Royal College of Physicians

# Invited reviews

## Guidance for healthcare organisations

Updated December 2024

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# Purpose of this document

This document contains guidance for healthcare organisations commissioning invited reviews. It describes the processes involved when the Royal College of Physicians (RCP) is undertaking an invited review for a healthcare organisation. This document is subject to an annual review.

# Introduction and background

Everything that we do at the RCP aims to provide the highest standards of patient care at all times.

The Invited Reviews Service was formed in 1998 and offers consultancy services to healthcare organisations which require independent and external advice and support. Reviews provide an opportunity to healthcare organisations to deal with issues and concerns at an early stage. The issues considered in reviews include:

- clinical practices and the delivery of care
- patient safety concerns
- increased mortality / 'red flags' in national data
- concerns around adherence to national guidelines
- workload and capacity issues
- individual behaviours/team working
- governance
- patient/family complaints/concerns
- service design.

Medical directors (MDs) or chief executive officers (CEOs) of healthcare organisations can request an invited review when they feel the practice of clinical medicine is compromised and there are potential concerns over patient safety. They may also request a review where there are no such concerns, to seek an external view on how best to design or develop a service. Fellows and members of the RCP may request an invited review, subject to agreement with their trust/health board management.

By dealing with problems at an early stage and seeking external expertise, healthcare organisations can demonstrate a proactive and open approach to reviewing concerns and service development. This may help to reassure regulators such as the Care Quality Commission (CQC), General Medical Council (GMC), Healthcare Inspectorate Wales (HIW), Regulation and Quality Improvement Authority (RQIA) or Healthcare Improvement Scotland (HIS). It may also help establish whether concerns have reached the threshold of involvement of the regulator.

By the nature of the issues involved, each invited review is unique. We wish to ensure that the reviews are open and fair to all. The RCP Invited Reviews Service aligns to the Academy of Medical Royal Colleges (AoMRC) framework of operating principles for managing invited reviews within healthcare. This guide is designed to inform and assist all those involved in the review process.

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# Types of invited reviews

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

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# When is an invited review inappropriate?

The invited reviews team are available for a preliminary discussion, which will indicate at the outset whether the RCP will be able to offer assistance. There are however some circumstances when an invited review may not be appropriate. For example:

- Where there are disputes concerning contracts and terms of service.
- When the GMC, CQC or Practitioner Performance Advice (PPA) are already undertaking an active investigation.
- When the Parliamentary and Health Service Ombudsman has undertaken a review.
- Where it is judged that concerns about an individual physician's competence or behaviour are so serious that the matter should be taken directly to the GMC.
- When litigation is already in progress.

# Indemnity

The healthcare organisation commissioning the invited review is required to indemnify the RCP, the specialist society/association, and members of the review team by signing a Deed of Indemnity (DoI). A review cannot take place until a signed copy of the DoI has been received by the RCP.

# Review conditions

In addition to the requirements and completion of the DoI, there are terms and conditions that are required for the review to proceed. By completing a request proforma and commissioning an invited review, it is understood that:

- **Review acceptance:** The executive management of the healthcare organisation agree to the invited review taking place.
- **Transparency:** All of those directly involved will be informed by the healthcare organisation that an invited review is taking place. The agreed terms of reference will be shared with, for example, the consultant physicians within the unit being reviewed, or the individual physician being reviewed in the case of an individual or clinical record review. Staff who are asked to attend interviews should be fully informed in advance regarding the purpose of and the arrangements for the invited review.
- **Review outcomes:** Any action taken following an invited review is the responsibility of the healthcare organisation. The RCP, the specialist societies/associations and/or the reviewers reserve the right to disclose to a regulatory body the results of any investigation and/or any advice or recommendation made to the healthcare organisation as part of the review. This may be to the GMC, the CQC or any other appropriate recipient. Such disclosures will be made in the public interest (but still in confidence).
- **Information sharing:** The primary responsibility for sharing information about an invited review resides with the healthcare organisation. However, if the RCP is asked to confirm (by regulators) if a review has taken place it will do so. In such circumstances the RCP will support the requesting healthcare organisation to be open about the circumstances of the review that has taken place. The RCP expects the executive management to share the final report with those who were interviewed and willingly provided information to the review team.

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- **Data protection:** Throughout the invited review process, all information that is created, stored and received in exchange between the RCP and the healthcare organisation must comply with obligations and confidence under the Data Protection Act 2018 and NHS Code of Confidentiality.
- **Payment:** The RCP will send an invoice to the healthcare organisation for payment of the invited review fee. This must be paid in full prior to the delivery of the final report. In addition to the invited review fee, the healthcare organisation is required to pay the accommodation, subsistence and travel expenses of the review team.
- **Feedback:** When the RCP makes a request for feedback on recommendations, the commissioning organisation will provide the RCP with an updated action plan or complete the progress form in timely manner and ideally within the timeframe specified (usually 1 month).

# Governance

RCP invited reviews are overseen by the Invited Reviews Oversight Group, which is made up of the medical director (MD) and deputy MDs for Invited Reviews and senior college representatives of the RCP to include the RCP registrar. The group meets twice a year to discuss learning and experience from invited reviews, and any feedback which supports the improvement and development of the service. The college representatives also provide advice on the handling of reviews, and support to the MD.

Members of the Oversight Group and relevant specialty association representatives' will quality assure all invited review reports.

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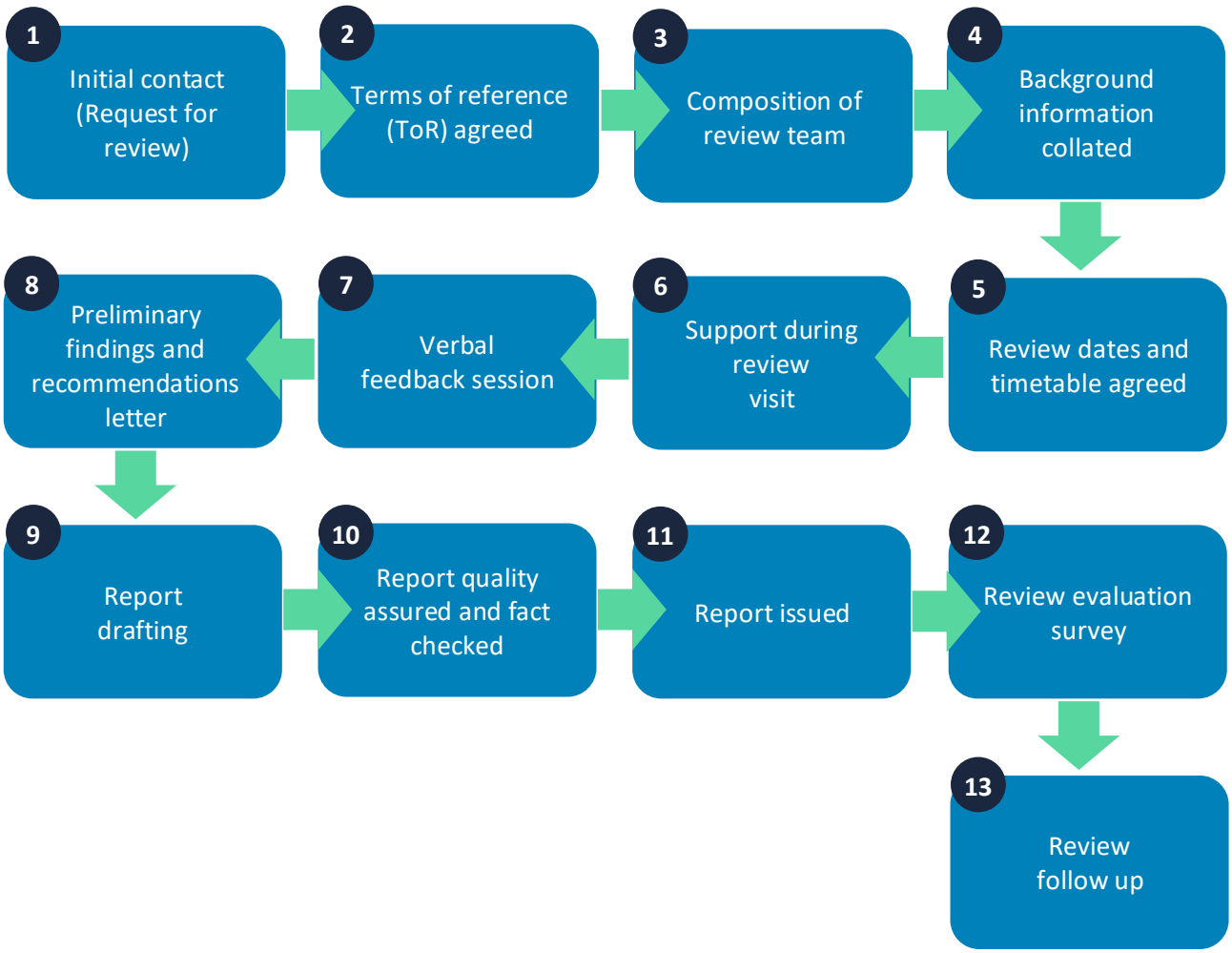
# Review process for service and individual reviews

## Overview

The graphic below shows each of the stages of a standard service or individual review.




Find out more about each of the above stages in more detail on the following pages. If the review includes a clinical record review, this will follow the process outlined here.

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# 1. Initial contact

Formal requests should be made by the MD/CEO by completing the appropriate RCP invited review proforma (available on request). The completed form should then be emailed to the invited reviews team at invitedreviews@rcp.ac.uk. Once a request has been received the invited reviews team will arrange for a preliminary telephone call between the healthcare organisation, the MD/deputy MD of invited reviews and the invited reviews team.

The initial telephone discussion will enable the RCP invited reviews MD/deputy MD to understand the scope of the issue and to give a decision as to whether the RCP is able to provide assistance.

The invited reviews team will liaise with the relevant specialist society/association to nominate suitable reviewers to undertake the review.

# 2. Terms of reference (ToR)

When an invited review is considered appropriate and the RCP can offer assistance, the ToR setting out the scope of the review will be jointly agreed between the RCP and the MD/CEO of the healthcare organisation.

In advance of the review visit, the commissioning organisation should share the ToR and guidance for interviewees (available separately) with the consultant physician(s) working within the service and all of those staff who will be interviewed as part of the review.

In an individual review the consultant physician under review will be asked to confirm in writing to their MD/CEO that they agree to participate in the review and that they have been fully informed by the healthcare organisation of its purpose and arrangements. This correspondence should also be copied to the RCP for information.

The review team will adhere to the ToR throughout the review visit. However, if during the visit the review team finds a new area of concern outside the ToR, it may be necessary to share these with the healthcare organisation where there is the potential to impact on patient care. The commissioning organisation may wish to consider whether a separate review visit is necessary at a later date.

# 3. Composition of the review team

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

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# 4. Background documentation

When agreeing the ToR the RCP will include a list of background documentation (and possible collation of clinical records) relevant to the ToR. The healthcare organisation will be asked to nominate a local coordinator to collate this information. The invited review manager will, however, ensure that appropriate support and guidance is offered to them and will be available to answer any questions. Please see Appendix A for a general list of documentation to collate prior to the invited review. This list is not exhaustive as additional specialty-specific information may be added to this and the healthcare organisation may also provide any other information deemed relevant to addressing the terms of reference of the review. The reviewers can also request further additional documentation where appropriate; however, this will be communicated to your healthcare organisation in advance of the visit.

We appreciate that not all the information requested by us may be available. However, it is our expectation that as much of the information as possible is collated for the review team. Therefore, it is important that a senior member of the relevant specialty department is contacted for assistance with locating the relevant information. Please be sure to make a note of any information that cannot be provided to the review team on the list of information document, detailing the reasons why.

The MD/CEO of the healthcare organisation should make available the documents required and these should be collated and sent to the invited reviews team as soon as possible but at the very least 3 weeks prior to the review taking place. Failure to send the documentation within sufficient time could result in the postponement of the review visit. All documentation should be sent by secure means in a way that ensures your organisation meets its patient confidentiality and data protection responsibilities. Information can be sent electronically using our secure file server. The invited reviews team will provide you with guidance for uploading documents.

For an individual review a copy of the documentation should be sent to the clinician under review. With service reviews one copy of all the documentation should be held centrally at the healthcare organisation and this should be made accessible to the members of the department should they wish to examine it. This includes a copy of any clinical records sent to the RCP (if applicable).

All background information relating to the review that is created, received, stored or exchanged must comply and adhere at all times with the Data Protection Act 2018, information governance principles and NHS Code of Confidentiality including dealing with any confidential and personal information.

## Patient identifiable data

Any information identifying patients provided should, so far as possible, be anonymised. Specific guidance on how to collate and send the patient medical record(s) will be provided. If it is not possible to anonymise/redact information the healthcare organisation should ensure that:

- patient confidentiality is maintained to the maximum extent possible and/or any necessary specific patient consent has been obtained
- any obligations (either for the organisation or the individual consultant physician) as data controller in any applicable case under the Data Protection Act 2018 have been considered.

The healthcare organisation may wish to seek advice from their Caldicott Guardian or legal advisers where appropriate on this issue.

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# 5. Review dates and timetable

Once the review dates are confirmed the RCP will provide a template timetable (Appendix B) of interviews for the review visit. The invited reviews manager will also arrange a meeting with the healthcare organisation coordinator to discuss requirements and logistics for the review days. The healthcare organisation should ensure that the key individuals, ie executive senior management, specialists, nurses, and resident doctors who work within the specialty service, are available for interview. Please see Appendix C for a list of potential interviewees we usually request to be included on the schedule. The healthcare organisation should provide a draft timetable for review by the RCP at least 2 weeks prior to the review visit.

Interviews normally last between 30 and 45 minutes, or 45 minutes to 1 hour for the key interviewees most relevant to addressing the terms of reference ie consultant physicians.

For service and individual reviews, the first interview should be with the MD and/or CEO (and appropriate members of the senior management team). They will welcome the review team on the first day and provide the review team with a summary of the events leading up to the review. The same group will also need to be available on the last session of the last day for the verbal feedback.

For individual reviews the consultant physician subject to the review should be scheduled at least a 1-hour slot for their interview. If a clinical record review forms part of the individual review the consultant's interview should be extended to 1½ hours in order to allow for time for discussion of these cases. Please schedule the interview with the consultant physician being reviewed to follow the interview with the MD and/or CEO. The consultant physician being reviewed may be accompanied and assisted by a third party (who may be a friend, colleague, medical defence society representative, British Medical Association (BMA) representative or legal representative) during the review. The identity of the person accompanying and their relationship to the consultant physician must be advised to both the healthcare organisation and review team in advance of the review. Verbal feedback will also be provided to the clinician subject to the review at the end of the visit (prior to the feedback given to executive management).

Some interviewees, for example resident doctors and nurses, may be interviewed in small groups of ideally no more than four people. In these instances, we ask that you first check with the interviewees that they are happy to be interviewed in a group setting. If this is not agreed upon then those requesting an individual slot will need to be scheduled separately. If an interviewee is unavailable, they may submit a written statement for the review team. All statements should be received prior to the end of the review teams' visit. The information for interviewees guidance document (available separately) provides further information on the interviewing process.

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# 6. Support prior to and during the review visit (service and individual)

We ask that the contact details of the key point of contact (or other suitable nominated individual) are provided to the review manager, should there be any queries relating to the programme or any additional supporting documentation required by the review team during the course of the review. A checklist of actions required prior to the review visit is available in Appendix D.

## Hotel (in-person reviews)

The invited reviews team will organise the hotel accommodation and evening meals (and meeting room, if required) and provide the healthcare organisation with the venue details in order to arrange taxis to and from the hospital. The cost of hotel accommodation and any subsistence is paid for by the healthcare organisation and will be included in the final invoice.

## Catering (in-person reviews)

The review team should be kept refreshed during the visit with tea, coffee, water and lunch. Additional water and cups should be supplied for the interviewees. The invited reviews team will inform the healthcare organisation if any of the review team members have special dietary requirements.

## Interview room (in-person/virtual reviews)

The healthcare organisation will need to book a private meeting room for all days of the review visit. It is important that the room for the interviews is large enough to accommodate the review team plus interviewees, who may attend in groups of up to four people. A room suitable for about 10 people should be sufficient. The healthcare organisation must ensure that there is a waiting room or area for the interviewees. This should not be directly outside of the interview room but nearby. The room will need to have power sockets for those review team members using laptops or video conferencing capability for virtual reviews. Wifi access and teleconferencing capability is also required during the review visit. It is recommended that someone to provide audio visual (AV) support is available during the days of the visits and that the technology is tested with the invited review manager a few days before the visit.

## Car parking (in-person reviews)

Some of the reviewers may choose to drive to the review so it is helpful to know whether there is parking available at the interview site.

# 7. Verbal feedback session

The chair of the invited review leads the verbal feedback session, and the findings and recommendations of the review team will follow in the written report. The chair will provide a brief overview of the review team's preliminary findings, clarify any factual points and request any additional documentation, and explain what will happen after the review.

It is important for appropriate personnel from the senior leadership team of the healthcare organisation to attend the feedback session.

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# 8. Preliminary letter/patient safety concerns

Following the completion of an invited review visit and prior to the delivery of the written report, the RCP will send a letter to the MD/CEO of the healthcare organisation outlining any preliminary findings and highlighting any areas for urgent attention surrounding patient safety concerns. The RCP will make recommendations to the organisation of any immediate actions that should be undertaken (if applicable).

In an individual review, if the review team identify any circumstances where an individual consultant physician's performance is unsatisfactory and patient safety may be at risk, appropriate recommendations will be made in their report for consideration and action by the healthcare organisation commissioning the review. Where the matter concerned is urgent, immediate advice will be provided to the MD of the healthcare organisation (or their nominated deputy) at the conclusion of the invited review visit. This advice will then be confirmed in writing by letter prior to the review team's production of their report, so that the healthcare organisation can take any recommended action as necessary to protect patients, staff, or in some circumstances the consultant physician(s) themselves.

Where a report recommends that the healthcare organisation involve another advisory or regulatory body, eg CQC, GMC, HIW, HIS or RQIA, the invited reviews team will follow up to confirm this has been done by the healthcare organisation. Alternatively, if the appropriate action has not been taken in a timely way, the draft report may be shared, in confidence, by the RCP with the relevant body to ensure the feasibility of the recommendation.

# 9. Drafting the written report

Following the completion of the review visit, the RCP will inform the healthcare organisation when they are likely to receive the final report. On occasion there maybe a delay to finalisation of the review report due to the complexity of the matters reviewed, and/or quality assurance and factual checking processes. The RCP will keep the healthcare organisation informed of progress.

The background documentation (information provided by the healthcare organisation and/or patient medical records for clinical record reviews) and information gathered from consultant physicians and other interviews will be relied upon in the writing of the report and addressing the ToR. While the final report will not attribute comments to interviewees, due to the nature of the issues it may be possible to identify the source of information in the report. When the review team is making judgements about standards of clinical care, or behaviour, these will be referenced to published standards documents within the specialty concerned, whenever possible. Where these do not exist, or the issues are more general, documents such as the GMC's Good Medical Practice will be referenced.

If it is suggested that key individuals working within the service have not had the opportunity to see all the documentation provided to the review team the RCP will contact the healthcare organisation to ask them to confirm that all documentation has been shared. An exception to this is any statements shared with the review team in the absence of an interview slot being available to them. Any comments made by the interviewees as part of this process will be considered by the review team as part of their process of finalising the report. The findings and conclusions of the report will be the independent, external opinion of the RCP. Where there are conclusions of a controversial or critical nature; legal advice may be required.

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## Recommendations

Invited reviews are not regarded as a replacement for, or negation of, the healthcare organisation's disciplinary procedures and own decision making. The review team comments on the resources and facilities that enable physicians to deliver safe care for their patients. In a clinical record review, the review team analyses and makes judgements based on the information in the patient medical records, and provides a perspective on the overall quality of care provided to the patient(s). The RCP has no statutory authority to implement actions following a review visit and can only give advice and recommendations for consideration – it is for the healthcare organisation to decide on the most appropriate action. It must be emphasised that any action taken following an invited review is the responsibility of the healthcare organisation.

However, if a serious concern has been highlighted and no action is taken by the healthcare organisation it is open to the RCP review team to inform the relevant regulator such as the GMC or CQC in accordance with their own responsibilities as registered medical practitioners.

In some cases, it may be advisable for the healthcare organisation's legal advisers to review the report before acting upon the recommendations.

Examples of advice or recommendations that may be given are:

- restructure of services
- realignment of responsibilities
- reorganisation of working practices
- recommendations for new appointments or resources
- recommendations for a detailed audit of clinical practice and outcome.
- recommendation for retraining of a physician
- a physician considered not fit to practise and the healthcare organisation should seek advice from the GMC or PPA.

# 10. Quality assurance and fact checking of the written report

Draft reports are quality assured internally by members of the Invited Reviews Oversight Group, the specialist society, and a lay reviewer and if necessary, reviewed by legal advisers. The RCP will then send the draft report to the MD/CEO of the healthcare organisation for correction of matters of fact. Draft reports are to be considered as confidential between RCP and the healthcare organisation and so are not for publication or disclosure.

To ensure that the review has been carried out in a fair and open manner, the RCP will write to the MD/CEO of the healthcare organisation to confirm that the report is 'factually correct'. Healthcare organisations will only be able to provide challenge to matters of fact (ie statistics, organisation structure, names of interviewees, documentation list etc). Comments from interviewees or the review team's overall conclusions and recommendations cannot be challenged by the healthcare organisation but consideration will be given by the review team as to whether any alterations are required to these conclusions and recommendations based on corrections made to factual elements.

In an individual review both the consultant physician under review and the healthcare organisation commissioning the review will be asked to confirm that the review report is factually correct and that they are clear about the documentation relied upon by the review team and the personnel that have been interviewed.

# 11. Written report issued

Following any corrections of fact, the final report is issued and becomes an official opinion of the RCP, and it is for the healthcare organisation to decide how the report should be used and who should see it. However, the RCP expects that the report will be shared with those who were interviewed and willingly provided information to the review team (consultant physician(s) and the patient(s) and their family in the instance of a single clinical record review). In due course a doctor or team will have the right to see the whole report, particularly if they decide to appeal or take the results and decisions to, for example, an industrial tribunal.

## Confidentiality, records handling and retention

All documents relating to the review remain the property of the commissioning healthcare organisation. The RCP will retain documentation of the review for four years following completion. Some records may be kept for longer for legal and service improvement reasons (signed deeds of indemnity, review follow up information). Reviewers will return or securely dispose of all information received in relation to the review as soon as the final report is completed and accepted by the healthcare organisation. The RCP will keep a copy of the final report indefinitely.

The review team will ensure that all those who are interviewed or willingly provided information to the review team as part of the review understand the confidential nature of the process. While the final report will not attribute comments to interviewees, due to the nature of the issue it may be possible to identify the source of information in the report.

The RCP is exempt from the requirements of the Freedom of Information Act 2000 but will release review data under instructions from the healthcare organisation for them to meet their obligations under the act. Due to the nature of the review, records will contain data about individuals (including the reviewers) which is deemed confidential. It is advised that healthcare organisations consider their obligations of confidence relating to the reviewers, and if appropriate observe the ‘breach of confidence’ exemption when disclosing.

## Media and communications

The RCP will not disclose to the public or any individual not directly involved, specific details of the review, unless required by law, the healthcare organisation, or for overriding reasons of public safety concerns. It is recognised that external publication of the report could have implications not only for the healthcare organisation but also the RCP. If the healthcare organisation decides to disclose confidential information relating to the review, it should notify the RCP as soon as possible regarding any plans for publication, including to the media. This is reiterated in the deed of indemnity.

In the event of media interest such as press enquiries or the preparation of press releases, this should be coordinated jointly between the healthcare organisation and the RCP communications team, unless previously agreed that the healthcare organisation or RCP will respond.

In the initial request proforma the healthcare organisation is asked to nominate an individual that can be contacted by the RCP communications team should media enquiries arise. In the event of such enquiries the RCP preferred policy is to provide confirmation that a review is taking/has taken place, but not disclose specific details of the review.

### Sharing information with regulators

The RCP has been requested by the CQC to provide a list on a 6-monthly basis of organisations in which reviews have taken place (England only). However, the primary responsibility for sharing specific information about a review visit still resides with the commissioning organisation. If another regulator has contacted the RCP to ask if a review has taken place, we will confirm the name of the healthcare organisation and the medical specialty that was reviewed. In such circumstances the RCP will also contact the organisation concerned and support them to be open about the circumstances of the review that has taken place.

## 12. Invited review evaluation

We seek feedback from healthcare organisations and review teams on the review process to improve the service provided. All feedback received is collated and reviewed by the Invited Reviews Oversight Group, and actions are made to improve the service.

## 13. Review follow up

The follow-up process indicates the final stage of the review. On issue of the final report the RCP will send the healthcare organisation a progress form to complete which measures the outcome of the review, and whether recommendations made in the report have been implemented. Around 6 months after the final report has been issued the invited reviews team will contact the healthcare organisation requesting an updated progress form. This provides an opportunity for the healthcare organisation to review progress following an invited review and understand whether a further review visit or assistance may be required.

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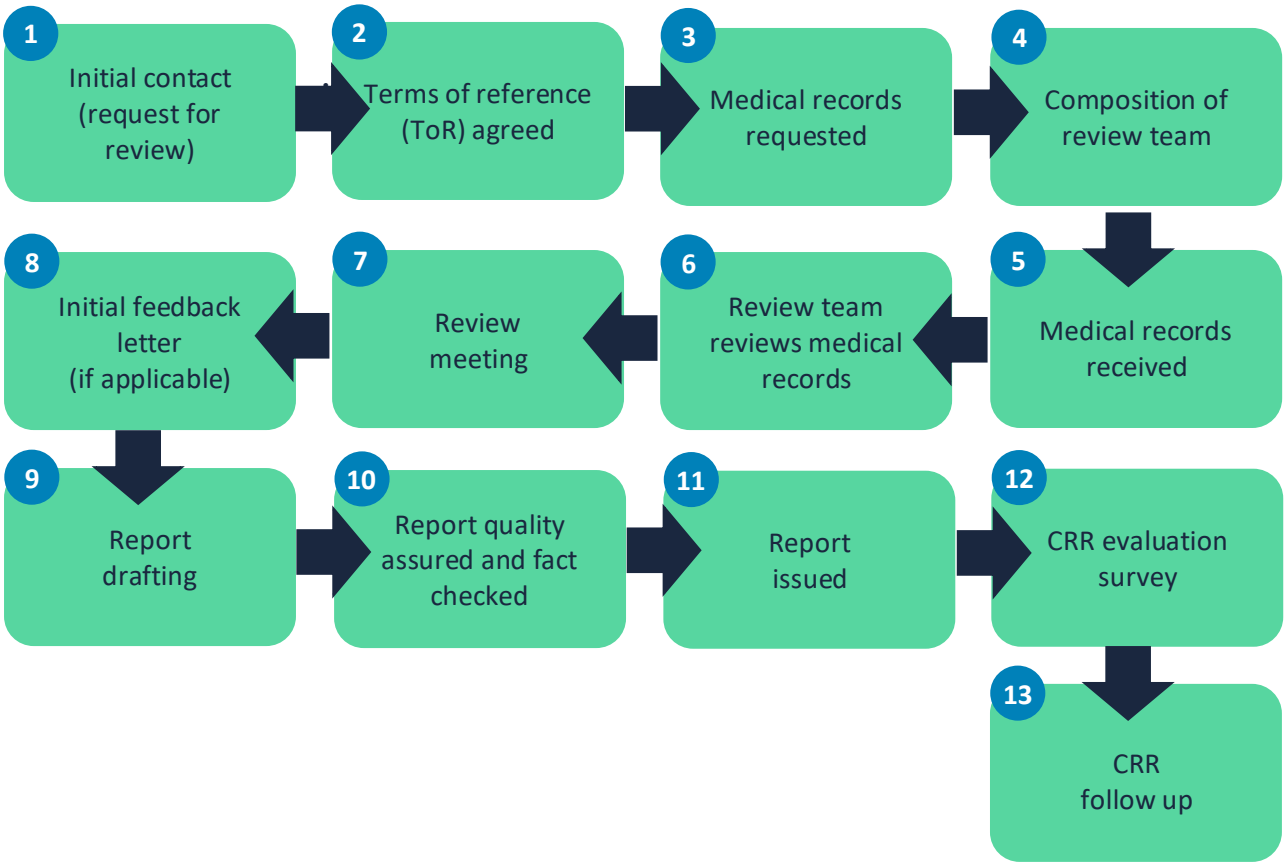
# Clinical record review (CRR)

## Overview

The graphic below depicts each of the stages of a CRR.




The aim of an RCP clinical record review is to provide an independent and expert view on the care provided in a specific case or series of cases based primarily on a review of patient medical records. Guidance on how to collate and send the patient medical record(s) is available separately.

Generally speaking, the main reasons why CRRs are requested are:

- concern that the practice of clinical medicine may not be in line with national good practice and guidelines
- complaints made by the patient and/or their relatives
- specific serious untoward incident(s) and/or aspects organisational care
- concerns raised by colleagues and/or members of the wider medical team.

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The purpose of a CRR is to analyse the clinical management of care and whether this meets the expected RCP or specialist association standards. The RCP works closely with the relevant specialist societies/associations to deliver this work. In providing an independent and expert opinion on the clinical care provided to the patient(s), the review team focuses primarily on the clinical notes available and assesses the standard of care against good practice and national guidelines in place at the time care was provided. In some CRRs we may interview the patient and/or their relatives as well as the clinical staff responsible for their care. This is decided on a case-by-case basis. Should interviews be undertaken, the invited review team will provide guidance for those who are to be interviewed. This should be circulated to all those involved.

The RCP is not a body that arbitrates on individual complaints this would be the remit of the Parliamentary and Health Service Ombudsman. As the commissioners of this review, we would ask the healthcare organisation to liaise directly with patient(s) and/or their relatives on all matters relating to the review.

## Data collection and structured judgement tool

Patient medical records are anonymised and referred to as RCP1, RCP2 etc within the report that is produced. There is however a separate index of cases provided to help identify patients.

The reviewers will undertake an independent review of the patient medical record(s), prior to attending a review meeting with the chair. Each reviewer uses a structured form adapted from the RCP's National Mortality Case Note Review (NMCRR) Programme,[*] to independently examine phases of care that the patient received. The review team also utilise a grading system developed by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD)[†] to give an overall perspective on the quality of care provided (Appendix E).

## Review meeting

Where possible, the RCP will have a minimum of two reviewers independently review each case before coming together to discuss and agree on gradings of care. The purpose of this meeting is for the chair and reviewers to meet to discuss their findings and conclusions based on their analysis of the patient medical record(s). During the meeting each phase of care is considered in turn and the clinicians present their views, followed by a 'confirm and challenge' discussion to agree the grading of phases of care and the overall care. In making judgements about the overall care provided to the patient, the review team consider national good practice and guidelines. The meeting is usually held virtually or in the RCP offices in London. Where the clinical record review forms part of a service or individual review, this will be completed prior to the review visit.

The CRR follows the same process as outlined in the review process for service and individual reviews earlier in terms of the initial contact, ToRs, composition of the review team, collating background documentation, drafting of the written report, quality assurance and factual checking the written report, issuing the written report, review evaluation and follow up.

[*] www.rcp.ac.uk/projects/outputs/national-mortality-case-record-review-nmcrr-programme-resources
[†] www.ncepod.org.uk/grading.html

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# Appendices

## Appendix A: Background documentation list

Please note that this list is not exhaustive, therefore any additional background information deemed relevant to the invited review not listed should be included.

| Clinical record review | |
|---|---|
| 10 | eg consecutive cases to be randomly selected |
| 5 | eg index cases where concerns have been raised |
| Additional supporting information, eg M&M minutes from the five index cases | |
| Please ensure that we are provided full notes and drug charts, scans, imaging and MDT minutes where these patients were discussed. | |

| 1. | Organisational-level information |
|---|---|
| 1.1. | Details of the healthcare organisational structure (including how the specialist service fits into this, and the reporting structure) |
| 1.2. | Strategic and business plans for the service |
| 1.3. | The most recent healthcare organisation board report |
| 1.4. | Chronology of issues, concerns and actions taken |
| 1.5. | Reports of other reviews and visits (to include internal and external reviews, GIRFT report etc) |

| 2. | Service-specific information |
|---|---|
| 2.1. | List of consultants and relevant members of the clinical dedicated to the service (nurses, physiologists, junior doctors etc and noting down WTE) |
| 2.2. | Facilities. (no of wards/beds associated with service) |
| 2.3. | Site map of relevant service |
| 2.4. | Details of the arrangements for the cover rota |
| 2.5. | Details of multidisciplinary team (MDT) arrangements (include minutes from meetings) |
| 2.6. | Relevant protocols, guidelines and pathways |
| 2.7. | Details of the arrangements for clinics that support the service |
| 2.8. | Appointment waiting times |
| 2.9. | Population figures – geographic and where patients are referred from |
| 2.10. | Activity data: |
| 2.10.1. | Activity data for the individual physicians within the service |
| 2.10.2. | Outcome data for the service relevant to addressing the terms of reference |
| 2.10.3. | Hospital Standardised Mortality Ratio (HSMR) data for the specialty service. |
| 2.10.4. | Mortality rates |
| 2.10.5. | Complication rates |

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| | Service-specific information |
|---|---|
| 2.10.6. | Readmission rates/follow up appointments/events |
| 2.10.7. | Any other indicators |
| 2.10.8. | Any local or national databases submitted to and information available from this. Include the data submitted to [the specific audit] |

| 2. | Clinical team |
|---|---|
| 2.1. | Staff details dedicated to the service |
| 2.2. | Job plans |
| 2.3. | Appraisals |
| 2.4. | Continued professional development (CPD) |

| 3. | Clinical governance |
|---|---|
| 3.1. | Details of clinical governance assurance systems in place at healthcare organisation level |
| 3.2. | Details of clinical governance assurance systems in place at service level |
| 3.3. | Agenda and minutes of directorate and clinical governance meetings in which the service has been discussed (last 2 years) |
| 3.4. | Clinical audit meeting arrangements |
| 3.5. | Morbidity and mortality (M&M) meetings (including agendas and minutes) (last 2 years) |
| 3.6. | Sample of attendance records, agendas and minutes for the above meetings. |
| 3.7. | Complaints, serious incident reporting and feedback on service (including patients) (last 2 years) |
| 3.8. | Details of all recent audits undertaken |
| 3.9. | Details of any quality improvement initiatives |
| 3.10. | Patient experience surveys |

| 4. | Doctors in training |
|---|---|
| 4.1. | Details of junior medical staffing |
| 4.2. | Copies of education programmes |
| 4.3. | Feedback on quality on training from deanery for results of GMC trainee survey where available. |

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# Appendix B: Template timetable

This is an example of what a standard invited review timetable might look like. Some reviews will require more/less time than this. Please discuss this with the invited reviews coordinator.

**[Date] (day 1)**

| Time | Event | Action by healthcare organisation |
|---|---|---|
| **08.30–09.00** | Invited review team to meet privately | |
| **09.00–09.50** | Pre-review meeting:<br>Invited review team to meet with key healthcare organisation personnel for overview of terms of references | This should include the medical director and other senior managers at executive level |
| **10.00–10.30** | Invited review team discussion | |
| **10.30–11.20** | Senior managers within the service | Other relevant executive managers |
| **11.30–12.20** | Dr Full Name<br>Consultant physician, specialty | Some individuals will require longer with the ISR team. Key individuals (see below) will require between 30–45 minutes. Groups will require up to 1 hour |
| **12.30–13.20** | Dr Full Name<br>Consultant physician, specialty | |
| **13.30–14.00** | Break for lunch | |
| **14.00–14.50** | Interview's resume<br>(Provide full details as above) | |
| **15.00–15.50** | Interview slot (Provide full details) | |
| **16.00–16.50** | Group interview | Names and job titles required |
| **16.50–17.00** | Invited review team to meet privately | |
| **17.00** | Conclude for the day | |

**[Date] (day 2)**

| Time | Event | Action by healthcare organisation |
|---|---|---|
| **08.30–08.45** | Invited review team to meet privately | |
| **08.45–09.35** | Interview's resume<br>Interview slot (Provide full details) | |
| **09.45–10.35** | Interview slot (Provide full details) | |
| **10.45–11.35** | Interview slot (Provide full details) | |
| **11.45–12.35** | Interview slot (Provide full details) | |
| **12.35–13.00** | Break for lunch | |
| **13.00–13.50** | Interview's resume<br>Interview slot (Provide full details) | |
| **14.00–14.50** | Interview slot (Provide full details) | |
| **15.00–15.50** | Interview slot (Provide full details) | |
| **15.50–17.00** | Invited review team prepare feedback | |
| **17.00–17.30** | Feedback given to the executive team | |
| **17.30** | Review concludes | |

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# Appendix C: Potential interviewee list

The reasons for an invited review will not be entirely related to medicine and its specialties alone. All individuals relevant to the clinical specialty and the issue in question should be interviewed and further details of these individuals would be listed in the final terms of reference/background documentation. Below are some examples of potential interviewees; however, not all those listed below will need to be interviewed for every invited review:

- CEO and/or MD
- Other relevant executive managers
- Relevant clinical directors and medical leaders
- Physicians from the specialty service and associated medical specialties
- Nursing staff, including nurse leaders, eg ward manger, matron and specialist nurses
- Allied health professionals
- Resident doctors
- Relevant managers both corporate and operational, eg risk management, business managers
- Representatives from the relevant commissioners or regional network.

In principle, it should be made clear that anyone who wishes to may speak to the review team or supply a written statement.

A review of services may require the presence of other personnel, such as ambulance staff, community representatives, managers etc if relevant to addressing the ToR of the review.

The commissioning organisation should ensure that all those to be interviewed have a clear understanding of the reason for the review and the role of the RCP. A guidance document (Information for interviewees) will be provided for those who are to be interviewed. This should be circulated to all those involved.

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# Appendix D: Checklist of actions required prior to the review visit

It is the responsibility of the commissioning healthcare organisation to carry out the following action points. We have provided the checklist below so that the status of actions can be recorded as arrangements are in progress.

| Requesting a review | |
|---|---|
| **Action required** | **Status** |
| **1. Initial request**<br>To request or discuss a potential review visit, the medical director/chief executive must contact the invited reviews team either via email: invitedreviews@rcp.ac.uk or telephone: 020 3075 2383. Please then complete the appropriate request proforma provided and return to the above email address. | ☐ Complete<br>☐ In progress<br>☐ Not started |
| **2. Telephone consultation**<br>An initial phone consultation will be arranged to discuss with the medical director for invited reviews the scope of the issues and concerns. Potential dates for the review and composition of the review team and those to be interviewed will also be discussed. Provisional terms of reference will be drafted by the RCP following these discussions and shared with the requesting healthcare organisation to consider and agree. | ☐ Complete<br>☐ In progress<br>☐ Not started |
| **3. Proposed review dates**<br>Following the phone consultation, the invited reviews team will make contact regarding convenient dates for the review. It is advised that the healthcare organisation ensures that:<br>a. key individuals are aware of the dates of the review visit and are available to attend interviews and discussions on the day of the review, eg CEO, MD, consultants etc<br>b. there are no special events taking place on the day of the review and meeting rooms are available<br>c. the date for review is finalised at least 10 weeks prior to the review visit and is confirmed with the invited reviews coordinator. | ☐ Complete<br>☐ In progress<br>☐ Not started |

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| Prior to the review visit | |
|---|---|
| **Action required** | **Status** |
| **4. Timetable and terms of reference**<br>The healthcare organisation will receive:<br>a. a template timetable for the review, including list of potential interviewees<br>b. the final terms of reference (Appendix A of this document contains the list of background documentation to collate) | ☐ Complete<br>☐ In progress<br>☐ Not started |
| **5. Secure transfer of documentation**<br>The background documentation and/or clinical records should prioritised as soon as the review visit is confirmed. This along with the timetable for the review visit should be ready to send to the invited reviews team by the requested deadline date (this is indicated in the contract letter and terms of reference document). For ease of reference electronic copies are preferred, sent electronically using the RCP's secure file server. The healthcare organisation will receive a documentation log and guidance on how to upload background documentation.<br><br>Electronic documents should be categorised and filed (sub-folders) and a folder structure for saving these will be provided to the healthcare coordinator. An index is also recommended.<br><br>**Important:** Some documents may be deemed personal. It is the responsibility of the healthcare organisation to ensure that consent is obtained prior to disclosure of any of the above documents where appropriate. Throughout the review process, all information that is created, stored and received in exchange with the healthcare organisation must comply with obligations and confidence under the Data Protection Act 2018 and NHS Code of Confidentiality. | ☐ Complete<br>☐ In progress<br>☐ Not started |
| **6. Draft timetable**<br>The healthcare organisation will be provided with a draft timetable to populate locally. A copy of the updated timetable for the review visit must be provided to the invited reviews team two weeks prior to the visit, as this allows time for the review team to approve and make any necessary amendments. | ☐ Complete<br>☐ In progress<br>☐ Not started |
| **7. Meeting room for interviews** (applies to in-person and virtual reviews)<br>A meeting room of an appropriate size for use by interviewees (such as a seminar or training room) to accommodate review team and/or group interviews and the feedback session.<br>a. The room should be spacious enough to accommodate 10 individuals around a table comfortably. Wifi access and teleconference capability as well as electricity power points in the room are also required.<br>b. Those being interviewed may feel anxious, therefore the choice of venue is important and should not be too formal. It is preferable to have a few chairs outside nearby the interview room. | ☐ Complete<br>☐ In progress<br>☐ Not started |

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| Prior to the review visit | |
|---|---|
| **Action required** | **Status** |
| **8. Transportation (in-person reviews only)**<br>Transport for the review team should be arranged, usually a people-carrier taxi from their hotel accommodation to the interview site and return to the hotel. At the end of the final day, transport will be from the interview site to the train station/airport. A telephone number for the taxi company should be provided to the invited reviews team prior to the review. | ☐ Complete<br>☐ In progress<br>☐ Not started |
| **9. Specific requirements (in-person reviews only)**<br>The invited reviews team should be contacted to enquire if the review team have any special dietary requirements or require a car parking space at the hospital site. | ☐ Complete<br>☐ In progress<br>☐ Not started |
| **10. Information for interviewees**<br>Once the timetable has been finalised, all interviewees should be provided with the following documents:<br>a. Information for interviewees<br>b. Terms of reference<br>c. Final timetable for the review | ☐ Complete<br>☐ In progress<br>☐ Not started |
| **11. Onsite coordinator**<br>The invited reviews team should be provided with contact mobile telephone number for the key individual making the arrangements for the review that can be contacted out of hours ie the evening before the review commences. An individual within the hospital organisation should be allocated to oversee arrangements on the day of the review visit to liaise with the review team regarding any changes to the timetable and assist with any requirements the review team may have. | ☐ Complete<br>☐ In progress<br>☐ Not started |

| On the day of the review | |
|---|---|
| **Action required** | **Status** |
| **12. Stationery (in-person review only)**<br>Notepads and pens should be made available in the interview room. | ☐ Complete<br>☐ In progress<br>☐ Not started |
| **13. Access (in-person review only)**<br>If required, the review manager should be provided the key to the interview room or any codes for entry. | ☐ Complete<br>☐ In progress<br>☐ Not started |
| **14. Welcome and housekeeping**<br>The review team should be greeted at an agreed meeting point on the first day of the visit (in-person visits only) by the onsite coordinator. Time should be spent at the start of the review running through administrative arrangements, housekeeping, and answering any queries or requests for further documentation. | ☐ Complete<br>☐ In progress<br>☐ Not started |

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# Appendix E: Structured judgement review (SJR) tool

Below is an example of an SJR form. This would be adapted to reflect the agreed terms of reference.

| | |
|---|---|
| **Case description:** | |
| **Initials of reviewer:** | |

**Background/summary of the relevant patient's history**

*[Please give a brief clinical history of the patient eg gender/age/comorbidities of patient/presenting condition/operation/outcome/any other relevant factual information from the notes. Make a note of key dates (bullet point if helpful)]*

Click here to enter text.

**The patient's treatment plan and implementation of this**

Click here to enter text.

**Please grade this phase of care (mark with an 'x'):**

☐ 1 = very poor care
☐ 2 = poor care
☐ 3 = adequate care
☐ 4 = good care
☐ 5 = excellent care

**Colleagues – evidence of communication with colleagues including delegation, referrals, MDT working**

Click here to enter text.

**Please grade this phase of care (mark with an 'x'):**

☐ 1 = very poor care
☐ 2 = poor care
☐ 3 = adequate care
☐ 4 = good care
☐ 5 = excellent care

**Interactions with patients and their family (sharing of information, discussion and agreement on management plans etc)**

Click here to enter text.

**Please grade this phase of care (mark with an 'x'):**

☐ 1 = very poor care
☐ 2 = poor care
☐ 3 = adequate care
☐ 4 = good care
☐ 5 = excellent care

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| Clinical record keeping – (general observations of record keeping, level of detail in letters and notes of conversations, use of bundles, user friendliness) | |
|---|---|
| Click here to enter text. | **Please grade this phase of care (mark with an 'x'):**<br>☐ 1 = very poor care<br>☐ 2 = poor care<br>☐ 3 = adequate care<br>☐ 4 = good care<br>☐ 5 = excellent care |

| Any other issues identified from clinical record review | |
|---|---|
| Click here to enter text. | **Please grade this phase of care (mark with an 'x'):**<br>☐ 1 = very poor care<br>☐ 2 = poor care<br>☐ 3 = adequate care<br>☐ 4 = good care<br>☐ 5 = excellent care |

**Reviewers' comments on the overall standard of care**

*We are interested in comments about the quality of care the patient received at each phase of care, and whether it was in accordance with current good practice (for eg your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.*

Click here to enter text.

| Clinical reviewer's overall perspective on quality of care (please mark x in the relevant box) | |
|---|---|
| ☐ | **Good practice:** A standard you would accept from yourself, your trainees and your institution. |
| ☐ | **Room for improvement:** aspects of clinical care that could have been better. |
| ☐ | **Room for improvement:** aspects of organisational care that could have been better. |
| ☐ | **Room for improvement:** aspects of both clinical and organisational care that could have been better. |
| ☐ | **Unsatisfactory:** several aspects of clinical and/or organisational care that were well below that you would accept from yourself, your trainees and your institution. |
| ☐ | **Insufficient information available** to make an assessment of quality of care. |

**Recommendations** (if you scored room for improvement/unsatisfactory – in a few words please suggest what could have been done better)

Click here to enter text.

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# Appendix F: Invited review fees

The minimum review fee for a service or individual review is £30,000 + VAT. This covers administrative costs, quality assurance and production of the report. However, this may change depending on the complexity of the request, scope and/or inclusion of a clinical record review.

The minimum fee for a single case clinical record review is £11,000 + VAT. More complex clinical record reviews of multiple cases are calculated on a case-by-case basis. The total fee will account for the quantum of medical records to be reviewed, complexity of each case, and if the review relates to any serious incident(s) or outcome of a serious incident investigation.

In addition to the review fee, reviewer fees (£500 per day) and any subsistence costs required for the review to take place must be met by the healthcare organisation.

As a guide, standard service and individual reviews (without a clinical record review) will typically last for two days with a pre-review meeting. Inclusion of a clinical record review will typically add a further two days to the review and will be accounted for in the review fee along with reviewers' time spent.

For all reviews we charge a £2,000 (non-refundable) fee for the scoping exercise undertaken following receipt of a signed request proforma. This covers work including:

Writing and agreeing terms of reference
- Liaising with the healthcare organisation regarding case notes
- Review administration
- Liaising with specialist societies to nominate reviewers
- Liaising with and confirming reviewers

For single clinical record reviews, we ask for payment of the full amount for the review fee and reviewer fees (minus the £2,000 deposit) once the work has been undertaken and prior to the issue of the report.

For individual, service and multiple clinical record reviews, we ask for payment of 50% of the review fee[‡] (minus the £2,000 deposit) prior to the record review and/or interviews being undertaken. We will then charge the remaining 50% of the review fee (or the remaining balance), plus reviewer fees once the work has been undertaken and prior to the issue of the report.

Please note once a request is agreed by both parties, and work undertaken, cancellation charges do apply. These are determined on a case-by-case basis, dependent on the work carried out at the point of cancellation.

[‡] Review fees are often quoted as a range to allow for unknown factors that may increase the work required to complete the review. We will always aim to keep to the lower end of the range where possible. The charge requested at this point will be 50% of the lower end of the range.

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