Royal College of Surgeons
ADVANCING SURGICAL CARE

LEARNING FROM INVITED REVIEWS

2019 Full report

Acknowledgements

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- Association of Surgeons of Great Britain and Ireland
- British Association of Oral and Maxillofacial Surgeons
- British Association of Otorhinolaryngology (ENT UK)
- British Association of Paediatric Surgeons
- British Association of Plastic Reconstructive and Aesthetic Surgeons
- The British Association of Urological Surgeons
- British Orthopaedic Association
- Society for Cardiothoracic Surgery in Great Britain and Ireland
- Society of British Neurological Surgeons
- The Vascular Society of Great Britain and Ireland
- The Faculty of Dental Surgery

We would also like to thank all the surgeons and lay people who act on our reviews teams as well as the representatives of the IRM RCS Patient Liaison Group who provide assistance with invited reviews.

This document was written by Ralph Tomlinson, Deputy Director (Professional and Clinical Standards), and Steven Wakeling, Head of Invited Reviews, with the support of Professor Tim Rockall, Chair of the Invited Review Mechanism.

For more information on the RCS invited review services, including details of how to commission an invited review, please visit: www.rcseng.ac.uk/irm

Contents

The purpose of this resource

The aim of this new interactive web resource is to improve the quality of discussion about surgical practice, and the action that takes place in response to it.

Surgery is a highly demanding and critically important part of patient care. It can involve challenging and emotive circumstances for patients and their surgeons. Providing the highest quality of surgical care can be difficult and complex. In many areas of surgery, patient outcomes are of a consistently high standard and surgeons are leading the way in delivering major improvements to the quality of peoples' lives. In a smaller number of other areas, more needs to be done to improve the quality, and to reduce the variability, of surgical outcomes and the standards of patient care provided by the NHS.

This resource describes the **challenges** that can arise from the **practice** of an individual surgeon or within a surgical service. It is based on the RCS's **experience** of invited reviews.

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We propose a proactive approach to thinking about surgical services and the challenges that can arise when delivering them. We have developed this interactive web resource to help surgeons and those responsible for surgical services to reflect on and improve the quality of patient care.

We hope that our resource can be used to improve the discussion of the challenges of surgical practice and to ensure they are addressed at an early stage, before they lead to problems that have an impact on the quality of patient care.

Executive summary

Caring for patients and ensuring that they receive the highest possible standard of surgical treatment is at the core of our values here at the RCS. The delivery of good surgical care is not straightforward, however, and there are many daily challenges for surgeons and their teams that can be difficult to resolve.

This makes it all the more important that any concerns about the performance of an individual surgeon or surgical unit are reviewed and resolved as soon as possible.

Since 1998, the RCS has offered an Invited Review service, which provides hospitals with an independent, external and professional review of an individual surgeon or surgical service. This typically involves two senior surgeons and one lay person being invited into a hospital to talk to staff on a confidential basis and examine information over the course of two to three days to determine whether there is a cause for concern and make recommendations for improvements.

We believe that Invited Reviews are a highly valuable resource to help hospitals deal with concerns before they develop into more serious problems and one that can offer practical solutions that improve care. Surgical teams work in high-pressure environments, and it is through reliable and trustworthy peer and patient led review that the answers to problems can be found.

The reports of specific reviews are the responsibility of the hospital to address, but we are keen to highlight the regularly recurring problems that are identified within surgery so they can help surgeons, managers and other healthcare staff to promote action being taken to resolve problems at an early stage.

We have surveyed a sample of 100 consecutive reviews that have taken place this decade and identified lessons about how problems occur and where improvements need to be made.

In over three-quarters of the 100 reviews we looked at there was a need for improvement in:

- an aspect of the way that surgical care was being delivered
- team working between surgeons

In over half of the 100 reviews we looked at there was a need for improvement in:

- the timely recognition and resolution of concerns
- multidisciplinary teamworking
- individual surgical behaviours
- leadership and management
- outcomes data
- facilities and resources

In over a quarter of the 100 reviews we looked at there was a need for improvement in:

- audit
- relationships with surgeons in training
- morbidity and mortality meetings
- activity data
- managing change
- appraisal
- learning from patient experience
- patient consent and candour

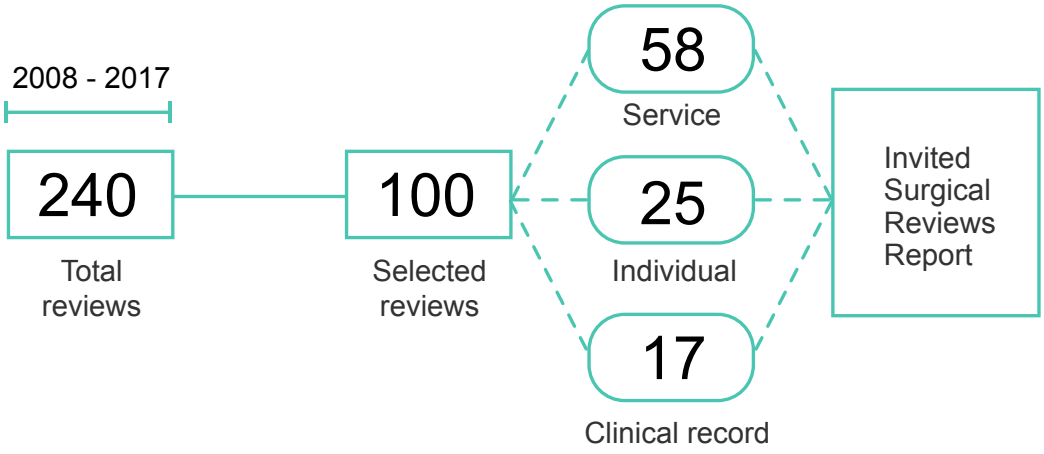
In 17 of the 100 reviews we looked at there was some form of concern about probity and in 16 of the 100 reviews there was an issue related to the introduction of new techniques or new technologies that needed to be considered further.

Invited review activity and themes

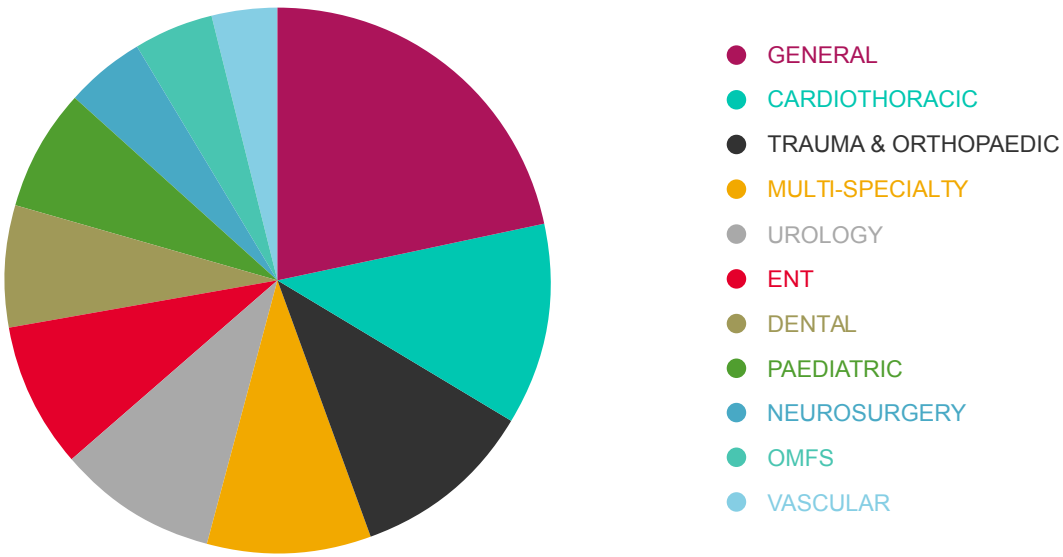
The RCS has completed 240 service, individual and clinical record reviews for healthcare organisations between 2008 and the end of 2017.

We have analysed 100 of these reviews and identified the problems that can occur in surgical practice.

Our sample includes 58 service reviews, 25 individual reviews and 17 clinical record reviews. This mirrors the distribution seen in the 240 reviews, with slightly more service reviews and slightly fewer clinical record reviews.



The distribution of surgical specialties in our 100 reviews matches the distribution across the total number of reviews, with plastic surgery being the only exception. While overall a small number of plastic surgery reviews were completed, none fell in the 100 reviews under analysis.



Safe surgical care

Surgical care delivery issues were a significant factor in 82 of the 100 reviews.

Since these are multidimensional and unique to each review, it is not possible to draw definitive conclusions about particular issues that relate to individual specialties. In addition, the sample size was comparatively small.

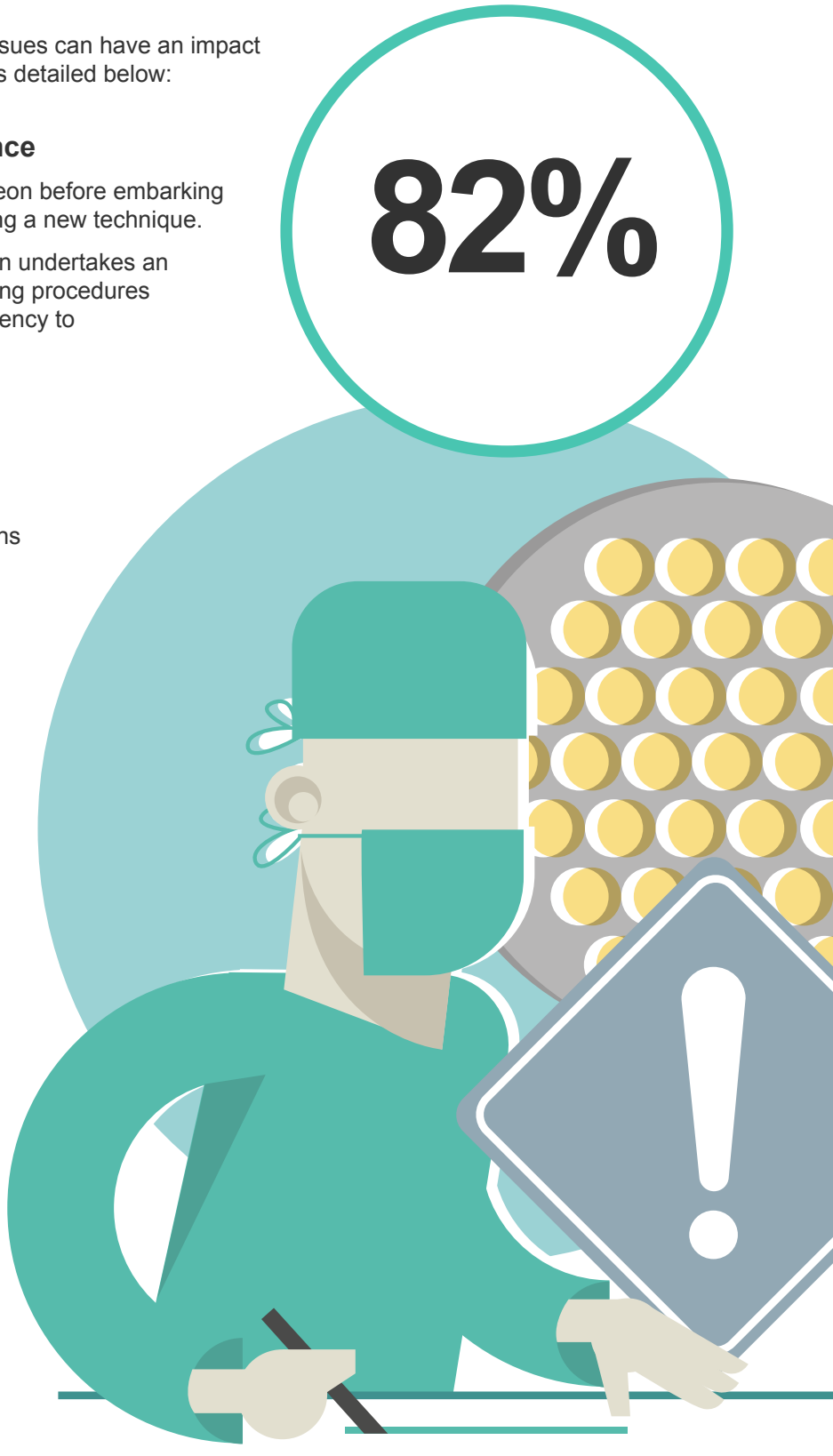
It is evident, however, that particular issues can have an impact on the delivery of safe surgical care, as detailed below:

Surgical training and experience

- The training undertaken by a surgeon before embarking on independent practice or adopting a new technique.
- The regularity with which a surgeon undertakes an operation and the means of ensuring procedures are conducted with sufficient frequency to maintain competence.

Preoperative care

- The preoperative assessment offered to patients.
- The range and type of investigations that take place before surgery.
- The way a patient is identified as a potential candidate for surgery and the process by which the operation is offered to a patient.
- The multidisciplinary team processes supporting this decision.
- The management of the surgical care pathway and organisation of patient waiting lists.
- The quality and timeliness of the identification of preoperative deterioration when a patient is admitted in an emergency.



Intraoperative care

- The specific surgical approaches taken and how the relevant decisions are made.
- The anaesthetic, nursing and operating department practitioner resources supporting the operation.
- The surgeon's technical ability.
- The quality of individual surgical decision-making during operations.
- The management of perioperative complications and attendant team support.
- The length of time taken to complete operations (it is recognised that this will vary and is not always a reliable determinant of the quality of surgery).

Postoperative care

- The quality of the immediate postoperative care.
- The high-dependency and postoperative intensive care unit resources that can be offered.
- The quality of the postoperative recovery facilities.
- The quality of the nursing support available to patients on hospital wards.
- The early identification of and response to postoperative complications.

Surgical resources supporting surgical care

- The quality and experience of trainee and non-consultant-grade surgical staff.
- The level of consultant surgeon input into care, particularly out of hours.

The quality of systems, processes and leadership supporting surgical care

- The consistency of protocols for preoperative, intraoperative and postoperative care at the hospital and how these are applied by the consultant surgical group.
- The quality of handover of patients between consultant surgeons and other staff.
- The management of regular consultant surgical ward rounds and the quality of surgical leadership that takes place.

All these areas require close monitoring to ensure patient safety is maintained. If the potential for concern exists, it is vital that matters are resolved at the earliest possible stage.

Resources

- GMC | *Good medical practice (2013)*
- Royal College of Surgeons | *Good Surgical Practice (2014)*
- WHO | *Safe Surgery*
- NatSSIPs | *National Safety Standards for Invasive Procedures*
- The Association for Perioperative Practice | *Standards and guidance*
- AAGBI | *Safety Standards in International Anaesthesia*
- BMA | *Safe handover: safe patients*
- Royal College of Surgeons | *Quality Improvement in Surgery*

Teamwork

Issues with aspects of teamworking were highlighted in 76 out of 100 reviews.

Specific points identified included:

Team identity

Factors that cause problems with teamwork include:

- Individuals not meeting regularly or effectively as a consultant surgical team. The result is that the team has little practical experience in using consultant surgical team meetings to develop, improve and assure the quality of a surgical service.
- Consultants being clinically isolated from one another, and missing opportunities for working together through dual-consultant operating, ward rounds or shared clinics.
- The absence of agreed working practices, such as those governing the handover of patients when on call. Although agreed practices may exist, they are not always followed.

Mergers and restructures

A recurring cause of tension between group members is when new teams of consultant surgeons form after a merger or restructure, without proper management to consolidate the new team. In the absence of suitable management support, teams can hold on to their previous sense of identity and internal divisions.

How teamworking problems can affect care

A disunited team can cause disagreement and ill feeling between individuals in a number of ways.

A **case study** in poor teamwork

An 'on call' system is not managed well:

- The variation in how emergency patients are managed by one surgeon leads to resentment from another, who has to take on patients who they feel could have been treated by the original surgeon. The second consultant then feels that they are having to perform operations that should have been carried out by someone else.
- A surgeon reviews all the patients they have operated on, rather than have 'their patients' reviewed by the on-call consultant, giving a message that they do not trust their colleagues.
- A treatment plan is discussed with a patient, who is later handed over to the next on-call consultant. The plan is changed without discussion because the second consultant disagrees with the original plan. Dialogue with the patient about this alteration leads the first consultant to believe their position has been undermined.

> **Without regular contact** between a consultant surgical team, **problems can occur** and **patient safety** can be **affected.**

Each of the individual clinical decisions in these examples may have been justifiable. However, without regular contact, one-to-one discussion, common understanding and agreed ways of working between a consultant surgical team, problems can occur and patient safety can be affected.

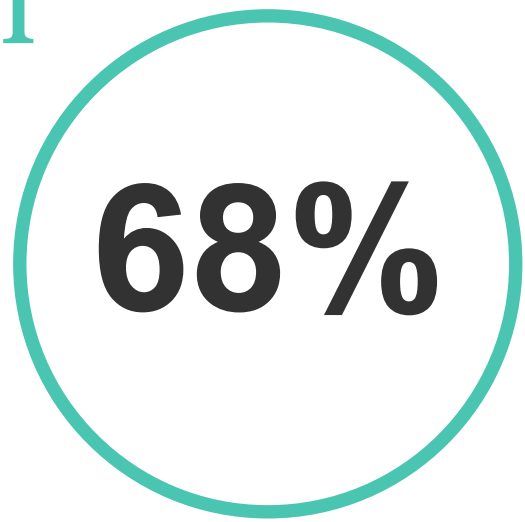
The need for action

It is imperative that any difficulties in a surgical team are addressed at the earliest possible stage. This will help ensure that consultants demonstrate appropriate behaviour and display high standards of teamwork, enabling the delivery of safe surgical care.

Resources

- GMC | *Leadership and management for all doctors (2012)*
- Royal College of Surgeons | *The High Performing Surgical Team (2014)*
- NCBI NIH | *Defining the technical skills of teamwork in surgery*

Timely recognition and resolution of concerns



In 68 of the 100 reviews, issues arose in relation to the raising of, and response to, questions about surgical care.

The manner in which an organisation responds to issues about surgical practice indicates its ability to provide safe care for patients and a psychologically healthy working environment for staff.

Reasons for the difficulty

Questioning surgical practice is a professional and social challenge. For example, it can be daunting for team members to draw attention to the practice of their clinical peers, or more junior team members (such as trainees or nurses) to highlight concerns about their senior surgical consultant colleagues.

Medical managers also face a dilemma when dealing with responses. This type of scenario often presents with complexities that they have never encountered. This is exacerbated by the fact that they may lack formal training in – or induction to – their role.

One example is where a medical manager has no direct clinical experience of specialised or technical areas in surgical care. The only individuals with the expertise to make a judgement about the individual under scrutiny may be close colleagues, who are neither independent nor objective.

Our experience

The standard of response to concerns being raised about surgery is highly variable. Potential issues with an individual or team can be known about for some time in informal hospital networks, yet a resolution has not been achieved. This is prevalent where concerns relate to poor standards of individual or team behaviour rather than clinical outcomes, or situations where behaviours are poor but clinical outcomes appear to be good.

Other situations include where deficiencies are recognised and attempts are made to address them, but any improvements are short-term. This can be exacerbated by changes of personnel at Medical Director, Clinical Director, or Service Manager level, all of which affect continuity of purpose and consistency of approach.

The sample of reviews here is a ‘self-selected’ group involving cases where a hospital has not been able to improve the circumstances without assistance. It involves situations where problems have persisted for some time. A core characteristic of our sample, however, is where issues have existed, they have done so for a long time and have not been resolved.

Therefore, a lack of early resolution means that the problems become far more entrenched and difficult, increasing the risks to quality of care.

Conducting discussion about surgical practice

It is our experience that discussion by surgeons (or other clinicians) about other surgeons can be strong and emotive, which in turn generates equally strong and emotive responses.

A small number of reviews showed that an individual may make unsubstantiated assertions that reflect a personal agenda. This leads to an extremely sensitive situation. In any dialogue that could become contentious, it is vital that distinction is made between issues that warrant further investigation and problems stemming from personal interactions between individuals.

The next stage

A delayed response to concerns can escalate to a situation where a discussion about surgical practice becomes confused with an interpersonal or organisational grievance or grudge.

This leads to the response to concerns becoming procedural rather concentrating on patients and the quality of their care. Organisations over-focus on process and fail to ask the key question: how is this situation affecting the quality of surgical care being provided to our hospital's patients today?

How this can improve

More effort should be made to improve the quality and frequency of discussions about surgical performance. Timely discussion of these challenges should be normalised, before they become more serious.

Organisations should seek external advice and support at an earlier stage so they have a better chance of resolving problems before they affect the safety of patients.

Resources

- GMC | *Raising and acting on concerns about patient safety*
- GMC | *Steps to raise a concern*
- Royal *College of Surgeons* | *Acting on Concerns*

Multidisciplinary teamwork

There were 57 out of 100 reviews that identified areas for improvement in multidisciplinary teamworking.

The following issues were highlighted:

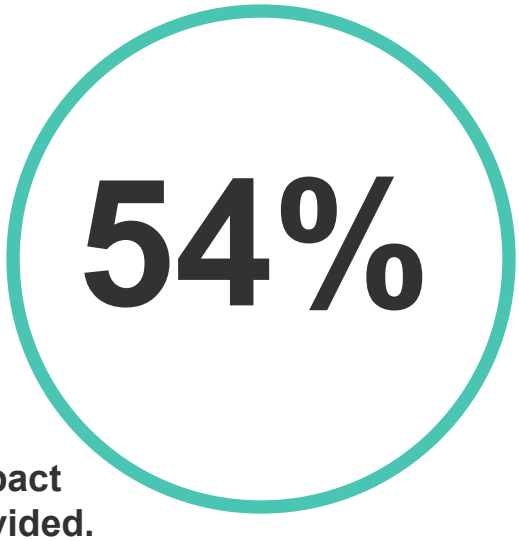
- Inefficient administration (lack of timely distribution of patient details to be discussed and the supporting information).
- Attempting to discuss more patients than is feasible in the time available.
- Erratic attendance by core MDT members.
- Lack of specialist input from key clinical areas (eg radiology, pathology and oncology).
- A lack of dedicated and pre-planned time for key clinical personnel to support the MDT.
- Ineffectual chairing of the MDT discussion and poor management of decision-making.
- Inability to manage disagreements concerning appropriate treatment for patients.
- Uncivil behaviours and lack of respect between group members.
- Lack of documentation regarding decisions.
- Failure to follow through MDT decisions and lack of effective communication with patients.
- Difficulties with technologies required to support a meeting (video conferencing, access to computerised patient records, pathology and radiology results).
- Low-quality audit of MDT activity.

Resolving MDT problems can be difficult but is important. An ineffective MDT does not focus on what should be its key priority: enabling a widely-trained and highly-experienced group of healthcare professionals to assess the best treatment options for a patient. If these issues are not addressed at an early stage, a poorly-functioning MDT can significantly affect the quality of surgical care.

Resources

- NHS England | *MDT*
- NHS England | *The Characteristics of an Effective Multidisciplinary Team*
- Queensland Health | *A guide to effective MDT Meetings*
- Ministry of Health New Zealand | *Guidance for implementing high-quality multidisciplinary meetings*

Individual behaviours



In 54 out of 100 reviews, there were concerns reported about inappropriate individual behaviour or a lack of respect between individuals and within teams. Our experience is that this detrimental behaviour can have an impact on the standard of surgical care being provided.

Blaming others

Surgeons in difficulty can be dismissive of the concerns that are raised about them – their immediate response will often be to confront the individual or organisation making such assertions, rather than providing reassurance about the quality of their care. They do not readily accept feedback and can become increasingly entrenched in their position. They become 'difficult to manage', 'controlling', or 'arrogant' in their approach.

Isolation

An individual under pressure can also become isolated within their surgical team. They respond defensively to concerns. It may become hard to source data that is needed to make judgements about the quality of the individual's surgical outcomes.

Strengths turn to weaknesses

Without appropriate reflective practice, some of the qualities an individual will have relied on to become a highly-trained autonomous surgical professional – for example strong, independent decision-making – can be magnified and manifest themselves in personality traits that create a negative atmosphere.

Individuals may become dismissive of other healthcare professionals. Behaviour can become highly variable, and range from being compliant and non-confrontational to being aggressive and demanding.

Reluctance to accept responsibility for complications

Individuals may be reluctant to accept and deal with complications in their surgical practice, and may attempt to explain these complications away without acknowledging their significance. A tendency to blame others emerges and relationships with other colleagues are affected.

Problems with wider working relationships

In scenarios where an individual's work is under scrutiny, maintaining appropriately professional relationships is far more testing and frustrations develop. Colleagues believe that they are 'carrying' their team member and that this is affecting the outcomes and overall reputation of the surgical team. Confidence is lost in the individual, leading to a deterioration in other important aspects of teamwork.

'Unusual' behaviours

Individuals under pressure can often behave in ways that are inappropriate for a 'normal' working environment. The manifestation of this behaviour can take an enormous amount of time to manage and address. Moreover, it has the potential to compromise the quality of patient care.

Insight, self-awareness and willingness to change

The insight an individual surgeon has into the strengths and weaknesses of their surgical practice, and the impact of their behaviour on people around them, is central to whether concerns about performance can be resolved.

Individuals who have concerns raised about them can demonstrate little self-awareness or appreciation of the significance of the situation or the seriousness of the concerns. They can be unwilling or unable to accept challenge and criticism of their performance. They find it extremely difficult to be dispassionate about their circumstances and see them from the perspective of those affected, or to be able to adapt their position and see the situation from the point of view of an objective, neutral observer.

Developing insight, self-awareness and a willingness to change are crucial to an individual's ability to maintain good surgical practice and display appropriate standards of individual behaviour.

Concerns about poor individual behaviour need to be addressed in a timely way and resolved before they affect the safety of surgical care.

Resources

- GMC | *Professional behaviour and fitness to practise: guidance for Medical students: professional values and fitness to practise*
- GMC | *Standards and ethics guidance for doctors*
- Royal College of Surgeons | *GSP 3.2.1 Individual behaviour*
- RCS Ed | *How Destructive Behaviour Can Affect the Team*
- RCS Ed | *Non-Technical Skills for Surgeons*
- Royal College of Surgeons | *Avoiding Unconscious Bias*
- Royal College of Surgeons | *How to reduce the risk of bullying*

Leadership and management

The topic of ineffective clinical leadership and/or the lack of good quality service management arose in 54 out of 100 reviews.

54%

Conversely, it was sometimes the case that those who have been working hard to lead and manage surgical services had faced negative and disruptive behaviours from members of their team.

The following are ongoing issues that can affect the leadership and management of surgeons:

A 'them and us' mentality

Clinicians and managers are perceived as operating in separate worlds, perpetuating a 'them and us' mentality, with the two groups apparently serving different priorities and unable to work together.

The 'reluctant leader'

The Clinical Lead or Clinical Director role is rotated among a group of 'reluctant leaders' who 'take their turn' but are not fully committed to the role. They do not enjoy the position or feel they have enough support to make a difference.

The 'overly dominant leader'

Although less frequent than the 'reluctant leader' there are examples of situations where a single, senior consultant remains the lead for too long in a highly autocratic manner and denies their colleagues the opportunity to lead (and in some cases modernise) their service.

The ‘unappreciated leader’

Too little dedicated, job-planned time is made available for important clinical leadership roles and the individual undertaking them has not been given appropriate training. There is a lack of appreciation from colleagues of the importance of these roles and it is perceived they are taken by individuals who are unenthusiastic about direct clinical care.

The ‘unsupported leader’

A lack of consistent and effective service management support can be inhibiting for clinicians trying to lead change. It can also be disruptive to efforts to try to improve standards.

Given the complexity of surgical services, it can often take time for a new manager to understand the service. Frequent changes to this position can significantly affect a surgical leader’s capacity to deliver high-quality care and achieve sustained service change.

The ‘leader without followers’

As highly-skilled autonomous clinical professionals, some consultant surgeons lack experience of being a follower rather than a leader. Consequently, decisions made by a Clinical Lead or Clinical Director are not always followed by the consultant surgeons within the team, or implemented within individual practice.

The impact

It is sometimes the case that when a particular scenario arises, a clinical leader is left with sole responsibility for managing the immediate response. However, they may have little access to other experienced personnel, who could provide guidance. The absence of experienced clinical leadership and effective service management can have a significant impact on the quality and safety of surgical care.

How to avoid these problems

- Our experience suggests that senior hospital managers need to retain a constant oversight of the experience levels, skills mix and training of those appointed to important surgical leadership positions.
- Early action is needed where senior managers are concerned that the right balance of skills and experience are not in place, before the quality of a surgical service deteriorates.

Resources

- GMC | *Leadership and management for all doctors (2012)*
- Royal College of Surgeons | *Leadership and Management of Surgical Teams*
- Faculty of Medical Leadership and Management | *How doctors can take steps into leadership and management*
- Health Careers | *Medical leadership*
- IHM | *Creating stronger relationships between managers and clinicians*
- Royal College of Surgeons | *Women in Surgery*

Outcomes data

53 out of 100 reviews identified concerns about the quality of surgical outcomes data that is available.

Those requesting reviews often lack accurate and universally-agreed information about the outcomes of the individual surgeons they employ, or the services they provide.

Common themes are:

- Absence of data on surgical complications such as leak rates and readmission rates, resection margins, lengths of stays and other indicators of clinical quality.
- Variable quality of data – some surgeons provide detailed information about activity and outcomes while others are unable to submit figures.
- Datasets are inconsistent, due to the methodology used or the accuracy with which the data was collected and presented.
- Variable submission of outcomes data to national databases.
- Inaccurate or incorrect coding of clinical procedures due to poor quality outcomes data collection or lack of capacity.

An inferior level of information means that hospitals cannot provide immediate reassurance if a problem occurs. Moreover, standards of patient care can be overlooked while debate takes place about the quality of data.

It can be concluded that hospitals and their surgeons must prioritise collation of high-quality outcomes data. Maintaining good quality information about activity, outcomes and rates of complication is a very clear indicator of effective management and leadership of a surgical service as well as the quality of surgical care.

53%

Resources

- Royal College of Surgeons | *Using data to support change in clinical practice*

Facilities and resources

In 51 out of 100 reviews, an aspect of the facilities and resources available needed further attention.

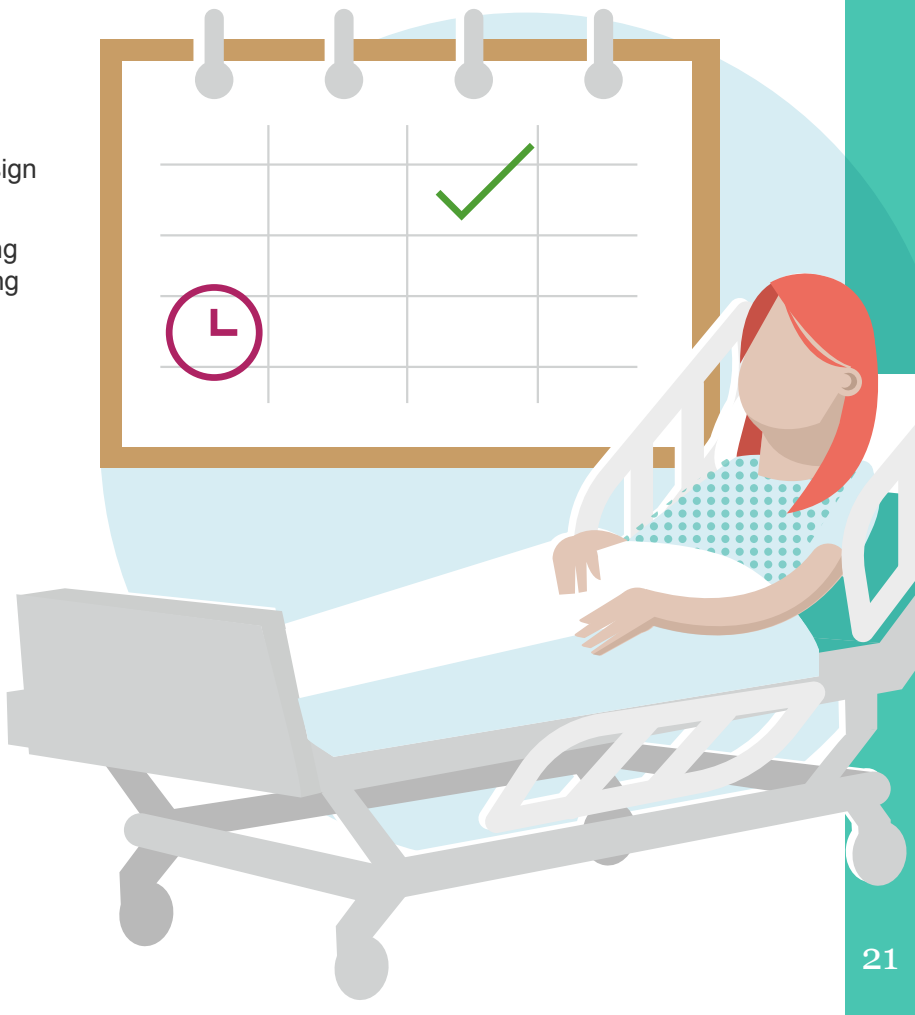
Areas where specific problems occurred were:

Facilities

- Lack of availability of surgical ward beds and/or the ability to ring fence beds for elective procedures.
- Managing acute admissions.
- Having properly timetabled access to appropriate operating theatres for elective and emergency surgical care.
- Getting access to sufficiently well-staffed, specialist, high-dependency and intensive care units.
- Ensuring that hospital facilities have been appropriately designed for the surgery undertaken (for example to support day case surgery, or enhanced recovery).
- Having appropriate instrumentation available and suitable processes for sterilisation and/or maintenance of instruments.
- Problems with processes for the design and review of surgical job plans.
- Access to appropriate and functioning hospital computer systems supporting the delivery of surgical care.

Resources

- The number and skill-mix of nursing staff supporting surgical services.
- A service's capacity to recruit consultant surgeons and other medical personnel.
- The administrative staff available to support the running of the service.
- Appropriate access to the expertise provided by other healthcare professionals, such as clinical nurse specialists or specialist physiotherapy.



Addressing concerns about facilities and resources before problems occur

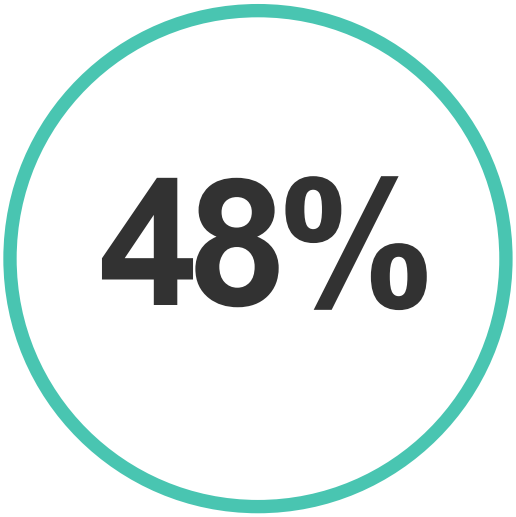
Hospital personnel are often aware of the shortcomings of their working environment for a long time. They have suggestions for improvement but are not in a position where they can put these into practice. Without careful attention, facilities and resources can significantly reduce the quality of surgical care. Staff should be supported to ensure that their suggestions for improvement are implemented. There should be particular vigilance against passively accepting a situation that is unsatisfactory and then unsafe.

Resources

- Department of Health and Social Care | *Facilities for surgical procedures in acute general hospitals*
- Department of Health and Social Care | *Facilities for day surgery units (HBN 10-02)*
- Royal College of Nursing | *Mandatory Nurse Staffing Levels*
- Quality Improvement Hub | *Step Guide to Improving Operating Theatre*

Audits

In 48 out of 100 reviews, the quality of audit practice was identified as an area for improvement.



Clinical audit underpins an effective surgical service. When deployed efficiently, it is a valuable process for assuring the quality of individual surgical practice, and a service's clinical outcomes. It can also provide a key starting point for driving quality improvement.

Evidence from invited reviews shows that the quality of audit undertaken by surgical services is variable. Furthermore, when a service is struggling, the level of clinical audit can be poor. Problems become acute when an individual or service's outcomes are questioned and there is no reliable data to demonstrate quality and safety.

Examples of inadequate audit reveal that problems occur when:

- The approach to audit has evolved around an individual's personal interests rather than the needs of the service and its improvement.
- The approach to audit has developed around helping individual trainees meet curriculum requirements rather than patient or service needs.
- There is a lack of functioning real time data collection systems.
- There is a lack of timely and accurate entry of data into existing systems.
- There is a lack of dedicated clinical and non-clinical staff resources and time to support data collection, analysis and reporting.
- There is a lack of local expertise in managing responses to divergence – ie situations where individual or team practice appears to be diverging from expectations of 'normal' surgical outcomes.

  Responses in this situation polarise around extremes. The surgeon or surgeons are not managed closely enough, or managed too closely with disproportionate action taken.
- Within a service, audit exists independently from the need for quality improvement. For example, an obscure area of surgical practice is examined, while much more significant areas of practice that have a far greater impact on patient safety are ignored.
- Audit is sidelined by senior management and regarded as low priority rather than being fundamental to a successful surgical service.

Robust clinical audit is vital if a service is to maximise its potential and demonstrate that it achieves safe, high-quality outcomes.

Surgical services should invest in their audit processes and regularly review their data. Results can then be used as an impetus to improve the calibre of care.

Clinical audits

- Royal College of Surgeons | *The criteria and indicators of best practice in clinical audit*

Relationships with surgeons in training

Issues regarding the relationships between consultant surgeons and non-consultant grade team members were identified in 45 out of 100 reviews.

45%

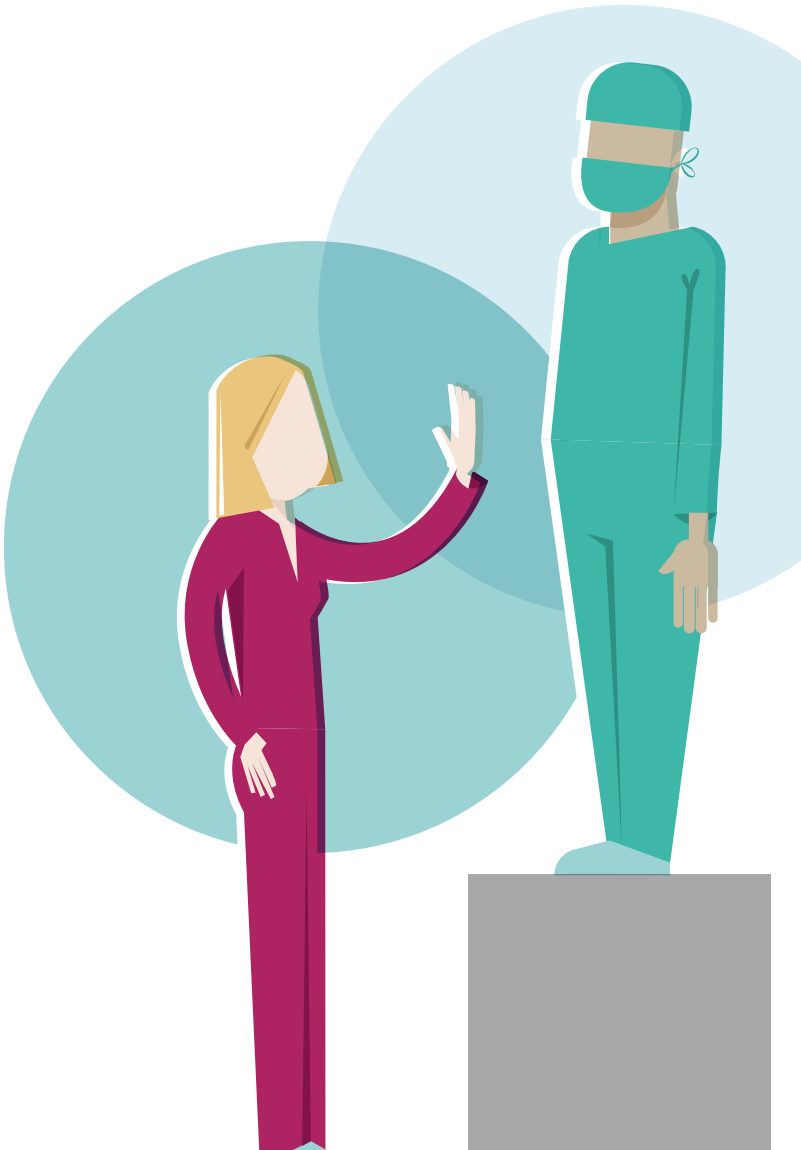
Trainee surgeons and other non-consultant grade staff who support surgical care can offer valuable insights when assessing a service.

Surgeons in training have worked in a variety of hospitals across a region and will be able to reflect on these experiences to form a clear perspective on the capabilities and areas for improvement of a service under review.

It should also be the case that if a service is working well a trainee surgeon would be keen to return to the unit later in their training or seek to gain a substantive consultant appointment. A well-functioning service will be organised around the needs of patients while providing trainees with high-quality and supportive training opportunities.

Evidence from our invited reviews demonstrates that where surgeons in training report a poor standard of teaching and learning, there is a strong possibility of issues with the delivery of safe surgical care. It is important to realise that where surgeons in training or other non-consultant grade clinical staff report poor quality interactions between those responsible for their training, this can also compromise safe surgical care.

All healthcare organisations should have well-structured processes for ensuring that the views of surgeons in training and non-consultant staff can be gathered, assessed and used to deliver tangible changes to the ways in which services are delivered.



It may be helpful to ask surgeons in training the following questions:

- Do you feel the care we deliver to patients is safe, effective, responsive, caring and well-managed?
- Do you think you have the appropriate facilities and resources to deliver good quality surgical care?
- How does the working environment in our hospital compare with others that you have experienced?
- Would you describe the interactions between the teams of consultant surgeons here as appropriate?
- How does the standard of teamwork between consultant surgeons here compare with other hospitals you have worked in?
- If you could make one practical change to improve this surgical service today, what would it be?

Resources

- Health Education England | *Enhancing junior doctors' working lives*
- Royal College of Surgeons | *Trainees*
- Association of Surgeons in Training (ASiT)
- Royal College of Surgeons | *Training and Assessment in the Clinical Environment*
- Royal College of Surgeons | *Training the Trainers: Developing Teaching Skills*
- Royal College of Surgeons | *Mentoring*
- Royal College of Surgeons | *Improving Surgical Training*

Morbidity and mortality meetings

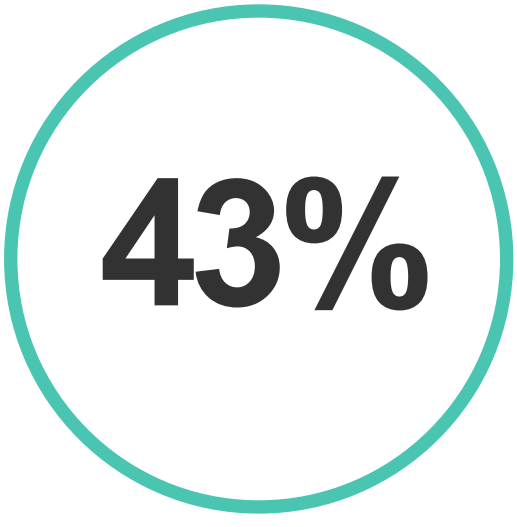
In 43 out of 100 reviews, there was discussion around the quality of morbidity and mortality processes.

The open discussion of patient deaths (mortality) and operative complications (morbidity) helps surgeons and those responsible for surgical services understand the effectiveness of surgery. It is also essential for ensuring that a surgical service learns from surgical complications.

Our experience from invited reviews is that surgical services do not always undertake morbidity and mortality review effectively. Examples include:

- Insufficient time being scheduled for meetings, with meetings either not frequent enough or not long enough.
- Discussion of clinical incidents taking place a long time after they happened, potentially due to issues with scheduling or availability for attendance.
- The selection of episodes of patient care for discussion at the meeting not being well managed and being perceived to be biased for or against a particular surgeon.
- A lack of regular attendance by key consultant team members, either due to individual behaviours or system issues such as problems with job planning.
- Inconsistent presentations of episodes of care when being discussed, in terms of format and/or quality.
- Absence of dedicated administrative support for the meeting.
- A lack of structure when discussing episodes of care, leading to missed opportunities for learning.
- A lack of constructive or well-managed challenge within discussions leading to missed opportunities for learning.
- Discussions not reaching specific conclusions about the contributory factors, or agreeing clear actions to improve care in the future.
- A poor recording of discussions, and the agreed actions.
- A poor follow up of agreed actions and how they are implemented.
- A lack of monitoring of overall trends in the problems that arise within the team's delivery of care to ensure future learning.

The absence of good quality morbidity and mortality processes means surgeons are not able to learn from their own and their colleagues' experiences. Our experience of the problems that this can cause for surgical safety shows how critical this is to providing a safe, high quality surgical service, and why it should be prioritised.



Resources

- Royal College of Surgeons | *Morbidity and Mortality Meetings*
- GMC | *Morbidity and mortality meetings to improve patient care*

Activity data

In 38 out of 100 reviews, we identified issues about the quality of surgical activity data.

Any service undertaking surgery should have access to good activity data. Our experience of invited reviews shows they often do not.

In some cases, services we have reviewed have lacked basic data on:

- The number of patients referred into and discharged out of the surgical service.
- The number of new and follow-up outpatients appointments completed by the service.
- The number and type of operations undertaken.

These data are critical for a number of reasons. The requirement is to:

- Understand the level of demand on the service, monitor changes to this over time and plan resources to match patient demand.
- Demonstrate that a sufficient number of procedures are being undertaken to maintain competence and ensure that suitable outcomes are achieved.
- Ensure the hospital is being appropriately reimbursed for the services it provides.

We are not suggesting that information does not exist somewhere within the organisation under review. Our experience is that:

- The personnel providing surgical services do not access and analyse the data in aggregate form and are unable to prepare suitable data as part of their preparation for an invited review.
- There is a lack of confidence in the accuracy of the data available, due to it being incomplete, poorly collected or coded, or because there are multiple, contradictory data sources.
- Changes to the clinician or service manager responsible for collecting, and presenting this data has left the service without access to the skills required.

We are aware that hospitals often do not prioritise and support the development of systems that enable the collection of good-quality activity and outcomes data. The realisation of how important this is only occurs when there is a problematic situation.

38%

Resources

- Royal College of Surgeons | *Using data to support change in clinical practice*

Managing change

35%

In 35 out of 100 reviews, there were negative views about the management of change.

The reality of healthcare today means that change is a constant. We often review services that are being reorganised, or reconfigured. A new surgical team is created at short notice due to the merger of previously separate hospitals, or a specialist service centralised through the creation of a new 'hub and spoke' model.

The quality of change management that occurs within healthcare organisations is highly variable. While substantial change within hospitals is sometimes managed effectively without disrupting care, we are aware of situations where the opposite holds true.

Problems occur when services lose focus on the experience of a patient in their hospital.

These are the key points that should be clarified within services undergoing change:

- Who is responsible for clinical quality and surgical safety within the service today while the service undergoes change?
- Who is leading the programme of change?
- How is the success of these leaders being measured and by whom?
- How are the individual clinicians ensuring their care is safe as the change takes place?
- How are the new teams that are being created coming together?
- What is the quality of these team members' interpersonal interactions?
- How are the individuals within these teams engaging with the change?
- Are team members accepting the change and working in line with their new working arrangements?
- What lessons are being learnt as the change is taking place?
- What immediate actions are being taken to address any safety issues, personnel issues, or service improvement issues that arise as the change occurs?

Resources

- NHS England | *Planning, assuring and delivering service change*
- NICE | *Understand, identify and overcome barriers to change*
- NIHR | *Change*
- Royal College of Surgeons | *Reshaping Surgical Services – principles for change*

Appraisal

There were 35 out of 100 reviews which identified sub-standard quality of surgeon appraisal.

We routinely request appraisal documentation as part of our preparation for invited reviews. In a significant proportion of reviews we found that the standard of appraisal of consultant surgeons was poor.

Examples of shortcomings with appraisal processes include:

- Documentation being out of date. Upon following this up there were instances where we discovered that some consultants had not been appraised for several years.
- Appraisals being superficially completed or demonstrating little to no evidence of any reflective practice.
- Appraisals lacking effective challenge of under-performance or simply not addressing this at all.

Appraisal was not often a primary feature in our sample of invited reviews. At times, however, they have been an important secondary factor, with interviews highlighting:

- Disagreement between parties about the selection of an appraiser by an appraisee.
- A general attitude towards appraisals that remained dismissive of their significance.

Revalidation was launched during the period within which our sample of invited reviews took place. This has the capacity to drive improvements in this area. Our experience in this area reinforces the extent to which improvements are required.

Resources

- GMC | *GMP Framework for appraisal and revalidation*
- Royal College of Surgeons | *Appraisal*
- Medical Protection Society | *Guidance with appraisals and revalidation*
- NHS England | *Medical appraisal guide (MAG)*
- Academy of Medical Royal Colleges | *Appraisal & Specialty Guidance*
- BMA | *Appraisals*
- Royal College of Surgeons | *Accredited CPD Events*

Learning from patient experience

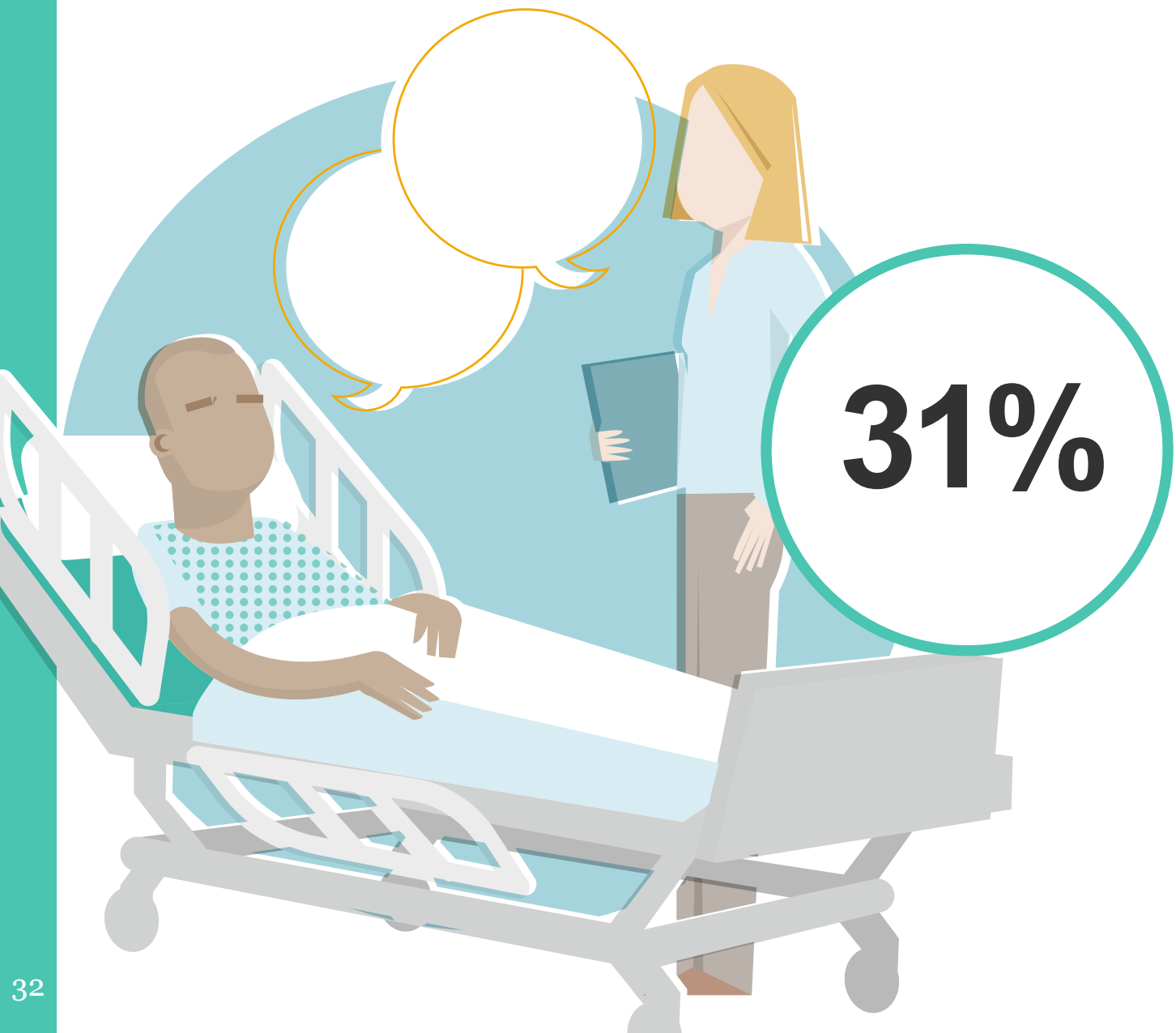
In 31 of 100 reviews, concerns were identified about learning from patient experience.

Meaningful engagement with information about the patient experience, and the ability to demonstrate how this information is being used to improve care quality is a helpful indicator of an effective service.

For each review, we requested information about patient complaints and the responses provided. This provided a valuable perspective on the management of a service.

Single episodes of care rather than overall quality of experience

Surgeons and services under pressure often lose sight of the patient's views about the quality of the service. They focus on the patient they are presented with on that specific day, and seek to resolve the immediate problem without reviewing the patient's overall quality of experience.



Engaging with and learning from patient feedback

The way a service engages with patient feedback and complaints is a useful indicator of its leadership. Surgeons or services in difficulty can become defensive about patient complaints and dismissive of the perspective of the complainant. Their desire is to resolve single issues in isolation without reviewing the patient's overall experience, or considering common themes that may occur throughout the care delivered by various surgeons.

Using patient feedback as an opportunity for wider learning

A further indicator of a surgeon or a service under pressure is where there is an attempt to 'close down' and 'contain' patient complaints rather than use them as an opportunity to improve individual practice or delivery of the service.

The best services will be proactive and derive ways to learn from patients about how the care they provide is experienced. They will take the longer view and seek to avoid problems before they arise.

Demonstrating how concerns have been resolved and how changes have occurred

Our overall experience is that while most complaints are responded to and resolved, the individuals and services do not discuss what has been learned and how they can ensure that a similar situation does not recur. Practice can be variable and we understand that while on some occasions lessons are learned, hospitals often lack sufficiently well-organised systems to do this routinely.

A service that is being well led and managed will be able to show clear examples of how:

- patient complaints have been responded to
- patient experience data is learned from
- concerns have been addressed and changes to practice implemented to improve patient care.

Resources

- NICE | *Patient experience in adult NHS services*
- The Patient Experience Library
- DHSC | *Measuring patient experience of integration in the NHS*
- GMC | *Colleague and patient feedback for revalidation*
- NHS Surveys | *Using patient feedback*
- Patient Experience Network (PEN) | *Improving Patient Experience for Children and Young People*

Patient consent and candour

Issues to do with patient consent and candour were identified in 30 out of 100 reviews.

Invited reviews show a range of concerns can arise around the process for supporting a patient to make a decision about surgery. These include:

- Whether the surgeon having this conversation is able to provide an accurate quantification of risks, derived from appropriate evidence.
- The information available to the patient about their surgeon's experience of the particular procedure, their recent outcomes and how these compare with national benchmarks.
- Whether the surgeon having a conversation about consent has sufficient surgical experience to ensure that the patient is fully informed about the procedure and its risks and benefits.
- The quality of discussion that takes place about a patient's treatment options, and the patients' individual priorities (particularly in the light of the Montgomery judgement).
- The extent to which the procedure proposed is established or a novel approach.

From our familiarity with reviewing clinical records, the documentation of discussions with patients can also be problematic, for the following reasons:

- A failure to document who was involved in the consent discussions.
- A lack of detail about the discussion with patients around consent.
- A lack of description of the procedure. This has proved particularly problematic in instances of 'never events' including multiple tooth extractions and wrong site removal of skin lesions.

Questions regarding consent can sometimes be indicative of wider issues with an individual surgeon or surgical team. Our experience is that the extent to which personnel report confidence in the patient consent process provides a useful indicator of the quality of the surgical service. It is also our experience that in a small number of situations where these processes go wrong, the impact on patients can be significant.

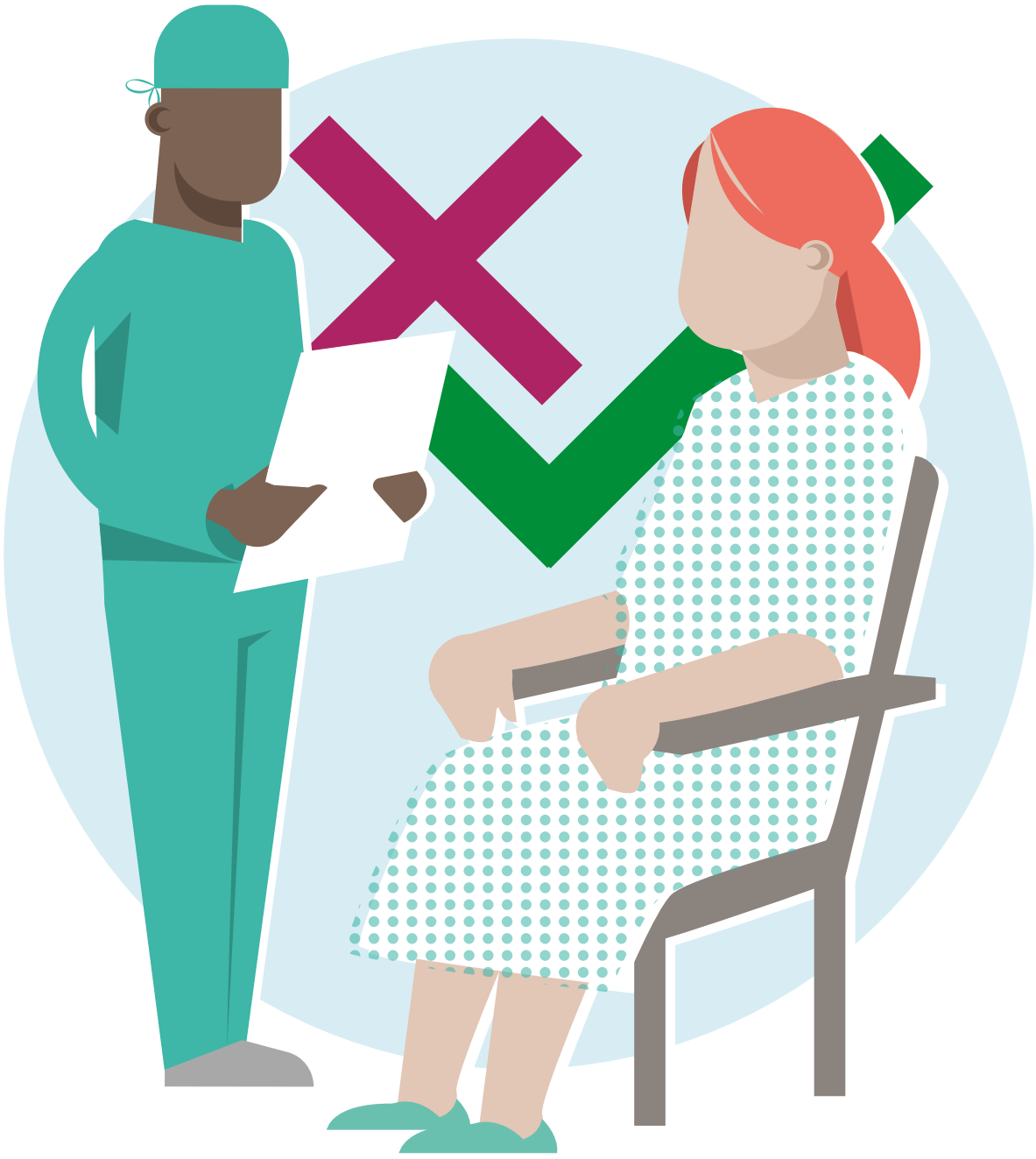
Candour

The introduction of regulations relating to the Duty of Candour took place during the period within which we conducted our sample of invited reviews. Therefore, the quality of these conversations became a topic that was examined in the invited reviews. Issues arising included:

- Conversations not being held in an appropriately timely manner to ensure that local processes were being followed correctly.
- A failure to be clear on what specific actions had been taken to provide assurance that Duty of Candour regulations had been followed.

Resources

- GMC | *Consent: patients and doctors making decisions together (2008)*
- Royal College of Surgeons | *Consent: Supported Decision-Making*
- BMA | *1. Guidance on seeking informed consent*
- Health in Wales Healthcare Excellence | *Patient Consent*
- The MDU | *Consent*
- DHSC | *Reference guide to consent for examination or treatment*
- GMC | *When things go wrong – The professional duty of candour*
- Royal College of Surgeons | *Duty of Candour – Guidance for Surgeons and Employers*
- The MDU | *Statutory duty of candour in secondary care*
- Royal College of Surgeons | *Consent and Ethics (eLearning)*



Probity

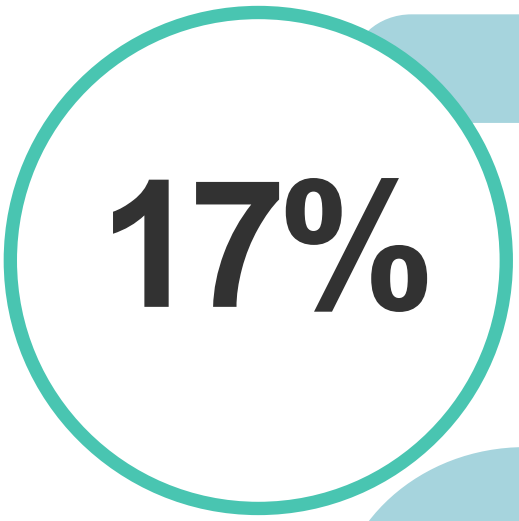
In 17 of our 100 reviews, there was a particular focus on the issue of probity.

It is rare for a hospital to request an invited review regarding the subject of probity. However, when examining clinical decision-making, team interactions, communication with patients and clinical record-keeping, the topic of probity emerges as an issue.

Where concerns are identified these can relate to:

- A lack of openness when discussing complications with colleagues. Surgeons should proactively alert their colleagues to complications or problems that have arisen in the delivery of surgical care, for instance, at morbidity and mortality meetings.
- Inaccuracy or incompleteness of clinical records documentation – comprehensively describing interactions with patients prior to surgery and documenting the nature of operations performed and any resultant complications is essential.
- Inappropriately counselling patients on their options and the relative risks and benefits associated with each, including failing to ensure that the advice of the MDT is accurately conveyed or that estimations of risks are appropriately evidenced.
- Conflicts of interest regarding private practice or other financial incentives – giving advice to patients that is not free from consideration of what may benefit the surgeon personally or failing to ensure time allocated to NHS commitments is used appropriately.
- Inaccurately representing research findings, not documenting failures and successes equally or accurately presenting findings to peers.
- Misrepresenting training, qualifications and memberships – either deliberately or inadvertently making a false representation of the surgeon's skills and experience in their CV or other documentation.

Where a surgeon's probity is called into question, it is often the case that their credibility among colleagues is affected. Colleagues may lose respect for the individual and devalue their judgements and advice. In the most serious circumstances, it could lead to resentment and hostility that may undermine the work of the department.



Resources

- GMC | *Probity*
- Royal College of Surgeons | GSP *4.1 Show respect for patients*
- NHS England | *Probity handout for appraisers*
- Medical Protection Society | *The GMC's expectations on probity*
- BMA | *Ensuring transparency and probity*
- NHS Education for Scotland | *Examples of common Probity issues to reflect upon*

The development and introduction of new techniques and technologies

In 16 out of 100 reviews, there were concerns about the way in which a new technique or technology had been introduced.

New techniques and technologies are crucial to advancing surgical care and improving patient outcomes. To be introduced safely they must be underpinned by rigorous clinical governance processes, supported by appropriate training, and come under tight scrutiny of patient outcomes.

Changes to established practice need to be properly managed. Those involved should consider the relative risks and benefits of the proposed new approach. They should discuss in an open and transparent manner the options for surgery or alternative treatments with the patients who will have the new procedure. Patients should be provided with clear data that shows the relative risk of the proposed approach, as opposed to the more established alternatives available.

Significant and serious problems can occur where new techniques and technologies are introduced without appropriate clinical governance arrangements and where senior clinical leaders do not maintain effective oversight of these processes. These difficulties can be highly challenging to resolve, and can affect the quality and safety of clinical care.

Our experience shows the introduction of minimally invasive operative techniques as well as the introduction of new and experimental treatment therapies can cause significant problems.

The following are areas that need constant oversight:

- The processes by which an individual trains in the new approach.
- The oversight and quality assurance of the training in the new technique or therapy.
- The individual approach to introducing the new technique or therapy.
- The learning curve they experience while undertaking the new procedure.
- How patients are identified as being able to benefit from the new approach.
- How the potential risks and the potential benefits of the procedure against more established alternatives are explained.
- Postoperative management of patients.
- Reporting and auditing the outcomes of the new approach.

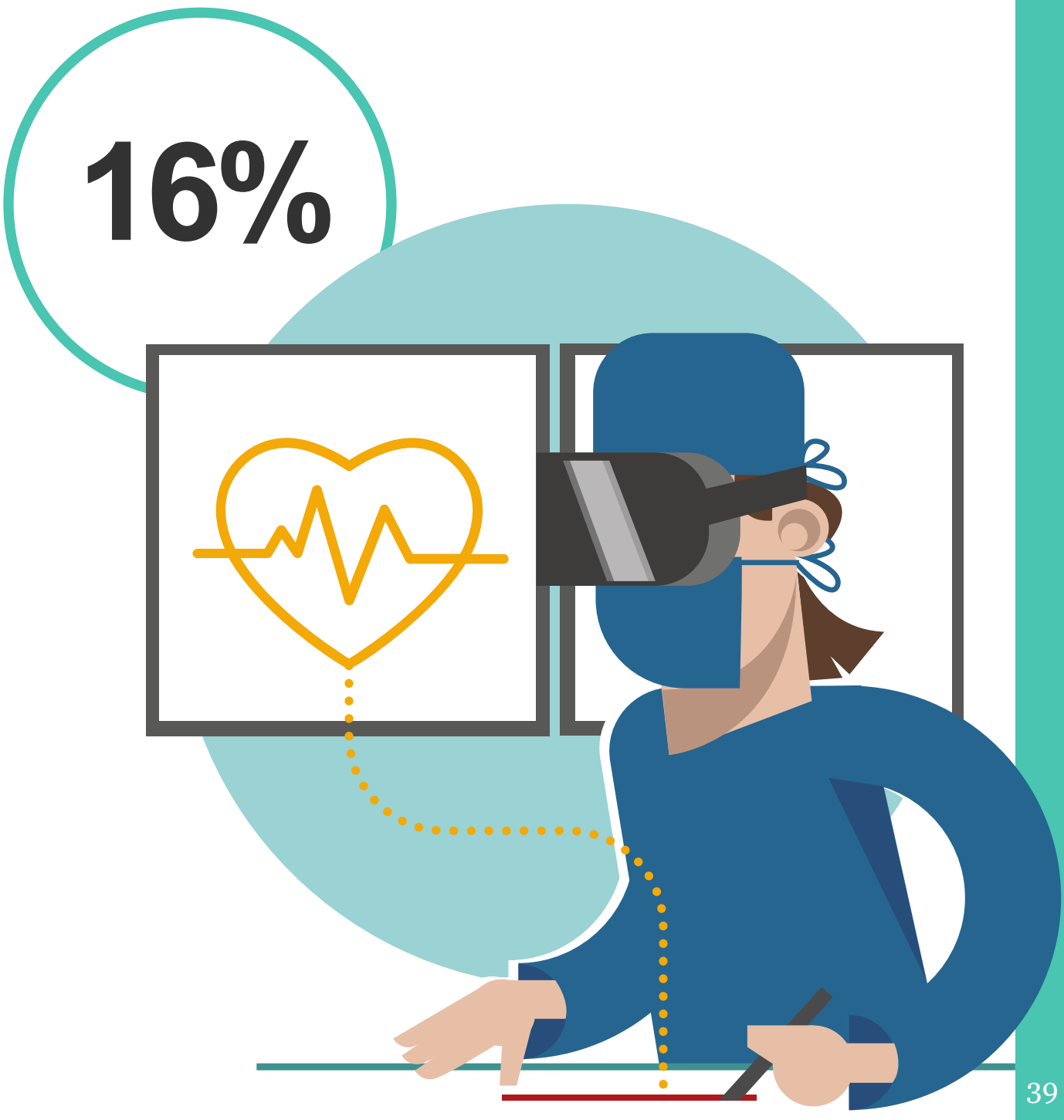
Problems can arise if any of these concerns are not appropriately managed by the individual surgeon introducing the new technique, technology or therapy. This can occur within both NHS and private practice, and it is critical that the organisation has proper oversight of any new practices being pursued.

When introducing new techniques, surgeons must ensure that these techniques are only adopted after they have had an appropriate period of training and mentorship. They should also ensure that their adoption is underpinned by appropriate clinical governance mechanisms, and effective multidisciplinary team-working arrangements. The new approach should also be subject to a rigorous outcomes audit.

Without following such processes, problems can occur, and patient care can be seriously compromised.

Resources

- Surgeons | *GSP 1.2.4 Introduction of new techniques*
- Royal College of Surgeons | *From innovation to adoption*
- Australian Safety and Efficacy Register of New Interventional Procedures-Surgical (ASERNIPs) | *A review of policies and processes for the introduction of new interventional procedures*



Key principles to act on

We hope this resource has helped you to reflect on the quality of your surgical practice. To help you to provide high quality care we recommend:

1. Having regular discussions about the quality of surgical performance between individual surgeons and their teams.
2. Acting on concerns at an early stage before they affect patient care.
3. Considering the value of an independent external perspective on the situation.
4. Ensuring your surgeons have appropriate facilities and resources to support them to deliver safe care.
5. Ensuring that your surgical services have clearly identified clinical leaders that these leaders want to do the job, and have the time and resources to make a success of it.
6. Reviewing the performance of your multidisciplinary teams regularly to ensure they are focused on supporting patients to get access to the best possible care.
7. Regularly reviewing the quality of the behaviour of all those involved in delivering surgical care within your services and addressing poor behaviour at an early stage.
8. Focusing on the immediate impact on patient care and safety when your surgical service goes through a significant period of organisational change.
9. Regularly reviewing your surgical service's processes for gaining consent from patients for operations, as well as the way in which your team introduces new technologies and techniques.
10. Regularly reviewing the standard of teamworking between groups of consultant surgeons to ensure that it supports the delivery of high-quality surgical care.
11. Using the experience of trainees to learn about the quality of a service, and the team dynamics that underpin it.
12. Ensure that your surgical service undertakes regular reflective practice. Including ensuring your service has:
    a. high-quality morbidity and mortality review meetings;
    b. programmes of clinical audit that demonstrate surgical safety and promote improvements in quality;
    c. comprehensive appraisal of individual surgical practice and the use of this appraisal to improve performance; and
    d. structured and effective learning from patient experience and patient complaints.
13. Ensuring your service has well designed systems for collating detailed, accurate and timely data on surgical activity and surgical outcomes. This data should be given high priority and sufficient resource for it to be used comprehensively to assure standards and improve quality.

We hope that this resource has been helpful to you in exploring how you can further improve your own surgical services. If you feel that you would benefit from external support and would like discuss a possible invited review please call us on 020 7869 6222 or email **irm@rcseng.ac.uk**. You can also visit **www.rcseng.ac.uk/irm** for more information.

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