Royal College of Obstetricians & Gynaecologists

Invited Reviews - A guide

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Abbreviations

BMA	British Medical Association
CQC	Care Quality Commission
DHSSPS	Department of Health, Social Services and Public Safety
ELA	GMC employer liaison adviser
GMC	General Medical Council
HCO	healthcare organisation
HIW	Healthcare Inspectorate Wales
IRP	Independent Reconfiguration Panel
MDU	Medical Defence Union
MPS	Medical Protection Society
NCAS	National Clinical Assessment Service
PIN	Partnership Information Network
RCOG	Royal College of Obstetricians and Gynaecologists
RO	responsible officer
RQIA	Regulation and Quality Improvement Authority
SASGs	Staff, associate specialist and specialty grade doctors

1 Introduction and purpose

Despite the introduction of continuing professional development, job planning, clinical governance, annual appraisal and revalidation, it is likely that from time to time responsible officers (ROs) and healthcare organisations (HCOs) will have concerns about:

- an individual's clinical performance
- a procedure that might be causing new or worrying complications
- patient safety
- the ability of the HCO to provide effective training in obstetrics and gynaecology
- workload issues and possible reconfiguration of services
- aspects of delivery of a whole service
- potential for service redesign/reconfiguration.
- workforce issues
- bespoke consultancy services

1.1 The General Medical Council (GMC) *Licence to Practise Regulations 2012*[1] and *The Medical Profession (Responsible Officers) Regulations 2010*[2] clearly state the role of the RO in providing assurance to the GMC that doctors with whom they have a connection remain up to date and fit to practise. On occasions, however, an RO may have information that raises concerns about the performance of a doctor.

1.2 The Royal College of Obstetricians and Gynaecologists (RCOG) regularly receives requests for invited reviews of obstetric and/or gynaecology services, or of individual clinical practice. This document sets out the RCOG's approach to such requests, which may come directly from a RO or from any organisation providing, planning or commissioning an obstetric or gynaecology service, including services based in community settings or in independent sector organisations.

1.3 This document defines the governance, structure and operational process to be followed when a request is received by the College, the rationale for determining the appropriate response and how this response is followed through, including the process for review and follow-up.

1.4 This guidance is clear about its limitations – where it emerges that the problems lie with an individual's behaviour rather than their performance, or a more systemic problem with service design, the RCOG may suggest that the RO or HCO consider an internal investigation against a clear framework, for example *Maintaining High Professional Standards in the Modern NHS*[4] and/or referral to a GMC employer liaison adviser (ELA), NCAS or another specialist agency focusing on doctors in difficulty. HCOs might consider discussing the concerns about the individual with NCAS before requesting an invited review from the RCOG.

1.5 This guidance applies to all four UK nations; terminology is intended to be interchangeable and acknowledge any regional variation in process, service design or external stakeholders. NHS organisations in England must comply with the requirements of *Maintaining High Professional Standards in the Modern NHS*[4] and this is good practice for all employers. In Scotland, the NHS Scotland *Standards for the Healthcare Workforce*[5] apply (including the *Partnership Information Network (PIN) Policy*[6]).

1.6 The RCM fully endorses the process that the RCOG undertakes during an invited service review as outlined in this guidance.

2 Definitions

2.1 Full details of linked organisations are provided in Appendix 2. These include regulatory agencies that are also involved in aspects of a service review and may take over the brief should this be appropriate.

2.2 A 'service review' is carried out in response to an invitation to visit and comment upon a current service, including meeting the clinical team, managers and other stakeholders, with the terms of reference rooted in the quality and safety of that service.

2.3 An 'individual performance review' is carried out following a request to examine the clinical practice of an individual doctor causing concern. Other requests such as for case note review or for independent second opinions would fall into this category.

2.4 For the purposes of this document, the referring organisation, such as a health board, education body (this could include local education training boards and schools, Health Education England and NHS Education Scotland), NHS healthcare organisation or independent provider will generally be referred to as the 'healthcare organisation' (HCO) and the doctor causing concerns (for individual performance reviews) as the 'doctor'.

3 Principles

3.1 One of the key objectives of the RCOG is to set standards to improve women's health. One way to achieve this is through the promotion of the highest standards of care for women accessing both obstetric and gynaecology services. Invited reviews provide an independent perspective where concerns are raised with regard to the standards of care being provided by an individual clinician or service, or where validation and advice on configuration of women's services is required.[7]

3.2 Issues of clinical governance, configuration, appraisal and revalidation, as well as legitimate public concern and awareness of healthcare performance, are resulting in an increasing number of requests for assistance from HCOs. The College recognises that it has a role to assist ROs and HCOs in these circumstances to:

- evaluate a service or individual's practice where concerns have been raised
- establish whether problems do exist and, if so, in which areas, and make recommendations to the HCO
- support HCOs in implementing standards
- provide a source of advice and 'signposting' for assistance where the College cannot itself directly respond to the request.

3.3 The RCOG acknowledges that, for individual clinicians, suspension or exclusion should be avoided wherever possible and that NCAS has a role in supporting early intervention to achieve this. (NCAS acts in England, Wales and Northern Ireland; in Scotland, refer to equivalent local arrangements.) In addition, in England, the *Restriction of Practice and Exclusion from Work Directions (2003)*[11] directs NHS bodies to comply with the framework contained within the document *Maintaining High Professional Standards in the Modern NHS*.[4] This document introduced a framework for the initial handling and investigation of concerns about the conduct and performance of medical and dental employees. It also introduced a

framework for restriction of practice and exclusion from work. The emphasis should be on rectifying causative issues and suggesting and supporting remediation. The College may be involved indirectly in remediation (through use of its competencies from the training curriculum or through signposting to supervision or peer coaching). The College is unlikely to have direct responsibility for designing and implementing a programme of remediation, but may liaise with NCAS if this is required.

3.4 RCOG assessors will act independently of other authorities and are able to offer advice and recommendations confidentially in an environment of trust. Where appropriate, however, the College will encourage dialogue by the RO or HCO with regulatory agencies and authorities such as those listed in Appendix 2 to ensure that the safety of women and their babies is paramount and that there is openness in identifying and addressing issues of concern. The RCOG encourages the sharing of the report with the CQC. The RCOG reserves the right in some circumstances to raise concerns directly with external regulatory agencies should obvious, serious and urgent issues of patient safety which are not being addressed become apparent. Occasionally, the College may be contacted by a member of staff concerned about either the clinical practice of a colleague or safety within a unit. In these circumstances, the RCOG personnel managing the process should discuss the matter with the Vice President, Clinical Quality to determine what advice should be given, or what action taken.

3.5 *Supporting Doctors to Provide Safer Healthcare* (2013)[12] suggests that 'Concerns about a doctor's practice can be separated into three categories: conduct, capability and health. There is often considerable overlap between these categories and concerns may arise from any combination or all three of these. An investigation will clarify the nature of the concern, confirm the facts, establish its severity and give an indication of the appropriate response.' Experience from NCAS suggests that behavioural concerns can cause problems even where the doctor remains clinically sound.[13] The RCOG review process does not undertake assessments of knowledge or direct observation of clinical practice, nor can it undertake occupational health or behavioural assessments which form part of the methodologies of NCAS and equivalent bodies.

3.6 An invited review undertaken by or on behalf of the RCOG can play an important part in evaluating concerns, protecting patient care and ensuring patient safety. It is not an accreditation visit or an audit review, which both require different methods of investigation. However, one outcome of an invited review may be a recommendation to formally undertake either of the above.

3.7 Each invited review will have its own specific terms of reference and will be unique. This guidance aims to inform ROs and HCOs how the RCOG can assist them and outline the process to ensure that each review is both robust and fair to all concerned, and that the terms of reference are designed to answer the questions and concerns raised. There is also guidance for assessors undertaking reviews, to ensure that they are supported through the process.

3.8 It is important that any review proceeds as swiftly as possible within its terms of reference to minimise any stress and expense to the doctor(s), their colleagues and the service involved.

3.9 Where possible, reviews will specifically consider the impact of current and proposed service arrangements on women and their families and on the quality of care experienced by them, established and gathered through meaningful and ethical means.

3.10 The RCOG will not disclose to the public or individual stakeholder any details of the review, or its involvement, without the permission of the RO, medical director or chief executive of the HCO, unless there is an overriding reason, such as urgent safety concerns where the regulator and/or commissioner must be notified. Such decisions, to disclose information to third parties without consent of the RO or HCO, must only be made by the RCOG Officers in consultation with the RCOG Chief Executive. It is, however, recognised that the reports may reach the public domain as part of a consultation or be disclosed under a Freedom of Information request and they will be drafted with due consideration of possible intentional or accidental publication. However, when an HCO requests a review that requires the expertise of a midwife, paediatrician, anaesthetist, etc., as well as the RCOG assessors, in the interests of transparency, the College may request that the report be shared with the appropriate Royal College, for example the Royal College of Midwives, the Royal College of Paediatrics and Child Health or the Royal College of Anaesthetists. The College may also consider it to be prudent, when planning a service review, to liaise with the appropriate Regional College Adviser, who may be able to provide insight into the context of the situation at a particular HCO.

3.11 Assessors will ensure that, during the review, all interviewees understand the confidential nature of the review but that their evidence will in most circumstances be used within the report, albeit in an unattributable way, and backed up by a number of other sources of information wherever possible.

3.12 Invited reviews will be carried out in accordance with the latest guidance, standards and recommendations from government, educational and regulatory authorities and, where a reference in this document has been superseded, the latest version stands.

4 Process – initial contact (see Appendix 1)

4.1 The initial request would usually come from an RO or the HCO's medical director or chief executive and be directed via the RCOG Director of Clinical Quality. A senior member of the Clinical Quality team and the RCOG Vice President, Clinical Quality will work together with the enquirer to determine the nature and extent of assistance required.

4.2 In the first instance, the College may only be asked for confidential advice as to whether a problem really exists, and this may comprise a short telephone or face-to-face discussion. Such approaches will be fully documented on a standard template and a record retained but may simply result in signposting to another agency, such as NCAS and/or a GMC ELA, and thus not fall into the formal review process. The Vice President decides with the Director of Clinical Quality whether the request is appropriate for an invited review or whether the RO or HCO should be directed to another relevant authority.

(a) For an *invited review*, the RCOG will deal directly with the HCO in terms of appointing assessors, liaising with them and providing a point of contact for information flows. The review is then College authorised. Assessors will have been recruited and selected according to an agreed RCOG job description, trained formally through a College-approved training programme, their details maintained on a register of assessors, and selected for each review based on the fit between their skill set, availability and location and the requirements of the review. Assessors will be suitably indemnified through the RCOG (see Appendix 5).

(b) Requests for clinicians to provide other services such as *second opinions* for HCOs will be dealt with on an individual basis. In some situations, an HCO may wish to seek a second opinion for a difficult case and want to go outside the local area – the College team may assist with this. Other situations, for example requests for expert witnesses who are asked by the court for their opinion on a case and paid for by the courts, would not at this time be managed by the RCOG but this will be reviewed periodically.

(c) Where the request is for a representative to *contribute to* a panel, short-term working group or project team on behalf of the RCOG, this will be handled by the Vice President and Director of Clinical Quality. They can identify the relevant expert member and link them where appropriate to other teams at the College, other Royal Colleges, the Care Quality Commission (CQC), etc. This process is outside the scope of this document.

4.3 Requests will usually be considered to be outside the scope of the RCOG invited review process where:

- conduct or capability procedures are to be instituted
- there are disputes concerning employment contracts and terms of service
- local disciplinary action is being taken (this does not include local decisions to restrict practice)
- external parties such as Counter Fraud Services in Scotland, NHS Protect in England and the police are already involved with the case
- the GMC or NCAS or equivalent are already involved in the review of an individual
- the issues relate solely to health, bullying at work, unlawful discrimination or harassment
- significant litigation is already in progress which relates to the doctor or the particular issues that are the subject of the review
- there are issues concerning allegations of misconduct (for example, theft, dishonesty, violence, threatening or abusive behaviour, disobedience, unauthorised absenteeism or being under the influence of alcohol or drugs)
- individual doctors who feel that they have difficulties in performance or relationships with colleagues approach the RCOG themselves; in such an event, the doctor will usually be encouraged to contact the British Medical Association (BMA), NCAS, the Medical Protection Society (MPS) or the Medical Defence Union (MDU) for advice.

4.4 If any of the above issues come to light during an invited review, the review should be completed in relation to its original remit but the assessors should point out that they cannot investigate or suggest solutions for what has come to light. The RO or HCO should undertake an investigation under existing internal or NHS mechanisms.

4.5 Throughout the initial phase, the RO or HCO has the opportunity (in confidence) to propose or reject (on the bases of conflicts of interest) individual assessors who meet the RCOG criteria to ensure that the review is objective and independent.

4.6 The criteria for initiating an individual performance review are diverse and HCOs should always ensure that internal processes such as ensuring adherence to requirements, compliance with contracts, clinical supervision and occupational health assessment have been attempted.

4.7 If issues of patient safety are raised at any time, the assessors may advise the RO or HCO to restrict the doctor's practice pending any review with reference to *Maintaining High Professional Standards in the Modern NHS*[4] (in England) and NCAS or equivalent.

4.8 The RCOG maintains good working relations with NCAS and the GMC and may discuss anonymously or specifically any issues relating to an individual doctor to establish that it is appropriate for the College to act in this capacity. Depending upon the issues under review, the College may recommend to a referring HCO that NCAS and/or the GMC is a more appropriate body to approach.

5 Process – the review (see flow chart in Appendix 1)

5.1 Once the Vice President has agreed for the College to proceed with an invited review, the RO or HCO is asked to:

- clearly define the issues requiring the review
- secure agreement from the chief executive, medical director and clinician or clinicians involved for a review to be undertaken (there are occasions when, to protect patients or as part of early planning, a visit might be necessary without the total support of the local consultant body)
- consider (in discussion with the Vice President) whether it is appropriate to involve other Royal Colleges, such as the Royal College of Midwives, the Royal College of Anaesthetists, the Royal College of Nursing or the Royal College of Paediatrics and Child Health
- agree the terms of reference and methodology of the proposed review in discussion with the College and the doctors concerned
- agree to the contractual terms, including indemnifying the assessors
- agree the fee proposal.

5.2 Once agreement has been reached to proceed with an invited review, the RCOG will identify and agree with the RO or HCO the names of the proposed assessors and a date for the review. Once the assessors have been agreed, the review should take place within eight weeks.

5.3 The invited review team will usually comprise two senior clinicians from an established list of individuals having the appropriate skills, qualifications and training to undertake the work required. One of these assessors will be appointed as the lead assessor and will always have had previous experience of conducting such reviews. In certain circumstances, there may also be an assessor representing another specialty such as nursing or midwifery should the terms of reference indicate the need.

5.4 Assessors are trained to:

- be objective and non-judgemental in gathering evidence
- aim to seek confirmation from more than one source and to record the sources of evidence
- look for evidence to substantiate or refute any criticisms or complaints made
- use evidence that relates only to the specific remit of the review
- base judgements on standards and statutory requirements where applicable.

5.5 Once the review has been agreed, the assessors will liaise with the HCO to arrange dates for the visit

5.6 To establish facts, and where concerns have been raised, the assessors will need to speak with a range of staff involved. Final details of the programme are agreed between the assessors and the RO or HCO depending upon the terms of reference, but interviewees may include:

- the chief executive
- the RO
- the medical director
- the clinical director or head of midwifery
- consultant obstetricians/gynaecologists
- other consultants, such as paediatricians, anaesthetists or radiologists
- trainees and/or staff, associate specialists and specialty grade doctors (SASGs)
- nurses, midwives, managers and nurse practitioners
- risk management coordinators
- directorate managers
- delivery suite coordinators
- clinical governance staff
- the Regional College Adviser
- the Head of School / Postgraduate Dean
- the commissioner, network or service planner
- patients and/or their representatives
- any other relevant individual.

If the invited review is to assess an individual's performance, the clinician will also need to be interviewed and should be given the opportunity to be accompanied by a friend or colleague (appendix 7)

It is important in most situations for the assessors to tour the facility in question as part of the visit, as this provides context and may help to provide confirmation of information contained in some statements.

5.7 It is the responsibility of the HCO to ensure that:

- a senior named member of staff (the designated HCO coordinator) has primary responsibility for coordinating the review and is available throughout the day(s) to assist the assessors and to ensure appropriate arrangements have been made
- all the supporting information requested is sent to the assessors at least two weeks before the review
- an agreed finalised programme, including names of interviewees and times, is sent to the assessors/RCOG at least two weeks before the review.

5.8 At the end of the review, the assessors should meet with the RO, medical director, chief executive or their nominee to:

- check the factual content of the information gleaned
- draw attention to anything that gives concern for patient safety.

5.9 The assessors will endeavour to finalise their views and plan their report at the end of the visit. The lead assessor will be responsible for finalising the written report (agreed by all the assessors) and will submit the report to the Director of Clinical Quality within four weeks of completion of the visit.

5.10 The final report will be an opinion of the assessors appointed by the RCOG. The College will check the content and format of the report before it is finalised and approved by the Vice President and Executive Director of Quality and Knowledge. It is expected that a draft report will be completed within a maximum of six weeks of the visit. If it is not completed within this timescale, the reasons for the delay will be discussed with the RO or HCO.

5.11 Where specialists from other professional disciplines, such as midwifery, are involved in the review, the process and timescale for sign-off, reporting and accountability will be agreed at the outset.

6 After the review visit

6.1 The final approved report will be sent by the RCOG in confidence to the nominated individual in the HCO, usually the RO, medical director or chief executive. It is expected that the entire report will be shared, except in the most exceptional circumstances, with the teams involved, and any other Royal Colleges involved in the review, but this is the decision of the RO, medical director or chief executive.

6.2 The possible outcomes of a review include:

- that there is no evidence to proceed further
- that concerns are justified, with recommendations to achieve correction
- that further evidence is required before making a decision as to how to progress
- in the interests of patient safety, a recommendation that consideration be given to limiting clinical practice of an individual or individuals until a full performance review has taken place
- that the RO or HCO should make referral(s) to NCAS or to the GMC.

6.3 The RCOG has no statutory authority to require action following an invited review and can only give recommendations and advice to an RO or HCO. Any action taken following an invited review is the responsibility of the requesting individual or organisation but, where concerns are raised over safety or staffing, the College would expect the regulatory authorities to be notified of the review and recommendations by the RO or HCO. If there is evidence that this has not happened, the RCOG reserves the right in exceptional circumstances to notify commissioning or regulatory authorities, such as CQC, directly.

6.4 Three to six months after the final report has been issued, the RCOG will contact the RO or HCO to discuss the outcome of the review visit and whether the suggested recommendations have been implemented. Feedback will also be sought in confidence on the conduct of the review to assist in continuous improvement of the service. Where appropriate, the Vice President will discuss this feedback in confidence with relevant individual assessors.

6.5 If the RCOG deems that actions taken in response to recommendations are insufficient, the Vice President, Clinical Quality, in conjunction with College Officers and the Chief Executive, may authorise further steps to address concerns. This may include reporting the findings to the appropriate regulatory authority

7 Records retention

7.1 All records relating to an invited review will be stored in a filing structure with a logical agreed naming convention.

7.2 All records will be retained in their original format to ensure their authenticity and integrity.

7.3 The RCOG will maintain records of invited reviews in line with data protection (and other relevant) legislation and following the advice provided to it by its legal advisers as appropriate.

8 Additional information for assessors

Planning a review visit

8.1 It is the responsibility of the lead assessor, in liaison with the RCOG Clinical Quality team and co-assessor(s), to organise the review visit. Important steps are listed below.

- A clear description of the problem to be investigated should be obtained before proceeding.
- A pre-review discussion should take place between the assessors and the Clinical Quality team, to agree an organisational plan and to review the methodology.
- The terms of reference should receive careful consideration and need to be agreed with the RO or HCO and the doctor under review before the commencement of the review visit (with College input).
- The earliest mutually convenient date should be agreed and the duration of the review visit determined, recognising that those in active NHS practice will have to give adequate notice to their own departments and employers (at present at least six weeks' notice to allow clinics, theatre lists and so on to be cancelled or rescheduled). An invited review visit normally lasts for two to three days.

- The assessors should identify what documentation and other information they will require. The RO or HCO should ensure that all information is available to the assessors well before the review visit so that they have adequate time to digest it before interviews commence. This includes any deposition by the doctor being reviewed.
- Clinical case notes (index and other selected cases) will only be available in the hospital during the visit.
- The assessors should keep the RCOG Clinical Quality team aware of progress throughout the planning of the review.

Documentation

8.2 The documentation required will vary depending on the nature of each review. However, a standard package of information should be encouraged and should form part of the RO or HCO's deposition. It should include comparative information for all members of the department where relevant.

8.3 *For individual performance reviews*, this may include:

- job plans, job descriptions, CVs, personal development plans, records of continuing professional development and appraisal records
- records of any previous reviews in the last five years
- audit data (such as returns to theatre within 24 hours and unscheduled admissions to intensive care or high dependency)
- blood transfusion rates during or following surgery
- case mix and referral pattern information
- length of stay and readmission rates
- comparative records of complaints, litigation records and incident reports
- workload statistics.

8.4 *For service reviews*, the information requested may include:

- management structure and overview
- information regarding services in the hospital
- relevant protocols of clinical care
- strategic documents and action plans
- guidelines for clinical practice produced by specialist societies which specify appropriately qualified staffing and equipment for the effective functioning of the specialty service.

8.5 These lists are not exhaustive and other documentation may be considered appropriate for inclusion by the lead assessor.

Case note review (for individual performance reviews only)

8.6 The lead assessor should request a random selection of about 20 case notes for review. These should be considered in addition to any index notes which may relate to specific cases already identified. The cases chosen should cover the breadth of the doctor's work practice and should be taken from an appropriate time frame.

Summary of cases

8.7 A brief summary of each case reviewed should be entered onto the case record pro forma (see Appendix 9; for example, 'a 49-year-old nulliparous woman presented with postmenopausal bleeding').

8.8 The records should be checked to ensure that the doctor was indeed involved in the care of the patient and that his or her level of involvement is accurately reflected. One assessor should review each randomly selected case record and complete the pro forma. However, all review team members should review the index cases forming part of any complaint, and independently complete the pro forma. The assessors should identify aspects of the clinical care and any surgical procedure undertaken which represent any satisfactory as well as unsatisfactory aspects of care, to provide a balanced overview, and come to a conclusion overall that the care was:

- entirely satisfactory
- satisfactory with room for improvement
- unsatisfactory (major concerns – reasons to be stated).

Anonymisation of cases

8.9 The information gained from the case note reviews will help to inform the overall review process. An overview will be included within the final report with patient data identified only by a case note review number (CN1, CN2, etc.). A list of the cases would be included in an appendix of the report. Assessors' written pro forma records must be kept and returned to the RCOG for safe keeping once the report has been finalised. These may be important in the event of an appeal or as evidence if the doctor is referred on elsewhere for assessment (for example, to the GMC or NCAS).

Other documentation

8.10 ROs and HCOs should make every effort to ensure that information required by the assessors is supplied in advance of the invited review visit and they will not normally be able to consider information given to them during the visit. Exceptionally, additional information that may significantly influence the assessors' conclusions may be considered during the visit. Copies of such information should also be given to the doctor before the final interview and he or she should be given the opportunity to comment. A list of documentation received and reviewed (for example, audit data, clinical governance reports, adverse incident reports and referral/workload figures) should be included and the information referred to in the final report. All of this documentation in a physical form (for example paper copies, memory sticks and mobile electronic media) must be returned to the RCOG for appropriate processing. If this documentation has been received from the HCO electronically, it must be fully deleted from all systems.

The interviews

Interviewing the doctor (for individual performance reviews only)

8.11 The doctor should be interviewed at the beginning and again at the end of the invited review visit. The initial interview will allow the doctor to explain his or her perception of the problems under consideration and will help to provide context for the information that will be received during the review visit. The lead assessor makes the introductions. The doctor will have been given general information beforehand but the lead assessor should check that this information has been received and reiterate very briefly the purpose of the review.

8.12 Every effort should be made to put the doctor at ease and help him or her to understand that this is a fact-finding exercise and not a 'witch-hunt'. The final interview gives an opportunity for the assessors to explain the information they have received and allows the doctor to challenge any aspects of it. They may wish to outline their overall conclusions unless more information is required to reach a final conclusion. In any event, care should be taken not to be too specific at this point.

Third party interviews

8.13 A list of those to be interviewed should be prepared and the doctor under review should be given the opportunity to add names to it. The interviewees should be chosen for their ability to contribute to the review of the doctor's performance and should not simply be character witnesses. The HCO should ensure all key witnesses will be available before the date of the review visit is finalised. The timing of interviews and programme for the day should be agreed, with adequate time built in to consider the information received. Between 11 and 13 third party interviews should be conducted (including three chosen by the doctor).

8.14 Potential interviewees may include:

- the chief executive
- the medical director
- the clinical or service director for obstetrics and gynaecology
- consultant obstetricians and gynaecologists
- other consultants, such as anaesthetists and paediatricians
- junior staff
- nurses, midwives, managers and nurse practitioners
- risk management coordinators
- directorate managers
- clinical governance staff
- GPs
- the Regional College Adviser
- the Postgraduate Dean/ Head of School

8.15 This list is not exhaustive and, depending on the circumstances, not all the above would need to be interviewed. Written or telephone evidence may be considered if planned interviewees are suddenly unavailable.

8.16 The assessors should check that the facilities for the interviews are satisfactory and as private as possible. There should be a designated HCO coordinator as the assessors' liaison point and this individual should be senior enough to ensure that their requirements are met.

8.17 The doctor and any of those interviewed may wish to be accompanied by a friend or colleague for support. This is acceptable, but it is not anticipated that this person would actively participate in the interviews.

8.18 The following is suggested:

- The interview room should be arranged so as to set individuals at ease.
- Allow 25–30 minutes for each interview. This will vary a little depending on the individual interviewee but a generous allowance of time should be made. Allow five minutes between interviews for reflection on the information received and for clarifying notes. Leave some slots for second interviews.
- Make sure there are suitable breaks for refreshments, and so on – again, the time can be well used in digesting information received.
- See the doctor under review and the medical/clinical director at the beginning and at the end.
- Use the designated HCO coordinator to ensure that interviewees arrive on time and that, if the schedule is running late, they are kept informed so that they have no undue waiting time. It is usually more convenient and less formal for one of the assessors to call in the interviewees.

Interview structure

8.19 The lead assessor should make the introductions and thank the interviewees. The interviewee will have been given general information beforehand but the lead assessor should check that this information has been received and reiterate very briefly the purpose of the review.

8.20 Questioning should be alternated between the assessors, with the other assessor(s) recording notes of information received on the structured form (Appendix 10 or 11, as appropriate). Use closed questions to confirm understanding. Separate opinion from fact: ask for examples. Beware of the 'witch-hunt' – no one is perfect. Secondary questions may be necessary to gain specific information.

8.21 At the end of the interview, summarise what you believe the individual has said to ensure agreement on the interpretation of their statements.

8.22 Dos and Don'ts:

- Do actively listen.
- Do consider the level/job role of the interviewee.
- Do remain focused.
- Do consider depth versus breadth.
- Don't make judgements yet.
- Don't relate your own experiences.
- In taking evidence, only accept direct observations of fact and disregard hearsay and opinion.
- Adhere to the timetable for the day.

8.23 After the interviews:

- Consider whether enough information has been provided.
- Are the concerns made valid?
- Separate organisational failings from individual ones.
- How can any failings be addressed?
- Make recommendations in your report.

Storage of documents

8.24 Your interview record forms and other relevant copies of all documentation (except patient case records) should be returned to the RCOG for safe keeping, once the report has been finalised.

Verbal feedback

8.25 In the case of individual performance reviews, the doctor undergoing review will probably be anxious to get the assessors' opinion and seek their views before they depart. The verbal feedback at the end of the review visit will allow the assessors to provide a brief overview of the preliminary findings but at this point feedback should be kept in general terms and not be specific. For service reviews, it may be helpful to arrange a final group meeting with all staff, so as to avoid 'mixed messages'. It should be explained that further discussion and documentation will be required before a final decision on the findings can be given, in the written report.

8.26 The same approach should be adopted when meeting the lead representative from the HCO at the end of the review (RO, clinical director, medical director, etc.).

Report writing

8.27 The final written report will be the opinion of the assessors appointed by the RCOG.

8.28 It is necessary to leave enough time at the end of the review visit for the assessors to discuss the general conclusions and the recommendations of their report. The lead assessor then drafts the report and it is refined by discussion among all of the assessors.

Format

8.29 The format of the report should include paragraph numbering and should be broadly as follows:

1 Introduction.
2 Names of assessors and the HCO.
3 Details of the individual requesting assistance and the reason for the request.
4 Terms of reference.
5 Chronology of events.
6 Context: simple summary of unit/demographics/workload, etc.
7 Description of the review process and sites visited, if relevant.
8 List of all documentation studied, before and during the visit (for example, case notes, complaints, audit, etc., which may be attached as appendices if specified). Patient details must be anonymised (CN1, CN2, etc.) and a list of relevant cases included at the end in an appendix.

9 List of interviewees, including a list of those not seen but who should have been seen, and reasons why not seen.

10 Statements from individuals who could not attend but wished to or were invited to contribute. Records of any telephone evidence.

11 Findings (statement of problem): clinical difficulties, relationships with colleagues, other staff or patients, professional attitude, lack of insight, poor communication or clinical governance within teams. Validate findings by examples.

12 Critical appraisal of evidence: identifying both good and poor practice to give a balanced overview.

13 Conclusions: also state whether the terms of reference have been met and whether they were appropriate.

14 Recommendations:

- specific – for example, need for attendance at specific courses to improve competencies, communication skills, etc.
- general – for example, problems within the unit, lack of resources, etc.
- further enquiries required (if relevant).

15 References/appendices.

16 The final report to be signed and dated by all the assessors.

Timing of the report

8.30 A timescale for the completion of the report should be agreed with the RO or HCO. This should be realistic and take into account that in practice, for confidentiality and other reasons, it is often the assessors themselves who type the report and that invariably a number of drafts will be required. However, it is expected that a draft report would be submitted to the RCOG within six weeks of the visit and a finalised report sent by the College to the RO or HCO within a further fortnight of receipt of the draft report. The assessors should agree in advance with the RO or HCO if a longer timescale is required.

Sending the report

8.31 The report must first be submitted to the College. The College will check the content and format of the report before it is finalised and approved by the Vice President and the Executive Director of Quality and Knowledge.

Discrimination

Unlawful discrimination

8.32 The RCOG's commitment to equality of opportunity acknowledges its legal obligations and social responsibility to provide a culture and environment in which unlawful discrimination, harassment and victimisation are unacceptable. Recognition of equality of opportunity allows the College and those with whom it comes into contact to meet its stated objectives of improving women's health.

8.33 The College and the assessors could be held liable for acts of unlawful discrimination that the assessors may commit during the course of an invited review. Assessors should therefore be familiar with the legal framework that protects applicants, employees and contract workers, among others, against unlawful discrimination on account of their race, religion or belief, disability, age, sexual orientation, gender reassignment, or part-time/fixed-term status.

Assessors' responsibilities

8.34 If any assessor believes during the course of an invited review that they may have acted in any way that amounts to unlawful discrimination or acted in a way that may have caused an individual to believe they have been victimised or subjected to harassment, or any complaint is received by the RCOG that an assessor has acted in such a way, then the assessor should take no further steps in the review pending further instructions from the College. The College may need to seek specialist advice and may in the particular circumstances require the assessor to withdraw from the review and appoint a substitute assessor, or, if this is not possible, abandon the invited review and appoint a new team of assessors.

8.35 The assessor should be prepared to offer an immediate apology to the individual under review if this is considered appropriate by the RCOG.

8.36 All assessors have a responsibility to ensure that those with whom they come into contact during the course of an invited review do not act in any way that would amount to unlawful discrimination. If they have concerns about the conduct of a fellow assessor who they believe to have acted in a way that amounts to unlawful discrimination, victimisation or harassment they should immediately report this to the College and in the case of others employed by the HCO or who provide services to the HCO they should report their concerns to the HCO's chief executive or medical director.

Honoraria

8.37 The RCOG recognises that a great deal of time is spent by the assessors outside normal working hours in preparing for the review visit and compiling the report afterwards. The principle that HCOs that request reviews should remunerate the assessors appropriately is therefore accepted.

8.38 Monetary payment can only partly recompense this time and effort but participating in an invited review provides some satisfaction to individuals both from helping the College in its work and assisting fellow obstetricians and gynaecologists to resolve problems within their units.

8.39 It is hoped that the time taken away from clinical duties to undertake a review will be recognised as contributing to the wider benefit of the NHS in a similar way that work on committees or for examinations is recognised. However, some assessors' HCOs may seek payment from the requesting HCO or may insist that individuals take special or annual leave. It is expected that, if this does occur, the requesting organisation would be asked to pay the assessor's employing organisation directly.

References

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2 *The Medical Profession (Responsible Officers) Regulations 2010*. Statutory Instruments 2010 No. 2841 [www.legislation.gov.uk/uksi/2010/2841/made].

3 Department of Health. *Maintaining High Professional Standards in the Modern NHS* [http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4103586].

4 NHS Scotland. Standards for the Healthcare Workforce. Performance Management of Healthcare workers. *Staff Governance* [www.healthworkerstandards.scot.nhs.uk/pages/PerfmanInd.htm].

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7 Royal College of Obstetricians and Gynaecologists, Royal College of Midwives, Royal College of Anaesthetists and Royal College of Paediatrics and Child Health. *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour*. London: RCOG Press; 2007 [https://www.rcog.org.uk/globalassets/documents/guidelines/wprsaferchildbirthreport2007.pdf].

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11 NHS Revalidation Support Team. *Supporting Doctors to Provide Safer Healthcare: Responding To Concerns About a Doctor's Practice*. 2013 [http://www.gmc-uk.org/static/documents/content/RST3.pdf].

12 NHS National Clinical Assessment Service (NCAS). *Handling Concerns About a Practitioner's Behaviour and Conduct: An NCAS Good Practice Guide*. NCAS; 2012 [www.ncas.nhs.uk/EasySiteWeb/GatewayLink.aspx?alId=131717].

13 Care Quality Commission. *Regulation for Service Providers and Managers* Guidance about Compliance. London: CQC; 2015 [http://www.cqc.org.uk/content/regulations-service-providers-and-managers].

14 General Medical Council. *Good Medical Practice*. GMC; 2013 [http://www.gmc-uk.org/static/documents/content/Good_medical_practice_-_English_0914.pdf].

15 NHS National Clinical Assessment Service (NCAS). *The Back on Track Framework for Further Training: Restoring Practitioners to Safe and Valued Practice* [www.ncas.nhs.uk/resources/good-practice-guides/back-on-track].

16 Whistleblowing Helpline: wbhelpline.org.uk.

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