considered by the review increases its complexity. The largest number of records considered by one review was 61 cases.

Clinical record review process

Select the sample

Case selection is best done in consultation with the invited review team, who can advise on approaches to sample selection.

Appoint specialist clinical reviewers

The RCP, together with the relevant specialty association, appoints a team of clinical reviewers who are experts in the field relevant to the terms of reference.

Methodology

Each reviewer uses a structured judgement review form adapted from the RCP National Mortality Case Record Review programme to independently examine all phases of care that the patient received. These are graded by the reviewers as 1 = very poor care, 2 = poor care, 3 = adequate care, 4 = good care or 5 = excellent care.

NCEPOD grading

The reviewers use a grading system originally developed by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD)[1] to give an overall perspective on the quality of care. This method is not without its limitations, and it is not uncommon to identify aspects of clinical care that could have been better when considered retrospectively. However, it is helpful in reaching agreement among clinical reviewers on where a case sits on a spectrum of good to unsatisfactory practice. The overall gradings are as follows: good practice; room for improvement – clinical; room for improvement – organisational; room for improvement – clinical and organisational; unsatisfactory; insufficient information.

Confirm and challenge

Having independently reviewed the cases, the reviewers then present them at a meeting chaired by the medical director (or deputy medical director) for invited reviews to agree the final grading of phases of care and the overall care. In doing this, the review team considers national good practice and guidelines.

Out of 451 cases considered as part of clinical record reviews:

33% (147) were rated 'unsatisfactory'

18% (82) were rated 'room for improvement for clinical reasons'

17% (77) were rated 'room for improvement for both clinical and organisational reasons'

14% (62) were rated 'good practice'

4% (20) were rated 'room for improvement for organisational reasons'.
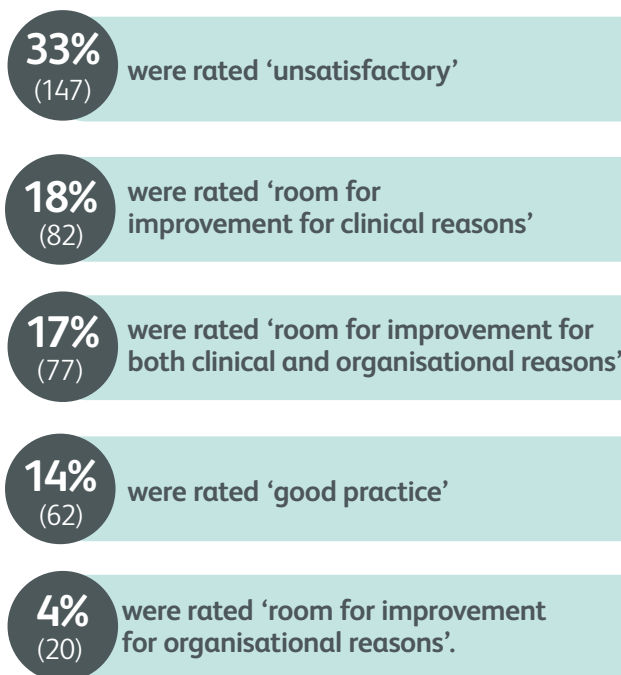
A further 10% were not rated, 2% utilised a different grading system and 1% were rated as 'insufficient evidence'.

Combined service and clinical record reviews

The RCP has undertaken 11 service reviews that included a record review element in advance of the visit to the healthcare unit.

Incorporating a record review component into a service review helps to inform the visit and the lines of enquiry. The site visit provides understanding of the context in which care is provided. Clinical record reviews allow for a focus on clinical management, which can be complemented by a site visit that considers areas such as team working, individual behaviours, leadership and clinical governance.

Concerns highlighted across reviews

Following analysis of the conclusions and executive summaries of the review reports, the top three concerns highlighted across all reviews were:

Clinical governance
6% (34)

Multidisciplinary team (MDT) working
5% (32)

Clinical effectiveness/ clinical practice
5% (31)

Other concerns highlighted included:

> service design (pathways and protocols) **5%** (27)
> clinical leadership **5%** (27)
> patient and/or family experience/communication **4%** (26)
> staffing and skillmix **4%** (25)
> consultant oversight of patient care **4%** (24)
> patient safety **4%** (23)
> record keeping **4%** (21).

Top 5 tips for medical directors and clinical leaders dealing with concerns

Keep contemporaneous and well-documented notes of arising issues and actions taken to address them. Avoid 'corridor conversations' – they do not hold up to external scrutiny.

Take time to understand the team's clinical governance arrangements and, if you can, attend one of their meetings. This will offer real insights into team dynamics, the approach to discussing cases, and how effectively learning is identified. This may inform whether an internal record review should be considered.

For services experiencing difficulties, put in place a senior and experienced service or general manager, ideally one with experience of project management, preparing businesses cases or developing strategic plans for services.

Seek advice either internally (eg from Human Resources) or externally, for example from the Practitioner Performance Advice (PPA) service or your local General Medical Council (GMC) employment liaison officer, or by commissioning an external review of the issues by one of the medical royal colleges or a similar body.

If you are dealing with concerns about an individual that are of a serious nature, be sure you know whether the individual is also employed elsewhere and, if so, that these issues have been appropriately communicated with other employers. Consider whether Occupational Health should be involved.
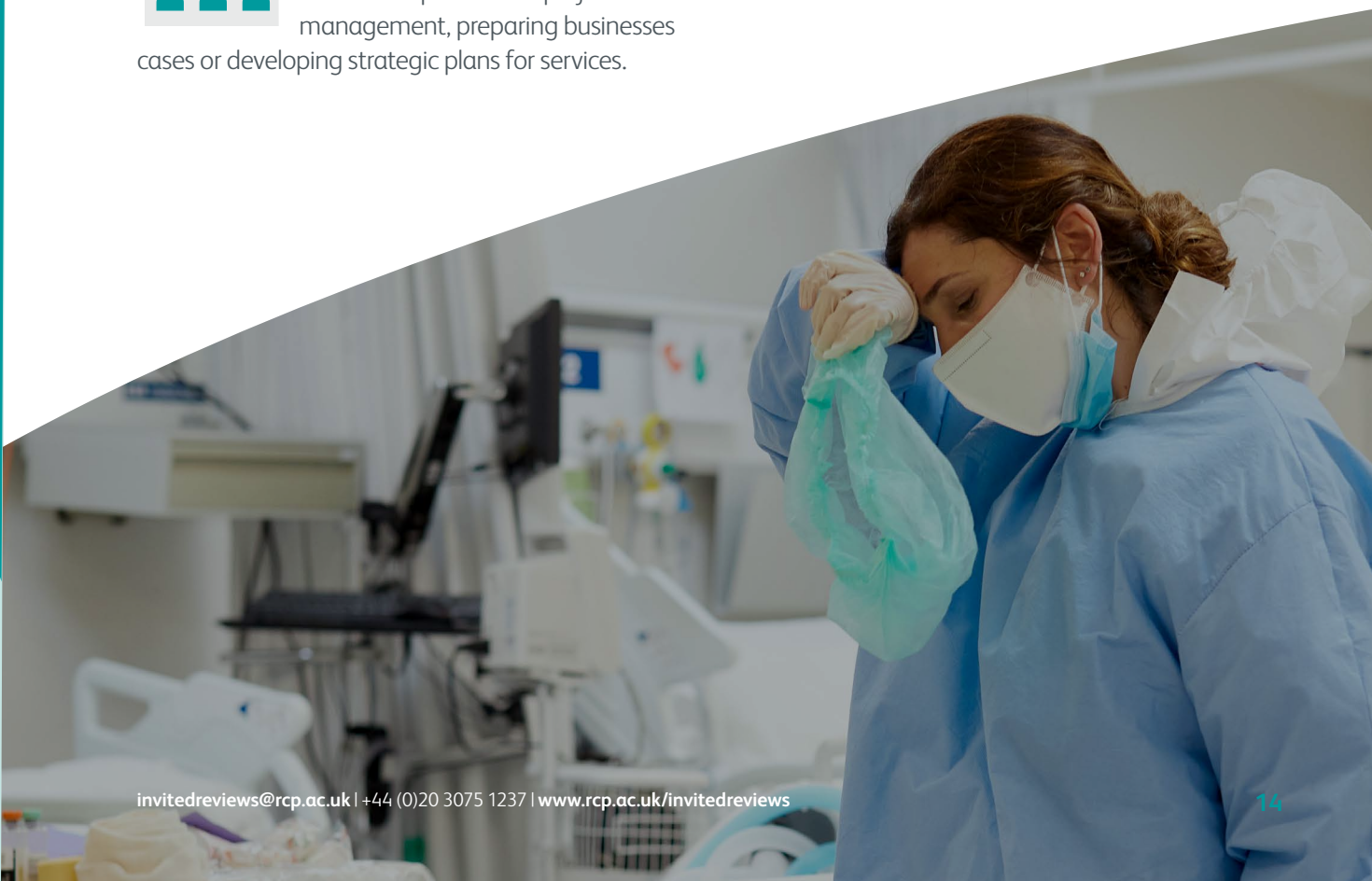
5. Drafting impactful reports

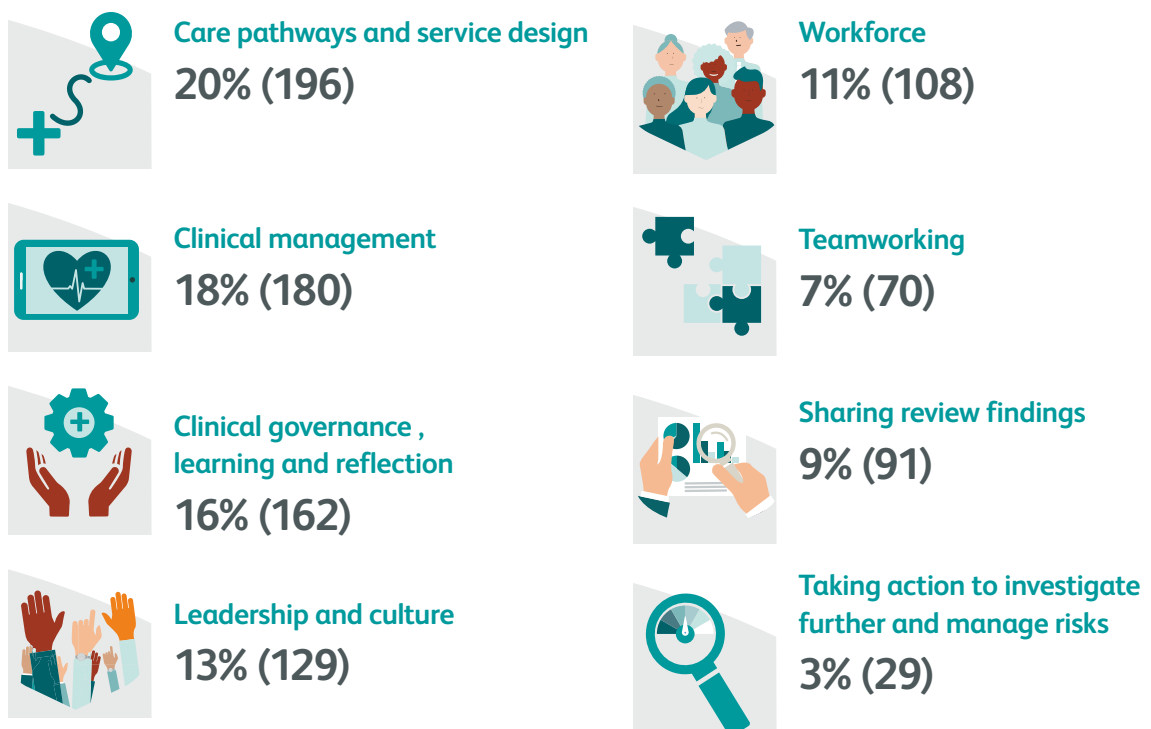## What areas do recommendations focus upon?

The overriding objective of RCP reviews is to support healthcare organisations to bring about improvements in patient care. Across 69 reviews the RCP has made 1,090 recommendations.

The approach to making recommendations has evolved over time. Reviews completed in 2014 and 2015 often made many recommendations (24 on average). Since then, the number of recommendations has fallen as the approach has become more targeted. The average number of recommendations per review between 2014 and June 2021 was 16.

Clinical record reviews were most likely to make recommendations relating to sharing the findings of the review with others (patients, families and/or regulators) and clinical management.

Service reviews were most likely to make recommendations focused upon leadership and culture, as well as clinical governance, learning and reflection.

The analysis grouped recommendations into the following eight themes; there were also a further 18 miscellaneous recommendations, seven related to private practice and one to best practice tariffs. The remaining 10 could not be grouped into a theme.

Care pathways and service design
20% (196)

Workforce
11% (108)

Clinical management
18% (180)

Teamworking
7% (70)

Clinical governance , learning and reflection
16% (162)

Sharing review findings
9% (91)

Leadership and culture
13% (129)

Taking action to investigate further and manage risks
3% (29)

The following sections examine the above themes in more detail.

Care pathways and service design

Healthcare organisations often seek advice on patient pathways and service design. Commonly, the impetus for an invited review is a concern that care pathways are not working as effectively as they might. Sometimes changes are already planned or underway, and the organisation seeks assurance from the RCP that the direction of travel aligns with best practice.

Concerns relating to service design often concentrated on two issues. The first concerned whether the service reflected best practice in that specialty area – reviews often encountered outdated patterns of service provision. The second issue related to the sustainability of the service, reflecting concerns over staffing levels, bed capacity and activity demands.

Recommendations relating to care pathways and service design

196 recommendations were made across reviews that were relevant to care pathways and service design. The top five types of recommendation under this heading are outlined in Table 2.

Table 2. Top five recommendations relating to care pathways and service design	Number of times recommendation made in this area
To inform process, pathways and service design	44
To forge links with other units, networks or tertiary centres	22
To develop or review standard operating procedures (SOPs)	19
To integrate or link with community services or primary care	17
To address issues with technical equipment, medicines, treatments or tests	14

Clinical management

Clinical practice and effectiveness

Concerns were raised under this heading across the range of clinical practice, including diagnosis, formulation of treatment plans, case management and the response to complications. These types of concerns were sometimes prompted by a review of case records. At times concerns over clinical practice centred on decisions regarding the transfer of patients from one clinical team to another.

Concerns raised by clinical record reviews under this heading were similar to those raised by the service reviews and covered the full range of clinical practice. This included:

> the approach to ordering investigations and the type of investigations selected

> missed opportunities for intervention and a lack of urgency

> missed or incorrect diagnosis

> management decisions and treatment plans

> inadequate follow-up arrangements

> poor risk assessments.

Patient safety

Patient safety concerns were highlighted in 23 of the 69 reviews. Reviewers are always alert to any risks to patient safety when conducting visits and any concerns will be raised with the medical director before leaving the unit so that immediate action can be taken to safeguard patients.

The types of patient safety issues highlighted across the reviews varied widely. Often healthcare organisations were aware of potential patient safety concerns and had already taken steps to improve care.

Examples of patient safety concerns arising from clinical record reviews included:

> prescribing decisions and requests for investigations that were considered unsafe because they did not meet national standards or were outside the practice of most other centres

> inadequate falls risk assessment in a patient who went on to experience a fall as an inpatient that caused them significant harm

> a failure to follow guidelines for the management of bacteraemia in a patient with a cardiac implantable electronic device (CIED) who subsequently died

> serious clinical errors in interpreting investigations that could lead to inaccurate diagnoses in patients and create the potential for harm.

Concerns were often found in cases that were highly selected where issues had already been raised locally. Review of a random sample of patient cases is important, therefore, to understanding whether the cases reviewed are representative of the doctor's practice or the wider service.

Consultant oversight of inpatient care

One theme arising from several service reviews concerned consultant oversight of patient care. Sometimes this manifested itself in terms of a lack of visible consultant presence on hospital wards and inadequate support for doctors training, nursing and other staff. Sometimes the concerns related to a failure by some consultant physicians to demonstrate the level of communication or ownership that colleagues who became involved in a patient's care would expect, particularly when complications were encountered.

It was also a recurring theme from several of the clinical record reviews, which found that consultant oversight of patient care was not always clearly visible from patient records, with inadequate documentation to establish which clinician and clinical team was taking clinical ownership and responsibility for patient care. This reflected the complexity of emergency care pathways with many patients undergoing multiple ward moves, with patients often referred from one clinician and team to another without a clearly articulated and documented plan. This absence of visible clinical leadership was sometimes the cause of a lack of momentum to a patient's care and a failure

to act with appropriate urgency. Effective senior clinical oversight can facilitate prompter and more appropriate decision-making, including decisions not to actively treat patients with a poor prognosis and instead move them to an end-of-life comfort pathway.

Patient experience and communication

Clinical record reviews are limited in their ability to reach conclusions regarding interactions with patients and their families by relying on what is documented in the case records. The types of issues that arose included a lack of evidence that patients or their families were involved in agreeing the patient's management plan. Often evidence for communication with patients and their families was stronger when patients were on an end-of-life care pathway and weaker at earlier stages of care. Another area of concern related to a lack of evidence that patients had been counselled adequately regarding 'aggressive' or 'risky' treatments.

Clinical record keeping

Clinical record reviews provide an understanding of the quality of clinical record keeping. It is of little surprise that concerns about record keeping were most likely to arise from these reviews. The specialist clinical reviewers reach judgements on the documentation provided to them by the healthcare organisation. Sometimes clinical records are incomplete, and, on further enquiry, the reviewers learn that sub-sets of records have been held in different files or locations. Healthcare organisations that still rely on paper records appear most vulnerable to records becoming separated from the main bundle and lost.

Common omissions in clinical records included documenting conversations with patients and their families regarding treatment options and demonstrating their involvement in the management plan. Another area of weakness tended to be in documenting discussions with clinical colleagues.

Care bundles, assessments or pathway documents were often incomplete. Sometimes this indicated documentation that was overly lengthy and onerous for staff to complete, particularly where staff shortages were an issue.

Some reviews raised concerns regarding record keeping by an individual physician, including inadequate documentation of patient history, examinations or investigations and diagnosis. Where these deficiencies were observed they were often contrasted with the approach to record keeping by other clinicians whose notes were included in the documentation, suggesting that the concerns related to an individual's approach rather than to systemic issues.

Prescribing

A theme that arose from several record reviews related to prescribing issues. One review considered a systematic prescribing error that occurred at a Trust over a 7-year period. Another review identified problems with the prescribing of one physician, which breached NHS guidelines for the treatment of the condition. This same doctor demonstrated a satisfactory technical knowledge of drug side-effects and their place in national prescribing guidelines but prescribed medications for which the rationale was sometimes unclear and not articulated in the clinical records. Another review raised concerns over the prescribing of antibiotics.

Recommendations relating to clinical management

Across the 69 reviews, 180 recommendations were made relevant to clinical management. The top five types of recommendation are shown in Table 3.

Table 3. Top five recommendations relating to clinical management	Number of times recommendation made in this area
To revise physician working practices and patterns	29
To support patient experience and communication	22
To address specific clinical concerns	20
To strengthen clinical record keeping	18
To improve prescribing or address issues with pharmacy or medicines management	16

Clinical governance, learning and reflection

Concerns regarding clinical governance were a recurring theme from service reviews. The main issues related to weaknesses in clinical governance infrastructure – ie the absence of regular meetings to provide assurance on quality and safety, in which data relating to matters such as such as patient outcomes and complications, serious incidents and patient feedback could be discussed.

Where meetings that support clinical governance existed, these were sometimes poorly attended by senior physicians. This could reflect issues with the scheduling of these meetings and conflicts with clinical commitments but in some cases it reflected a lack of engagement by some physicians with clinical governance.

Problems can also arise when review of the data underpinning clinical governance happens in professional silos, with physicians reviewing data as a team (sometimes with doctors in training) but separately to nursing and other clinical staff. This can leave other staff missing out on important learning and the opportunity to improve quality.

In-depth review of clinical incidents can be an issue, with limited discussion around the potential root causes of incidents, such as falls, and a lack of mortality review. Data triangulation tended to be an area where many units could have improved. The patient voice was often notably absent from the information reviewed at governance meetings and therefore there was a lack of externality.

Another important area where healthcare organisations were often found to be lacking related to resolving concerns and 'closing the loop' to ensure that actions were taken and learning was shared. Some reviews were triggered by serious incidents that staff showed little awareness of, raising questions over the dissemination of learning points and resulting quality improvement activity.

In total, 162 recommendations were made relevant to clinical governance. The top five types of recommendation under this heading are outlined in Table 4.

Table 4. Top five recommendations relating to clinical governance, learning and reflection	Number of times recommendation made in this area
To support the development of clinical governance	36
To strengthen departmental audit or to undertake a specific audit	31
To strengthen morbidity and mortality review	21
To ensure compliance with best practice standards and guidelines	19
To improve shared learning (eg from incidents)	14

Leadership and culture

Some reviews showcased excellent examples of effective clinical leadership; however, weaknesses in this area were a recurring theme. Often reviews highlighted gaps in clinical leadership, which were sometimes long-standing as units struggled to find leaders to step forward. Such issues can reflect challenges created by the organisation's leadership structure, particularly in multi-tiered hierarchical structures, which can make clinical leadership roles appear onerous to prospective leaders, put off by the number of hurdles to jump before decisions can be reached. Cross-site leadership roles can also prove unattractive to clinicians, particularly where relationships between the two sites are not well developed. Such arrangements can be confusing for staff, left feeling unclear as to the arrangements for reporting upwards.

Gaps in clinical leadership structures sometimes reflected tensions or distrust between clinicians and the executive leadership team. A recurring concern was organisations not allowing adequate time for individuals to deliver clinical leadership roles within job plans. Job planning is an area that many organisations could strengthen, both in ensuring that job plans reflect the activities that doctors undertake and in allocating time for leadership activities.

Often, when organisations are under pressure, the need to nurture clinical leaders and give a concerted focus to clinical leadership drops off the list of priorities. Reviews observed that challenged healthcare organisations were more likely to exhibit styles of leadership, across general managers as well as clinical leaders, that were hierarchical and autocratic. This can lead doctors to disconnect from organisational issues. Transformational leadership styles, in which executive teams encourage, motivate and inspire staff to create change, can be more successful in shaping the future of a healthcare organisation.

Concerns can arise when the same clinical lead has been in post for too long, preventing the department from moving forward or agreeing a shared vision. Clinical leadership arrangements were not always clear in the organisations visited, leaving staff uncertain over who to approach with issues and thwarting decision-making.

Recommendations relating to leadership and culture

108 recommendations were made across the 69 reviews that were relevant to leadership and culture. The top five types of recommendation under this heading are outlined in Table 5.

Table 5. Top five recommendations relating to leadership and culture	Number of times recommendation made in this area
To update job plans to properly recognise time for responsibilities	30
To address issues relating to a lack of clinical leadership capacity or capability	24
To develop a strategy, plan or vision for the service	23
To increase management and leadership support	17
To encourage clinical leadership succession planning	11

Workforce

Issues raised by reviews with respect to this area often focused on physicians' rotas. Physicians frequently highlighted to reviewers a case for increasing consultant numbers, and sometimes reviewers agreed. More often, however, the way physicians organise their working patterns and practices held the key to addressing many of the pressures faced by the service.

Changes to consultant working patterns can often reap benefits for nursing staff. Some of the pressure on consultant physicians can be relieved through better use of middle grades and the appointment of clinical fellows. The support offered to more junior doctors (ie those in their foundation years) sometimes required improvement, reflecting a need for consultants to have time scheduled in their job plans to provide teaching to this group of doctors on the ward as well as in formal sessions.

Utilisation of alternative roles such as physician associates and/or upskilling of staff to advanced nurse practitioner roles can also help to fill gaps in medical staffing, providing good governance procedures are in place to ensure proper support and supervision for these staff. Ensuring that doctors and nursing staff were clear about the role and remit of advanced nurse practitioners was also identified as an issue in some reviews.

The pressure nursing staff were working under often surfaced during reviews. Frequently the pressures were associated with a high number of vacancies that resulted in significant use of agency staff. This invariably contributed to poorer patient experience and weaker controls on the quality of patient care.

Recommendations relating to workforce

Across the 69 reviews, 108 recommendations were made relevant to workforce. The top five types of recommendation under this heading are shown in Table 6.

Table 6. Top five recommendations relating to workforce	Number of times recommendation made in this area
To alter the skillmix or better utilise non-medical staff	21
To adjust physician workforce numbers and skillmix	20
To introduce new and extended roles (eg physician associates and advanced nurse practitioners)	20
To strengthen junior doctor training	18
To strengthen training for staff generally	15

Teamworking

Teamworking can be a challenge for physicians as much as for any professional group. The types of issues uncovered by reviews included a breakdown in communication and teamworking between consultant physicians, and behaviours that reviewers have, on occasion, described as unprofessional and below the standards of the GMC's *Good Medical Practice*[2] with respect to domain 3: 'communication, partnership and teamwork'.

Sometimes interpersonal and intergenerational issues underpinned teamworking issues, with more senior consultants trying to assert authority over more recently appointed consultants. Poor teamworking invariably impacted negatively on service planning, cross-cover arrangements and the culture of the wider team.

Issues arising from clinical record reviews with respect to teamworking tended to focus on a lack of evidence of multidisciplinary team collaboration and discussion regarding a patient's care, including nurse/doctor communication and the involvement of allied health professionals. Sometimes it reflected insufficient evidence of clear and effective communication with the patient's GP.

Recommendations relating to teamworking

Across the 69 reviews, 70 recommendations were made relevant to teamworking. The main types of recommendation under this heading were to improve MDT working (50%, 35) and to support effective teamworking with colleagues (24%, 17).

Sharing review findings

Across the 69 reviews, 91 recommendations were made relating to sharing the findings of the review, shown in Table 7. Involving the board of the organisation that requested the review is particularly important in helping to ensure that changes are driven forward. If patient safety concerns are raised, the RCP advises the healthcare organisation to contact its relevant regulatory authority. Sharing reports with the individuals and teams involved as well as with the healthcare organisation's board is encouraged. Invited reviews provide a platform for change, with recommendations that are practical and feasible. Ongoing engagement from the RCP with the healthcare organisation can help shape solutions to what can be challenging situations.

Table 7. Recommendations relating to sharing the findings of the review	Number of times recommendation made in this area
With the healthcare organisation's board or board quality committee	27
With the clinician concerned or the clinical team	25
With the GMC, CQC or other regulator	21
With patients and relatives	18

Taking action to investigate further and manage risks

Sometimes reviews raised questions that fell outside the scope of the terms of reference for the review, or that required further analysis. On 17 occasions, the RCP recommended to the healthcare organisation that further review activity should be undertaken – either a service or clinical record review, or a different type of inquiry process.

On eight occasions, the RCP recommended that restrictions should be imposed on an individual physician or aspects of the service, or for oversight to be given to a doctor. Where one organisation had imposed restrictions on the practice of a consultant physician, the review team was able to recommend a continuation of the restrictions and provided additional clarity to assure patient safety.

On four occasions, the RCP recommended that the organisation's complaint or investigation processes should be reviewed.

Duty of candour

The RCP sometimes recommends that healthcare organisations consider their duty of candour to specific patients or their relatives. This happened in 11 reviews where the specialist clinical reviewers were concerned that the care or treatment to a specific patient had the potential to cause harm.

6. Effective quality assurance

Quality assurance provides an independent opinion on whether the review report contains conclusions that are clear, relevant and achievable, and that reflect national or specialty guidelines/standards. Draft reports are quality assured by members of the invited reviews governance group, the specialist society, lay reviewers and if necessary, legal advisers. Quality assurance is essential to ensure that invited review reports are authoritative, comprehensive and adequately address the agreed terms of reference.

7. Accuracy by fact checking

The RCP writes to the MD/CEO of the healthcare organisation to confirm that the report is 'factually correct'. Healthcare organisations can provide challenge to matters of fact (ie statistics, organisation structure). Comments from interviewees or the review team's overall conclusions and recommendations cannot be altered; however, the review team will consider whether any amendments are required.

8. Report issued

Following any corrections of fact, the final report is issued to the healthcare organisation. The RCP expects that, depending on the nature of the review, the report will be shared with those who were interviewed and willingly provided information to the review team (consultant physician(s) and the patient(s) and their family in the instance of a single clinical record review). In due course, a doctor or team will have the right to see the whole report, for example if they raise a freedom of information request.

9. Closing the loop

The RCP follows up with healthcare organisations 6 months following the issue of the final report. If recommendations are made to address potential patient safety concerns the RCP will follow up earlier. Progress made against the report recommendations are shared with the review team for feedback. Once queries from the review team against progress have been addressed by the healthcare organisation, follow-up will be closed. The RCP will enact its escalation process should a healthcare organisation fail to respond to a request for an update on progress against recommendations.

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