Royal College of Surgeons
ADVANCING SURGICAL CARE

# How to avoid problems and thrive in your surgical practice – what we have learnt from RCS invited reviews

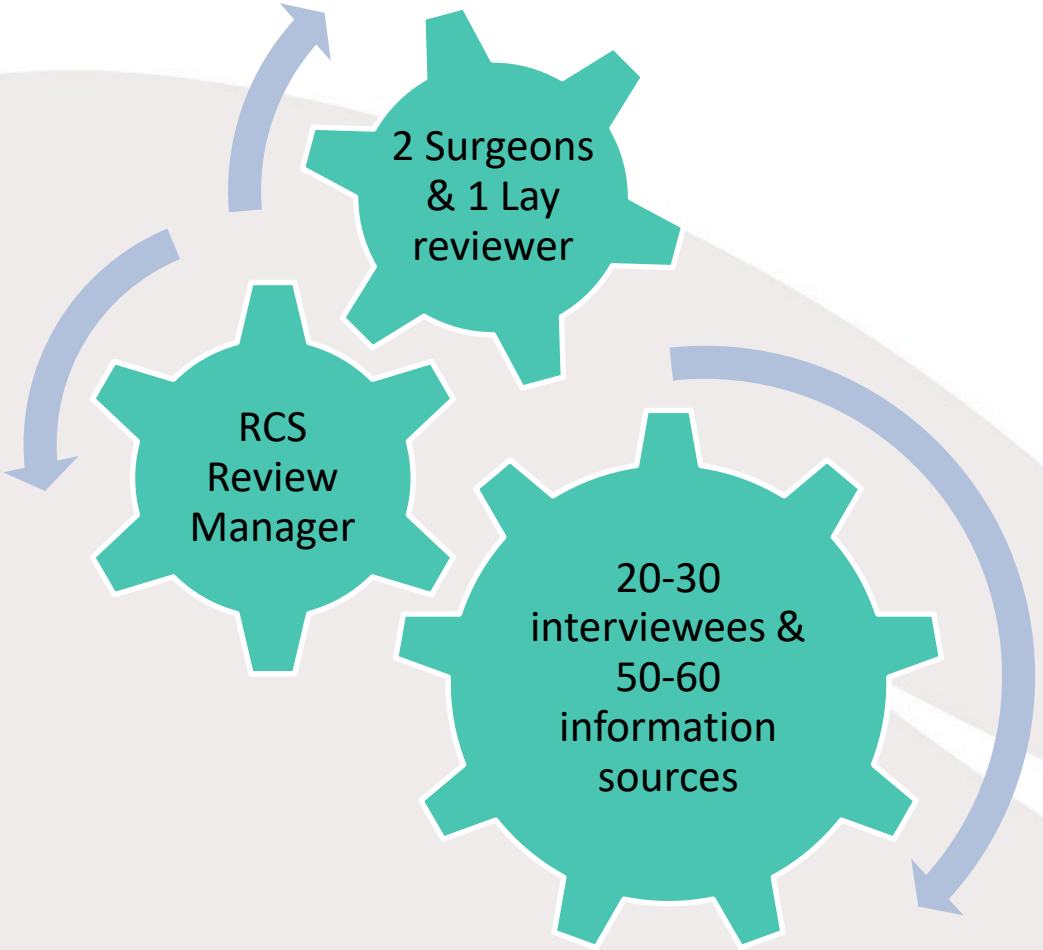
**Steven Wakeling**
**Head of Invited Reviews**

# Overview of invited reviews

| | | |
|---|---|---|
| Invited by a senior manager at a Provider | Partnership between RCS, SSAs and the PLG | Identifies whether or not causes for concern exist |
| Confidential | Independent and impartial | Peer led - expert |
| Recommendations made | Duty to protect patient safety | RCS committed to highest standards of surgical practice and care |

# Who is involved and how long does it take?

- Timescales vary case to case but typically **10-12 weeks request to visit**
- Immediate **advice at end of visit** (and confirmed in writing)
- **Report** in about **8 weeks**
- Sometimes includes a doctor or health professional nominated by another College



# What happens after a review?

The healthcare organisation decides if, and how, a report is published or shared and what actions are taken

We follow up every review, monitoring action against recommendations

In most cases it takes 6-12 months to act on all of the recommendations. Sometimes it takes 18 months+

Escalation of patient safety to the regulator if issues unaddressed

# Learning from reviews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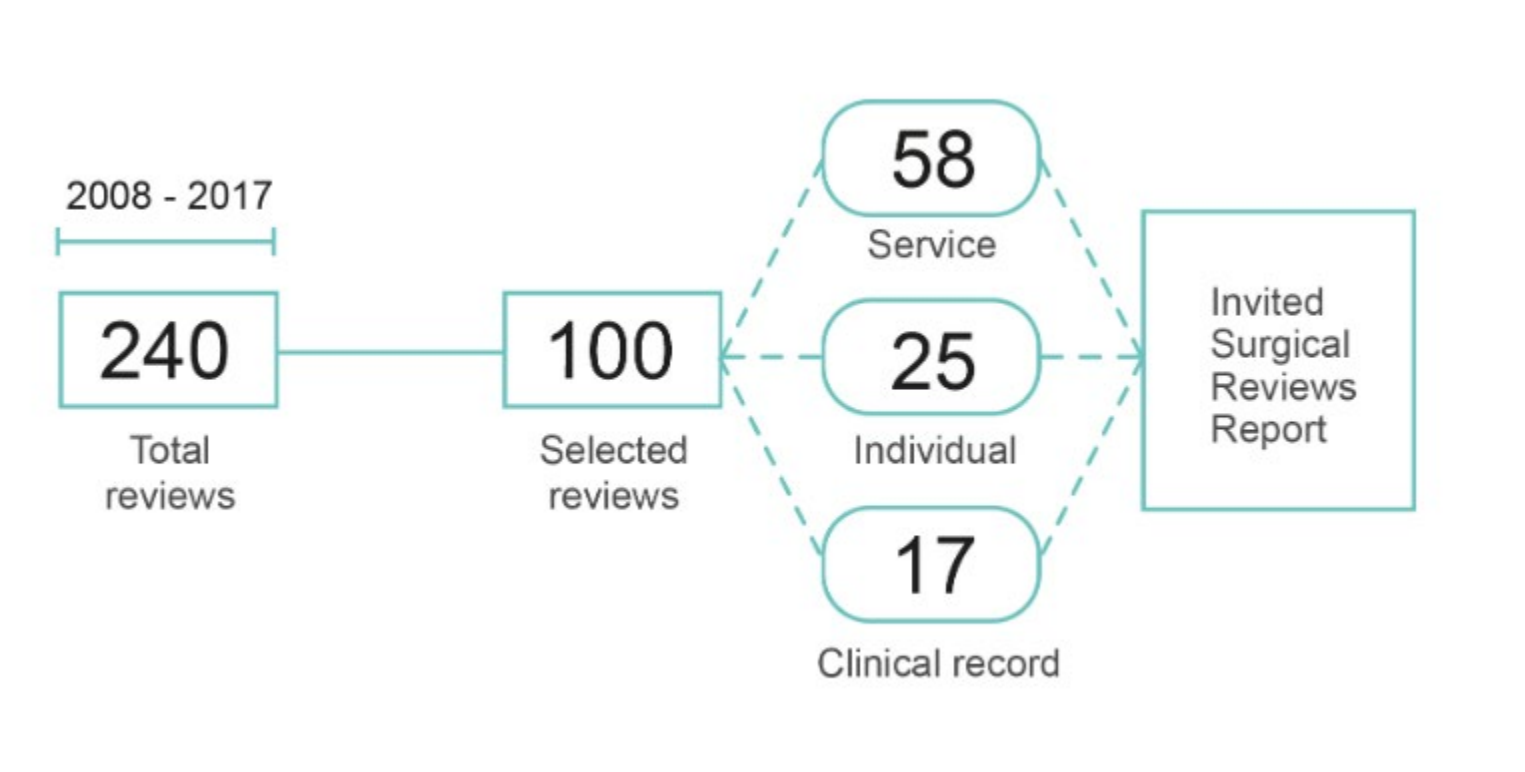
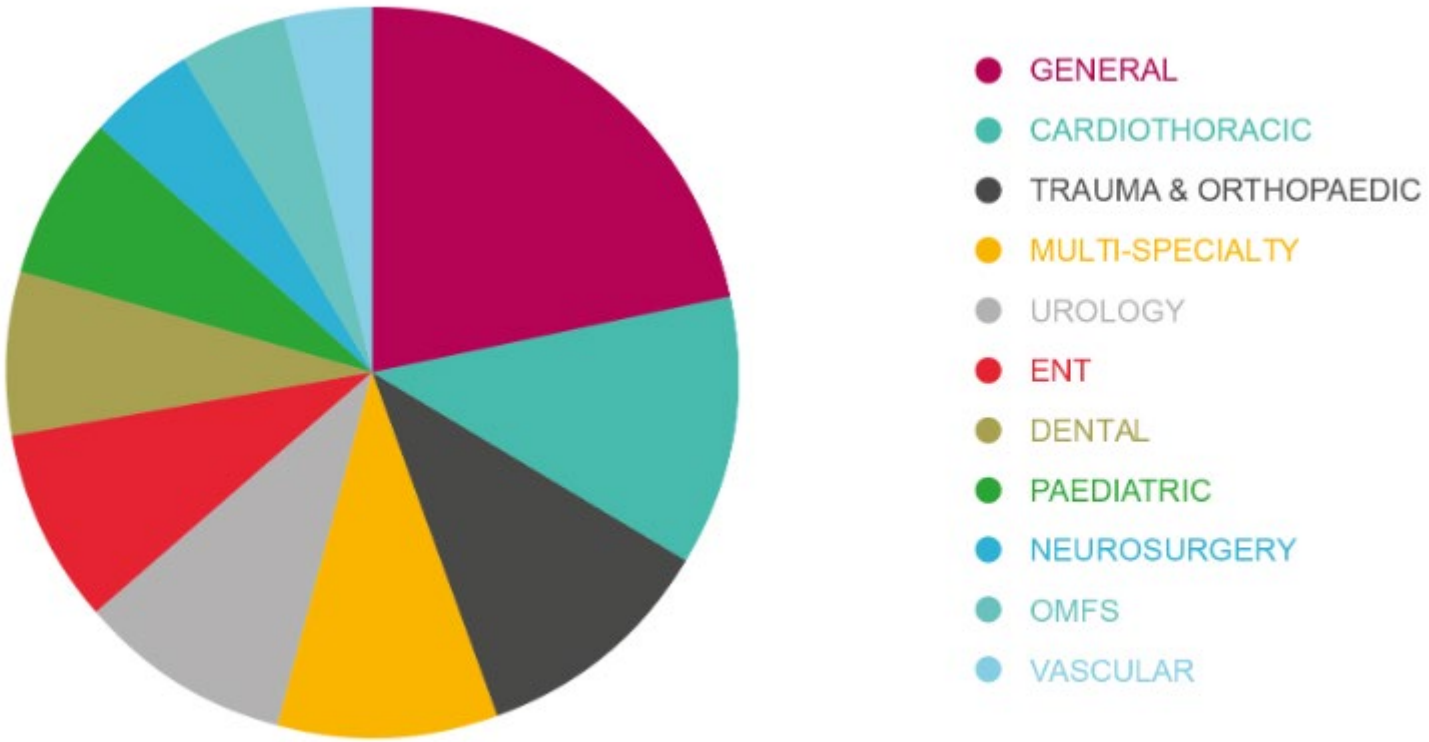
INVITED REVIEWS
Full report
IN
OUT

# The methodology

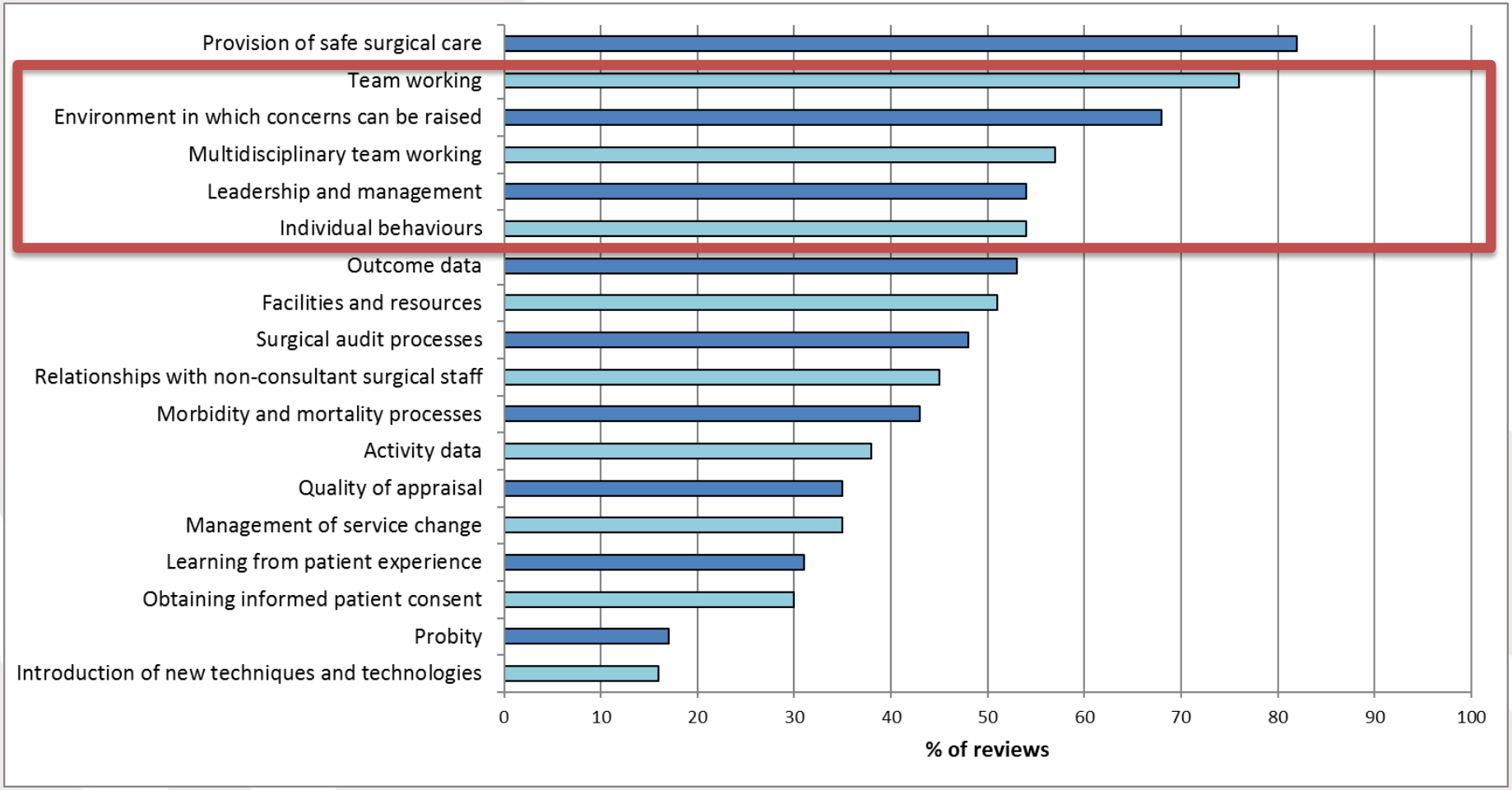


# The cases included



# The 18 key issues

# Where problems occur



# Teamwork

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

**76%**

**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

**68%**

**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.

**57%**

## 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

**54%**

**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

7

Are you happy with the quality of your team's surgical outcome data and that all surgeons submit this consistently?

YES NO

# Resources and key principles

## 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*

# 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.

# Questions?

## Further information

Invited Review Mechanism
T: 020 7869 6222
E: irm@rcseng.ac.uk
W: www.rcseng.ac.uk/irm