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Report Title:	Royal College of Surgeons' Invited Service Review				
Sponsoring Executive Director:	Dr George Findlay				
Author(s):	Dr George Findlay, Prof Katie Urch				
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Executive Summary:					
This paper includes the report from the Royal College of Surgeons following their invited review, as well as the context to the review, and Trust's responses.					
Key Recommendation(s):					
The Board is asked to NOTE this report.					

Paper to the Board
Dr George Findlay

When I took up role as CEO in June 2022 I was very clear that we faced a significant number of challenges and areas where we simply weren't doing well enough.

One of these areas was surgical services at the RSCH site.

A number of issues had been raised by previous internal and external reviews into Surgery at RSCH. We used this information to ensure that a comprehensive improvement plan was in place to address the challenges in this service. That plan was agreed in October 2022 and progress has been made since that time, with executive leadership in place alongside strong programme management arrangements, and Board oversight through the Quality Committee.

We are determined to make the improvements that our staff and patients need and deserve. The reason I invited the Royal College of Surgeons (RCS) to come and review matters in May 2023 was primarily to test our improvement plans: Were they correct and focusing on the right areas? Were there gaps we had not spotted? Was there evidence that the plans were making a difference? Were there any immediate safety concerns that we needed to respond to? In addition, I wanted to ensure that staff had the opportunity to raise, in confidence, any concerns they had.

Our Chief Medical Officer Prof Katie Urch has provided a summary of the RCS findings, their recommendations, and our response, and that follows this paper. But first I wanted to provide my reflections on the report of the Invited Review.

There are some tough messages for staff and us as Trust leaders, and for patients - but being clear and honest brings the opportunity to make further significant, positive changes. Problems can't be solved without first being openly acknowledged.

I am bringing this report to the Board in public at the earliest opportunity because it is so important. We received the report towards the end of January 2024 and the detail needs to go through our usual Board governance processes. I know this will go through the Quality Committee very soon, and the Board conversation today can help shape that work.

I am bringing this to Board today as I want to signal a way of working that is important to me and I believe also to staff, patients and stakeholders. This is the first Royal College external review that I have commissioned as CEO and I wanted it to be shared freely with staff, partners and stakeholders in a transparent and open way.

Many of the problems that exist date back many years and sadly cannot be solved overnight. The RCS review recognises our improvement plans and the results they have produced so far. I do believe we have made some significant strides forward and recognise there is much more to do.

The report raises concerns about senior leadership, and I welcome a conversation with Non-Executive Director colleagues on that topic. I was brought into the Trust with a clear expectation that we had to deliver positive change. The executive team has been brought together and all executive directors are now in place. There is a huge amount to do and colleagues have been working in hugely pressured environments for many years. Our executive team is focused on the main, overriding task of improving care, and giving our staff the tools they need to do the job.

Lastly, I wanted to emphasise my message of realistic optimism. There are many areas of progress highlighted in the report and we should be optimistic about that, and use this feedback to recognise the efforts of our staff. However, I am realistic that there is very much more to be done to provide the service that our patients and staff want and deserve.

Royal College of Surgeons Invented Review

Board Summary

Prof Katie Urch

Introduction

This short paper is intended to accompany the full report from the Royal College of Surgeons (RCS), which was received by the Trust in January 2024.

This paper seeks to summarise the key findings – both positive, and areas of ongoing concern – along with the recommendations being made to our Trust, and most importantly the actions which have been taken, or are being taken, to try to introduce and embed better working conditions, practices, and outcomes. It also follows on from the paper from our Chief Executive Officer Dr George Findlay, offering his perspective on the RCS report.

Context

The RCS conducted the Invented Review into Surgery services at the hospital in late May 2023. Their report was received in January 2024, and follows this paper.

Some findings pose challenges to both the Trust leadership, and members of the Surgery division, and solutions will not be immediate. Surgery in Brighton has faced significant difficulties for more than a decade, and there was a clear recognition from the current leadership group in early 2023 that significant changes – some of which may be long-term in character - were still required to promote better care, better performance, and better relationships.

The known residual challenges included issues regarding physical capacity, workforce capacity and skill mix, and working relationships – both within the teams themselves, and between those teams and the succession of executive leadership groups.

Even within this highly challenged position it was also recognised that the staff were highly committed, skilled, and dedicated to providing the best possible care for their patients.

The RCS review findings

The RCS was specifically asked to look into clinical governance, benchmarked patient outcomes, safety monitoring systems, opportunities to reflect and discuss the delivery of safe care, and culture and behaviours. The areas were chosen specifically because previous assessments had identified them as having deficiencies, or potential shortcomings.

The full findings are set out in detail in the RCS review itself, but some of the key issues highlighted are summarised below.

Positive findings

- All staff were open and engaged with reviewers, and wider staff groups commented positively
- Strengthened governance – improved quality of data for national audits
- Good practice and evidence of learning – regular quality and safety processes, well structured mortality reviews, whole day patient experience meetings, new governance leads and support staff

- New leadership seen as able and effective, and clearly engaged at division, directorate and local levels
- Feedback from junior doctors improved, mandatory requirements meet to enable Health Education England to approve return of trainees
- New Chief of Surgery seen positively, as a good leader

Concerns

- Staffing levels in both nursing and medical roles, including long-term use of locum consultants
- High workload and unequal workload distribution – impacting on cancellation levels, and responsiveness to the (high) level of complaints
- Lack of capacity in terms of the ward environment, leading to high numbers of ‘outlier’ patients and associated challenges in providing continuity of high quality care
- Surgical capacity for planned work
- Morale – suspension of upper GI cancer resectional surgery had a negative impact on retention, and recruitment is difficult
- Culture – ongoing sense that staff are fearful of speaking up to the executive team, or do not believe such actions will bring about positive change, and as a result are reluctant to raise concerns
- Culture – issues in terms of behaviours within the Surgery teams themselves.

RCS Review recommendations

The RCS made a number of recommendations for the Trust – including the observation as to the importance of this review being acted upon, given the number of previous reviews which have already taken place.

The full set of recommendations are contained within their report, but the key elements for the Board to note are:

- The need to establish a Surgical Assessment Unit, and ‘hot’ pathways to help insulate planned work from peaks in emergency demand
- Recommendations to restore the surgical bed base, expand theatre capacity, expand outpatient capacity, and ensure sufficient elective capacity is available
- The suggestion that membership of governance meetings should be widened to include teams from elsewhere in the Trust
- A need to continue to focus on inter-professional communication within Surgery, and issues of problematic team working, poor relationships between senior clinicians, and interpersonal behaviours
- The suggestion that executive members spend time, regularly, with the surgical teams, and commit to implementing recommendations from previous reviews.

Responses and improvements

The RCS review provides important insight for everyone involved in the task of delivering better conditions and practices for the Surgery teams – from theatres to the Executive.

It is important to note that the review reflects a moment in time eight months ago, and that much has changed since, without for a moment losing sight of the clear need for further improvements both in terms of infrastructure, workforce, practice, and relationships.

The following actions have either been enacted or are being progressed:

- Successful approval of a business case to expand the number of consultant surgeons and junior doctors, and recruitment is underway

- Approval of a new Surgical Assessment Unit in Brighton – space within the hospital site has now been freed up and plans are fully developed for it to open in 2024, along with the development of new 'hot' pathways, as recommended
- The agreement with NHSE for them to approve the re-starting of trainee placements
- Start of an executive-led project to move some planned theatre work to other sites to mitigate capacity pressures – this is a clear recognition of the need to 'decompress' the site, which will be a major undertaking
- Commitment to shorter, emergency-only inpatient ward rounds
- Commitment to a review of the surgery bed base, and consultant rota, co-ordinated with re-allocation of elective work
- A Trust-wide drive to examine, and improve culture is underway, with potential for bespoke support to Surgery teams
- Reviews of individual consultant job plans are underway, alongside team work planning
- An identified cohort of surgeons will hold cancer surgery, allowing for stronger opportunities for sharing knowledge, learning, and support better patient care.
- Members of the executive team, working closely with the Chief of Surgery, will ensure greater direct contact between them and the surgical teams, in a bid to strengthen relationships and trust, and encourage open dialogue.

But the recognition remains that the division faces long-term challenges, and that overcoming those challenges must also be considered as a long-term endeavour which will require continued, consistent attention.

Delivering the identified improvements, monitoring their impact, and then being responsive to the need for further new thinking will be essential, alongside the necessity of building trust and a better dialogue both within the Surgery teams, and between them and the Trust leadership.

Recommendation

The Board is asked to note this paper, and the Royal College of Surgeons January 2024 report, following the completion of their Invited Review in May 2023.

Invited Service Review Report



Royal College
of Surgeons
of England
ADVANCING SURGICAL CARE

Report on the general, (emergency, upper
gastrointestinal and lower gastrointestinal)
surgical service on behalf of

University Hospitals Sussex NHS Foundation
Trust

Review visit carried out on: 24-26 May 2023
Report issued: 17 January 2024

A service review on behalf of:

The Royal College of Surgeons of England

Association of Surgeons of Great Britain and
Ireland

Review team:

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1. Introduction and background

On 26 January 2023 Dr Rob Haigh, Deputy Chief Medical Officer for University Hospitals Sussex NHS Foundation Trust ('the Trust'), wrote to the Chair of the Royal College of Surgeons of England's ('RCS England') Invited Review Mechanism (IRM) to request an invited service review of the Trust's general surgery department, with a specific focus on upper gastrointestinal (GI) (UGI) surgery, lower GI (LGI) surgery and emergency general surgery (EGS).

The general surgery service, alongside UGI and LGI surgery, as well as EGS, operates from two out of the seven hospitals run by the Trust: the Royal Sussex County Hospital ('RSCH') in Brighton, and the Princess Royal Hospital ('PRH') in Haywards Heath.

The request highlighted that the general surgery department was a service which had been under scrutiny for many years, with a history of internal reviews, and concerns being raised by consultant surgeons as well as other members of staff within the department, including through staff surveys, and reviews from external bodies including the Care Quality Commission (CQC) and Higher Education England (HEE).

As a result of the concerns, opportunities were identified to improve the leadership, culture and ways of working, morbidity and mortality (M&M) processes multi-disciplinary team (MDT) processes and practices, and delivery of emergency care.

The Trust therefore commissioned a 12-18 month corporate executive sponsored improvement project in October 2022, to focus on workload, service model of care, culture and behaviours, training and operational delivery. Part of the corporate project involved commissioning an invited service review of the general surgery department.

Within the invited review request, the Trust indicated that they wished for the service review to assess:

- Clinical governance arrangements within the department, with a focus on safety, outcomes, quality, benchmarking against comparative national outcome audits and M&M processes in accordance with RCS England best practice guidelines.
- Whether benchmarked outcomes were within acceptable national standards.
- Whether appropriate systems and processes were in place to robustly monitor safety and ensure high quality outcomes.
- Whether current clinical governance processes allowed standardised and consistent opportunities for the department to discuss, review, reflect and learn.
- The clinical outcomes for the general surgeons and whether they gave rise to concerns about poor outcomes.
- Whether individual and departmental practice was acceptable and safe care was being delivered to patients.
- Cultures and behaviours within the department as a whole.

Prior to requesting the invited service review, the Trust held discussions with staff, conducted reviews of clinical records as well as internal audits and investigations.

This request was considered by the Chair of the IRM and a representative of the Association of Surgeons of Great Britain and Ireland ('ASGBI'), and it was agreed that an invited service review would take place.

An invited review team (the review team) was appointed and an invited service review visit took place on 24-26 May 2023 at the Royal Sussex County Hospital site.

Prior to the review visit, the review team had requested specific background documentation, including M&M information, MDT outcomes and attendance records, and the reports from previous

reviews undertaken, including the Dawson and Edgecumbe reviews¹. These were not forthcoming prior to the visit, and were either provided during the visit, or subsequently, in June and July 2023.

The appendices to this report list the [members of the review team](#), the [individuals interviewed](#), the [service overview information](#), the [documents provided to the review team](#) and the [information provided to the review team from the documentation considered and the interviews held](#).

The Terms of Reference for this review were agreed prior to the review visit, and are set out in [section two](#). The review team's conclusions are based on the information provided to them during interviews and through considering the documentation submitted. These conclusions are set out in [section three](#). Recommendations based on these conclusions are set out in [section four](#).

Overview of the Trust and General Surgery Department

The Trust serves a catchment population of an estimated 985,762² people within Brighton and Hove and parts of East Sussex and West Sussex, running seven hospitals in the region:

- Worthing Hospital, Worthing, West Sussex;
- Royal Sussex County Hospital, Brighton, East Sussex;
- St Richards Hospital, Chichester, West Sussex;
- Princess Royal Hospital, Haywards Heath, West Sussex;
- Royal Alexandra Children's Hospital, within the grounds of Royal Sussex County Hospital;
- Sussex Eye Hospital, Brighton; and
- Southlands Hospital, Shoreham-by-Sea, West Sussex.

General surgery, UGI and LGI surgery and EGS are provided across two of the Trust's sites: the Royal Sussex County Hospital (RSCH)³, an acute teaching hospital located in Brighton, and the Princess Royal Hospital (PRH), an acute, teaching and general hospital located in Haywards Heath.

Hospital services at the Trust are grouped into eight clinician led divisions, which are separated into two areas: unscheduled (emergency) and planned (elective) care. The Trust runs the following divisions:

Unscheduled care:

- Medicine and urgent care (West Sussex)
- Medicine and urgent care (Brighton and Hove)
- Women and children
- Clinical Support Service

Planned Care and Cancer:

- Cancer
- Specialist Services
- Surgery and Critical Care (St Richard's, Worthing and Southlands Hospitals)
- Surgery and Critical Care (Royal Sussex County and Princess Royal Hospitals)

In order to meet the needs of local people, geographical boundaries have been maintained by the Trust.⁴

¹ See pages 7 and 8

² Service Overview Information and Estimated Population Growth provided by the Trust in May 2023.

³ Service Overview Information.

⁴ Information up to date as of November 2023: <https://www.uhsussex.nhs.uk/>

Overview of general and emergency surgery and gastroenterology⁵ services within the Trust

General surgery services provided by the Trust include emergency, inpatient and day case care. A wide range of surgical procedures are performed within the service typically involving the chest and abdomen, such as breast conditions, colorectal, UGI, gallbladder, hernias, appendix, transplants and more. UGI and LGI surgeons working within the service are trained to undertake emergency as well as elective surgery⁶.

The specialist team within the gastroenterology service treats conditions affecting the oesophagus, stomach, small bowel, colon, liver, bile ducts and pancreas, as well as caring for patients with gastrointestinal conditions⁷, in the Trust's combined gastroenterology and surgery ward. The service provides a range of diagnostic and therapeutic techniques, including endoscopy⁸ and radiological examinations⁹. The service includes local surgeons, pathologists and microbiologists and the dietician department, and works with specialist nurses who provide support and advice to patients with conditions such as cancer, inflammatory bowel disease, alcohol related disorders and liver disease. As well as having local expertise, the service has links with tertiary centres in London, Surrey and Sussex, and may facilitate referrals for second opinions and/or specialist care when required¹⁰.

Between January and December 2022 the general surgery department, operating across the RSCH and PRH sites, saw over 55,000 outpatients, over 5000 non-elective admissions and over 11,000 elective admissions.

As of May 2023 there were 12 substantive consultant surgeons, three fixed-term contract locum consultant surgeons and an associate specialist grade surgeon on the consultant rota in the general surgery department. There were also two funded UGI vacancies, with scheduled interviews due to take place. Programmed Activities per consultant had ranged from three to 13 in terms of direct clinical care, excluding regular regular waiting list initiatives activity.

Excessive demand on the on-call consultant rota led to demand and capacity being reviewed. This led to the highlighting of opportunities for the general surgery department to improve its leadership, culture, ways of working, including M&M and MDT processes and delivery of emergency care. A key driver for gaps in performance were the mismatch between current demand for the service (as of May 2023 with a patient tracking list of 7000 patients), and the availability of workforce, physical and infrastructure capacity. In order to deliver such improvements, it was recognised that there would be a need for new models of care to balance the service's management of elective and emergency care, which would enable compliance with the standards of a major trauma and cancer centre, alongside the standardisation of the department's operational management processes. With the department's history, including a decline in reputation for surgical junior doctor training, sustainable improvements would need to be demonstrated across all elements of the department, in order for the placement of surgical trainees to be reinstated.¹¹

Previous Reviews

The Trust has a history of internal and external reviews, about which the review team were provided background information as part of this review. The review team did not seek to reach findings on those conclusions and recommendations made by other bodies, which was outside of their remit.

⁵ Also known as digestive diseases.

⁶ Information up to date as of August 2023: <https://www.uhsussex.nhs.uk/services/general-surgery/>

⁷ Disorders of the digestive system.

⁸ Involves cameras looking into the oesophagus, stomach, colon, small bowel and bile ducts.

⁹ Ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI) scans and barium examinations.

¹⁰ Information up to date as of May 2023: <https://www.uhsussex.nhs.uk/services/gastroenterology/>

¹¹ General Surgery Improvement Corporate Project, Introduction to RCS Reviewers PowerPoint Slides, May 2023

A summary of the most pertinent reviews in relation to general surgery, UGI and LGI surgery and EGS is provided below.

a) HEE¹²

On 2 July 2021 the Regional Postgraduate Dean wrote to the Chief Executive of the Trust expressing concerns about the safety and effectiveness of the clinical learning environment for foundation trainees in general surgery at the RSCH site, as well as the vulnerability of Foundation Year 1 (FY1) doctors, due to restrictions on their clinical learning opportunities during the COVID-19 pandemic. The General Medical Council (GMC) had previously placed enhanced monitoring requirements on general surgery training in Brighton in January 2016. The Postgraduate Dean's specific concerns related to:

- Rota gaps which risked breaching the conditions the GMC previously placed on general surgery, and it being unclear whether additional support posts which the Trust intended to recruit would be in place by August 2021.
- The department not appointing a dedicated consultant lead for education and training, as per HEE's mandatory requirements to ensure the safety and effectiveness of the clinical learning environment.
- The Trust's response to bullying and undermining comments received in the recent GMC National Training Survey, which suggested that the particular trainee who made the comment acted unprofessionally in raising the concerns, and the Trust was proposing to take this further with the GMC, which was felt to be inappropriate.
- That there would be a significant number of unfilled core and higher specialty general surgical posts as of October 2021 due to trainees specifically not selecting the department for their rotations.
- The August cohort of foundation trainees being considered to be vulnerable given their relative lack of experience and likely reduced exposure to training due to the COVID-19 pandemic.

The Trust put in mitigations, which they described in a meeting on 9 July 2021 (with HEE, GMC, NHS Improvement and NHS England (NHSI&E), Integrated Care Systems (ICS) colleagues with the then Chief Medical Officer, then Medical Director (East) newly appointed Director of Medical Education). This included the recruitment of advanced clinical practitioners, provision of additional junior medical staff until Advanced Clinical Practitioner training was complete, additional out of hours shifts, substantive prescribing pharmacist recruitment and responding to specialist practice registrar trainee feedback. At this meeting it was agreed that the Trust would provide further information and assurance, and a written response would be provided in July 2021 to address the following matters:

- Trainee rotas and support.
- Progress on consultant appointments.
- Progress on prescribing pharmacists.
- Mitigating gaps due to lower numbers of registrars from October 2021.
- Escalation and outreach.
- Educational and welfare supervision of trainees.
- Leadership and surgical educational supervisor.
- Organisational development work on culture with consultants.
- Governance, executive and board monitoring.

¹² Appendices Attachments to Introduction to General Surgery PowerPoint Slides, May 2023: Response to HEE Concerns on Foundation Doctors from the Trust, July 2021; Letter from HEE 9 December 2021; and email correspondence between HEE and the Trust in February 2023 and April 2023.

A Foundation General Surgery Trainee Focus Group was held on 26 October 2021. Following this a meeting was held on 1 December 2021 between the then Medical Director and the Director of Medical Education at the Trust with representatives from HEE, the GMC, NHSI&E and Sussex NHS Commissioners. A letter confirming the conversation and next steps was sent to the Trust on 9 December 2021. This included trainee feedback having indicated improvements to the educational experience, including:

- Measures to address immediate concerns about supervision and support for foundation general surgery trainees out of hours.
- The positive impact of the consultant lead for education and training.
- Praise for the support provided by the Senior Nurse Education Fellow.
- Unprofessional behaviours being addressed promptly by the Trust.

During the meeting on 1 December 2021 information was provided about underlying wider concerns, which whilst impacting on education and training, did not fall within the HEE's regulatory remit. This included: leadership, culture, service pressures and workload, staffing and rota gaps. It was agreed that a broader approach from the Trust would be needed to address these issues in order to support medium and long-term sustainable improvements in the educational and trainee experience. It was agreed that going forward:

- HEE would work with the GMC to revert to routine quality monitoring of educational issues linked to HEE quality standards via the action plan process. The existing action plan would be updated to reflect recent feedback, and to outline requirements and timescales for further monitoring.
- HEE would forward any intelligence received relating to broader concerns to the Sussex Health and Care Partnership for management through their governance processes, with input from the regional NHSE&I team as appropriate.
- Foundation general surgery at RSCH would remain under GMC enhanced monitoring, with previous GMC conditions on the approval of the foundation training programme in the general surgery department, relating to supervision, workload and access to educational opportunities, to remain in place.
- HEE would write to the current cohort of foundation trainees to share the outcomes of this process, and highlight routes to raise any concerns should they arise, acknowledging the significant amount of feedback provided by trainees already. The Trust would also continue to brief trainees on improvement measures being taken locally to address areas of concern identified within the focus group feedback.

On 1 February 2023 HEE wrote to the Trust to inform them of changes to their enhanced monitoring status, as well as acknowledging the comprehensive response provided in relation to the issues that were raised by the HEE leading to the enhanced monitoring process, including College Tutors who had worked hard to improve the experience of doctors in training. Whilst there remained ongoing work and change ahead, it was felt that there was a significant reduction in risk to learning and training, and the HEE indicated they were looking forward to working with the Trust further to address the outstanding issues.

On 29 March 2023 a general surgery work programme meeting was held, which was followed up in correspondence from HEE to the Trust on 25 April 2023. The Trust was informed that all mandatory requirements, which had been issued following an urgent risk review on 19 October 2022, had now been closed. An updated action plan was also provided for the Trust's records. The Trust was informed that the next work programme meeting would take place on 27 July 2023, to focus on work to support the re-introduction of surgical trainees to the general surgery department in October 2023.

b) Edgecumbe review

The Trust's Chief Executive Officer commissioned the Edgecumbe Group¹³ to undertake a review, in order to make recommendations to improve culture and the functioning of the consultant team. This review was undertaken, with the final report provided in June 2022. A summary presentation of this report, dated July 2022, was provided to the RCS England invited review team in June 2023, which featured the findings reached, recommendations made, and anonymous quotes from staff.

c) Dawson review

The Trust's Chief Medical Officer asked Professor Peter Dawson¹⁴ to undertake an independent review of departmental culture, junior doctor training and supervision within general surgery in August 2022, due to the long standing concerns raised. A redacted copy of this report was provided to the RCS England invited review team in June 2023.

d) Care Quality Commission¹⁵

In August 2022 an unannounced CQC inspection took place. An 'inadequate' rating was given and the CQC made the decision to suspend the Oesophago-Gastric (OG) cancer resection services at the RSCH site of the Trust.

Since then, and as part of the 12-18 month corporate improvement project, it is understood that staff have been working towards making improvements and restoring the reputation of this service. This involved communication with the CQC and evidencing the improvements which had been made.

In December 2022 the Trust submitted a response to the CQC, for the return of UGI cancer resection services, and an updated response was submitted in March 2023. There were ongoing discussions with Surrey County Hospital to align Sussex and Surrey OG cancer resection surgery with the Sussex and Surrey Cancer Alliance (SSCA), with a surgical hub at the Royal Surrey County Hospital in Guildford.

It was reported that staff had been under the impression that the CQC would allow this service to return, based on the above responses and prior communication. However, three weeks prior to the RCS England invited review visit, staff were informed that this would not be happening, and in the future, all UGI cancer resections would only take place at the Guildford site.

The CQC's most recent inspection took place in October 2022, with the findings and report being published on 15 May 2023¹⁶, just over a week prior to the invited service review visit at the Trust.

Corporate Improvement Project¹⁷

A prominent theme of previous reviews, including the Edgecumbe and Dawson reviews, was a lack of meaningful action from the executive leadership team, as well as reporting common/similar key themes on culture and behaviours. Following this, and the revised CQC rating of inadequate in August 2022, as well as the other long standing history of scrutiny within the service over many years, the executive-sponsored general surgery corporate improvement project was launched in October 2022.

¹³ <https://www.edgecumbe.co.uk/>

¹⁴ <http://s861800506.websitehome.co.uk/>

¹⁵ Information provided to the review team throughout the course of the review, including the Introduction to General Surgery PowerPoint slides, May 2023; and that provided during interviews during the review visit in May 2023.

¹⁶ <https://www.uhsussex.nhs.uk/%20https://www.cqc.org.uk/provider/RYR?referer=widget3>

¹⁷ Introduction to General Surgery PowerPoint Slides, May 2023.

The goals of the project were to restore the reputation of the service, to improve culture and behaviour, to secure the return of trainees to the Trust and to reinstate UGI cancer resection services, which were suspended by the CQC in August 2022. The Trust's executive leadership launched the project with a workshop in October 2022, which saw representation across the department with clinicians, nurses and operational staff, to provide staff within an opportunity to feedback on the commissioned reports into culture and behaviours within the service, the steps the executive leadership team were taking and the introduction of the beginning of a new approach to service delivery within the department.

When the invited review request was made, the Trust also provided the RCS England with summary slides of the general surgery corporate improvement project. This included reporting on the progress of the project thus far, as of October-December 2022. At this stage:

- The programme had been fully mobilised, with work stream leads in place, and the department was engaged with the goals of the project.
- A detailed review of M&M processes had taken place, to ensure meetings were well-attended and fit for purpose in the future, which resulted in immediate process change, the appointment of new UGI and LGI governance leads, as a result of which the quality, content and attendance at M&M and governance meetings were reported to have substantially improved.
- A review of the existing MDT meetings had taken place, to benchmark against best practice, with a delivery plan being constructed.
- A new leadership model for the general surgery department had been developed with clinical lead posts advertised for LGI, UGI and EGS, who would report to a clinical director once in post.
- A key focus of the project was the restoration of the UGI cancer resection service at the RSCH site, and therefore was committed to responding to the CQC with evidence of outcomes and strengthened departmental quality governance processes.
- It was also identified that the surgical handover venue was not fit for purpose, and this had been improved by decluttering the space and a standardised handover process was being developed.
- National reporting of NBOCA¹⁸ and NOGCA¹⁹ data had also been submitted for the latest reporting period, in real time data validation, to ensure accuracy was established.

The next focus of the project was to:

- Complete the gateway review.
- Complete the review of demand and capacity in order to inform a proposed new service model.
- Develop a new service model.
- Complete a quality governance maturity review.
- Complete a review of medical leadership and training capabilities, including assessing programmed activities required for delivering training.
- Developing a revised structure for MDT meetings.
- Review training and education requirements and make use of HEE support; and
- Have the RCS England invited service review visit take place.

As part of the invited review visit, a further update was provided in May 2023 regarding the progress of the corporate project, from the executive leadership team. This included:

- The programme progressing across all workstreams and being on track with aligned deliverables in the last quarter.

¹⁸ National Bowel Cancer Audit: <https://www.nboca.org.uk/>

¹⁹ National Oesophago-Gastric Cancer Audit: <https://www.nogca.org.uk/>

- Recruitment of new divisional leadership with the posts of clinical leads for LGI, UGI and EGS, who would report to the Clinical Director, having been filled.
- Establishment of access to coaching and mentoring to support the newly formed team in the delivery of their clinical leadership roles.
- The completion of the demand and capacity modelling, to identify gaps and formulate a service and workforce model which would meet the demands of the service and put patients first.
- Completion of a proposed new service and workforce model, which was reviewed in April and March with three options: 1) doing nothing/the bare minimum; 2) increasing consultant numbers to provide a robust EGS service at the RSCH site; or 3) increasing the workforce at a number of levels and moving some elective activity to the PRH site in a phased way. A fourth option was also explored, which would involve addressing the backlog recovery.
- The drafting of a summary of recommendations, based on the proposed new service model, which would form a pre-requisite for a business case to be developed.
- Professor Peter Dawson²⁰ conducted a visit at the Trust on 11 January 2023, and reviewed the accuracy of the data submitted to NBOCA, and this review demonstrated no major issues with the data. The Dawson review's recommendations were implemented by the Trust as part of a plan to improve data quality and submissions.
- Review of the NELA²¹, NBOCA and NOGCA data and quality assurance was in place, with data being continuously submitted on time.
- Completion of detailed review of the relevant NICE guidelines²², which was circulated to the consultants within the department.
- Compassionate leadership training had been delivered in January and March 2023 to six consultants and registrars, with members of the general surgery department having signed up to attend the next training session.
- Revision of workplan, resource allocation, membership, timeline and risks to be aligned with the project's goals and delivery.
- Review of the directorate's M&M meetings, with reported positive improvement in attendance and engagement. M&M structure and processes had been audited, the outcomes and recommendations from which were incorporated into the UGI and LGI workstream plan.
- Review of the MDT meetings by an external subject matter expert and MDT leads, with one month observation of the UGI and LGI MDTs by the SSCA. Recommendations from this review were incorporated into the UGI and LGI workstream plan. Face-to-face MDT meetings were reinstated to improve their quality and effectiveness, as per the recommendations of the SSCA.
- Review of the UGI and LGI operational policy and standards of care, to support staff with routine and best practice operations, as well as ensuring robust and patient-centred MDT processes.
- Application by HEE for an extended surgical team being successfully approved and revised to include two advanced clinical practitioners. Discussion of the junior doctors training programme with HEE in March 2023, agreed in principle, and now being worked on. FY1 doctors giving positive feedback to HEE during their visit in March 2023 in relation to consultants, registrars, level 9 nurses, improved to take out shifts, simulation days and rota coordinators. In April 2023 HEE indicated a timeline for return of middle grade trainees to the Trust in October 2023.

²⁰ A redacted version of this report was provided to the review team in June 2023, after the invited service review visit.

²¹ National Emergency Laparotomy Audit: <https://www.nela.org.uk/>

²² National Institute for Health and Care Excellence (NICE) guidelines are evidence-based recommendations for health and care within England, and which set out to health and social care professionals the care and services suitable for most people with a specific condition or need, in particular circumstances and settings: <https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines>

- External consultants reviewed the Dawson and Edgecumbe recommendations and confirmed that the corporate project had considered every recommendation.

At this stage (May 2023), alongside the invited service review visit taking place, the focus for the project over the coming months was the:

- Completion of the 'good governance maturity' assessment of the department.
- Completion of a summary of recommendations for the new service model.
- Development of a workforce model to deliver the recommended new service model.
- Continuation of developing standardised LGI and UGI MDT processes and structures, including a written and stratified standard operating policy and standard of care documents.
- Completion of the current recruitment programme for dieticians and clinical nurse specialists.
- Completion of the gateway review for the corporate project.

2. Terms of reference for the review

The following Terms of Reference were agreed prior to the review visit between the RCS England, the Trust commissioning the review and the review team.

Review of the general surgery service at University Hospitals Sussex NHS Foundation Trust ('the Trust') under the Invited Review Mechanism (IRM).

Review

The review will involve:

- Consideration of background documentation regarding the general surgery department, with a specific focus on upper gastrointestinal (GI), lower GI and emergency surgery.
- Interviews with members of the general surgery department, those working with them to provide the service and other relevant members of staff within the Trust.

Terms of Reference

In conducting the review, the review team will consider the standard, quality and safety of care provided within the general surgery department, with a particular focus on upper GI, lower GI and emergency surgery. The review will have specific reference to the following:

1. The effectiveness of current clinical governance practices and clinical leadership within the departments to ensure safe outcomes for patients, including:
 - a) The standard of outcome measures/audits to uphold patient safety, including complication and mortality rates, and how these compare with regional and national benchmarks, and whether appropriate processes and systems exist to ensure high quality outcomes.
 - b) The effectiveness of current clinical governance processes, including mortality and morbidity (M&M) meetings, and whether the processes:
 - i) Provide standardised and consistent opportunities for shared review, discussion, reflection and learning.
 - ii) Align with best practice guidelines.
2. The quality and safety of surgical care provided at individual and department level, with specific regard to:
 - a) Whether the management, selection and distribution of cases within the upper GI, lower GI and emergency surgical service is equitable.
 - b) Whether the clinical decision-making and treatment provided to patients is appropriate and timely.
 - c) The clinical outcomes for all general surgeons within the department, and whether this gives rise to concerns about poor outcomes.
3. Multi-disciplinary team (MDT) working, communication, behaviours and culture within the department, including:
 - a) The effectiveness of MDT working and discussions, and documentation of this.
 - b) The balance between service delivery and junior doctor training, including the effectiveness of rota design to allow adequate training opportunities for trainees during daytime hours.

Conclusions and recommendations

The review team will, where appropriate:

- Form conclusions as to the standard, quality and safety of care provided within the general surgery department, including whether there is a basis for concern in light of the findings of the review.
- Make recommendations for the consideration of the Chief Medical Officer of the Trust as to courses of action which may be taken to address any specific areas of concern which have been identified or to otherwise improve patient care.

The above terms of reference were agreed by the RCS England, the Trust and the review team on 27 March 2023.

3. Conclusions

The following conclusions are based on the information provided to the review team from the interviews held and the background documentation submitted by the healthcare organisation. They are largely organised according to the [Terms of Reference](#) agreed prior to the review but also take account of the themes that emerged whilst reviewing this information.

3.1. General conclusions

The review team were made aware that the Trust's history of internal and external reviews, press and public attention and reputational damage, as well as complicated geographical/regional challenges, resulting from a merger between Western Sussex Hospitals NHS Foundation Trust and Brighton and Sussex University Hospitals NHS Trust in April 2021²³ had inevitably had a significant impact on the morale of staff at the Trust. It was within this wider context which the review team sought to provide their conclusions and make recommendations as to the way patient care and the services being offered could be improved for the benefit of patients, staff, the services and the Trust in the future.

The review team found all staff interviewed during the visit to be extremely engaged, open and helpful. Within the constraints of current challenges they were facing, it was clear that staff worked very hard to offer the best possible service for their patients. The review team heard a number of positive comments from staff about working for the Trust, as well as hearing complimentary comments about various teams, including the consultants surgeons, junior doctors of all grades, nurses, other allied healthcare professionals and various non-clinical and managerial staff. The review team identified concerns regarding staffing levels, recruitment and retention challenges and having an adequate mix of experience and expertise within the teams, including the numbers of clinical nurse specialists (CNSs) and consultants. However, the review team also found that there were sufficient numbers of junior doctors, and that the surgical ward nursing levels were relatively healthy.

Following the review visit the review team were made aware that the police were investigating the deaths of patients within the general and neurosurgery departments between 2015 and 2020, due to concerns which had been previously raised by whistleblowers. The review team were contacted by the Trust on 10 June 2023 to advise them of this matter, which was also reported in the press, including in a Guardian article published on 9 June 2023²⁴. Whilst the review team did not seek to draw any findings in relation to this matter, it noted the investigation pertained to a specialty they were reviewing, and sat within the context of information received during interviews and as part of background documentation provided by the Trust throughout the course of this review.

3.2. Effectiveness of current clinical governance practices and clinical leadership to ensure safe outcomes for patients

3.2.1. Standard of outcome measures/audits to uphold patient safety, including complication and mortality rates, and how these compare with regional and national benchmarks, and whether appropriate processes and systems exist to ensure high quality outcomes

With regard to the history of challenges within the general surgery department, including a number of internal and external reviews, the review team found that the introduction of the corporate improvement project by the executive leadership team was a positive step, and this had resulted in improved working practices. The review team considered this to include the appointment of specific governance staff who were responsible for collating, managing and

²³ <https://www.uhsussex.nhs.uk/news/landmark-sussex-hospitals-merger-goes-live-today/>

²⁴ <https://www.theguardian.com/society/2023/jun/09/police-investigate-dozens-of-deaths-royal-sussex-county-hospital-brighton>

inputting data. The review team were of the view that there was good inputting of data into national audits, including the NELA and the NBOCA.

The review team identified that the colorectal cancer outcomes appeared to be acceptable, including within the normal range for 30 day mortality. However, they considered that the NBOCA data showed that there was a disproportionately high rate of urgent or emergency surgery admissions for colorectal cancer patients (54%), which was far higher than the national average (20%) and the regional average. The review team considered that this was likely to be as a result of inadequate capacity for elective colorectal cancer surgery, with reported long waits for elective cancer patients, in some cases necessitating re-imaging and the development of metastatic disease.

The review team considered that the NELA data showed a higher than national average 30 day mortality for emergency laparotomy patients, with poor performance for timeliness of arrival in theatre and involvement of geriatricians in the care of high-risk patients. They were of the view that this reflected sub-optimal care for emergency patients, which was a threat to patient safety. The review team considered that this was likely to be due to poor organisation of ward rounds and emergency theatres.

Major concerns were identified by the review team over high rates of cancellations of elective patients. This was often on the day of surgery, after patients had been waiting for up to seven hours, having prepared for surgery, for example, by not eating and/or drinking. The review team heard about patients being cancelled multiple times and this was causing patients psychological distress.

The review team considered there was an absence of patient survey data and recommend that the Trust starts coordinating and collating this, to consider the patient experience and how this can be improved.

3.2.2. Effectiveness of current clinical governance processes, including M&M meetings

The review team considered that the corporate improvement project had resulted in improved clinical leadership within the general surgery department and the development of better clinical governance processes.

Improvements included holding regular and structured M&M, MDT and Quality Safety Patient Experience (QSPE) meetings. The review team found the appointment of specific governance staff to be positive. They were involved in coordinating preparation, minute taking and management of these processes and meetings. The review team noted that M&M meetings ran collegiately, and provided a standardised opportunity for shared review, discussion, reflection and learning. They were encouraged by the live literature searches which took place at M&M meetings, so that research could support decision-making, with dedicated personnel available to assist with these searches. The review team noted that, whilst these meetings should be in person by default, the practice still existed of people participating online, which resulted in less engagement and a lack of team building. The review team therefore considered that more should be done to ensure these meetings are held with face-to-face attendance to support consultants feeling part of the team. The review team were of the view that best practice and other ways of working could be seen across the Trust's other sites, and the surgical team should be encouraged and given time to visit and learn from other units in the same Trust.

The review team found that there had been appointments of motivated staff to support better clinical leadership and clinical governance processes. This included the creation and distribution of new clinical leadership roles for EGS, UGI and LGI, to replace the previous system of a clinical lead to cover all of these roles. The review team found the appointment of one of the consultant surgeons to address clinical governance, education, training and EGS to be positive, and considered they had taken up this role with enthusiasm. However, the review team were

concerned about this high level of workload for a relatively new consultant who, at the time of the review visit, was on a locum contract, with no obvious mentorship in place.

The review team considered the appointment of the Chief of Surgery to be positive and this individual was described as being attentive and responsive when staff escalated concerns. The review team noted that staff would not hesitate to bring their concerns to the Chief of Surgery's attention, and it was found without exception that staff felt confident that when they raised concerns, the Chief of Surgery would listen, take these seriously and take robust action.

The review team noted that there was a high volume of complaints from patients²⁵. The most common theme of complaints was around communication, in terms of patients having a clear understanding of and expectations of their treatment. The review team were encouraged to hear about effective processes for managing and responding to patient complaints through the Patient Advice and Liaison Service (PALS), which was supported by the newly appointed governance staff. The review team noted there were delays in responding to patient complaints, and a number of reports were overdue. This was largely due to consultants being slow in providing comments for investigations, which impacted on the ability to feedback to patients in line with expected timescales. The review team considered that this was due to the workload of specific consultants, and they were encouraged to hear about governance staff working with clinicians to support them in addressing delays in responding to patient complaints. The appointment of a member of staff to draft outstanding patient safety investigation reports was also considered a positive development by the review team in supporting these processes. The review team considered that consultants should be given protected time to enable them to respond to patient complaints in a timely manner.

3.3. Quality and safety of surgical care provided at an individual and department level

3.3.1. Whether the management, selection and distribution of cases within the upper GI, lower GI and emergency general surgery service is equitable

The review team found there was an inequitable distribution of workload amongst the consultants, including a variation in who undertook on-call duties. A number of consultants appeared to have adjustments in place for health reasons, but such adjustments had reportedly never been reviewed. The review team noted this was causing resentment and unfairness, with no adjustment in pay despite a variation in duties. It resulted in the onus being on a few consultants to provide an emergency on-call service.

The review team considered that there were good attempts by the current LGI MDT lead to distribute cases fairly amongst colleagues with no major concerns. However, they noted that LGI surgery struggled with capacity. The review team found that LGI cancer patients were waiting eight to ten weeks for surgery, thereby missing the 62 day timeframe recommended within the pathway. In addition, they noted that one of the consultants who was trained in robotic surgery was not being supported to use the robot, which had been placed in another Trust site. The review team also noted a reported reluctance of the LGI surgeons at Worthing Hospital to work with the surgeons at RSCH and to look after their patients when referred to them.

The review team were aware of the decision by the CQC to suspend the OG cancer service and that whilst staff were under the impression this would be returning, and they had been working hard to make improvements to ensure this occurred, staff were made aware in the weeks preceding the review visit that the OG cancer service would not be returning. The review team noted that the intention moving forward was for all OG cancer surgery to be undertaken at the Royal Surrey County Hospital in Guildford. The review team considered that this decision had inevitably had a negative impact on the morale of staff, particularly for those trained in OG cancer surgery. The review team noted that this decision had led to resignations, and there were concerns about the ability to attract UGI surgeons in the absence of an OG cancer service. The

²⁵ [Appendix B – Service Overview Form](#) and information provided during interviews.

review team also heard about difficult relationships between the surgeons at RSCH and the Guildford site, with reports that the RSCH surgeons had not been welcomed by those in Guildford. The review team noted that the intention was for outpatient services and patients' post-operative care to be managed at the RSCH, with surgery undertaken in Guildford. The review team noted there was a lack of coordination with respect to benign UGI cases, as well as concerns that 'hot' gallbladder surgery was not being done. The review team considered that a lot of work is required to consider and develop the direction of the OG cancer surgical pathway as a result of the CQC decision, as well as developing better links and relationships across the region. They were of the view that there is a need to ensure a range of work, with robust and interesting job plans, for UGI surgeons, to ensure the Trust can attract and retain personnel within the service.

It was of concern to the review team that the UGI service appeared to have retained all of its operating capacity, despite losing OG cancer resections, whilst LGI surgery struggled with capacity. In order to address this, the review team recommend redistributing some UGI theatre lists to LGI.

3.3.2. Whether clinical decision-making and treatment provided to patients is appropriate and timely

The review team considered that the appointment of a Surgical Liaison Geriatrician was positive, resulting in improved communication and collaboration with surgical staff, better NELA performance data and more thorough and holistic provision of care to elderly and frail patients. However, the review team noted that the capacity of this Geriatrician was stretched and considered that the recruitment of further individuals within this specialty could potentially enhance surgical performance and the ability to review more patients in a timely manner.

The review team had significant concerns about the shrinking of the surgical bed base on ward Level 9A, which was halved from a 70-bedded area to a 35-bedded ward by allowing gastroenterology to use 35 beds. The review team found this resulted in the scattering of emergency surgical patients across multiple non-surgical wards in the hospital, with approximately 30% outliers, and sometimes these patients were reported to be overlooked on ward rounds.

Management of the emergency workload and unselected take was of concern. The review team noted that there had previously been organisation of the surgical teams into three teams (UGI, LGI and EGS), which had been efficient in reducing the number of patients per team, with shorter ward rounds, more patient discharges and more timely decision-making. However, the review team found that this arrangement had been inexplicably abandoned in favour of a return to a two-tier system (UGI and LGI). The review team considered that the new two-tier system, with the halving of the surgical bed base and an increase in the number of surgical outliers, meant that the daily ward rounds by on-call surgeons, which included elective and emergency patients, were lengthy, sometimes finishing as late in the day as 17:00. This impacted on the flow of patients, with a lack of ability to make timely decisions including the discharge of patients. In addition, the review team found there were overburdened CEPOD²⁶ lists and elective surgical patients, including cancer patients, were being regularly cancelled. In this respect, the review team noted there were cancellations on a daily basis and some patients had been cancelled multiple times, which was causing them psychological distress with an increase in the volume of complaints. The review team also found that these issues were resulting in disgruntlement and disengagement amongst the surgeons.

It was noted that there was no dedicated Surgical Assessment Unit for the assessment and management of acute surgical admissions. This resulted in unwell patients being left in chairs or corridors whilst a bed was found somewhere in the hospital for them. The review team found

²⁶). Dedicated theatre lists for emergencies during normal working hours in healthcare organisations. These were introduced into UK hospitals in the early 1990s as a result of recommendations of the Confidential Enquiry into Peri-Operative Deaths (CEPOD).

there was a lack of patient ownership, with the absence of named consultants for patients. This led to a lack of patient continuity, and difficulties in escalating problems in a timely manner when a patient's condition deteriorated. In this respect, the review team noted that when ward staff tried to escalate deteriorating patients, they were met with resistance from surgeons in making prompt decisions regarding patient care. The review team also found that there tended to be poor consultant cover for wards, which also impacted on escalating deteriorating patients.

The review team considered that there should be an urgent review of the two-tier system, with the return to a three-tier system incorporating EGS surgeons, the establishment of a Surgical Assessment Unit and the reinstatement of a 70-bedded space for surgery with the redeployment of gastroenterology elsewhere. The review team considered that the ward rounds for emergency and elective patients should be entirely separate, with dedicated elective surgeons undertaking ward rounds for elective patients, leaving the on-call surgeons to concentrate on emergencies.

The review team had concerns over the management of CEPOD lists, which appeared to be overburdened. They noted there were instances of patients waiting on emergency lists for five days before undergoing emergency surgery. The review team were concerned by this, as this could potentially compromise patient safety and lead to poor outcomes. They found that CEPOD lists were poorly organised, with multiple specialties competing for space. The review team heard that theatre teams had identified that, in order to cater for the workload, two CEPOD lists were required each day, but the review team noted that this rarely occurred. The review team considered that, whilst experienced theatre staff tried to drive the work through the CEPOD list, a lack of engagement from surgeons and no team briefing/huddle at the start of the day meant there was a lack of leadership, coordination and priority setting, resulting in the list being 'chaotic'. The review team were of the view that there should be an urgent evaluation of the CEPOD list function and needs, with two lists available every day, in addition to the practice of an early morning 'huddle' around 08:00/08:30 with all stakeholders including all surgical teams wishing to book cases, in order to determine the priorities for the day.

The review team considered that there were significant delays in the allocation of patients to theatre lists, and then delays on the day of surgery. The review team considered that there was an insufficient amount of theatre space for the number of cases which should be taking place at a major trauma centre. The review team had regard to the reports of regular elective cancellations, with a number of staff expressing the opinion that the RSCH site should be an 'emergency only' site. It was clear to the review team that there was a lack of effective management of elective and emergency case allocations, with a high demand from emergency cases, which impacted on consequent elective cancellations. They considered that a more effective system is needed to ensure elective cases are protected, with matching of the amount of theatre time needed for the emergency and elective cases required to be operated on and allocated accordingly, even if this is on a different hospital site.

The review team were told that when surgeons came onto the intensive care unit (ICU) they did not communicate with ICU staff, who found this caused difficulties and confusion over clinical decisions. ICU staff also reported that it was difficult to find consultants to operate on ICU patients at weekends.

3.3.3. The clinical outcomes for all general surgeons in the department, and whether this gives rise to concerns about poor outcomes

The review team considered that the data from the NBOCA outcomes showed acceptable 30-day mortality rates for colorectal cancer resections.

The review team were told of complications for colorectal resections relating to one of the locum colorectal surgeons, but there was little further detail provided in relation to this.

The review team found the outcome data available from NELA and NBOCA was within normal ranges. However, they noted that local Trust data regarding surgical outcomes was not provided.

3.4. Multi-disciplinary team (MDT) working, communication, behaviours and culture within the department

3.4.1. Team working, communication, behaviours and culture

The review team found there was dysfunctional team working and a lack of cohesion and unity amongst the surgical teams and within the general surgery department. They were told that consultant surgeons were dismissive and disrespectful towards other members of staff and displayed hierarchical behaviours towards allied healthcare professionals, particularly junior members of staff. The review team found that, whilst consultant surgeons were pleasant as individuals, they did not function well as a team and had developed more individualised and silo working practices, which negatively impacted MDT working and had the potential to compromise patient safety.

Reports of negative culture and behaviours within the general surgery department and wider Trust was of concern to the review team. They heard reports of staff witnessing or hearing about instances of bullying and harassment. The review team were particularly concerned to hear reports of two trainees being physically assaulted by a consultant surgeon in theatre during surgery.

The review team were of the view that the lack of unity within the department was partly due to low staff morale as a result of a number of historic and recent challenges within the department and the Trust, including the decision by the CQC in the weeks preceding the review visit with respect to the UGI service. The review team considered that the Trust will need to maintain efforts to address fractured relationships within the department in order to restore unity. In addition, it is imperative that robust action is taken to tackle unacceptable behaviours, given the reports of bullying, harassment and physical abuse.

3.4.2. Effectiveness of MDT working and discussions and documentation of this

The review team found that there were improved MDT practices, particularly with dedicated leadership of the MDT, as a result of the corporate improvement project. However, they were concerned about the lack of 'ownership' of patients discussed at MDT meetings, with a lack of named consultants allocated to patients early on in their pathway. The review team found this resulted in variable presentation of patients and consultant attendance at MDT meetings.

It was noted by the review team that LGI surgeons were often unable to participate in MDT due to timetabling and surgeons often had insufficient time to prepare for MDT meetings. This and the lack of patient allocation reduced their participation and engagement in MDT meetings. The review team considered that this was frustrating for other members of staff, in particular the radiologists, who spent significant amounts of time preparing for meetings, only to find that consultants were unaware of specific patients. They found that engagement in meetings was also impacted by virtual attendance at meetings, and considered that in-person attendance should be encouraged as much as possible. The review team considered that there were often too many patients allocated for MDT meetings, which affected the quality of meetings, owing to an inability to discuss all patients in the time allocated.

The review team considered that consultant surgeons should work in small teams, allowing patients to be allocated to surgeons early on in the pathway. They were of the view that this would enable better preparation for MDT, to enable more patients to be presented, as well as more ownership and engagement in the MDT. They considered that this would potentially result in clearer decisions around diagnostic and treatment pathways. The review team were of the view that there is a need to re-define which patients need to be discussed at MDT meetings, given the reports of excessive numbers.

There appeared to be a lack of cohesion amongst the LGI surgeons, and poor leadership demonstrated by the LGI MDT lead in terms of bringing people together. The review team considered that there was a need to re-evaluate the LGI MDT lead role in this respect.

The review team were provided with attendance reports for the LGI and UGI MDT meetings and considered that there was effective record keeping with respect to attendance. However, they were unable to comment further on documentation of MDT discussions, having not been provided with any other documentation, such as meeting minutes.

The review team considered that the effectiveness of MDT working was impacted by reports of a lack of CNSs/MacMillan nurses for UGI and LGI surgery. The capacity amongst the CNS staff had been affected by long-term staff sickness, and some roles within the service being part-time. The lack of CNS capacity meant that it was rarely possible for a CNS to be present in clinics with consultants for newly-diagnosed cancer patients, or to see patients in endoscopy or on the wards. The review team found that whilst there was a focus on CNSs being involved at the stage of diagnosis, more funding would allow CNS support when there was a suspicion of cancer. In addition, the review team found that, due to a lack of capacity, nurse-led clinics, which were important in order to holistically assess patient needs (and had received good patient feedback), had to be stopped. Furthermore, the review team noted that often 'breaking bad news clinics' were happening at weekends when CNS staff were not available, and this was another service which would benefit from CNS input. The review team heard that CNS staff did their best to support patients throughout their pathway; when there was sufficient capacity CNSs would provide support to patients at diagnosis, with telephone calls after MDT meetings to go through treatment options, provide support through diagnostic staging investigations, calls ahead of surgery to see how patients were feeling, as well as providing support throughout treatment and post-operatively. However, the review team found that given the staffing issues, the CNSs lacked the capacity to undertake these duties which helped to minimise psychological distress for some patients.

It was encouraging to hear that CNS capacity was improving, with staff returning from long-term sickness, particularly within the UGI service. However, the review team considered there was a need for further CNS support in the LGI service. The review team welcomed the news that funding had been allocated for more CNS staff by the SSCA and considered that such efforts should continue to ensure there are sufficient levels of support and communication for cancer patients throughout their pathway, including CNSs being able to provide support in managing the MDT, including the allocation of patients and giving feedback to patients after MDT meetings.

3.4.3. Balance between service delivery and junior doctor training, including the effectiveness of rota design to allow adequate training opportunities during daytime hours

It was noted that there had been a lack of effective training opportunities for surgical trainees, which had previously led to the withdrawal of trainees by HEE. The review team found there was a disparity in terms of the treatment of Deanery and non-Deanery trainees. Whilst non-Deanery trainees reported being appointed with no difference in terms of balance between service delivery and training in their job plans compared to Deanery trainees, there was a period of time when all training opportunities were given to Deanery trainees, resulting in months where non-Deanery trainees were doing no theatre lists and only undertaking on-call duties.

The review team heard that registrars had no protected time built into their job plans for teaching, training and education. This had resulted in registrars only being used for service delivery owing to the pressures of the service. It was apparent to the review team that trainees' needs for their annual review of competence progression and any requirements to fulfil this were not being considered.

It was concerning to hear that registrars were not undertaking outpatient clinics. The review team noted that, prior to the COVID-19 pandemic, registrars would undertake clinics with a consultant doing their own clinic next door, meaning that support would be available. With the onset of the pandemic initially there were telephone clinics, with consultants sat next to

registrars. However, consultants then stopped working at RSCH for prolonged periods of time due to health concerns and they were given virtual clinics to be undertaken from home. The review team found that, when the pandemic slowed down, these consultants did not return to on-site working and carried on doing clinics remotely from home. This meant registrars were focused on service provision, including on-call duties, meaning that if they were to return to undertaking clinics this would affect clinical capacity, including ward cover. The review team considered that there was a need to reinstate registrars undertaking outpatient clinics and that this would improve training as well as reducing waiting lists and backlogs. The review team noted that clinic management and attendance was often affected by availability of clinic rooms, and considered there was a need to allocate sufficient clinic rooms for trainees, so that clinics could be held face-to-face, for the benefit of patients and trainees.

The review team considered that there was a lack of provision for endoscopy training for registrars. They were concerned to hear reports of junior doctors having to undertake endoscopy sessions on non-working days in order to gain experience, given the lack of protected time for this. In addition, the review team found that lengthy ward rounds, with 40-50 patients on the list, were not conducive to teaching and training, but were focused on service delivery.

It was noted at the time of the review visit that there was a plan for the return of Deanery trainees to the Trust in October 2023. Whilst the review team had no information as to whether this had been successfully facilitated, they considered that there is a need to urgently evaluate the commitment of the Trust to training, alongside service provision, to ensure the success of any programme of return. A training programme for trainees should be put in place, including teaching ward rounds, clinics, endoscopy and formal teaching of at least two hours per week.

3.5. Other

The review team made observations on the following matters, which formed important context and background to this review.

3.5.1. Leadership within the Trust

Serious concerns about a wide disconnect between staff within the surgical teams and the executive leadership within the Trust were identified. The review team found that there was a lack of visible presence of the executive leadership 'on the ground' amongst staff, for example on the wards, and a reluctance to engage with the department, and therefore a lack of true understanding of the challenges affecting clinicians. The review team noted that this was commented upon by a number of interviewees.

The review team were particularly concerned to learn that a 'culture of fear' existed amongst staff when it came to the executive leadership team. There were concerning reports of bullying by members of the executive leadership team, with instances of confrontational meetings with individual consultant surgeons, when they were told to "sit down, shut up and listen", with no ability to express their own concerns, and where they were alone and outnumbered. The review team noted that several consultants had reportedly left the Trust as a result of these issues and others were reluctant to engage with the executive leadership team, including refusal to attend further meetings.

The review team found that staff were reluctant to respond to whistle-blowing requests, given they had experienced instances of other staff members raising concerns through such mechanisms reportedly facing bullying and being dismissed. Whilst the appointment of the Chief of Surgery was found to be positive, as staff felt when they raised concerns they would be taken more seriously, the review team found that the listening stopped at this level, with repeated reports that communication with the executive leadership team was poor.

Several interviewees commented that a number of internal and external reviews had taken place, but there had been a lack of adequate communication about the outcomes, actions and progress in relation to those reviews. The review team heard that staff had several meetings with

senior management, but described these to be 'all talk and no action', with nothing changing as a result of those meetings when they tried to raise concerns.

There is a need for the executive leadership team to spend regular time with clinicians within the department, to create more of a visible presence and to truly understand the challenges faced by clinicians and break down the current disconnect which existed. This could involve members of the leadership team spending a day each week on the surgical wards, theatre and outpatients to appreciate the hurdles faced by staff working in the department. The review team considered that having a more visible presence would demonstrate to staff that they are valued and that the executive leadership team want to help them in addressing concerns and challenges. The review team considered that in meetings between clinicians and the executive leadership team there should be more robust action to show that concerns raised have been listened to and that they will be actioned. Those concerns should be documented in thorough meeting minutes, with action points for specific owners clearly defined in the meeting minutes, so that progress can be monitored and followed up at routine intervals.

3.5.2. Internal and external reviews, and reputational damage

The review team found there was a history of an extremely challenged department and Trust, with a number of internal and external reviews having been undertaken, including by the CQC, HEE and other bodies. This had resulted in a negative reputation for the Trust, particularly with a lot of press and media attention. The review team considered that there were common themes in previous reviews around the following: poor leadership, a disconnect between clinicians and management, a negative working culture and poor behaviours. They heard that staff reported receiving no feedback about these reviews, or evidence of change and recommendations being implemented. In addition, a number of staff reported regularly taking issues to management, who appeared to listen but no action was taken as a result. As a result, the review team found many staff were not hopeful that this invited service review would result in change.

It was apparent to the review team that there was a feeling of relative hopelessness within the general surgery department and it was clear that these reputational and cultural issues had affected the morale of many passionate and committed members of staff, some of whom had worked in the Trust for 20-30 years. There had been a loss of long-standing members of staff, and the negative reputation of the Trust was impacting recruitment, meaning that high-quality consultants were unlikely to apply to work in the Trust. The decision of the CQC in the weeks preceding the review visit regarding the UGI service had further negatively impacted the reputation of the general surgery department, reportedly contributing to resignations and also affecting the willingness of surgeons, particularly UGI, to apply and work for the Trust.

The review team concluded that there was an urgent need for the executive leadership team to take seriously the recommendations from all previous reviews, the recommendations from this invited service review, and to take robust action to address the issues identified. The executive leadership team should ensure feedback from reviews and the action which will be taken is provided to staff in a timely manner. Given what appeared to be a history of commissioning further reviews without taking pertinent issues forward, the review team would suggest that the Trust focuses on addressing all issues identified and implementing substantial improvements before requesting any further reviews. The review team concluded that there will need to be commitment from leaders and managers to rebuild an extremely strained department and organisation with sufficient resources dedicated to this.

3.5.3. Staffing and recruitment

It was acknowledged that there had been difficulties in retaining staff, with several resignations reported, as well as difficulties in recruiting permanent and substantive staff. However, the review team considered there was too great a reliance on short-term and long-term locum contracts in order to keep the services and department going. The review team noted there were reports of variable and inconsistent clinical performance from locums, which resulted in a greater burden of responsibility for permanent staff, an inequitable distribution of workload and a lack of continuity of patient care. The review team were also concerned by the fact that the clinical lead

for EGS, who had taken up roles in governance, education and training, was on a locum contract. They considered that there was a need for staff to be rewarded, incentivised, respected and valued when it came to recruitment and retention, and this specific example suggested a lack of reward and value of this individual, in addition to the level of workload, for someone who was a relatively junior consultant.

It was noted there had been a number of UGI consultant resignations following the CQC decision preceding the invited review visit, and the uncertainty regarding the OG cancer service. There appeared to be a lack of plans to recruit UGI surgeons, although the uncertainty regarding the OG cancer service would impact on the ability to attract UGI surgeons. In order to address this the review team considered there to be an urgent need to determine the future OG cancer service pathway and what this will look like in collaboration with the Guildford site.

As previously detailed in [section 3.4.2](#), the review team noted there was a significant lack of CNS staff, meaning that newly diagnosed cancer patients were not being seen and counselled in a timely manner. They considered that there was an urgent need to appoint more CNSs.

The review team noted that there was only one dietician and geriatrician within the general surgery department. The review team heard of the value that both of these individuals provided, but found them to be stretched in capacity. The review team considered that further posts will need to be recruited, which could potentially enhance surgical performance and the ability to see more patients in a timely manner.

3.5.4. HR policies and processes

The review team heard reports about inefficient Human Resources (HR) processes meaning that there were delays in writing to candidates who were successful at interview, resulting in potential appointees reportedly taking up roles elsewhere. The review team heard that one of the consultants had resorted to contacting candidates directly, which was not within their job remit. The review team found that there was a need to ensure all aspects of recruitment are watertight, in order to build safe and sustainable staffing levels across the Trust.

The review team were particularly concerned by reports of a lack of adherence to thorough disciplinary processes, which should be in place to ensure fairness and protection towards employees. The review team heard concerning reports of staff being asked to attend disciplinary meetings without any prior notice, without access to a representative or an accompanying individual for moral support, which resulted in staff feeling intimidated and overwhelmed as a result.

As previously mentioned at [section 3.5.1](#), the review team considered that there was information to suggest that whistle-blowers were poorly treated. They noted that staff were reluctant to raise concerns and utilise whistle-blowing mechanisms given experiences of previous staff who did so reportedly being subject to bullying, disciplinary procedures, referral to their professional regulator and facing being dismissed. The review team considered that the treatment of whistle-blowers supported the reports of a 'culture of fear' which existed amongst staff within the general surgery department. The review team were of the view that there is an urgent need to review whistle-blowing and disciplinary policies, to provide training so that all staff are aware of these and their own responsibilities, and this should be monitored to ensure that these policies are closely followed. They considered this to be essential so that clinicians feel able to raise concerns.

4. Recommendations

4.1. Urgent recommendations to address patient safety risks

The recommendations below are considered to be highly important actions for the healthcare organisation to take to ensure patient safety is protected.

1. The Trust should review the contents of this report, and discuss them with all relevant staff within the general surgery department and the Trust. Prior to doing so, the Trust should consider its obligations towards staff in relation to confidentiality, and to patients in relation to GDPR²⁷.
2. The findings of this report should be brought to the highest levels of the leadership of the Trust for their consideration.
3. The Trust should urgently determine the future direction of the OG cancer surgical pathway. In order to foster collaboration, better links and relationships will need to be developed across the region, including with surgeons at the Guildford site, where OG cancer surgery is now taking place. The Trust will need to ensure there are robust and interesting job plans for the UGI surgeons, in order to attract and retain these individuals within the service.
4. In order to establish better control over the emergency and elective workload, more control and management of ward rounds and the reduction of outliers:
 - a) There should be a return to a three-tier system for the general surgical teams (EGS, UGI and LGI).
 - b) Appointment of additional EGS surgeons, in order to manage the emergency workload, should take place. Appointment of a minimum of six dedicated EGS surgeons is recommended.
 - c) There should be recovery of ward Level 9A as a 70-bedded surgical unit, with the redeployment of gastroenterology patients elsewhere.
 - d) A Surgical Assessment Unit, either attached to the accident and emergency department or to ward Level 9A, should be established.
 - e) Ward rounds for emergency and elective patients should be separated, with dedicated elective surgeons undertaking ward rounds for elective patients, alongside the on-call surgeons for emergency patients.
 - f) Senior decision-makers should see the most unwell patients early on in the day during ward rounds.
 - g) There should be efforts to ensure the timely discharge of patients and to encourage patient flow.
 - h) An improved system to determine ownership and accountability for emergency patients, to ensure patient deterioration can be appropriately escalated and timely decisions can be made by a consultant regarding their care, should be put in place.
 - i) There should be an urgent evaluation of CEPOD list function and needs, with two lists available every day. An early morning huddle around 08:00/08:30 with all stakeholders involved in surgery should be established to ensure a timely start to surgical cases and to determine the priority of cases for the day.
 - j) There should be better control of emergency theatres in order to improve flow and free up capacity.

²⁷ The General Data Protection Regulation (GDPR) 2016: <https://gdpr-info.eu/>

- k) A consistent number of theatre lists to match surgical needs should be maintained by matching the amount of theatre time required for emergency and elective cases and ensuring they are allocated accordingly.
 - l) Teams of surgeons should work consistently together, with a named team of surgeons to manage the whole patient journey. The consultant surgeons should be run as small teams, with handover between each other, joint ward rounds, cross cover and to enable knowledge of who to contact when patients are deteriorating.
 - m) Consideration should be given to redistributing some UGI theatre lists to LGI in order to address issues with capacity.
5. To improve team working, communication and the unity of the department:
- a) Robust action should be taken to tackle unacceptable behaviours, including addressing hierarchical and unprofessional behaviours and poor communication directly with individuals, and to send a message that this will not be tolerated.
 - b) Managers and leaders should be invested in addressing poor practices and behaviours, taking appropriate action to respond to concerns and to improve working culture. To assist with this, appropriate training should be given to managers and leaders where necessary.
 - c) There should be a concerted effort to address fractured relationships in order to promote healing and build cohesion within the department. The Trust could explore external mediation sessions for the consultants and senior management in order to address fractured relationships.
 - d) Opportunities for face-to-face discussions within the department, on a formal and informal basis, should be maximised.
 - e) Improvements and achievements within the department should be celebrated, with best practice shared. Effort should be made to ensure positive feedback is given to staff who are doing a good job. There should be consistent efforts to ensure the surgical teams feel respected and valued.
6. In order to ensure the successful return and integration of trainees, as well as a balance between training and service delivery:
- a) There should be a reinstatement of registrars undertaking outpatient clinics, with the allocation of sufficient clinic rooms to enable this to take place face-to-face.
 - b) A training programme for trainees, including teaching ward rounds, clinics, endoscopy and formal teaching of at least two hours per week, should be introduced.
 - c) There should be a weekly face-to-face meeting between the consultant body and the junior doctors to allocate training opportunities and manage the service requirements.
 - d) There should be a weekly session where consultants meet registrars, with sufficient teaching and training opportunities, such as joint ward rounds.
 - e) A lead for Deanery trainees should be appointed to ensure the fair allocation of training, rather than this being subject to consultant preferences.
7. The Trust should ensure all colorectal surgeons are trained in robotic surgery, with opportunities to undertake this at the PRH site.

4.2. Recommendations for service improvement

The following recommendations are considered important actions to be taken by the healthcare organisation to improve the service.

- 8. The job plans of all consultant surgeons within the general surgery department should be reviewed to check the ongoing suitability of historical arrangements and reasonable adjustments, and to ensure a fairer and equitable distribution of duties, particularly with regards to the on-call rota.

9. Job planning should be undertaken as a whole group of surgeons, rather than individually, to encourage individuals to work together, to break down silo working and to ensure the needs of the service are met.
10. To improve the effectiveness of M&M meetings, these should be held with in-person attendance being the default, in order to encourage greater team building, particularly for consultants who work on different sites so they feel more part of the team.
11. The Trust should encourage the surgical team to visit and learn from other Trust sites, in order to replicate best practice and good ways of working with regard to M&M and clinical governance processes.
12. There should be a fairer distribution of governance duties and workload amongst the different clinical leads. Support should be given to the locum consultant to ensure that additional duties do not impact on their clinical performance, in addition to consideration of their status as a locum.
13. The LGI lead role should be re-evaluated to ensure effective leadership is demonstrated.
14. In order to improve the effectiveness of MDT working:
 - a) Consultant surgeons should work in small teams to enable patients to be allocated to surgeons early on in the pathway and so those patients can be presented as cases at MDT meetings.
 - b) Consultant surgeons should have sufficient job planned time for preparation of patient cases for presentation at MDT meetings.
 - c) Consideration should be given to consultant surgeons' job plans to ensure they have protected time to participate in MDT meetings.
 - d) There should be a re-defining of which patients need to be discussed at MDT meetings, to avoid an excessive number of patients on MDT lists. Formal criteria for referral to MDT should be established, written and available to all staff.
 - e) CNS staff should support the management of the MDT, in terms of the way patients are allocated and managed, in addition to giving feedback to patients after MDT meetings.
15. Consultant surgeons should be given sufficient job planned time in order to respond to patient complaints in a timely manner.
16. Efforts should continue to increase the capacity of CNS staff through allocation of additional funding for more posts as appropriate, in particular within the LGI service, to ensure that there are sufficient levels of support and communication with cancer patients throughout their pathway.
17. There should be recruitment of at least one additional dietician and an additional surgical liaison geriatrician within the general surgery department, to address current capacity issues and to enhance the ability to see more patients in a timely manner.
18. There should be more effective workforce planning, with efforts to attract, recruit and retain permanent and substantive staff and therefore reduce reliance on locum and other more precarious employment contracts.
19. There should be efforts to foster more collaborative regional links, including developing better working relationships between the surgeons at RSCH, Worthing Hospital and the Royal Surrey County Hospital, Guildford.

4.3. Additional recommendations for consideration

The following recommendations are for the healthcare organisation to consider as part of its future development of the service.

20. To break down the disconnect between clinicians and the executive leadership team:
 - a) The executive leadership team should have a more visible and regular presence within the general surgery department. This could involve leaders spending a day each week on the surgical wards, in theatre and in outpatients to greater understand the day to day realities and challenges faced by clinicians. Such shifts should take place within the department over a number of months so that clinicians know that leaders are committed to taking their challenges seriously.
 - b) There should be regular meetings between clinicians and the executive leadership team. Leaders should be transparent with feedback from all internal and external reviews and should set up discussion forums for staff about these reviews.
 - c) Leaders should show that they are listening and taking concerns seriously with a commitment to robust action, as well as ensuring this is documented thoroughly in meeting minutes, so that action points and progress can be monitored and followed up at routine intervals.
 - d) Training should be provided to leaders in taking effective action to respond to concerns, in handling whistle-blowing and disciplinary processes and in addressing unacceptable practices such as bullying and harassment.
 - e) Consideration should be given to the suitability, professionalism and effectiveness of the current executive leadership team, given the concerning reports of bullying.
21. The Trust should ensure robust action is taken to address issues and implement recommendations as a result of previous reviews and this invited service review. The Trust should avoid commissioning further reviews until all issues from previous reviews and this invited service review are addressed.
22. The Trust's HR department should review policies and processes to ensure:
 - a) Avoidance of unnecessary delays during recruitment of staff, with time limits being set.
 - b) All staff are aware of their responsibilities with regards to whistle-blowing and disciplinary policies and processes, and that these are enforced.
 - c) Effective support should be provided to whistle-blowers so that they feel psychologically safe in raising concerns. Open discussions should be encouraged.
 - d) Exit interviews are conducted for all staff leaving the Trust, and themes are taken on board from feedback for improvements.
23. The Trust should start coordinating and collating patient survey data, in order to consider the patient experience and how this can be improved.

4.4. Responsibilities in relation to this report

This report has been prepared by the Royal College of Surgeons of England and the Association of Surgeons of Great Britain and Ireland under the IRM for submission to the healthcare organisation which commissioned the invited review. It is an advisory document and it is for the healthcare organisation concerned to consider any conclusions and recommendations reached and to determine subsequent action.

It is also the responsibility of the healthcare organisation to review the contents of this report and in the light of these contents take any action that is considered appropriate to protect patient safety and ensure that patients have received communication in line with the responsibilities set out in the Health and Social Care Act 2008 (Regulated activities) Regulations 2014, Regulation 20.²⁸

4.5. Further contact with the Royal College of Surgeons of England

Where recommendations have been made that relate to patient safety issues the Royal College of Surgeons of England will follow up with the healthcare organisation that commissioned the invited review to ask it to confirm that it has taken to action to address these recommendations.

If further support is required by the healthcare organisation the RCS England may be able to facilitate this. If the healthcare organisation considers that a further review would help to assess what improvements have been made the RCS England's IRM service may also be able to provide this assistance.

²⁸ The Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014: <http://www.legislation.gov.uk/uksi/2014/2936/contents/made>

Appendix A - Information provided to the review team

The following section represents a summary of the information provided to the review team during the interviews held and in the documentation submitted.

This section is largely organised according to the [Terms of Reference](#) agreed prior to the review but also takes account of the themes that emerged whilst reviewing this information. Information provided by interviewees during their interviews is presented as it was reported to the review team at the time of their review and circumstances may have changed subsequently. It is summarised in an amalgamated and anonymised format.

The information presented will sometimes reflect the viewpoints of individual staff members and some viewpoints described may be contradictory or may have been expressed in the absence of further, substantiating information. Recording these viewpoints is not intended to imply their factual accuracy. The information in this section does not necessarily represent the review team's opinions, which are provided in the [Conclusions section](#) of this report.

1. Effectiveness of current clinical governance practices and clinical leadership to ensure safe outcomes for patients

- a) Standard of outcome measures/audits to uphold patient safety, including complication and mortality rates, and how these compare with regional and national benchmarks, and whether appropriate processes and systems exist to ensure high quality outcomes

The review team heard that governance was in the embryonic stages of development with staff hired to manage data coordination and input. They were told that there was a need for better data, with the governance and MDT coordinator needing to sit together and verify data in real time.

The review team were told during the review visit that the NELA and NBOCA data had been submitted without any issues. It was reported that the clinical governance coordinator and Personal Assistant would liaise with the audit coordinator regarding the submission of data. The audit coordinator would cross-check everything to ensure data was accurate, and if there were any issues, they would request clinical notes to double check.

- b) Effectiveness of current clinical governance processes, including M&M meetings

Governance

The review team heard that the corporate project identified issues with getting people together in person and a lack of engagement with meetings held online. It was reported that the corporate project had given staff the ability to say things which were being noticed and listened to and that things were changing. The review team heard that there were now more robust governance processes, which were still in development and, if this continued, the service should be able to identify issues straight away.

It was reported that 12 months into the corporate project (at the time of the review visit) there were proper clinical governance processes, including the development of M&M meetings, MDT meetings and consultant meetings, with improvements in culture, teaching and training. The directorate was reported to be better resourced with a governance lead, a Personal Assistant and operational managers. The review team heard that the MDT meetings had good attendance, taking place in person and online. The review team heard that whilst in-person attendance had increased, this was difficult to mandate as it created issues of accessibility. It was stated that the meetings were in person unless individuals had clinical commitments or were on another site.

The review team heard that with the appointment of the Chief of Surgery and the new clinical leads, staff felt their concerns were listened to and acted upon. This included nurses being

listened to and a reported improvement in working relationships across the MDT. It was reported that, previously, there had been issues in escalating deteriorating patients, but this was now acted on, with doctors coming to the nurses to speak about their concerns.

The review team were told that bi-weekly directorate governance meetings were held to go through complaints and serious incident risk registers. There were weekly meetings to go through Duty of Candour letters and delays. It was reported that at the end of these meetings participants would look at learning and try to understand trends.

Complaints

The review team heard that there was a high volume of patient complaints within the directorate, with 45 open complaints at the time of the review visit. It was reported that the most common themes with complaints were:

- Communication, for example around appointment times and patients not understanding their treatment plans;
- Staff attitudes in terms of being patronising, rude and dismissive; and
- Waiting times.

The review team were told that surgeons needed to be clear to patients when delivering news on pathways, treatment and complications to ensure that patients understood and their expectations were managed. In this respect, it was reported that it would be good to have the initial consultant present at the first appointment available after the operation to speak to the patient post-operatively. With two consultants present, one could more easily say what was and was not said; and that if this could not happen, a discussion with two consultants should be arranged. The review team heard that it caused doubt for patients going to see different consultants.

The review team were told that since the Chief of Surgery was appointed there was a clear route to share concerns about staff attitude, and conversations with staff were enabled, along with robust action being taken. The Chief of Surgery was reported to attend patient meetings and to be supportive in liaising with patients' families for difficult complaints.

The review team heard about the complaints process; complaints would be acknowledged within three working days, and patients would be contacted by telephone for an introduction and to understand their expectations. The complaints manager would seek comments from clinicians and investigate the complaint. The review team were told that, whilst the target time for a response to a complaint was 25 days, this was unachievable, and therefore the team worked towards a 40 day deadline. It was reported that a relationship was maintained with the patient, so that they knew the investigation was progressing. The review team heard that patients were called to give assurances and to let them know someone was working on the complaint if they had not heard from anyone in a while, as well as apologising for delays.

The review team heard that having specific governance staff had improved the surgical response to complaints, as there was more support and ownership in reviewing, tracking and progressing complaints. Meetings were reported to be held on a weekly basis to review complaints and identify any glitches in the process. It was reported that there had been a reduction in complaints over time. Individual surgeons' practice had reportedly improved through complaint processes with examples provided. The review team also heard that CNS staff encouraged patients to feedback issues to the PALS to ensure their voice was heard, but beyond that the CNSs were the patient advocates.

Incidents and Investigations

The review team heard that specific governance staff had been appointed to oversee investigation of patient safety incidents and the Duty of Candour process. They would go through complaints and ensure they were responded to in a timely manner as well as looking at learning and action points to feed into governance discussions. It was reported that the resources were previously not in place, so there was no communication with patients and

families about investigations, and some reports and investigations were overdue, with some being outstanding for one year. The review team were also told that surgeons were often not allocated time to respond to complaints and write reports, with one or two of the surgeons having a substantial amount of outstanding complaints, but a high workload. It was mentioned that there were historic serious incident cases which needed reporting on, and a report writer had been employed to work on these reports. The review team heard that these new governance roles would provide the coordination support in order to oversee outstanding reports.

The review team heard that clinicians needed time allocated to get on top of outstanding governance administration and then, once they had, they would only need an afternoon or one day per month. It was reported that there were times where there was no other solution than to reduce clinical commitments or clinicians agreeing to do an additional session in order to complete governance work. The review team heard that surgeons needed clarity on processes for patient safety investigations, in terms of how they arose, were reported, investigated, outcomes, learning and implementation, in addition to training on the Duty of Candour process.

The review team heard that outcomes and learning points from complaints and investigations were fed back at M&M meetings, to ensure learning was complete.

Meetings

Views were expressed that it was positive that meetings had been held virtually since the COVID-19 pandemic, making it easier for people to join, and it was positive that patients could speak remotely to people. However, it was also reported that this had been detrimental for clinical working and the functioning of teams. It was mentioned there were meetings held where some people had cameras off, therefore there was more encouragement of face-to-face meetings, particularly for difficult cases, as it was considered important to meet as a group which was conducive to team working and building. However, the review team heard that whilst many staff would like to mandate in-person attendance, there was an issue of a lack of space.

It was reported that there used to be weekly colorectal and UGI meetings to go through all patients which had worked well but this had stopped. The review team heard that all colorectal surgeons from St Richards Hospital, Chichester and Worthing Hospital had been invited to a hub meeting and, whilst the Worthing Hospital surgeons attended, the Chichester surgeons reportedly did not respond to the invitation.

New Clinical Leads

Historically, the leadership of the surgical department had reportedly not been good, with one surgeon leading the service and covering all governance issues, which was reportedly 'impossible' for one individual to do. As part of the corporate project there were now leads for LGI, UGI and EGS, as well as a Clinical Director to distribute leadership. The clinical leads were tasked with issues which had been repeatedly raised, including governance, patient safety, quality of services and behavioural issues. The leads were described as being "dynamic" and it was considered by staff there had been a shift and change. The review team heard that the leads had been effective with respect to MDT meetings and governance and really wanted to help. It was reported that, with the leads in place, there was now a route to raising concerns regarding patients, complications and M&M. It was reported that it had been a positive move giving these lead responsibilities to new individuals, with a 'fresh pair of eyes', in order to provide a different perspective. The review team heard that regular meetings were held with the leads, matrons and ward managers to tackle issues, in addition to a senior nurse acting as a voice for the FY1 doctors, speaking with the lead about logistical, practical and behavioural issues.

The review team heard that the leads were starting to receive coaching, as they needed leadership support. A coach had been identified to provide 'etiquette stability saves lives' type training. It was reported that the leads would be provided with someone external to speak to in order to develop them as leaders.

It was reported that one of the clinical leads had taken on responsibilities in acute surgery, governance and education. They were a junior consultant, and it was mentioned that usually these duties would not be distributed to such an individual, but no alternative person had been identified as suitable for the position. This individual was described as a 'breath of fresh air' in terms of their style and leadership approach and was doing well with their multiple duties. However, it was reported that there was an issue with this individual's own operative complications, and they had agreed there was a need for mentoring and dual consultant operating. In addition, the review team heard that this individual was a locum, therefore it may be difficult to get 'buy in' from colleagues in terms of improvements. The review team were told that there was too much responsibility for this individual, and the department was not providing support in sharing the workload.

M&M

M&M meetings took place once a month on Fridays and were held for two hours. These meetings were open to the entire department, including clinical, administrative and managerial staff. It was reported that the department would try and ensure everyone was available to attend M&M, but there was pressure with clinical activity, and cancelling commitments could be challenging when they were already struggling to keep up with clinical work. The review team heard that in person attendance was encouraged for more engagement but there was an online option for those with clinical commitments, although there were views that people joining meetings online lost the sense of team building.

The review team heard that consultants would tell the FY1s and clinical assistants about cases and complications, and senior house officers would prepare presentations detailing the sequence of events, issues and learning points which junior doctors would present. This would then be opened up to the group for comments, questions and obtaining feedback. It was reported that consultants would give updates on the ward rounds which the clinical assistants would summarise, and the ward clerks would make notes of cases with complications put forward for M&M.

It was reported that since November 2022 processes had been in place to capture the meeting minutes which were then available on the shared drive. The review team heard that cases had sometimes been presented without notes available, but processes were now in place to ensure the notes were available and that the consultant involved in the patient's care was present to comment where possible. It was mentioned that literature searches could be done live in meetings so there was an evidence base to support decisions. There was a librarian available to go through live articles and research on a database, which provided for analysis of data, results and patient thoughts. It was reported that outcomes from complaints and investigations were fed back at M&M meetings, which ensured there was learning from these meetings.

It was reported that M&M meetings had seen a positive change, with good, healthy discussions taking place. The review team heard that the meetings were helpful and collegiate. There were occasions when there were 'spirited' discussions, but in an open way with explanation of rationale. It was reported that, if there was a complication or problem, staff would feel comfortable in raising it as M&M helped to support challenging cases.

2. Quality and safety of surgical care provided at an individual and department level

a) Whether the management, selection and distribution of cases within the upper GI, lower GI and emergency general surgery service is equitable

The review team heard that there was a need to spread elective capacity. On some days one elective case might be booked for an ICU or High Dependency Unit (HDU) bed, whilst on other days, six cases might be booked. It was reported there was a piece of work ongoing to spread this out, with the expectation that there would be three to four elective cases per day. The review team heard that some general surgery was done at PRH but not complex general surgery or emergencies. It was reported that PRH ICU had capacity to do more work, but a lot of their

services, such as interventional radiology, had been removed, meaning that cases ended up needing to go to RSCH.

It was reported that some surgeons were 'hanging onto' lists, whilst others were doing what they were given on the day. The review team heard that some surgeons had regular lists, protected time and were operating frequently, but that newer staff were 'lucky to have half a list once a week or once a fortnight'.

The review team heard a wide range of reports regarding equitable distribution of duties. These included:

- Some of the more senior surgeons were doing fixed sessions but were not providing on-call/emergency duties.
- Three LGI surgeons did on-call ward rounds, but the rest had issues with health and were taken off the rota.
- The rota was based on how things were during the COVID-19 pandemic, when people came off the rota, but were not put back on. There were 18-19 surgeons, but only seven to eight of the surgeons did emergency duties, including overnight on-calls. These adjustments had never been reassessed, and this had reportedly set a precedent, with half the department not undertaking certain duties. It was reported that a lot of these adjustments and special arrangements suited people due to their age.
- The review team heard that these adjustments led to some consultants doing extra duties, which introduced inequity and unfairness, leading to anger and resentment. In this respect, it was reported that lots of important work was not carried out by three senior surgeons and surgeons were refusing to do things, which led to the resentment of other surgeons given those individuals were fully paid despite not undertaking certain duties.

It was reported that the workload had significantly increased, with a deceleration of elective work. The review team heard that the department would 'pick up the pieces' for emergency work, which had a negative effect on elective work.

The review team were told that the department was under resourced. For example, there was a time where there were 34 all day lists for colorectal, and only one or two lists for UGI. It was reported that ideally there would be four to five colorectal lists a week (one per day). It was reported that, whilst there had been an increase in surgeons, there had not been an increase in theatre lists. The review team heard views that there should be collective/group job plans in order to address any gaps, which staff reportedly were in favour of.

Emergency General Surgery

It was reported that the delivery of EGS had been poor at the RSCH, with ward rounds of 50-60 patients, which was unmanageable. There were plans for a three-'firm' team within general surgery and this had not progressed, but there was a plan to move forward with UGI, LGI and EGS. The review team heard that there needed to be dedicated emergency general surgeons who could manage trauma, rather than getting general surgeons to do this, and that trauma patients would need to go to a dedicated firm and allow on-calls to be separated.

The review team were told that the RSCH was the biggest hospital for EGS, but it was reported that patients could wait four days for an emergency appendicectomy. It was reported that emergency cases impacted on the UGI and colorectal services. The review team heard that there was an issue if 20 additional patients were admitted as emergencies as the service could already have 40-50 patients on the inpatient emergency list at any given time.

Interviewees expressed the view that the RSCH should be an emergency and trauma-only site, with colorectal work going to Worthing Hospital (which had a robot), and UGI going to the PRH, which would require junior doctors to support with post-operative care. The review team were told that there had been a previous decision to bring all elective surgery from the PRH to the

RSCH, but that elective work could be taken back to PRH, and that nursing staff would need to be trained and the consultant set-up rearranged for this.

Upper GI Service

The review team were told that things had previously been going 'well' within the UGI service, which included expansion and receiving cancer cases from Eastbourne and Hastings. It was reported that there had been good outcomes and no mortality. However, in August 2022, following an on-site review, the CQC declared the service to be unsafe and implemented an emergency suspension. This reportedly led to two surgeons resigning. The review team heard that, following this decision, a lot of changes were made, including funding for new CNS staff, dieticians and surgeons and securing more theatre space. It was reported that staff responded to, and met with, the CQC in March 2023, and it appeared to those interviewed that the CQC were happy with the changes made and that things were going in the right direction, after a lot of hard work over the previous nine months. This included the February 2023 NELA data which appeared to show that RSCH results were better than average compared to other units and that the mortality rate was reportedly acceptable.

However, three weeks prior to the RCS England invited review visit, it was reported that staff were told that the UGI service would not be returning, that it would be going to the Royal Surrey County Hospital in Guildford indefinitely and that the RSCH would be a satellite centre managing patients' post-operative care. It was also reported that the hepato-pancreato-biliary service²⁹ would be going to the Guildford site. Staff were reportedly told that, if they wanted to do UGI work, they could work at the Guildford site. It was mentioned that going forward pre-operative work would be done at the RSCH, with the pathway staying there, but patients would go to the Guildford site for their surgery. The review team heard views that this decision would impact patients, who would have to travel and that their pathway would become 'muddled'. They were told that patients were already unhappy that staging investigations were taking too long for UGI.

This decision was reported by staff to be 'devastating' and 'unfair', and that it led to the loss of two UGI surgeons, leaving one UGI surgeon within the department who could not manage these operations alone throughout the year.

The service was also reported to be unsustainable with a lack of staff, meaning the Trust could not support complex operations, the UGI on-call rota and benign cases.

The review team were told that there was no plan for UGI cancer surgery returning to the RSCH and there would only be benign surgery, and anything more complex would go to the referral centre. It was reported that it would not be possible to attract UGI surgeons, including registrars, without an OG cancer service. The review team heard that the UGI surgeons were frustrated, having not operated since August 2022, and therefore they were not keeping their skills up to date. Interviewees said that management needed to indicate what the plan was, in terms of whether services would be kept or moved to other hospitals.

The review team heard views from some interviewees that the suspension of the UGI cancer service was the correct decision but not for the right reasons. It was explained that it was not that surgery was being performed unsafely or that surgeons were unsafe, but that the MDT function was not working properly, with patients not getting the service they should have on the diagnostic pathway. It was reported that there had been delays from the two week referral, performing CT scans, reporting CT scans and the processes involving the MDT. This also included delays from interventional radiology, endoscopy and access to beds when patients were attending for procedures and radiology. The review team heard that the UGI MDT had not been well led, with too much focus on the MDT supporting the pathway but lacking clinical leadership. It was reported that there was a lack of CNS staff to support patients referred from Worthing Hospital and East Sussex, and that the CNS staff felt unsupported and demoralised, with only one dietician providing full support to the cancer patients.

²⁹ Diagnosis and treatment of surgical diseases of the liver, pancreas, biliary tract and gallbladder.

It was reported that there were two UGI surgeons who were engaged with getting things 'back on track' with a desire and commitment to 'turn the MDT around'. The review team heard that they had worked hard to amalgamate clinics, so that 'breaking bad news' clinics were held at a better time, as well as securing funding for extra full-time CNS staff and a dietician support worker to improve the services. It was considered by some interviewees that focusing on responding to the CQC in order to get the UGI service back would not be the right focus. Instead, some staff considered that it would be preferable to bring the services together and strengthen the surgical team by building links with the Guildford site, in order to build a joint MDT, which would strengthen the quality of the MDT function, and that a joint approach made sense from a patient perspective.

However, the review team heard reports that there was a strained relationship between the RSCH and staff at the Guildford site, with the latter reportedly not supporting joint working, which would make building the pathway a challenge. It was reported that the RSCH UGI surgeons were not given a warm welcome at the Guildford site, and that the Guildford surgeons had undermined the RSCH surgeons with fractious meetings held between them. In addition, it was stated that the Trust leadership did not encourage links with the Guildford site, with their focus and priority being on getting the UGI service back. The review team heard that, given the UGI service had moved to the Guildford site, there was a need to develop good relationships and bridge gaps, with interested parties to operate, teach and train. This would include appointing new surgeons to build those links with the Guildford site and this being recognised in their job plans. The review team were told that in addition to developing a regional MDT between the RSCH and the Guildford site, local MDTs could feed in from Worthing Hospital and Eastbourne. The review team heard that, ultimately, the UGI service needed to return on a joined-up and regional level, and that it did not matter where the operation was done, but that the service needed to deliver a safe pathway for patients. The review team heard views that whilst, in the interim, it was not a bad idea for the service to be suspended, it needed to re-emerge in the longer term in a form capable of attracting excellent clinicians.

The review team heard that the UGI CNS staff would discuss patients at MDT meetings, and if surgery was decided upon, the case would be referred by the MDT coordinator to the Guildford MDT meeting on a Tuesday morning in order to make an informed decision. The review team heard that a patient would see an oncologist at the RSCH, would have any treatment prior to surgery including chemotherapy and radiotherapy, would go to the Guildford site for surgery and then return to the RSCH. However, the review team were told that patients were often not happy about having further investigations in addition to their surgery at the Guildford site, if they could not be accommodated at the RSCH. The review team heard that it was not ideal for patients to meet one surgeon, have someone else do their operation elsewhere and then go back to see the first surgeon for follow-up; therefore it was considered by some interviewees that having the UGI service return to the RSCH would make a difference for patients.

The review team were told that, with the loss of UGI surgeons capable of opening a chest, and a lack of thoracic surgeons, management of chest trauma was compromised. They heard this would be dealt with conservatively, by inserting a chest drain and transferring the patient elsewhere. It was considered by interviewees that it was not ideal for the RSCH to be a major trauma centre without surgeons who electively open the chest on a regular basis. The review team heard that there was a need to decide what UGI surgery was going to look like at the RSCH, and whether this would be a benign service only. It was stated that benign UGI surgery would probably need to involve complex gallbladder surgery.

The review team heard that the CQC decision had made it difficult to advertise for UGI consultants as it was not known what the job plans would look like. It was said that permanent posts would need to be advertised cross-site to do operations at the Guildford site and other surgery at the RSCH. This would involve re-doing job plans and giving people the work they wanted to do. The review team heard from some staff that the only solution was 'hub and spoke' working with the Guildford site, with cross-Trust practising privileges. This would involve joint contracts for operating on both sites with the same level of teaching and training.

Robotic Surgery

Some interviewees reported that whilst surgeons at RSCH were involved in purchasing a robot, this was placed at PRH, so it could not be used at RSCH, and there was 'no strategy' for where RSCH surgeons would do robotic surgery. In this respect, the review team heard that robotic surgery had not been embraced at the RSCH. It was reported that robotic surgery had also been invested in at Eastbourne, taking colorectal surgery away from RSCH. The review team heard that at PRH the digestive diseases robotic lists started on time, with the arrival of surgical staff promptly, and that the robotic theatre was one of the most efficient.

b) Whether clinical-decision making and treatment provided to patients is appropriate and timely

The review team heard positive comments in relation to clinical decision-making and treatment provided to patients. It was reported that the employment of a Surgical Liaison Geriatrician had been positive, including the provision of ward cover when they were absent. In addition, the critical care outreach team was said to be good. It was reported that when patients were ill, the critical care and emergency team, consisting of a critical care outreach team nurse and an emergency senior house officer or registrar, would be available straightaway. The review team also heard that advanced trauma was managed well in accident and emergency, that there was an excellent anaesthetic and ICU team and that the nurses and doctors in the HDU were very good.

The review team heard that many staff agreed with the idea of a morning 'huddle' to manage the CEPOD lists. It was reported that, at the time of the review visit, a printed emergency list was used, but it was difficult to determine prioritisation. The review team were told that, whilst a morning huddle was previously agreed and suggested for 08:00/08:15, the surgeons were resistant as they needed to see patients first and undertake handover. It was also reported that it was difficult to have a morning huddle with no set meeting area or room. The review team heard that without a morning huddle taking place to decide on cases based on priority, theatre managers ended up making decisions based on what they thought needed doing but not necessarily in terms of true clinical priority. In addition, the review team were told that a divisional meeting took place at 08:45 on Mondays to Fridays to discuss beds and flow, and that whilst some clinicians engaged in this, surgeons were generally not interested in flow; surgeons reportedly were only interested in whether they would be able to operate and therefore did not attend these meetings.

The review team were told that when reviewing patients on the surgical wards, based mainly on ward Level 9A, the nurses and junior staff were not able to easily find senior support to listen to problems, give advice and to escalate deteriorating patients. It was reported that this had resulted in patients becoming more unwell and reportedly an increase in emergency calls and cardiac arrests.

The review team heard that there was a high emergency presentation for colorectal cancer, with patients with bowel cancer having developed bowel obstruction. It was reported that things had become worse since the COVID-19 pandemic, and that these patients were on elective waiting lists but they were still coming through as emergencies.

The review team heard that there were lots of issues with theatre capacity and flow through the wards, with Level 9A being extremely busy:

- It was reported that there was a lack of room in the emergency department, and there were regularly no beds and physical cubicles for patients, with patients left sitting on chairs in corridors in cramped spaces.
- With patients 'crammed' in corridors, this resulted in delays when on-call consultants were seeing patients.
- There were reportedly long waiting times but a lack of a waiting area for patients to wait. This led to patients becoming agitated, which was not good as their first entry point into the hospital.

- Due to capacity, the sickest patients had to be taken first. There was no surgical assessment area, so patients went wherever they could be fitted in, and if emergency patients were taken in other patients had to be moved elsewhere.
- The review team were told that a Surgical Assessment Unit would make a huge difference, allowing some control over the emergency intake, but this facility had not been factored into plans for the new building. It was reported that if this unit was not put in place the patient experience and surgery would not improve.
- There were views that the accident and emergency department was not fit for purpose for a major trauma centre.

The review team were told that there was an increase in the patient-to-nurse ratio on the wards, meaning that tasks did not get done and observations were delayed. This resulted in accident and emergency patients who needed admission being left to wait on chairs, potentially becoming more unwell before they could be admitted to a ward. It was reported that the whole Trust struggled with managing the flow of patients, being unable to discharge patients at sufficient pace.

The review team heard that ward Level 9A used to be a 58-bedded ward, and this expanded to a 70-bedded ward with an increase in pressure on surgery. There was then a decision to split this into two 35-bedded wards, one for general surgery and one for gastroenterology. This meant that the 70 original surgical beds were halved. The review team heard that this had resulted in difficulty accommodating all surgical patients onto Level 9A, and patients were geographically scattered throughout the hospital, for example on the trauma, neurosurgery, vascular, orthopaedic or gynaecological wards. It was reported that 30% of surgical patients (around 20-30) were outliers all the time, meaning staff had to work across different systems on multiple wards and buildings. Having to visit all these patients meant that ward rounds were inefficient and took far too long and that patients were on wards with an inadequate skill mix making it potentially less safe.

It was considered by some interviewees that Level 9A should be a surgical ward only, and that gastroenterology should be moved elsewhere to accommodate this. It was reported that this was hoped for with the new building, and that this would result in more beds on one unit, the ability to better manage patients and fewer outliers with all surgical patients on Level 9A. The review team were told that having an UGI and LGI side on Level 9A would mean surgeons could own those areas and be responsible for managing those beds. This would reportedly mean more support for juniors in theatre, and make services more effective with fewer cancellations, as well as reducing patients' length of stay.

The review team heard a potential way forward was a three-tier team of UGI, LGI and EGS, with a view to splitting up the responsibility for patients. It was reported that this had been agreed seven to nine years previously as a department, but this was not current practice. The review team were told that it was part of the target operating model of the corporate model to create three teams of eight. At the time of the review visit it was reported there were 17 consultants, and that four consultant fixed term contract posts were being advertised in order to facilitate this model. It was reported that three teams of eight would divide up patients and make ward rounds more manageable. The review team heard that more numbers in each team would mean more rotation on a regular basis, rather than relying on people to cross cover.

It was reported that consultants undertook daily ward rounds of 50-60 patients which was described as 'unmanageable', in that these tended to last all day, finishing as late as 16:00/17:00. The review team heard that this resulted in fatigued decision-making, particularly when seeing patients at the end of the day when surgeons were tired, and that this could potentially result in unsound decisions and compromise patient safety. It was reported that this was impacted by seeing patients who were not on surgical wards, and therefore they had potentially not been managed according to surgical processes and protocols. The review team heard that it had been agreed as a department that such large ward rounds were unsafe and unsustainable with the level of outliers, yet this practice continued to happen. It was reported that consultants had to do their ward rounds quickly, otherwise FY1s would not be released to

do their jobs in the afternoon. With ward rounds 'rushed', they would need to be completed by midday, which meant consultants were not being thorough with the patients. The review team were told that with the lack of a three-tier system, the on-call consultant had to see all patients. It was viewed that there needed to be an elective team to see elective patients and an acute team for emergency patients.

The review team heard that, with ward rounds of 50-60 patients, there were insufficient patient discharges. It was reported that it was difficult to make decisions regarding discharge late in the day, and that these decisions needed to be made early in the day. Whilst the review team heard that teams tried to identify patients for discharge the day before, often they were not identified until on the day, meaning the coordination was missing for processes to happen before they were discharged. It was reported that 'board rounds', to identify patients ready for discharge early in the day, were not happening; the value of these was not seen with patients scattered around the hospital. It was considered by some that board rounds would make expectations clear at the start of the day. The review team also heard that there were occasions where patients were supposed to be discharged but were missed off the ward round, so that they remained in hospital until the following day. It was reported that an average of a quarter of patients were fit for discharge but were 'just sitting there'.

The review team were told that there had been a piloting of an EGS team for four days to help with flow, and during those days there were more patient discharges, ward rounds were quicker and more acute patients were seen by the team. It was reported that there were plans to run another pilot for seven days, to see how a whole week including weekends affected patient flow, and that patient surveys would be taken during this pilot. Nurse feedback from the pilot of four days had been positive, particularly due to the increase in patient discharges.

It was reported that there had always been challenges with capacity and the ability to support elective activity, in terms of bed pressures and managing elective and emergency cases. The review team heard that elective surgery cancellation rates were high due to a lack of beds and theatre staff, with many patients cancelled on the day, and often patients were cancelled multiple times. This was reported to be happening on a daily basis, with at least one patient cancellation per day. It was said that patients were often in the theatre waiting area, and were cancelled from theatre admissions before being admitted, having prepared for surgery, which included starvation. The review team heard that sometimes patients were sat waiting for six or seven hours before they were cancelled.

It was reported that there were more theatre cases than could be dealt with, and each week theatre managers had to work out how to keep a list, with a number of lists being cancelled. This affected patients undergoing major surgery, including for bowel cancer, who had had long waits and were acutely ill. It was reported that theatre managers often had to start the day looking at who they were going to cancel. The review team also heard that when nursing and junior doctor strikes were held this resulted in further cancellations.

The review team heard that a 'hot and cold' split (separation of emergency work from elective work) would be very difficult. Whilst other sites allowed cancer cases to be protected from acute cases, it was reported that the RSCH had not managed to address this. The review team heard that 'cold' beds needed to be ring-fenced on another site so that patients operations could be carried out on the day. The review team heard that sometimes when there was capacity, there were no surgeons available to do a theatre list. It was reported that more lists and beds were needed, in addition to looking at capacity across sites and clinics and job planning appropriately, with job plans being aligned as a group.

It was reported that it was difficult for patients when booking surgery a few weeks in advance, as it was unknown if the surgery would go ahead; patients would plan and get mentally ready, only to have their surgery cancelled, potentially resulting in physical suffering. The review team heard that more patients were being referred for psychological support due to lengthy waits, delays and cancellations. Patients were reportedly in tears after being cancelled a number of times. It was reported that there were a lot of telephone calls from PALS and complaints in relation to cancellations, and a lot of time was spent reporting on reasons why patients had been cancelled.

The review team also heard that the inpatient experience 'was not' good with patients outlying for a while, being late onto the wards, not being picked up quickly and a lack of experienced staff where they were outlying. Pre-operative surgical patients were sometimes on the wrong wards.

In addition to theatre cancellations, it was reported that theatre lists did not start on time, especially when there was no ring-fenced ICU/HDU bed. The review team heard that some lists started without such a bed, which was a potential risk. The review team were told that staff could not get theatre start times to improve as a decision on bed availability was not made until 08:30 at the earliest.

It was reported that the psychological side of preparing for cancer treatment had improved, as previously patients were given one week's notice of surgery, causing psychological distress, but subsequently they were given four to six weeks' notice, with more time to prepare.

The review team heard that staff sometimes felt they were resolving practical surgical problems for patients but not addressing their holistic needs. It was reported that many patients would benefit from psychiatric input, particularly patients admitted under general surgeons following self-harm. However, it was also reported that psychiatry services were constrained.

c) The clinical outcomes for all general surgeons in the department, and whether this gives rise to concerns about poor outcomes

The review team heard that there were no concerns about surgical outcomes and patient safety. It was reported that all staff cared about patients. However, they heard that processes could be better. The review team heard that at the time of the review visit cancer performance had improved over the previous six months in terms of outcomes. It was reported that national audits demonstrated that the department was doing well. The review team were told that patient focused outcomes demonstrated improved leadership in the department.

3. MDT working, communication, behaviours and culture within the department

a) Team working, behaviours and communication

The review team heard from some staff that within the general surgery department there were 'amazing' and caring medical staff, nurses and theatre teams. It was reported that everyone, including the surgeons, cared and was passionate and did everything they could to provide the best service for their patients, amidst resource constraints and other challenges. It was said that the surgeons cared about their patients, colleagues and the profession. It was expressed that the surgeons were a team who could turn to each other for support. This included the colorectal surgeons, who were reported to work well together, providing cross cover, email exchanges, discussion and clarification around prioritisation and decision-making. It was reported that the colorectal surgeons would pick up the telephone and seek help with difficult cases.

However, at the same time the review team heard various reports about divisions, factions, a lack of cohesion and collaboration and a lack of team ethos within the general surgery department. They were told that there was a lack of collective ownership and pride in the service being provided. It was reported that the consultants worked as individuals, and that the service had evolved from 'a couple of surgeons doing things their way' and never having a team structure. It was said that when consultants were then under pressure they ended up focusing on what they alone were doing. The review team heard that the lack of team identity resulted in a lack of consistency, with one consultant on the ward one week and someone else there the next week, making it difficult to know how patient care would progress.

The review team were told about various issues with team working and communication with the consultant surgeons:

- Consultant surgeons were reported to be 'fine' as individuals, in that staff would get on well with them one on one, and they were approachable, receptive and helpful.

However, it was reported that they were disparate and individualistic, lacking communication skills and there were personality clashes with strong characters.

- There were said to be hierarchical issues with the consultants, in that there was a difference in their communication with more junior staff. For example, it was reported that nurses were not listened to and the behaviours of surgeons towards nurses was dismissive and unprofessional. The review team heard that suggestions raised by nurses would be ignored, but if raised by someone more senior, surgeons would consider them. In addition, nurses often had to resend emails to surgeons to get a response.
- The review team heard that nurses escalated concerns but these were often not heard and dealt with, and they were often shut down by consultants when standing up for themselves.
- It was reported that the surgeons were focused on looking after themselves and fighting their own corners.
- There was said to be dysfunction and a lack of cohesion, meaning that consultants could not work things out together.
- Consultants would become stressed and take things out on each other.
- It was reported that there was public friction between consultants, sometimes in front of patients and nurses and they displayed challenging and unprofessional behaviours, including shouting.
- These issues had impacted on trainees, who were reluctant to take on surgical jobs due to the behaviours of the consultants.

The review team were told that these behaviours and attitudes had been evident for a long time. It was reported that repeated behaviours had not been dealt with firmly enough in the past to prevent their recurrence, with no opposition voice, and there had been no consequences for poor behaviours so things continued as they were with incidents recurring. The review team heard that warnings had been given about formal processes but behaviours were still repeated. It was reported that those who were coming to the end of their careers were reluctant to change, and therefore certain individuals 'needed to go' as they would not change their behaviours. In this respect, the review team heard it expressed that new staff needed to come in with new ideas, beliefs and understanding to encourage staff in terms of how they should and should not behave.

The review team were told that the corporate project had started to address historic issues with behaviours, with behavioural contracts, team building exercises and the appointment of certain individuals. It was reported that there had been an investment in HR processes to send a strong message in relation to individual behaviours, for the benefit of the team and the safety of patients. The appointment of the Chief of Surgery had reportedly made a difference, in terms of monitoring and managing these issues, and they were said to be well respected by the team. The review team also heard that the appointment of certain clinical leads had made a difference, as they listened and wanted to make things better. Things had reportedly also improved since new consultants started, who were accessible, friendly and interactive with the team.

The review team heard that during the COVID-19 pandemic it was positive that patients could speak to clinicians remotely, but that this had been detrimental for clinical working and the functioning of teams. It was reported that people joining meetings online lost the sense of team building that was gained from face-to-face meetings. There were views that there needed to be more face-to-face meetings, as it was important to meet as a group.

The review team heard about specific incidents in relation to trainees, including a trainee experiencing shouting and berating from a consultant. Staff reported hearing of incidents of sexual harassment but they had no direct involvement, and that such staff who perpetrated such incidents had since left the Trust. Other trainees, however, did not report experiencing or witnessing incidents of bullying or sexual harassment. The review team also heard reports of a consultant who had slapped the hands of two trainees during theatre, and the incident reportedly

had not been properly resolved. It was reported that this individual had a poor relationship with the junior doctors.

An opinion was expressed that there needed to be a 'rebranding' for a sense of team identity and pride in the team and a need to find a way to work better as a team. Staff reported wanting to see teams work in harmony with more togetherness and less of a divide and 'us and them' mentality. The review team heard that the nursing and non-medical staff were starting to really come together, and it was opined that others should see what non-medical colleagues were doing in order to roll out best practice.

b) Culture

It was reported that there had been historic issues with the reputation and culture of the general surgery department, which had been under scrutiny for some time. The review team heard that the department had a reputation for being challenging and difficult to work in. The culture was described as being 'negative, aggressive and agitated'. One of the biggest issues with regards to culture was the behaviour of consultant surgeons in terms of their interactions and communication amongst each other and their relationship with trainees (see [section 3 a](#)) of the report). It was reported that concerns raised by junior doctors had not been listened to and acted upon. The review team heard that the leadership had therefore been minded to remove trainees from general surgery before HEE instructed this to happen. It was described to be humiliating to have the registrars removed from the department, but it was reported that trainees did not want to work in the department due to its history and reputation. The review team heard that the unannounced CQC inspections in 2021 raised significant issues around culture and behaviour in general surgery, with deteriorating team working, negative feedback from trainees and a hands-off approach and poor availability from consultants. This contributed to the decision to launch the corporate project.

The review team heard that some of the most significant issues with the culture of the general surgery department were time pressure and perfectionism. There was time pressure due to a lack of staff and people being overworked. It was reported that the general surgery department lacked an open culture where mistakes could be learnt from and instead there was pressure and negativity and a feeling of a need to be perfect and to not have complications. It was reported that there was a culture of negative relationships with authority, with surgeons refusing to take 'orders' from someone in authority, and a sense of working against authority rather than working together. The review team heard that there was 'firefighting' but a lack of nurturing of the consultants, resulting in many consultants leaving.

The review team were told that it was difficult to be listened to or heard in the Trust. There was reportedly a culture in which there was a lack of change or attempt at solutions when escalating problem issues. It was reported the consultants felt jaded and disengaged with nothing appearing to change until the threat of trainees being taken away.

It was reported that reputation and culture were having an impact on recruitment, and the more that could be done to address this, and to have a department which stood out, the better the applicants would be. The review team heard that coming out of the COVID-19 pandemic there was a sense of change amongst the executive team, due to staff feedback and issues raised by junior doctors. This resulted in the corporate project and it was reported that culture was starting to change for the better since the implementation of the project, although this was very much at the start of the journey.

c) Effectiveness of MDT working and discussions and documentation of this

The review team heard various reports about a lack of patient ownership by consultants:

- 'Hot weeks'³⁰ were described as being an issue, involving seeing patients one week and then not for another eight weeks, and handing them over to other surgeons. It was reported that this meant there was no formal plan or ownership of patients by consultants following patients throughout their pathway resulting in a lack of continuity. The review team were told that this meant there was a lack of recognition of deteriorating patients, a lack of decision-making and a lack of direction given to nurses, resulting in patients becoming more unwell.
- Some consultants were reluctant to give specific direction for patients who were very unwell.
- It was reported by some staff that no one had any idea who was responsible for the patients and that, when there was an issue, no consultant was willing to take responsibility to escalate and make a decision. This also meant a consultant may be allocated for a patient's surgery as the named consultant, but that the patient may never see them again after the operation. The review team were told that surgeons did not like this as they may be the ones to tell a patient they had cancer, but not the one to operate on the patient. In this respect, it was reported that a traditional firm structure had the advantage of a named person making decisions.
- If there was a consultant ward round, with named consultants for patients, it would enable decisions to be made about patient discharge.

It was reported that patients were on wards for inordinate lengths of time without being checked by the medical team. The review team heard that if issues with patients were raised with clinicians they would advise to continue with the plan but did not make informed decisions. For example, this could result in patients being on antibiotics for weeks without needing them. It was reported that registrars would give a similar response as they considered consultants should be the ones making a decision.

The review team heard that only four out of six surgeons were able to regularly attend MDT meetings. The MDT lead did the preparation, including fifty percent of the administration. Cancer patients were reportedly allocated to the MDT once they were on an operating list. Patients were discussed in order of priority to ensure a critical spread of cancers amongst the surgeons. Surgeons would be allocated patients four weeks in advance so that they could be seen in surgeons' outpatient clinics.

It was reported that MDT meetings were sometimes smooth and at other times they were 'chaotic', and this depended on who was chairing. Meetings lasted for two hours and at times there was an excessive number of patients, sometimes as many as 58 patients. The review team heard that radiologists spent a lot of time reporting and preparing, which was a high volume of work, but reportedly surgeons often were not prepared, and often nobody knew the patients. Without such preparation, patients ended up being 'recycled', as scans were not reported. The review team heard that it felt like 'a waste of time' if clinicians had spent hours preparing for the MDT meeting but the Chair did not know the patients and was not prepared. It was reported to be a long-standing issue in terms of surgeons not having job planned time for MDT preparation.

The review team heard that sound MDT processes were lacking, and there was a need for more formal processes agreed by the MDT. The review team were told that staging investigations were being repeated for patients as they had often already waited for three months in their pathway. The review team heard that there was a challenge in getting through patients in a timely manner at MDT meetings, particularly with not having an identifiable surgeon at the beginning of the patient journey. It was reported that there was a need to identify best practice in MDT pathways and to replicate this.

³⁰ A surgeon's on-call week, when they do not undertake any elective work, and are available the entire time for emergency surgery, clinics or ward work.

The LGI MDT was reported to be fragmented, with conflict due to a lack of good leadership. It was reported that the LGI MDT lead was 'strict', and that staff could only communicate with this individual about what went on the MDT list, even though the LGI MDT lead only knew the patients if they had seen them.

At the same time, the review team heard positive reports about current MDT processes. It was reported that the MDT had evolved from individual surgeons seeing their own patients and bringing them to MDT to a much more integrated approach. There had been a system where a patient was seen in clinic and then everything flowed under that consultant's care, including outpatients, surgery and post-operative care. It was reported that there was now a system where patients were discussed at MDT meetings, not under a named consultant and, when surgery was decided upon, the patient would go on a list. The MDT lead would speak to theatre managers once a week to allocate patients onto a list, looking at their needs to ensure fair distribution. The list would be drawn up six weeks in advance and surgeons were asked to check this in advance to ensure everything was done for patients and in order to raise any issues.

It was reported there was an evolution to the MDT hearing about cases as soon as the patient was diagnosed with cancer. The CNS would see the patient for an initial nurse-led consultation to go through a holistic needs assessment. It was reported that this speeded up the pathway getting CNS staff involved earlier, as there was usually a wait to see a surgeon and an oncologist. It was reported that when there was CNS capacity there was a proper structure, with clinics for patients to be followed up, patients mapped to scans and going straight to the MDT, which worked well in terms of patients having a clear follow-up template and structures, including when they would have surgery. The review team heard that this had improved the patient experience and timeliness of investigations, and there was excellent patient feedback around meeting a CNS within the first few weeks of diagnosis.

The review team heard that the MDTs were supported by a 'fantastic' coordinator, reasonable technological support and good radiology and pathology involvement. It was reported that there was good CNS input which had helped shape the MDT and working patterns. The MDT was reported by some staff to be functioning well.

The review team heard that during the COVID-19 pandemic MDT meetings started to be held online which worked well at that time. However, it was reported that staff would ideally like to return to in-person meetings, but there could be issues with room availability.

CNS Support

The review team heard that CNS staff get involved in patient care at the stage of cancer diagnosis. CNSs support patients through diagnostic staging investigations and treatment, with calls after MDT meetings so patients were aware of treatment options. It was reported that, as soon as a CNS met a patient, they would be given a new patient pack with contact details to contact the CNS if there were any concerns. The review team heard that, as soon as the first diary appointment was made, the patients would be on the CNSs 'radar'.

There were issues reported with regard to CNS capacity. It was said that three years previously the MacMillan service was fully staffed with a good functioning MDT, but it was reported that there were now staffing issues due to long-term sickness and staff leaving and some CNSs working part-time, resulting in a lack of CNSs. At the time of the review visit the service was reported to be reduced by forty percent with an impact on MDT working and the patient experience. It was reported that the CNSs had to prioritise with community patients over a helpline.

With these workforce issues it was reported that CNS capacity had reduced, resulting in them only being able to manage clinics and outpatients. The review team heard that CNS' used to book telephone calls with patients ahead of surgery to see how they were feeling, as well as several times throughout their treatment and post-operatively. CNSs would also visit patients on the wards after surgery but, given the staffing issues, the ability to undertake such duties (which minimised psychological distress) was reduced.

It was reported that the CNSs were doing nurse-led clinics, which received good feedback and surgeons were keen on this, but these had to be stopped due to staffing capacity. It was hoped they would return in order for CNSs to undertake holistic needs assessments and that such a first meeting was important to get to know patients. The review team also heard there were issues in securing rooms for nurse led clinics. The RSCH was reported to be an outlier where surgeons were seeing cancer patients without a CNS present and that, in most other units, if cancer was diagnosed, the surgeon would have a CNS with whom to see the patient. This was routinely brought up by surgeons in terms of not having a CNS in their clinics. It was reported that with sufficient CNS capacity they were the mainstay of understanding the patient journey, but with capacity constrained patients were not being seen by either a CNS or surgeon.

'Breaking bad news' clinics were reported to be 'all over the place' and were often held at weekends, when CNS staff were not available meaning CNS staff arrived at work on Mondays to see patients who had received bad news at the weekend. It was reported that patients were waiting longer for support that they needed following bad news. The review team heard that CNS staff had requested consolidated clinics to dedicate time for nurses to see patients.

The review team were told that when CNSs were struggling with capacity, they could allocate nurses from other teams to check messages and respond to patients. It was reported that if patients needed to be seen, CNS staff would try and accommodate this, but the biggest constraint was lacking access to a room to bring patients in regularly.

The review team heard that it was important for CNSs to visit patients, to provide support and continuity; the impact of the capacity issues had been detrimental to patients. The review team heard that the CNS staff appeared stressed and overworked with high caseload volumes, and these issues had impacted CNS morale. It appeared there was less focus on the importance of the CNS role and a lack of investment. It was said that they needed to be an increase in funding in order to get involved at the stage when there was a suspicion of cancer, not just at diagnosis.

It was reported at the time of the review visit that capacity was improving, with staff returning from long-term sickness. In particular, it was mentioned that CNS capacity within the UGI service had improved, but there was a need for more CNS support in the LGI service, although there had been no extra funding for this.

The review team heard that CNSs could have a bigger say in the way patients were allocated and managed in the MDT, but this could be influenced by the consultants. It was reported this would not happen in the LGI MDT due to the poor relationship between the consultants and nurses, the way the MDT was run and nurses not being listened to.

It was reported that a bid had been put in for a CNS rotational development programme to support their progression, training and development.

d) The balance between service delivery and junior doctor training

General

The review team were informed of historical issues with regard to the management of trainees. It was reported that limitations had been placed on working practices by HEE, which impacted all trainees, including those of staff or registrar grades, senior house officers, core surgical trainees and foundation doctors. This included registrars and house officers being removed from the service due to a lack of training and senior support. The review team heard that this had resulted in more temporary and locum staff, which had not been good for long-term planning or strategic thinking.

In relation to trainee capacity views reported included:

- Registrars rarely went to endoscopy lists as there was not enough time, or they ended up doing this on their days off.

- Junior doctors often had to take annual leave in order to undertake training courses.
- Registrars were not doing any outpatient clinics, partly due to a lack of registrars available for ward work and because of a lack of physical rooms for this. It was reported that it was 'difficult enough' for consultants to get rooms to see patients, 'let alone registrars'.
- Registrars could fail exams if they could not attend and speak about what they did in clinics.
- More space was needed in order to arrange a rota for the returning registrars in October 2023.

The review team heard that trainees had been unhappy with the on-call rota and level of training. It was reported that across all levels of trainees there was a lack of cohesion in education and training, with trainees frequently reporting being treated unfairly, feeling demotivated and not getting opportunities to undertake training. The review team heard that one consultant preferred not to undertake education and so did not take junior doctors into theatre with them. Such behaviour reportedly became endemic, meaning other consultants said they would not deliver training. It was reported that trainees were asked by consultants not to be on their ward rounds, were not invited to theatre and were not part of an active teaching programme. The review team heard that consultants were not undertaking educational supervisor roles and therefore did not want to pass on their expertise. This reportedly resulted in junior doctors becoming alienated as they were not getting the experience they needed. The review team also heard that many trainees had been worried about their futures with a senior consultant leaving, and they had been concerned that the supportive culture and learning environment that had developed under this consultant would not continue, so they started looking for other jobs.

It was reported that there was a hierarchy between those who had trained through the UK system and those who had come from abroad through CESR³¹ routes, but there was now an active programme for long training registrars to support them getting their CESR. It was reported that some of the consultants were good at engaging with trainees, giving them time for learning and opportunities for discussions and this built a better relationship between consultants and junior doctors, with trainees wanting to learn and consultants being more willing to give their time.

The review team heard that the Trust had been working with HEE and the GMC to ensure that the training environment was fit for purpose. It was reported that foundation trainees had not been fully withdrawn, but had been removed from night working. Middle grades were not formally withdrawn, but were strongly advised not to undertake night duties. Issues had been revealed with previous HEE visits, including reports of bullying, which was also reflected in the national training survey. It was reported that there had been significant improvements over the six months prior to the invited review visit, with assurance provided to HEE about middle grade Trust employed doctors. The review team heard that there had been positive feedback from foundation trainees in January/February 2023 regarding support, mentorship and pastoral care from educational supervisors and middle grades. The review team were told that educational supervision had improved to reflect HEE requirements and engage surgeons in a positive way.

At the time of the review visit, it was reported that HEE took all special measures and monitoring requirements away and recommended trainees returning to the RSCH in October 2023, with four trainees as a core to support each other, and that the Deanery intended for six trainees to return in October 2023 if issues were resolved. The review team heard that in the run up to this there was focus on who would be looking after these trainees, what lists they would be doing and where medical students would go, to avoid those with 'problematic behaviours' being paired with the trainees. The Trust was reported to be committed to restoring professional trainees in October 2023, and giving them consistency in terms of experience and a place to base themselves throughout their career.

³¹ Certificate of Eligibility for Specialist Registration (CESR). This is a route of entry onto the specialist register for doctors who have not followed an approved training programme.

It was reported that with the planned return of Deanery trainees this needed to involve, and not separate out, non-training doctors, to avoid clashes and trainees not staying for long. The review team heard that the RSCH had a lot of potential as a teaching hospital, with a large cohort of trainees and lots of expertise amongst the surgeons. In this respect, it was reported there was a good medical school with the ability to undertake new projects, an exceptional level of research from fellows and student feedback and engagement within the medical school was very good.

Clinics

It was reported that there was not enough clinic capacity within consultants' job plans to keep up with increased patient demand, and they would need to do three to four clinics a week to keep up with demand and see patients. It was reported that, with the plan for registrars to return in October 2023, they would need to sit with consultants to see patients. The review team heard that, at the time of the review visit, there were no registrar led clinics, but that it would help with capacity if these were held. The review team also heard there were room constraints for clinics.

The review team heard that prior to the COVID-19 pandemic registrars would have an allocated consultant doing a clinic next to registrars doing their clinics. If there were any issues the registrar would wait for the consultant to finish seeing patients and then ask for help, which provided good support. With the onset of the COVID-19 pandemic, it was reported there were telephone clinics for the first two to three months, where consultants sat next to the registrars. Then, due to health concerns, some of the consultants stopped working at the hospital for prolonged periods of time, and they were given virtual clinics to be done from home. Once the COVID-19 pandemic slowed down, these consultants reportedly did not return to on-site working and carried on doing clinics remotely. This reportedly left a period of a time where registrars were constantly doing their on-call commitments and no clinics.

It was reported that when staffing improved the focus was on service provision, so there was no time for registrars to undertake clinics. The review team heard views that it was important for trainees to be in clinics, as they were different from theatres, and it would be difficult to manage clinics as a consultant, if doing so few in training. It was reported that clinics needed reinstating, but staffing was so inadequate that, if registrars were doing clinics, it would not be possible to maintain ward cover.

The review team heard views on outpatient clinics including:

- Outpatient clinics had been cancelled to get consultants to do ward rounds, discharge patients and increase flow, but that this was not necessary for surgery.
- It was considered that consultants could do ward rounds in the morning, but did not need to see patients in the afternoon if there were no major concerns, and that trainees could do this.
- Cancelling outpatient clinics increased the backlog.
- Trainees needed to undertake more clinics to get training, reduce waiting lists and ensure clinical effectiveness, and consultants could be doing their clinic next door in order to provide support (as had previously been the model).
- Trainees could be given a trainee list, with patients they could handle, which would help manage emergency admissions and patient flow. The review team heard that this issue had been raised repeatedly, but had reportedly been rejected by the executive team. However, it was also reported that the executive team was receptive to reducing clinical activity to allow such training to occur when they heard that these issues would be raised in interviews as part of the invited service review.

Non-Deanery Trainees

The review team heard that in non-Deanery trainees' job plans most of their time was allocated to service provision. It was reported that the only teaching was in theatre, which involved doing parts of an operation, but this was dependent on the surgeon. Time off for teaching was not

formalised and these trainees tended to go to whoever they were working with. The review team heard that the training system was not structured in the way it was for Deanery trainees, with no regular meetings with educational supervisors, and not all trainees having an educational supervisor. It was reported that some trainees 'just met with consultants to get things signed off'.

The review team heard that previously there was no difference between Deanery and non-trainees, and the contract was signed on the basis of being treated equally. However, there was then a period of time where all training was given to Deanery trainees, resulting in non-Deanery trainees only undertaking on-call duties. This was reported to be professionally difficult for non-Deanery trainees, with no clinics, teaching or support.

The review team were told that previously consultants had been challenging to work with, but they were now more approachable, engaging and willing to work together. It was reported that non-Deanery trainees were able to reach consultants by telephone, including when on-call in the middle of the night, and they were able to receive the required support. The review team heard that junior doctors tended to go to registrars for support, who, alongside the senior house officers, were accessible and available.

It was reported that some consultants wanted to see all patients on ward rounds, whereas others wanted to see outliers and were happy to delegate other patients to registrars, and then would come together at the end of the ward rounds to compare lists and notes.

The review team heard that ward rounds were not being used as an opportunity for teaching, with most registrars preferring to split the ward round with the consultant and talk through the list at the end. It was reported that if there were questions or something was of interest, the consultant would talk through cases but not routinely. The review team were told that teaching ward rounds used to happen when there were fewer patients, but at present, there were often ward rounds of 60 patients, which made this difficult, and these tended to be service ward rounds rather than teaching opportunities. It was reported that consultants had a clear idea of what they wanted to achieve, so that at the end of the ward round there would be time for discussion, teaching and learning.

The review team heard reports of non-Deanery trainees coming in on their days off to participate in endoscopy lists, as this was not in their job plan and there was no support from the Trust to do such extra activities.

Deanery Trainees

It was reported that the Deanery trainees all had educational supervisors with whom they met to go through and assess progress against objectives, as well as designated protected teaching time each week. The review team heard that Deanery trainees had been able to go into theatre and observe and scrub in when consultants needed someone to assist, with the consultant talking through the whole procedure. It was reported that consultants were approachable, and made time on a Thursday for teaching, and that they would take time to explain interesting cases on ward rounds. The review team heard that Deanery trainees were encouraged to do audits and academic work. They were each allocated an audit to do, and would present in front of the surgical team at clinical governance meetings.

The review team heard that Deanery trainees would approach senior house officers, who were very experienced, for support, as getting hold of registrars could be difficult. If it was difficult getting hold of someone on-call, trainees would message in a WhatsApp group, and one of the on-call consultants would assist. The review team heard that trainees would work with clinical assistants who undertook administrative duties, blood requests, scanning results and updating lists when new patients came in, so that the doctors could focus on their role and seeing patients. Clinical assistants would attend ward rounds, complete pre-ward round sheets and put the information into patients' notes.

The review team were told that Deanery trainees tended to be on the rota in the same place and with the same team for a few days which allowed for more ownership and continuity for patients

and which was better for patient safety and care. The review team heard that there was good senior support on the wards in order to escalate deteriorating patients to senior house officers or registrars. It was reported that concerns about staffing had been addressed, but it was still a struggle to retain staff.

It was reported that FY1 doctors had good support and training and that they were busy but the workload was manageable. They received teaching and training by clinical fellows and dieticians as well as safeguarding teaching. The review team heard that FY1 doctors had protected time within the rota to attend MDT meetings once a month to observe and understand how they worked, as well as a day of protected time to prepare for M&M meetings. It was said that general surgery was good for surgical training as there was a lot of exposure to surgery and therefore the ability to learn from operations.

4. Other

The review team heard information which related to contextual matters and the background to this invited review.

a) Leadership within the Trust

Reported views in relation to Trust leadership included:

- Some staff reported that it was 'unfair' that the poor reputation of general surgery had developed, as this was more of a Trust and leadership problem.
- The Trust reportedly lacked strategy, with every change in Chief Executive resulting in a change in plan and direction; such constant change was not good for an organisation.
- There had been poor management of services for over 20 years at the Trust.
- The organisational management was reported to be bureaucratic, giving little autonomy to anyone else, was defensive to new ideas, with the CQC 'on its back', and it lacked an individual who could make things work.
- The Trust needed someone from the outside to come in and resolve issues with strategic direction and to reverse the defensive culture.

The review team heard views in relation to previous reviews, including the Dawson and Edgecumbe reviews (the reports of which were provided to the review team as part of the background documentation):

- It was reported that staff, having been interviewed for these reviews, had received no feedback from them, and were not provided with the reports.
- Whilst there were multiple reviews over several years, senior management did not do anything to respond to these reviews. Staff reported feeling doubtful that this invited service review would lead to any change.
- It was reported that a number of meetings were held with senior management but no decisions were made and no action came about as a result.
- Staff reported feeling as though Trust leaders listened but no action was taken, and that the leadership had never really heard the department's concerns and suggested areas for improvement. In this respect, it was reported that there was no leadership from the Trust, which was described as 'just a talking shop'.

The review team heard of a long history of a 'culture of fear' within the Trust, with whistle-blowers reportedly being badly treated. Staff reported being reluctant to put any concerns in writing, as they would then worry about being victimised, referred for regulatory action and/or dismissed, as they believed this had happened to colleagues. This 'culture of fear' was said by some to exist in association with a number of Chief Executives, with their 'tactic' being to reportedly pick on someone in the department who spoke up and then to dismiss them. It was reported that staff were offered face to face meetings with the executive leadership team

following the CQC report, but they were fearful and would not attend these. It was reported that this was frustrating for staff who felt they could not escalate issues further.

In this respect, it was reported that members of staff were reportedly invited to attend meetings with members of the executive leadership team and, when attending, they were told to 'sit down, shut up and listen'. Reportedly, whilst the staff members tried to speak up, the leadership team would not listen, and those staff members were blamed for issues within the service. Staff members described such experiences to be 'raw and unpleasant'. The review team heard that the executive leadership team took on a 'divide and conquer' approach with the staff in this respect, holding meetings where individuals would be outnumbered. It was reported that staff had been called into meetings and put under disciplinary processes, without any prior notice, and no opportunity to bring an individual with them to the meeting for moral support or representation.

It was reported by staff that they did not think things would change with the current executive leadership team. The review team heard that this culture had resulted in staff resignations when they were giving their opinions, not being listened to and being told to 'shut up'.

Reported views in relation to the Trust executive leadership team included:

- There was a hierarchical system with the executive leadership team, with an impossibility for staff to go straight to this team with their concerns. Staff often had to speak to a middle person who would then raise it with the executive team.
- It would be better for the leaders to spend time and have a visible presence on the ground with managers and staff and to ask questions.
- Leaders ought to be present to see what it was like to be in theatres, including running lists when there were no beds, and what it was like to be on-call.
- Leaders did not understand the problems, and therefore they should 'come down to the level of staff' to appreciate issues and to stop making unnecessary changes.
- Senior management were extremely difficult to liaise with, with meetings being regularly cancelled.
- Staff wanted to work with senior management, as staff had skills they lacked and vice versa.
- There should be better representation of consultants and staff at executive and Board level meetings in order to get their voice heard.

The review heard that the Chief of Surgery was very committed, delivering a high level of leadership within the surgical division with a number of successes. Whilst it was reported that this individual worked hard to support staff, it was said that if concerns were raised to other leaders nothing would happen.

b) Reputation

The review team heard that press reports about the Trust were usually negative, with patients made aware of waiting list problems and the fact that the RSCH was struggling. It was reported that whilst the Trust had status as a medical school, it lacked the income stream and strategy to develop that type of model. Whilst there used to be funding for academic posts, there was no longer funding for these and academic posts got 'eaten up' into clinical posts and disappeared. The review team were told that the RSCH needed to re-establish itself as a centre of excellence, to lift quality, with cancer care having an equal place at the table as emergency care.

c) Staffing

The review team heard that following the COVID-19 pandemic the Trust had reportedly lost fifty percent of the nursing workforce, but since then had worked hard at retention, and at the time of the review visit there were reportedly a low number of nursing vacancies.

The review team heard views in relation to locum staffing including:

- The general surgery department was run by locums, which should be the exception, and this meant that patient care was impacted.
- Reportedly, fifty percent of consultants were locums and whilst the long-term locums were good, the short-term locums were described as 'hit and miss'.
- Views were expressed that there was 'always a problem with these locums', who 'did not know the Trust and systems'.
- It was reported that with locums 'coming and going' there was no regularity and patients did not know who was looking after them, resulting in poor patient care.

The review team heard that there was difficulty accessing consultants for escalation and decisions with issues of supporting and supervision of the locums, and it was hoped that fixed term/substantive appointments would rectify this. The review team were told that there was a need for more colorectal consultants, ideally eight for an elective service. At the time of the review visit it was reported that the department was advertising for four fixed-term consultant contracts, with a plan to then make those staff permanent.

More generally staffing issues were reported across the board. The review team heard that there were severe skills mix issues, which affected theatre lists. It was reported that prior to the COVID-19 pandemic there was a rich skills mix, so there was no need to worry about where to place staff.

It was reported that there was a lack of junior doctors at senior house officer and registrar level. The review team heard that HR processes impacted this, as, reportedly, candidates were interviewed, but HR then 'did nothing' and candidates ended up finding jobs elsewhere. It was reported that one of the consultants had to resort to contacting candidates directly although this was not within their remit.

The review team heard that there was a 'superb' dietician consultant, but that having one person for the whole UGI service was not enough. It was reported that the surgical liaison geriatrician would see patients over 80, and those aged 65 and above with certain conditions. This individual was on a half-time equivalent contract, but establishing the service and relationship with patients had taken time. It was reported that the geriatrician would have a FY1 doctor with them each day, with this being a different one each day since December 2022, and that this would be planned in blocks from August 2023, which would be more educationally and clinically effective. It was reported that the geriatrician was stretched in terms of capacity, and therefore there would be added value in more appointments to this specialty. The review team also heard of capacity constraints amongst the CNS staff, and that there was a plan to appoint two or three more Band 7 staff, a Band 6 support worker as well as additional dietetic support.

d) Regional Working

The review team were told that the general surgery department was interested in opportunities to use Trust sites in a more holistic and patient focused way, with new opportunities since merging with Worthing Hospital and St Richards Hospital, Chichester and staff across sites being able to educate each other through collaboration and discussion. It was reported that such collaboration with other sites was important, given the amount of trauma and emergency work at the RSCH, and there needed to be prioritisation for moving elective activity elsewhere. The review team heard that there was 'fantastic' capacity at PRH, Worthing Hospital and St Richards Hospital and there was a need to use these sites to their full potential and merge surgical divisions to be more strategic across regions.

It was stated that when booking cases onto other sites staff would need to check with the wards that they could care for patients safely post-operatively. For example, the review team heard that PRH reportedly was not set up in a way for staff at PRH to be comfortable or safe with complex care post-operatively, and so if cases were going to go to PRH some work would need to be done around this.

It was reported that a lot of elective work which was cancelled due to lack of beds at the RSCH was sent to Worthing Hospital, and therefore it was important to use this site, with the main constraint at RSCH being theatre and bed capacity. The review team also heard that some of

the RSCH consultants worked at Worthing Hospital for six weeks, which they enjoyed. It was reported that for some time elective work was moved to Worthing which worked well. However, the review team heard that there were issues with the Worthing Hospital consultants saying they would not look after these patients, and RSCH surgeons saying they would not go there to do post-operative ward rounds. It was reported that it was not a case of an 'easy lift and shift' in terms of where the patient would have surgery, but there needed to be some thought about post-operative care. The review team were told that there needed to be meetings between the two sites as well as job planning for the surgeons and agreeing a sensible rota.

The review team were told that if the two colorectal departments at Worthing Hospital and RSCH were to be merged this would require a major 're-jigging' of job plans. The Worthing Hospital colorectal department was reported to work well, with fewer CEPOD cases and a small number of on-call cases, and fewer emergency constraints than at the RSCH. However, it was reported that the Worthing Hospital consultants did not want to merge with RSCH, and therefore there was a need to build better relationships between the two sites, in order to establish and develop regional links.

The review team heard that there were no reported issues with behaviours at PRH, with good relationships between their surgeons and those at RSCH and good communication amongst the teams, with good attendance at surgical briefings and de-briefings. It was reported that the HDU at PRH had more capacity than RSCH, which could be utilised. At the time of the review visit, for instance, it was reported that there were eight HDU beds at PRH, but only three were being used.

Appendix B – Service overview information

Prior to the review visit the healthcare organisation was asked to complete the following 'service overview form'. The information presented below is what was provided to the RCS England in May 2023.

Information request	Number	Additional notes
Local information		
Catchment population	947,857	<p>2020-2021: 472,690</p> <p>2021-2022: 475,167</p> <p><u>Trust population:</u></p> <p>The UH Sussex Trust Catchment population was defined by the Office for Health Improvement and Disparities (OHID) as being: 970,423 in 2020.</p> <p>Population projections split by age and sex are available from ONS by local authority up to 2043. These cover all the local authorities covered by the Trust. However, for some local authority areas, a smaller proportion of residents would be considered to be within the catchment for the trust, these include areas such as Wealden, Horsham, Mid Sussex and Adur.</p> <p>Using data provided by OHID giving catchment percentages of each Middle-Layer Super Output Area (MSOA), I have applied this to the local authority projections and age profiles by relevant MSOAs to give an annual growth rate for the trust catchment from 2021 up until 2032, adjusting for the proportion of local authority area covered by trust.</p> <p>Also, we know the hospital population is different to the general population, we tend to see older age groups using our services. Therefore I have applied an age weighting to better reflect the aging profile of patients we expect to see - age and sex breakdown of our critical care cohort for 19/20 has been applied to the our Trust catchment projected population profiles until 2032.</p> <p>ONS base population growth within the trust catchment area is expected to increase by roughly 0.5% per year, and by nearly 5% by 2032. Using a weighted population calculation for the critical care cohort, we would expect a figure of demand closer to 1.2% per year and 12.5% by 2032.</p>

		<p><u>Population split by site:</u></p> <table border="1"> <thead> <tr> <th></th> <th>2020</th> <th>2021</th> <th>2022</th> <th>2023</th> </tr> </thead> <tbody> <tr> <td>PRH</td> <td>138,986</td> <td>139,714</td> <td>140,446</td> <td>141,183</td> </tr> <tr> <td>RSCH</td> <td>331,239</td> <td>332,976</td> <td>334,721</td> <td>336,475</td> </tr> <tr> <td>SRH</td> <td>211,175</td> <td>212,282</td> <td>213,395</td> <td>214,513</td> </tr> <tr> <td>Worthing</td> <td>289,023</td> <td>290,538</td> <td>292,060</td> <td>293,591</td> </tr> <tr> <td>UH Sussex Catchment</td> <td>970,423</td> <td>975,509</td> <td>980,622</td> <td>985,762</td> </tr> </tbody> </table> <p>Further information found within 'Estimated Hospital Population Growth' Spreadsheet provided by Trust prior to the review.</p>		2020	2021	2022	2023	PRH	138,986	139,714	140,446	141,183	RSCH	331,239	332,976	334,721	336,475	SRH	211,175	212,282	213,395	214,513	Worthing	289,023	290,538	292,060	293,591	UH Sussex Catchment	970,423	975,509	980,622	985,762
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Sites providing specialty service		Royal County Sussex Hospital (RCSH) Princess Royal Hospital (PRH)																														
General Surgery Personnel as of 1 March 2023 (the review team were informed of some consultants having left the service since this date during the course of the review)																																
Consultant Surgeons within specialty service	16	As of May 2023: 12 substantive consultant surgeons, 3 fixed term contract locums and 1 SAS grade surgeon.																														
Consultant Surgeons within specialty service - UGI	9	As of 1 March 2023: P.R. Substantive A.E. Substantive S.J. Substantive (left Trust on 23 April 2023) M.S. Locum (long-term) M.K. Substantive (left Trust on 15 May 2023) A.A. Substantive (Clinical Lead for UGI) G.K. Substantive K.S. Substantive A.J. Locum (one year) As of May 2023: 2 funded Upper GI vacancies with scheduled interviews.																														
Consultant Surgeons within	9	As of 1 March 2023: M.L. Substantive (Clinical Lead for General Surgery) A.T. Substantive C.S. Substantive																														

specialty service - LGI		K. A-J. Locum (long-term) J.G. Locum (long-term) (Clinical Lead for Emergency) H.P. Substantive (Clinical Lead for Colorectal Surgery) M.U. Substantive J.C. Substantive E.M. Substantive
Surgeons within wider team		Not provided
Surgical registrar posts		7 registrars on 10 person rota. All registrars are ST6+ One of our 7 registrars has recently handed in notice: leaving end of May 2023 so will be 4 vacant posts Currently 3 vacant posts out to advert
Junior doctors supporting the service		8 SHOs (CT1 and CT2) on a 10 person rota. 3 rotational trainees and 5 fixed term SHOs. 2 gaps which were being recruited to. FY1s – 12 rotational Deanery trainees on a 12-person rota. No gaps but since December F1s have not been allowed to work on the ward at nights, we are covering F1 Night on Call gap every night with locum SHOs. This is an essential provision so locum cover is essential
Details of on-call		
Consultant surgeon on-call		One ward round/on-call week every 6 weeks One UGI Consultant and one LGI Consultant on ward round Monday - Sunday each week Not all consultants within the service currently contribute to emergency general surgery on-call activity.
Surgical registrar on-call		Patterns of on-calls split over 10 weeks 3 consecutive on-calls and 4 consecutive on-calls separated 2 weeks apart 24-7 On Call cover is currently a challenge due to reduced staffing levels Registrars also support CEPOD theatres 7 days per week and assist surgeons in RSCH theatre lists as part of their training Monday - Friday. Safe staffing levels also require a minimum of one registrar supporting the team on the Surgical Ward Monday - Friday
Facilities		
Service dedicated ward beds		Number of wards are spread between the following:
ICU beds		7 ITU beds at PRH. 16 ITU beds RSCH.
HDU beds		15 HDU beds RSCH
Theatres used by the service		There are 7 theatres across both sites in which Digestive Disease (DD) procedures may take place (emergency CEPOD lists or elective lists). 2 of these are dedicated, 1 dedicated to CEPOD. 1 dedicated to DD.

Inpatient elective lists per week		10 weekly (5 at PRH and 5 at RSCH) plus an additional all day list for 2 out of every 4 weeks - average of 0.5 per week. So the number of lists is 10.5 per week on average.
Day case elective lists per week		The lists are not split between inpatient and day case.
Emergency lists per week		There are 8 CEPOD (emergency lists per week - week days only). These are all shared lists.
New patient clinics per week		Not provided
Follow up clinics per week		Not provided
Activity numbers per year for the past two years		
Outpatients seen		<p>January-December 2021</p> <p>New: 25434 (General: 6674, Breast: 6915, Colorectal: 6762, Upper GI: 3241, Vascular: 1842)</p> <p>Follow Up: 42393 (General: 32895, Breast: 2991, Colorectal: 2836, Upper GI: 988, Vascular: 2683)</p> <p>Total: 67827 (General: 39569, Breast: 9906, Colorectal: 9598, Upper GI: 4229, Vascular: 4525)</p> <p>January-December 2022:</p> <p>New: 23383 (General: 2831, Breast: 6964, Colorectal: 8799, Upper GI: 2842, Vascular: 1947)</p> <p>Follow Up: 31709 (General: 19714, Breast: 3122, Colorectal: 4315, Upper GI: 1393, Vascular: 3165)</p> <p>Total: 55092 (General: 22545, Breast: 10086, Colorectal: 13114, Upper GI: 4235, Vascular: 5112)</p>
Acute admissions	9589	January-December 2021: 4467 (General: 3180, Breast: 0, Colorectal: 328, Upper GI: 263, Vascular: 696)

		<p>January-December 2022: 5122 (General: 4043, Breast: 0, Colorectal: 255, Upper GI: 181, Vascular: 643)</p>
Elective admissions	20,661	<p>January-December 2021: 9499 (General: 2477, Breast: 498, Colorectal: 4258, Upper GI: 1462, Vascular: 804)</p> <p>January-December 2022: 11,162 (General: 2490, Breast: 549, Colorectal: 5464, Upper GI: 1618, Vascular: 1041)</p>
Number of patients undergoing surgery – specify total and number of emergency, inpatient and day case procedures	3806	<p>January-December 2021: Total: 1851 (General: 1041, Breast: 370, 77, 133, Vascular: 230) Inpatient: 891 (General: 488, Breast: 103, Colorectal: 32, Upper GI: 77, Vascular: 191) Day Cases: 940 (General: 533, Breast: 267, Colorectal: 45, Upper GI: 56, Vascular: 39)</p> <p>January-December 2022: Total: 1955 (General: 1061, Breast: 385, Colorectal: 194, Upper GI: 210, Vascular: 105) Inpatient: 816 (General: 502, Breast: 92, Colorectal: 67, Upper GI: 78, Vascular: 77) Day Cases: 1140, General:559, Breast: 293, Colorectal: 128, Upper GI: 132, Vascular: 28)</p>
18 week breaches	1223	<p>February 2022: 559 (General: 33, Breast: 27, Colorectal: 253, Upper GI: 209, Vascular: 37)</p> <p>January 2023: 664 (General: General: 25, Breast: 25, Colorectal: 269, Upper GI: 271, Vascular: 74)</p>
Patients on elective waiting list	16,002	<p>February 2022: 7475 (General: 302, Breast: 736, Colorectal: 3709, Upper GI: 2288, Vascular: 440)</p> <p>January 2023:</p>

		8527 (General: 326, Breast: 749, Colorectal: 3631, Upper GI: 3091, Vascular: 730)
Clinical governance arrangement for the past two years		
MDT meeting frequency	Weekly	MDT meets every Wednesday morning from 11:00- 13:00
Time scheduled for MDTs	2 hours	Caseload ranges from 30 - 50+ patients. See comments for more information.
Average consultant surgeon MDT attendance (%)	98.8%-100%	More information provided within MDT attendance reports for Colorectal MDT and Upper GI MDT.
M&M meeting frequency	Monthly	Third Friday of each month.
Time scheduled for M&M	2 hours	8-10 cases typically discussed.
Average consultant surgeon M&M attendance (%)		85-90%
Number of audit days last year		Are staff free of clinical commitments for these? Yes.
Time scheduled for audit days		Not provided

Other regular governance meetings	Monthly Quality Governance (QSPE) cross-site – all day meeting bi-monthly. Surgery Divisional Governance meeting – monthly
National databases submitted to	National Bowel Cancer Audit (NBOCA) and National Emergency Laparotomy Audit (NELA)
Complaints, incident reporting and SUIs in the last two years	
Number of incidents	7415 Site specific for surgery: Community: 14 Eastbourne District General Hospital: 1 Hove Polyclinic: 9 Hurstwood Park: 46 Princess Royal Hospital: 1685 Royal Sussex County Hospital: 4899 Sussex Eye Hospital: 317 Sussex Orthopaedic Treatment Centre: 395 The Vale, Haywards Health: 1 Victoria Hospital, Lewes: 11 Worthing Hospital: 3 Trust wide: 3 Other: 31 Severity (from surgery division at RSCH and PRH): Catastrophic: 24 Low: 2059 Major: 53 Moderate: 130 No harm – impact prevented (near miss): 690 No harm – impact not prevented: 4459
Number of SUIs	26 2020-2021: 10 2021-2022: 16
Number of patient complaints	199 2020-2021: 96 2021-2022: 103

Number of never events	4	2020-2021: 3 2021-2022: 1 All 4 Never events have been closed.
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Appendix C – Documents received during the review

The following items of documentation were provided to the review team before, during or after the review visit. It is requested that the healthcare organisation responsible for commissioning the review retains a copy of all items of documentation for its own records, and to be in a position to make it available on request and to comply with information access requests. Once the RCS England issues the report, it will not keep a copy of this information indefinitely.

1. [Service Overview Information May 2023](#)
2. Introduction to General Surgery Corporate Improvement Project, May 2023 PowerPoint Slides, with the following attachments:
 - a) Improving General Surgery at the Royal Sussex County Hospital, October 2022 PowerPoint Slides
 - b) Letter from Health Education England to the Trust, dated 9 December 2021
 - c) Trust's written response (undated) to concerns raised by Health Education England regarding foundation doctors' training
 - d) Email correspondence providing written feedback from Health Education England to the Trust, as well as Trust responses, dated 1 February 2023
 - e) Response to Care Quality Commission: Upper GI Surgery at the Trust, dated 16 March 2022, PowerPoint Slides
 - f) The Oesophago-Gastric Specialised Cancer Surgery Patient Journey and Service Achievements, 4 July 2022, PowerPoint Slides
3. Proposed Target Operating Model Part 2 General Surgery Department version 5
4. Redacted Report of Mr Neil Cripps in relation to Digestive Diseases Centre, dated August 2017
5. Redacted Report of Professor Peter Dawson (review of departmental culture and junior doctor training and supervision in General Surgery at RSCH), dated August 2022
6. Redacted Edgecumbe Group Report of Feedback from General Surgeons at RSCH to the Chief Executive, dated July 2022
7. Email correspondence from Trust dated 10 June 2023 regarding police investigation into patients deaths within the general and neurosurgery departments between 2015 and 2020
 - This was reported within the press at the time, with reference to the following Guardian article: <https://www.theguardian.com/society/2023/jun/09/police-investigate-dozens-of-deaths-royal-sussex-county-hospital-brighton>
8. Data and Audits:
 - a) Estimated Hospital Population Growth, 22 February 2023
 - b) General Surgery Activity Data for 2021-2023
 - c) General Surgery Personnel as of 1 March 2023, including information about on-call arrangements
 - d) UGI and LGI Crude Mortality Data 1 January 2022-1 May 2023
 - e) National Bowel Cancer Audit Results for RSCH and PRH 2020-2021
 - f) Rectal Cancer Audit 2011-2021: Pre-operative Decisions and Margin Positivity, presented at LGI MDT September 2022

- g) LGI Outcome Data broken down by Surgeons (Mortality, Return to Theatre, Anastomotic Leak Rate and Total Resection Number)
- h) Cancellations and Postponements for Digestive Diseases, 2022-2023

9. Mortality and Morbidity Meeting Information:

- a) Sample Meeting Agenda dated 24 February 2023
- b) Meeting minutes dated 31 March 2023
- c) Meeting slides, minutes, logbooks and data for November 2022
- d) Meeting slides, minutes and data for December 2022
- e) Meeting slides and minutes for January 2023
- f) Meeting agenda, slides and minutes for February 2023
- g) Meeting slides and minutes for March 2023
- h) Meeting slides and minutes for April 2023

10. Complaints and Incidents Information:

- a) Quality Safety Patient Experience Meeting Minutes, dated 17 January 2023
- b) General Surgery Complaints April 2020-February 2023
- c) Surgery Incidents 2020-2023, broken down by site and severity and Datix report summaries

11. MDT Information:

- a) UGI Specialist MDT Meeting and Medical Decision Making Diagnostic, Specialist and Hepato-Pancreato-Biliary Outcomes January-May 2023
- b) UGI Specialist MDT Attendance Reports for April 2022-March 2023
- c) Colorectal Medical Decision Making Outcomes for February and March 2023
- d) Colorectal MDT Meeting Outcomes for January-May 2023
- e) Colorectal MDT Attendance Report for January-December 2022

12. HR Statement in relation to the Medical Workforce, dated 25 May 2022

13. General Surgery Directorate Governance Structure Chart

14. Trust Divisional Organogram as of 12 April 2023

15. Medical Assurance Appraisal and Revalidation Report for Surgery Division, 2023

16. Other:

- a) CQC Inspection Report, dated 15 May 2023
 - This was not provided by the Trust but was publicly available, with the link to the report listed on the Trust's website when the report was published: <https://www.uhsussex.nhs.uk/https://www.cqc.org.uk/provider/RYR?referer=widget3>

