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THE ROYAL COLLEGE OF SURGEONS OF ENGLAND

INVITED REVIEW MECHANISM

A SERVICE REVIEW REPORT ON BEHALF OF:

THE ROYAL COLLEGE OF SURGEONS OF ENGLAND
35 – 43 LINCOLN'S INN FIELDS, LONDON WC2A 3PE

ASSOCIATION OF SURGEONS OF GREAT BRITAIN AND IRELAND
35 – 43 LINCOLN'S INN FIELDS, LONDON WC2A 3PE

REPORT ON GENERAL EMERGENCY SURGICAL SERVICES

WORCESTERSHIRE ACUTE HOSPITAL NHS TRUST

23-24 JANUARY 2014

REVIEWERS:
Names redacted

Acknowledgements

The reviewers would like to thank the Worcestershire Acute Hospital NHS Trust for the assistance given to them during the course of the review and in particular:
Names redacted

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1. Background to the review

On 20 October 2013, Mr Mark Wake, Chief Medical Officer at Worcestershire Acute Hospital NHS Trust (WAH) wrote to the Chair of the Invited Review Mechanism (IRM) to request an invited service review of the Trust's general surgery service and in particular to review the way in which the general emergency surgical service is currently being delivered. This request was considered by the Chair of the RCS IRM and a representative of Association of Surgeons of Great Britain and Ireland, where it was agreed that an invited service review would take place. A review team was appointed and an invited review visit was held on 23-24 January 2014.

2. Terms of reference for the review

The following terms of reference for this review were agreed prior to the RCS's review visit between the RCS and the Trust commissioning the review.

a) To review the way in which the hospital's general surgery service is being delivered.

b) To consider whether concerns exist in relation to the Colorectal, Breast and Upper GI service with specific reference to:

- the quality of the out of hours emergency surgical care
- post-operative care provided to emergency general surgical patients
- team working and dynamics between those delivering emergency general surgery
- current clinical governance processes in place to support emergency general surgery
- the overall sustainability of the hospital's current emergency general surgery service
- the current workforce available to support emergency general surgery
- the risks presented by any delay to the reconfiguration of this service (please note - the reconfiguration process itself is out of scope).

These concerns have been raised by individual Consultants, the Anaesthetic Department, the Associate Medical Director Patient Safety and the Directorate manager (Surgery).

The reviewers will make recommendations for the consideration of the Chief Executive and Chief Medical officer of the Trust as to:

- whether there is a basis for concern about the general emergency surgery service in light of the findings of the review;
- possible courses of action which may be taken to address any specific areas of concern which have been identified.

3. Royal College Review team	
Lead reviewer	**Name redacted**
Clinical reviewer	**Name redacted**
Clinical reviewer	**Name redacted**
Lay reviewer	**Name redacted**
A brief biography of each member of the review team can be found at appendix one.	

4. Details of surgical team being reviewed

At the time of the review visit the general surgical services at the Alexandra Hospital was being delivered by a combination of substantive and locum consultants. These included:

Redacted names and job titles

Any gaps in the service are filled by additional locum consultants. The consultant team is supported by eight middle grade doctors (seven substantive and one locum).

5. Visit timetable

23 January 2014

- **All names and job titles redacted**
- **24 January 2014**
- **All names and job titles redacted**

No patients were interviewed or examined during the course of the Invited Review visit.

6. Documents reviewed as part of the Invited Review visit

The review team asks that the Trust keeps a copy of all the below documentation for their records and in order to be in a position to make it available on request to those reading a copy of this report. Once the report has been provided to the Trust the RCS will not keep a "master copy" of this information – it is for the Trust to do this should this be required for reference purposes.

1. Organisational structure and details of the service

- Trust structure (as at November 2013)
- Divisional structure (as at November 2013)
- Divisional meeting structure (as at November 2013)
- Trust governance structure (as at December 2013)
- Trust structure (as a July 2012)
- Job Descriptions
- Job Plans
- CVs
- Appraisal documentation
- Arrangements for relevant surgical rota and cover
- Arrangements for Clinics:
- Schedule of Clinics Summary
- Clinic Arrangements to Support the Service

2. Details of concerns raised with the trust about the service

- Chronology of concerns and actions taken by the Trust with further documentation evidence
- Reports from other reviews and visits undertaken about the service:
- Royal College of Surgeons Report and Outline Actions
- Cancer Peer Review Visits
- Serious Untoward Incident Reports
- **Redacted patient identifiable information**
- External SUI Summary
- Potential Serious Concerns October
- Incidents Affecting the Service
- Complaints Summary

3. Activity and outcome data

- Service data:
- Summary Report
- Breakdown by each Consultant
- Outcome data
- Length of Stay:
- Summary Report

- Breakdown by each Consultant
- Readmission Rates
- Charts
- Summary Report
- Breakdown by each Consultant
- Hospital Standardised Mortality Ratio (HSMR) Charts
- Breach of target date data:
- Cancer Monitoring Data 2011-2014
- 62 Day Success and Failure Summary October 2011-2013
- Two week wait data
- EPOCH Study

4. MDT/AUDIT/M&M DATA

- Meeting Arrangements for M&M meetings/Clinical Audits
- Attendance records and Arrangements for MDT:
- MDT Colorectal Summary 2013
- MDT Breast 2013 Summary 2013
- Sample of minutes:
- Audit/M&M
- Clinical Governance
- Sample minutes from Directorate meetings
- Audit Programme Summary
- SHMI data

5. Documents in the public domain considered by the review team

- Redditch and Bromsgrove Clinical Commissioning Group document titled '(Draft) Prospectus for Local Acute Hospital Services – 2014/15 dated August 2013
- HSJ article entitled 'Analysed: acute hospital services in Worcestershire under review' dated 25th September 2012

6. Documents received during the review

- (Draft) Interim Emergency Surgery Admission Pathway (Acute Bowel Obstruction and/or Peritonitis (January 14, version 7)
- Chronology of concerns and actions taken by the Trust with further documentation evidence (updated)
- Document entitled 'The Future of Acute Hospital Services in Worcestershire – Report of the Independent Clinical Review Panel' January 2014
- Up to date HSMR and SHMI data as at January 2014 produced by **name redacted**
- Appraisal completion rates as at 15th January 2014
- **Redacted name and job title** written submission and enclosed documents to review panel.

7. Information reviewed that supports the conclusions reached

The following information represents a summary of the information gathered by the reviewers during the interviews held during the service review visit and from the documentation submitted. It is organised under the headings of the themes that emerged. The information presented reflects the viewpoints of those individual staff members being interviewed; it does not necessarily reflect the views of the RCS or its reviewers on these circumstances.

Background

The Worcestershire Acute NHS Trust is made up of three hospitals, namely to include the Alexandra Hospital (AH), the Worcestershire Royal Hospital (WRH) and the Kidderminster Hospital and Treatment Centre (KTC). The Trust provides a wide range of services to a population of more than 550,000 in Worcestershire as well as caring for patients from surrounding counties and further afield.

Reconfiguration of Emergency services

It is accepted that the Worcestershire Acute NHS Trust is undergoing a process of reconfiguration of its services to ensure that they are meeting the needs of the catchment population and are being delivered in a safe and sustainable way. Integral to this process of reconfiguration is the way in which the Trust will decide to deliver its emergency services in the short and medium term.

The review team understands that following a process of consultation with the Clinical Commissioning Group and a review by the Independent Clinical Review Panel the Trust will seek to move from running independent emergency services at both the AH and WRH to a consultant-led emergency surgical service county-wide. In doing-so, further development of the Level Two trauma unit at the WRH (which will become a 'Major Emergency Centre') and 'Centres of excellence' for elective surgery at both the AH and WRH will take place.

Future of the Emergency Services at the Alexandra Hospital

As part of the future developments the Alexandra Hospital will have an 'Emergency Centre' and will also retain a 24/7 adult only emergency service. During the day the emergency service will be covered by a 'consultant of the day' who will be free of any elective commitments. Out of hours it is planned that there will be cross county cover from a group of around 12-13 surgeons; initially eight Lower GI and four Upper GI consultants who will share the on-call (**Redacted name and job title**, **Redacted name and job title** will come off the on-call rota). The surgeons will be largely based at the WRH when on-call. In retaining a 24/7 service at the AH there will continue to be on-call cover on site and this will be provided by eight middle grade doctors supported as needed by consultants at WRH, who will attend if patients are unfit for transfer.

Interim Arrangements

As of the 3rd February 2014 (following the IRM review visit) the Trust implemented a new surgical pathway for an interim period of around six to nine months whilst the process of wider hospital reconfiguration was finalised. When in effect, this pathway would see those patients presenting in the Alexandra Accident and Emergency Unit with a suspected Acute Bowel Obstruction and/or Peritonitis being assessed on site and transferred to the Worcester Royal Hospital (bypassing A&E) to receive emergency surgery or on-going surgical management. It was estimated that this would equate to around two or three patients a week. It was heard that two additional beds at the WRH had been 'ring-fenced' to account for the additional capacity. Following emergency treatment those patients requiring on-going in-patient care could be transferred back to the AH if appropriate.

The review team were informed that, should a situation arise where the patient being transferred required critical care, then an anaesthetist would travel with the patient. If the patient was not in a condition to be transferred, the consultant surgeon on-call at the WRH would attend to treat the patient.

The review team were satisfied that this new pathway was appropriate. However, having interviewed a number of staff at the Alexandra Hospital the review team detailed in their feedback session to the Trust that they were unable to completely reassure themselves that the implementation of this pathway was ready to proceed without risk. A summary of their reservations was detailed in writing to Dr Wake, Chief Medical Officer on the 31st January 2014. A copy of this letter can be found in Appendix two of this report.

Whilst the review team were not asked to specifically comment on the appropriateness of the future reconfiguration of the emergency services, they were of the view that in principle the Trust's vision for the future of this service appeared well thought through and appropriate to meet the needs of the catchment population and to ensure the future sustainability of the service in a manner that is safe for patients. However, the review team were of the view that any changes to the delivery of the service would require close monitoring and on-going review, with any required amendments being made in a timely manner.

Events that led to the request for a IRM review

While the process of reconfiguration has been underway the WRH and AH have continued to provide general and emergency services relatively independently. It was during this period that, in recent years, concerns were raised by staff about the general emergency service at the Alexandra Hospital. A summary of those concerns has been provided below. (This account is based on the chronology of events provided by the Trust).

In Spring 2012 concerns were raised in relation to the practice of one of the Lower GI

surgeons. Following a period of restriction and subsequent review of the individual's practice by the IRM (in October 2012) the surgeon was formally suspended from practice (this remained the case at the time of this review visit).

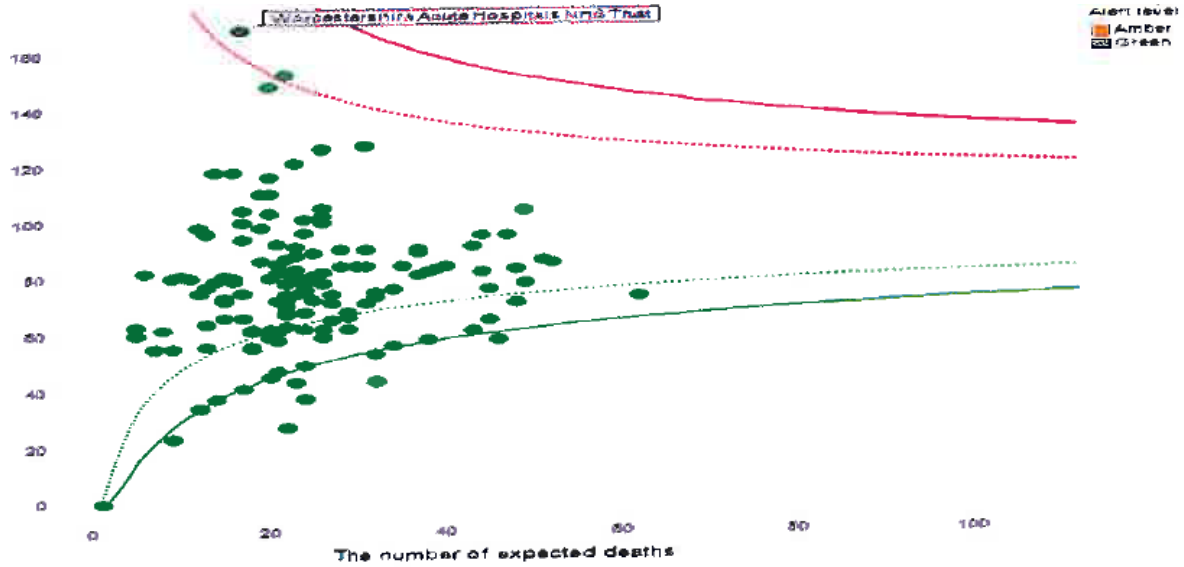
In June 2012 Anaesthetic and Intensive Care Consultants raised additional concerns about the general surgical care at the AH. It was heard that these concerns related in particular to the recognition of complications post-operatively and the timeliness with which deteriorating patients were being assessed and responded to.

In May 2013 the concerns were escalated by individuals who provided the Trust with examples of a number of surgical patients to contextualise the issues. These concerns again centred around late recognition and action with respect to patient deterioration either pre-surgery or in the post-operative period.

Following this the Trust undertook a series of reviews of the HSMR data to establish if these concerns were isolated issues or a systemic problem. A summary of the findings from the HSMR data has been provided below.

<u>HSMR</u>

It was noted that for the period of April 2012 to August 2013 the HSMR for the Alexandra Hospital alone (excluding the WRH mortality) was 169 with a total of 28 deaths from 537 patients treated, compared with an expected number of deaths of around 17. As illustrated in the below graph this sits outside the two standard deviation confidence intervals and is the highest for any Hospital in England.

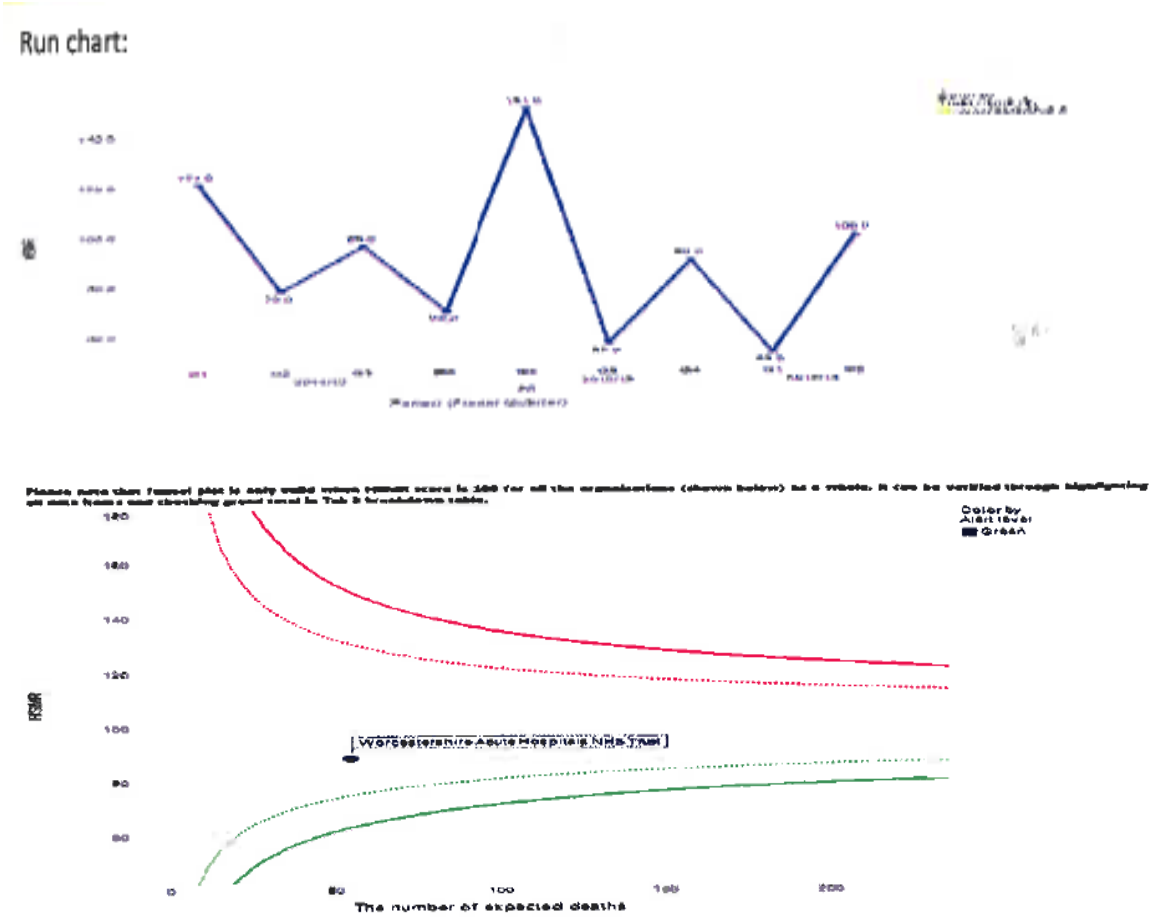


Name redacted, was asked by the Trust to complete further analysis of this data and to

compare the WRH and AH hospitals' outcomes.

In his review report dated the 23rd October 2013, **Name redacted** detailed that both the WRH and AH comply with standards set by the RCS for the management of acute surgical emergencies. **Name redacted** notes that the major difference between the sites is that the WRH site has a dedicated HDU facility and the AH has a multidisciplinary Critical Care Unit. It is **Name redacted's** view that there is no clear evidence to suggest any unmet needs in terms of critical care facilities to manage acute surgical emergencies at the AH. With this in mind, **Name redacted** completed a relative risk (RR) comparison for both sites for patients over 18 years of age and admitted as an emergency under a general surgeon with a primary diagnosis of abdominal pain, cancer of the colon, cancer of the rectum or anus, intestinal obstruction and peritonitis or intestinal abscess. The results for the 2011-2013 period are presented below:

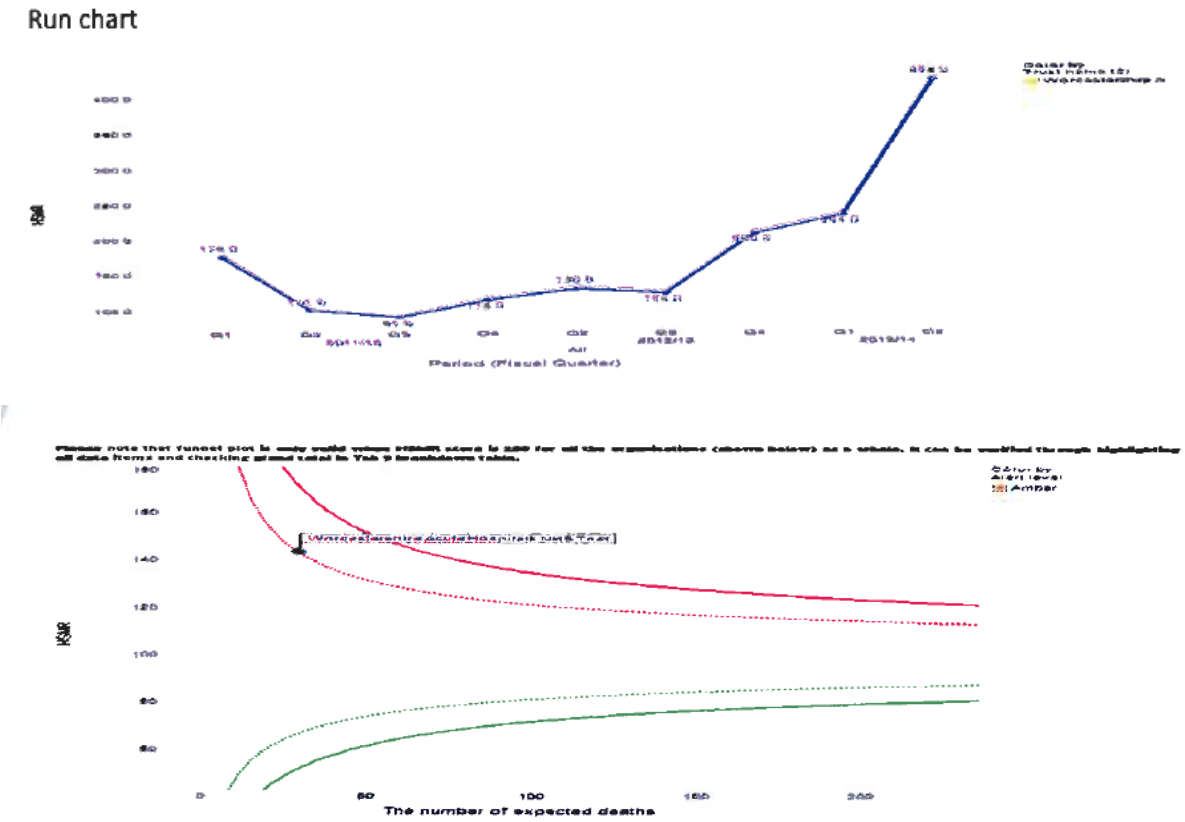
<u>Worcester Royal Hospital</u>



The WRH comfortably sits below the average value of 100 at 84. RR for patients admitted at

the weekend is 86 and RR for those admitted on a weekday is 83.

Alexandra Hospital



The RR at the AH is notably rising and sits on the cusp of unacceptability with the above average value of 116. RR for patients admitted at the weekend is 134 and RR for those admitted on a weekday is 110.

In summary, **Name redacted** concluded "*the relative risk for patients admitted to each site is markedly different. Over the time period in question the supporting resources available have not altered. The trend at the AGH (AH) is clearly in the wrong direction and if the trend continues will very soon become a cause for serious concern.*"

Review of patient care

Name redacted completed a review of deaths for the six month period leading up to February 2013 which covered the care of 13 out of 18 patients (5 records were unavailable). Having reviewed the care **Name redacted** concluded that "*of the 13, death was unavoidable in 12 and possibly avoidable in 1. However themes were identified with respect to the overall care delivered that echoed the patterns raised by the Anaesthetic team namely; lack of routine senior input and delays in escalating deterioration.*"

This prompted the request by the Trust for an invited review of the hospital's general emergency service. A summary of the review team's findings has been provided below.

Terms of Reference one: To review the way in which the (AH) hospital's general surgery service is being delivered.

At the time of the review visit, following a series of retirements and the suspension of one of the consultants, there were three substantive consultants and two full-time locum consultants providing the general surgery services at the AH.

It was widely heard from interviewees that because of the reconfiguration process and uncertainty about how services would be delivered in the future, the Trust has struggled to attract staff across all levels. Because of this there was said to be significant reliance on locum consultants, bank agency staff and goodwill to support and fill gaps in the provision of services. Supporting the consultants are eight middle grades (seven substantive and one locum). There are no surgical trainees at the Alexandra Hospital. The review team understand this to be a decision made by the deanery some years ago because of negative feedback about the training opportunities available. Training recognition was therefore withdrawn from AH.

In seeking staff members' views of the service delivery it was said by one recently appointed member of staff that the general surgical service at the Alexandra was "twenty years out of date and not in line with modern day practice". The laparoscopic equipment was said to have been more than twenty years old and had been placed on the risk register but had not been replaced. The review team understand that because of this, those patients who meet the criteria to have their procedure carried out laparoscopically are operated on at the WRH. The peer review of the colorectal multi-disciplinary meeting (MDT) noted from their review of the NBOCAP data (National Bowel Cancer Audit) that the number of patients treated laparoscopically at the Trust was well below the national average.

Other trends reported by interviewees were that the percentage of colorectal cases being carried out as day cases was only around three per cent and that there was no stenting of obstructed patients. In addition, it was reported that there was a real struggle to get the surgeons and staff to endorse the concept of enhanced recovery.

The review team were initially concerned to hear these accounts but were reassured by the Trust that they were in the process of taking steps to address these concerns with the investment in new laparoscopic equipment and with a move towards a county-wide service which would see the influence of the Worcester Royal in sharing good practice.

The review team have not commented more specifically on the clinical governance arrangements in place for elective general surgery such as the Mortality & Morbidity meetings (M&M) and MDTs as it was understood that the Trust has commissioned a separate

review of these by an external company.

To consider whether concerns exist in relation to the Colorectal, Breast and Upper GI service with specific reference to the quality of the out of hours emergency surgical care

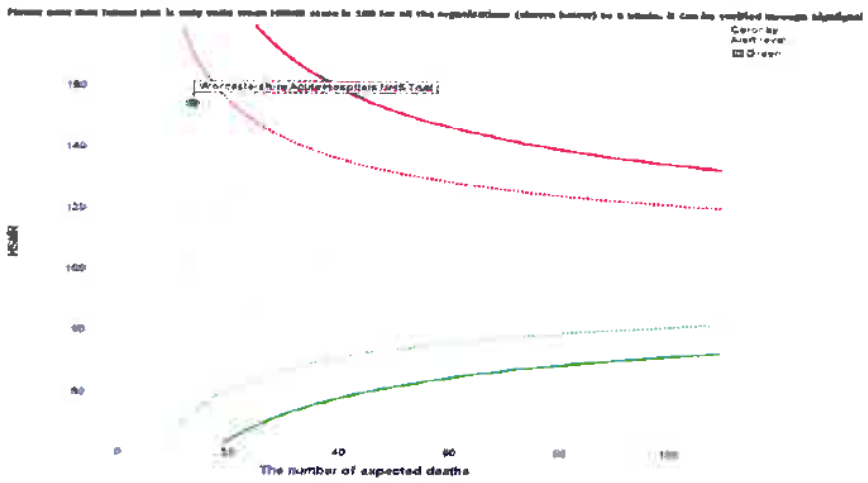
The review team considered whether there were on-going concerns about the quality of the out of hours emergency surgical service.

The review team were of the view that, at the time of their visit, the Trust management was in a position where it had acknowledged that there was evidence to validate the concerns raised about the delivery of the out hours service and that, left unaddressed, this would have the potential to develop into a serious cause for concern about the safety of patients. The review team also noted that, having gone through a process of identifying the areas of concern, the Trust had openly consulted the appropriate parties and had invited the Clinical Commissioning Group to carry out a quality assurance visit (visit date 17th October 2013) and an external review of the service through the IRM.

The Trust also created an Emergency Surgery Task force to develop actions to address their concerns. The key measures included limiting the consultants from undertaking elective work whilst on-call, introducing a twice daily consultant ward round and working with the nursing staff to increase their awareness and confidence in escalating concerns regarding deteriorating patients.

It was reported that following the implementation of these measures the Trust had seen its HSMR rates improve and fall within the accepted confidence limits (illustrated below).

<u>HSMR data for the thirteen months to November 2013 for AH</u>



The HSMR for the Alexandra Hospital was 154 for this period.

Whilst the review team were pleased to see that the Trust has been able to improve the HSMR outcomes they observed that there is still a noticeable difference in the outcomes of both the WRH and the AH (please see below) at the WRH the HSMR for the same period was 72.

The review team did not consider it would be possible at this stage to establish conclusive reasons for such marked differences in outcomes or whether the interim measures alone could account for the reduction in mortality but they did consider that such a variance in outcomes between the two sites could indicate a significant gap in the quality of the service being delivered. The reasons for the differences between the sites are likely to be multifactorial and have been explored in more detail below.

The review team discussed with interviewees their views of the out of hours emergency surgical care and any potential concerns they had with regards to the service. A summary of their views has been provided below.

Quality of surgery being performed

Throughout the internal review of the quality of the emergency service there had notably been no concerns reported about the clinical ability of the consultant surgeons who partake in the emergency on-call rota (with the exception of the one surgeon who is currently suspended from practice). However, it was reported that the level of expertise in the middle grades was significantly variable, with some requiring considerably more supervision than others. Interviewees were of the view that this may be a reflection of the diverse background and training of this tier of staff.

It was also reported by theatre staff that initially there had been some difficulties in getting the surgeons to carry out the WHO surgical checklist in theatre but that after an initial period this was said now to be routinely adopted.

On-call

At the time of the review visit, the on-call rota at the Alexandra Hospital site was being shared between the Upper GI, Lower GI and Breast surgeons. This equated to a one in six on-call with any gaps due to inadequate staffing levels being covered by **Redacted name and job title** and **Redacted name and job title** as extra duties, on a regular basis. The consultants are supported on the on-call rota by seven middle grade doctors who operate a one in seven rota.

The review team noted from the peer review of the colorectal MDT that there were concerns reported about the management of acute bowel obstructions being undertaken by non-

colorectal surgeons. The peer review reported that it was confirmed that the numbers dealt with by non-colorectal surgeons was small, two cases, but considered that this was of concern.
The review team heard reports that previously whilst on call the consultants would continue to undertake elective surgery. Having discussed this further with the senior managers responsible for the service and with staff, it was heard that at least two of the surgeons would regularly carry out elective work whilst on-call and another would do so occasionally. More worryingly it was heard that those surgeons would expect the junior staff on-call to be in theatre with them. The review team were unsure how long this practice had been allowed to continue prior to the urgent measures introduced following the HSMR data, but were not made aware of examples of patients whose care had been adversely affected by it. Nonetheless this approach was not viewed be in line with good practice as indicated in a number of the NCEPOD (the National Confidential Enquiry into Patient Outcome and Death) reports. It is expected that the team on call would be expected to be readily available to a patient who presents at the hospital as an emergency and these patients should be treated as a priority.

It was widely described by interviewees that historically the general surgical provision for emergencies was good, with a stable consultant body and surgical trainees. However, more recently it was suggested that the removal of trainees, suspensions, sickness and retirements had caused some issues. Some of the interviewees were of the view that those left behind had done well to cope in the circumstances and that they did not consider that there had been an adverse impact on the service or patients.

Other staff described an over reliance on the middle grade doctors for the on-call service. Interviewees described the level of ability amongst this group as significantly variable. Because of this over reliance and variability, the quality of the out of hours service depended on which middle grade was on-call.

From those middle grade doctors interviewed during the course of the review, it was heard that the on-call service was, in their view, good but they agreed there was room for improvement. In their experience they did not have any problems contacting the consultant surgeon on-call.

The review team heard that, as with the middle grades, there were concerns held by the consultant surgeons about the radiologists who shared the on-call rota. Individuals varied in skill sets and not all were able to perform interventional radiology. Contrary to this, it was heard from one radiologist that everyone on the on-call rota was able to perform percutaneous drainage if necessary but that some preferred not to if it could wait until the next day. Some radiologists felt that some surgeons were very engaged in emergency work, but others were not. Staff changes in surgery had been so frequent that consultants in radiology and surgery were often working together on call, yet had never met professionally.

No concerns were reported by interviewees about the quality of the current emergency medicine doctors or nursing staff.

Paediatrics

The review team heard that the AH had a paediatric unit which operated with extended hours. Children would be seen initially at the AH by the middle grade staff and once seen they would be sent to the paediatric ward. Any child under three years would be transferred to the WRH or Birmingham Children's Hospital.

To consider whether concerns exist in relation to the Colorectal, Breast and Upper GI service with specific reference to the post-operative care provided to emergency general surgical patients

The review team were aware that the most common concern raised about the emergency surgical service was around the post-operative care provided to patients and in particular the recognition of deteriorating patients. These concerns have been explored in further detail below.

As mentioned previously, the review team were provided with the findings of **Name redacted's** review of the care provided to 23 patients who had died following admission at the AH since January 2013 with a primary diagnosis of abdominal pain, colonic cancer, rectal cancer, peritonitis or intestinal obstruction. An additional patient's care was included in this cohort as, although the patient had survived, considerable concern regarding the patient's care was raised. It was noted that only twenty-two of the case notes were available for review. The conclusions of this review have been discussed under separate headings below.

Post-operative complications

Name redacted concluded that in "12 patients delays in intervention were identified which may have had an impact on patient outcome in 9 of these cases". Poor planning of post-operative care was identified in four patients' treatment, which was said to have had an impact on the outcomes of three of the patients. A lack of timely consultant input was identified in three cases which was said to have had a minimal impact.

The review team, having considered **Name redacted's** report (the review team did not review the actual case notes themselves), agree that from a retrospective review, these cases certainly raise concerns surrounding the delay in management steps, the delay in recognising deteriorating illness and the delay in involvement of radiology/critical care.

Having discussed post-operative care with interviewees, it was also reported that there had been issues in the past of high risk patients not routinely being referred to critical care following surgery.

As with the on-call system, there were concerns reported by interviewees about the middle grades' ability to recognise deteriorating patients in a timely way. The general perception given by interviewees was that this was true for about half of the middle grade team. When clarified further, it was heard that these concerns centred on clinical judgement, reluctance to accept surgical complications, and a lack of urgency and drive. It was felt that some of the middle grades were task orientated and because of this sometimes missed opportunities to escalate care. A common view was that the middle grades were not proactive enough, sometimes being content to "wait until tomorrow" when action was needed more urgently.

Of those middle grades interviewed, some detailed that the radiologists were often reluctant to accept the opinion of anyone other the consultants. Contrary to this, the review team also heard from a range of staff that often requests for scans followed problems that were present twelve hours before, that staff in critical care would feel the need to bypass the middle grades and go directly to the consultants to get scans requested, and that the requests made to radiologists were often lacking in detail and thus one would question the clinical indication for the requests.

Post-operative care

Accounts given by interviewees were that in general the nursing staff were very good and there were no concerns about their confidence in raising and escalating concerns about deteriorating patients. The review team heard that in order for senior managers to reassure themselves of this, additional training had been given to nursing staff recently to ensure this continues.

The nursing staff themselves reported that they had felt empowered by the pass score system for assessing patient risk.

Concerns were reported by the nursing staff themselves as to the management of diabetic patients and in particular the number of forms required for insulin prescriptions which view caused confusion and could be a serious event waiting to happen. The review team highlighted this particular concern to the Trust in a separate correspondence following the review visit as it appeared that the lack of resolution of this issue was at odds with the accounts provided by senior managers.

The review team also heard that there had been a lack of support for the introduction of an enhanced recovery programme.

End of life care

Concerns were raised by staff as to the quality of the 'end of life' care provided to patients and their families. This concern was upheld by **Name redacted's** case note review of 22 surgical patient deaths which concluded that in five instances the end of life care was considered to be suboptimal. The particular concerns highlighted were the timeliness of the

end of life discussions with patients and their families, poorly documented reasons for decisions not to proceed with surgery and the arrangements made for dying patients. It was also noted that there were difficulties in getting senior doctors to see relatives.
Nursing staff detailed that they have an 'amber pathway' form to assist with the end of life care which they viewed to be a success for those who used it. However, the nursing staff reported that whilst they actively used the pathway, the middle grade doctors would vary in their use of it and the consultants did not use the form. The nurses reported that they constantly had to ask the senior doctors to fill in the sections relevant to them and that this was a source of frustration.

A further concern detailed by staff was that there was no dedicated room for breaking bad news or suitable alternatives such as a relatives' room. Because of this staff had to use the Ward Sister's office which was at the centre of activity and was very busy.

The review team noted that improvements to the quality of the 'end of life' provision feature prominently in the Trust's Emergency Task Force action plan.

The review team are aware that following their receipt of **Name redacted's** report the Trust has undertaken work to give additional training to nursing staff in recognising and escalating deteriorating patients, which was said to be a success. In addition, the senior managers were said to have spoken to each of the consultants about responding to patients in a timely way and making them accountable for patient care. However, the review team were unsure if these measures had been successful, as the Trust did not appear to have the clinical governance systems in place to continuously monitor this. The issue of clinical governance has been discussed in further detail below.

To consider whether concerns exist in relation to the Colorectal, Breast and Upper GI service with specific reference to the team working and dynamics between those delivering emergency general surgery

The review team considered both the wider team working between the AH and WRH sites and more specifically within the AH itself.

<u>Across sites</u>
The review team frequently heard reports that the Worcester Royal Hospital general surgical team and its staff providing emergency care worked extremely well together. Two consultants were said to be available each day and praise was also given to the anaesthetic department who were reported to run a successful outreach programme. However, historically across the two sites there was said to be limited interaction between the general surgical teams.

Senior managers reported that in their vision, for the plans for reconfiguration there will be an integration of the speciality services and teams – and that this process had already begun

with the colorectal service, which now conducted a joint MDT across the sites in order share good practice. The ultimate aim of this work would be to ensure that there is equity of care across the Trust's sites.
The review team also understands that the WRH consultants were keen in principle for a county-wide delivery of service but had previously shown resistance to this because of concerns about the equipment available and capacity. The Alexandra consultants currently employed at the Trust were said to be in support of the county-wide move and those resistant to change have recently retired.

With the reconfiguration in motion, the Trust reported that the two most recent consultant appointments were made to county-wide positions. In the future the surgeons will work on two sites which will be either Worcester Royal/Alexandra or Worcester Royal/Kidderminster.

Alexandra Hospital

The team working at the Alexandra Hospital was not rated highly by interviewees. Whilst they did not consider any consultants to have unsafe practices, they did not consider that all the consultants demonstrated contemporary practice, and they each have relatively independent practices from one another. Interviewees mentioned that lack of cohesion among the consultants has an adverse effect on the middle grades.

It was also apparent to the review team that there was no clear leadership within the department with many staff giving differing accounts of who they would go to if an issue arose.

Interviewees' views on the wider general surgical team working at the Alexandra suggested that the middle grade doctors were somewhat isolated. The middle grade doctors were also said to lack incentive and motivation to do better. Not having surgical trainees as a stimulus was given as a potential reason for this. The middle grades themselves reported that they did not consider that they had a stable routine or voice within the organisation. Additionally, career development, personal development programmes and other components to support development were reported to be sporadic across this group with training opportunities very limited.

Senior managers acknowledged this to be a potential problem but hoped that this would be addressed with having a 'consultant of the day' and the re-introduction of trainees on the Alexandra site from the Worcester Royal who would work on both sites in the county-wide service.

In general the review team heard from staff at all levels that the morale amongst the team was low. The reconfiguration had made staff feel unsettled. Some staff detailed for example how promotions were sometimes temporary and only given on a six month basis.
The review team heard frequently of a sense of detachment among staff who felt that they

were “out of the know” about the reconfiguration plans and had not been involved in or consulted about their views on future strategy.

To consider whether concerns exist in relation to the Colorectal, Breast and Upper GI service with specific reference to the current workforce available to support emergency general surgery

The review team were asked to consider the current workforce available to support the emergency service.

The review team considered that in a period of transition this was difficult to assess as the workforce numbers were still relatively fluid. However, it was agreed by the Trust and the review team that the current consultant workforce was not sustainable. The Trust had clearly struggled to make appointments across all levels of staff while the process of reconfiguration continued. However, it was the review team’s view that now that the Trust has agreed on a county-wide model this would go some way to relieving that uncertainty.

Consultants

The county-wide move will see a proposed workforce of 12-13 consultants: eight Lower GI and four Upper GI. These surgeons will all share the on-call rota. The review team heard that two new county-wide consultant appointments have already been made as well a six month locum position. The review team were surprised, however, to hear that the Trust had not attempted to include the Alexandra consultants in the recruitment processes of these two new appointments. It was confirmed by those surgeons interviewed that they had not been involved in the conversations to short list potential candidates and were not invited to sit on the interview panels. The review team were of the view that this was a potential source of the feelings of isolation and exclusion of the Alexandra staff.

It was also understood that the Trust had struggled to replace one of the recently retired breast surgeons and that the potential reason for this was that the job description had included on-call cover. With the county-wide service there would be no requirement for breast surgeons to participate on the on-call rota.

The review team supported the proposed workforce changes but were concerned about the prospect of non-Upper GI surgeons carrying out complex emergency Upper GI emergency surgery and similarly non-Colorectal surgeons undertaking acute bowel obstruction emergencies. The review team were not made aware of the number of cases this would equate to but were of the view that further consideration should be given to developing pathways for transferring patients to neighbouring Trusts when the relevant skill mix was not available on site.

Middle grades

The review team consider that it is very unusual for a Trust to be in a position where they

have seven substantive middle grade doctors in post and one additional locum. It was heard that a few of these staff members were approaching retirement and that potentially the Trust may struggle to fill those positions.

Trainees

It is understood that the Alexandra Hospital will not yet be in a position to have trainees returning fully to the hospital. However, as the Worcester Royal general surgery department does have a training programme in place, the county-wide service will mean the Worcester Royal surgeons will in the near future start to operate more regularly at the Alexandra Hospital for elective surgery. Providing there are no objectives from the deanery, this will bring their trainees to operate with them. This is hoped to bring a positive influence and drive back to the Alexandra.

Nursing and theatre staff

As with the consultants, the review team heard that the Trust had struggled to attract both nursing and theatre staff because of the uncertainty of the Alexandra's future. It was stated that because there were several hospitals in neighbouring towns which had vacancies and were not going through the same restructuring process, potential employees would opt to travel to them rather than face uncertainty. The review team were aware that the Trust had recently appointed 20 nurses from Spain.

A senior member of nursing staff checks that staffing levels are safe every day. The responsible nurse has the power to shut Ward 17 (the ward for emergency patients) if staffing levels are insufficient for safe care.

Goodwill

It was clear to the review team that the Trust was fortunate to have some very dedicated members of staff who cared about raising the standards of the service and providing a good service to patients. It is apparent that the Trust has depended to some extent on the goodwill of these individuals. This was reflected in the rotas for the middle grade doctors who struggled to plan their lives more than a week in advance, and those surgeons who it was reported would undertake additional clinics in order to maintain the service and make sure that patients were being seen in a timely fashion.

To consider whether concerns exist in relation to the Colorectal, Breast and Upper GI service with specific reference to the Clinical Governance

Having considered the events that led to the request for an IRM review, the review team were concerned to hear that it was effectively only when concerns were raised by the critical care staff that this had triggered a wider review of the mortality and outcome data by the Trust. The review team were of the view that this raised concerns about the effectiveness of

the clinical governance systems to monitor the quality and safety of the service. These systems have been discussed in more detail below.

System for reporting concerns

The review team were provided with details of the Trust's relatively new infrastructure that has been in place since November 2013. Prior to this structure it appeared to the review team that the clinical governance systems in place were not effective in acting as early indicators for potential concerns.

Serious Untoward Incidents (SUIs)

It was heard that all SUIs would be reviewed at Board level and that the SUIs would not be signed off until appropriate remedial action was taken.

Datix

The review team were informed that the Trust uses a Datix system to report adverse incidents and near misses and they were provided with a summary overview of these incidents. Examples of complaints noted included poor documentation of clinical decisions, delays in diagnosis, poor discharge planning, nursing staff attitude, infection control, not undertaking the WHO checklist, missing discharge information, staff communication failures, not following pathways and failure to monitor patients appropriately.

There were two main concerns that the review team noted. Firstly, the complaints were compiled and combined for both the Worcester Royal and the Alexandra and secondly, there was no apparent summary of trends. Upon request for the data to be separated by hospital and for a summary of the trends, it was found that this was not available and it was suggested to the review team that this was due to lack of resources. The review team were of the view that this use of pooled information, like the mortality data, could obscure the picture at the individual hospital levels and potentially producing a false positive.

The review team discussed this with senior managers and heard that management did not receive any complaint analysis and that there was no feedback of this data to them. The general feeling of these individuals was that these concerns were not being looked at appropriately and that there had not been attempts to triangulate the data.

The review team heard that often the incidents would be dealt with on an individual basis. In doing so the complaint would be reviewed, discussed with the relevant individuals, actions agreed and the complaint signed off. The review team did not hear of any mechanisms in place to monitor whether the actions were successful in addressing the complaint or whether these actions were being adhered to. The review team did hear that work had been done by the senior nursing managers themselves to look at the trends of those complaints relating to nursing and actions taken to address any issues identified.

The review team were not aware if the consultants themselves actively checked and reviewed the Datix incidents relating to them or whether these complaints were discussed at the surgeon's appraisals. The general view was that this was not the case.
The review team were informed that there was a backlog of Datix complaints. However, senior managers said that the "serious ones" had been discussed.

It was reported that with the new structure each division will have a Quality and Safety Committee which will meet monthly and going forward will be chaired by a non-executive director who has a clinical background. There will also be a Patient Safety Committee which will be Trust wide. In this new structure the Patient Safety Committee will receive and sign-off all SUIs.

The review team had sight of the minutes from these recent directorate meetings and it was noted by the review team that whilst there was a good presence from non-consultant staff there did not appear to be many consultants in attendance. This was attributed to a lack of engagement from the consultants.

Audit and outcomes

It was reported that the HSMR data and outcomes for emergency general surgery was not routinely being discussed or reviewed in any detail at either consultant surgeon level or at a senior management level prior to the concerns being raised by staff. The review team were concerned to hear this since audit and review of this data is an essential part of reflective practice.

The review team were not provided with details about the frequency of these audit meetings, those invited to attend, or rates of attendance. It was reported that the HSMR data and SHMI data was not routinely being reviewed at these meetings. It was heard from one interviewee that attempts had been made to introduce templates for surgery to discuss their outcomes but that it had been a struggle to get people to engage. This raised questions as to the effectiveness of these meetings, and the engagement of staff.

The review team were surprised to find that, even at the time of the review visit, some of the nursing staff were unaware of the recent HSMR figures until the review team had told them in their interview.
In the new system it was heard that HSMR data will be reviewed on a weekly basis by senior managers as well as on a monthly basis as part of the Integrated Governance Committee.

MDT and M&M

It was reported by one consultant that the standard of discussion at the M&M and MDT meetings was not good. It was heard that because of this they had opted to attend the MDT at the Worcester Royal Hospital long before these meetings had formally combined.

The review team understand that the M&M meetings used to take place every month but more recently these took place every two months. In addition staff who attended the meetings told the review team that because of the format of these meetings, in their view it would be possible for patients to "slip through the net" and not be discussed at the meetings.

The review team understand that the relevant MDTs will become county-wide in order to drive up standards. A separate external review of this is apparently in progress.

Raising concerns

It was reported by senior managers a culture was emerging, if not embedded, where staff felt comfortable to raise concerns. However, the review team were unsure about whether this was indeed the case and also queried the response times by the Trust to investigate concerns that had previously been raised.

For example, the review team observed that initial concerns about the delays in the recognition of complications and deteriorating patients were first raised in June 2012. However, it was not until almost a year later in May 2013 that a review of the HSMR data and cases took place.

Furthermore, the review team heard that in a bid to update the laparoscopic equipment which was considered unfit for purpose, resistance from the then clinical lead was encountered. It was said that in escalating this further to the Chief Executive the clinical lead had objected in an aggressive manner. Feeling frustrated about the speed of the response to safety concerns one individual had been on the verge of wanting to leave the Trust. This was said to no longer be the case.

Clinical Leadership

The review team heard divergent views from staff as to who they would go to if they had a problem or concern. The review team were aware that **Redacted name and job title** in the new county-wide structure and yet some nurses and middle grades at the Alexandra reported being unaware that such a role existed.

Appraisals

The review team were not provided with the appraisals of the consultant surgeons prior to the meeting, but summary data were provided during the review. The rate of completion for appraisals was not as good as it could have been, with one surgeon stating that he had only had two appraisals in seven years. The appraisal completion rate as at the 15 January 2014, was only 61 per cent for the general, vascular and urology surgeons. The review team were not aware if these figures included the other hospital sites and did not have this data broken down further to show just the general surgeons.

Job plans

The review team were provided with the job plans for the current consultant staff at the Alexandra. With the interim plans now in place, the review team were conscious that these job plans were effectively no longer relevant and have therefore not commented more specifically on the appropriateness of these.

However, as mentioned earlier in the report the review team were made aware that some consultants had been continuing to undertake elective work whilst on-call. The impression given was that this was by the surgeons' choice and not because this was in their job plans. One consultant confirmed to the review team that they had made a conscious choice to undertake elective work to prevent the waiting lists going up.

The middle grade doctor job plans were reported to be chaotic and not fixed. Because of this the review team heard that middle grade doctors would frequently be told at the last minute to report at one hospital site or another and to cover one clinic or another. Frequent clashes of annual leave were said to also have caused issues with the provision of care.

The review team were made aware that with the move to a county-wide system, the middle grades will be given six week advance schedules to avoid such problems.

Any other concerns

The review team considered the information provided by the Trust and interviewees and have detailed below other issues they viewed as potentially having an impact on the future of the service and any potential risks the Trust should consider addressing.

Patients

The review team were overall very positive about the Trust's future vision for the general and emergency general surgery service and for ensuring the service was safe. However, they were of the view that the execution of the plans and the effect on patients did require further consideration and planning by the Trust.

The review team heard from both the clinical commissioning group and a group of patient representatives during the course of the review. Both groups agreed that patient safety was a priority but the CCG representatives in particular raised concerns about the costs of taxis for patient's families who will want to visit their relatives as it was reported the distance between the Alexandra and the Worcester Royal was approximately 24 miles. It was also heard that currently there are no good public transport links between the Worcester Royal and Alexandra. For a relatively ageing population this was viewed to be problematic, as many of the relatives, like the patients, are elderly.

Communication

There was a vision from senior managers of where the service was going and how this was going to be achieved. Staff on the ground, however, appeared disengaged and detached from these plans and the review team frequently heard accounts of them not being invited to attend meetings and not being consulted on the future plans.

The staff did have access to a daily bulletin with updates from the Trust but reported that they did not often have time to read the information. They commented that they found the bulletins hard to understand. It was not easy to digest all the information because of the number of changes taking place, or to filter through to the issues relevant to them.

The review team considered that there appeared to be significant weaknesses in communication which constituted a potential risk to the future success and safety of the reconfigured services.

Workforce

Trust senior managers provided the review team with an account of the future vision for the workforce to cover the on-call services. This was an acceptable plan but the review team considered that the trust would need to give further thought to 'seven day working' and whether potentially two consultants on-call at any one time would be required to effect the county-wide plan.

Ambulance capacity and staffing levels were raised as a concern by several interviewees. It was heard from the Chief Executive that the Ambulance service had put in a bid with the CCG to cover anticipated extra costs associated with emergency patient transfers. The review team considered this should be monitored to ensure safe transfers and no delays for these vulnerable patients.

Pathways

As mentioned previously in the report the review team considered that further consideration would need to be given to emergency complex upper GI and acute bowel obstruction pathways of care.

In addition, whilst the treatment and management of paediatric emergency patients has not to date resulted in any concerns, the review team did not hear any detail of how this care would or could potentially be affected by the planned changes. It is important that this pathway is reviewed alongside any further reconfiguration plans.

Monitoring of outcomes

The review team cannot emphasise enough how important it will be for the Trust to actively monitor the performance of the service to ensure that it is safe. The Trust needs as a priority to be in a position to reassure itself that it will be able to pick up immediately on any patient safety concerns or failings in a pathway, so that this can be addressed in a timely way.

8. Conclusions

Basis on which conclusions are reached

The following conclusions are reached on the basis of the documentation reviewed (as set out in section 6 above) and the interviews held with staff at Worcestershire Acute Hospital NHS Trust (as described in section 5 above).

Overall conclusions about the surgical service under review

The review team were asked to provide a view as to whether there was a basis for concern about the general emergency surgery service being delivered at the Alexandra Hospital. The request to review fell at an important time for the Trust as it is in the midst of making substantial changes to the way it delivers this service. The Trust had made significant efforts to remedy concerns raised by staff and the review of HSMR data and had developed an action plan to address these. The implementation of these actions was in its infancy and the review team therefore considered it to be difficult at this stage to evaluate the success of these.

Nonetheless, after consideration of the information made available as part of this review and at the end of their visit, the review team agreed with the Trust that the current delivery of the general surgery emergency service at the Alexandra Hospital was not sustainable and that, if left unaddressed, it had the potential to be a cause for concern. A clear plan needs to be in place to address this.

<u>Delivery of the general surgery service</u>

The review team did not undertake an in-depth review of the wider elective general surgical service and they were not made aware of any concerns about the clinical performance of the current general surgical team. Moreover, with reconfiguration, a number of retirements and new appointments plus the suspension of one of the consultants, the delivery of this service was subject to change.

However, the review team were of the view that general surgery had, until recently, been outdated in several respects and was not in line with modern day practice. There had clearly been issues with getting surgeons to engage and update their practices. For example, the number of procedures undertaken as day cases, enhanced recovery, the use of “amber pathways” and increasing the percentage of patients being offered laparoscopic surgery. The review team were reassured to hear that the Worcester Royal Hospital general surgery service was in line with modern day practices and that with the county-wide service these good practices would now be shared with Alexandra.

The review team also understood that the MDT and M&M meetings for the elective provision were being reviewed by a separate external party and so the review team did not comment on the effectiveness of these.

Quality of the emergency care

The review team were of the view that there are concerns about the current provision of the out of hours service but considered that the Trust had undertaken substantial work to identify and address these concerns and had implemented a clear plan to improve this. The review team were also pleased to hear that the Trust had introduced a 'consultant of the day' to ensure senior input in provision of care. Having undertaken a second review of the HSMR data it appears that the risk of mortality has decreased.

However, the review team did not consider that the Trust could assure themselves that interim measures alone accounted for the reduction in mortality and that this would require on-going monitoring.

There were concerns that the level of ability amongst the middle grade doctors who supported the on-call rota varied significantly. Similarly the radiologists' on-call service appears to be subject to variable skill levels, depending on who is on call. The review team considered that this could have had an impact on the level care being provided out of hours. A useful suggestion was made that the 'consultant of the day' should do an evening round, and that steps should be taken to ensure that all middle-grade doctors were "up to speed" on recognising complications such as sepsis, and the need to be proactive in seeking a consultant opinion and arranging timely transfers to the Worcester Royal when appropriate. The review team feel strongly that safeguards for care at weekends, as well as overnight, need to be as robust as during daytime working hours and need on-going monitoring.

The review team were of the view that the Trust's new surgical pathway for out of hours emergency patients was sensible but were concerned to hear it reported by some interviewed that the Trust had not engaged key staff with the development of this pathway and had not communicated the new pathway effectively to staff.

The review team were made aware **Redacted name and job title** had been made the new clinical lead for emergency surgery county-wide. However, it appears that this message had not been filtered through to staff on the ground-level. The review team were keen to ensure that with on-going significant changes to the service it needed to be clear who was the clinical lead and for staff to know who to report any concerns to.

Post-operative care

The review team consider that the provision of post-operative care was of concern. In particular, in the past, the failure of the escalation of deteriorating patients was a recurring theme. The review team were pleased to hear that senior nursing staff had pro-actively

attempted to address this with additional training to their staff. However, the review team were concerned to note that this same approach had not been taken with other members of staff who provide the out of hours service, particularly the middle grade doctors.

The lack of engagement with the amber pathway by the consultant surgical staff and intermittently by the middle grade doctors clearly was also a source of frustration for nursing staff. The review team considered that not following key pathways had the ability to impact adversely on patient care and it was not acceptable for some members of staff not to follow them.

Team working

The review team visited the general surgical team at time where there had been a series of recent retirements of long standing consultant surgeons. From those consultant surgeons still working at the Alexandra Hospital interviewed (**Redacted name and job title** was unfortunately on sick leave at the time of the visit) and from accounts provided by staff, the review team were of the opinion that there was clearly an absence of team working. The perception was that the surgeons had, historically, run very independent practices from one another with little overlap. It was heard from the more recently appointed members of staff that the unit was outdated and in need of a shift to modern day practice. The review team considered that by widening accountability in a larger integrated team there would be far less opportunity for any potential failings in care to go unnoticed, and a real opportunity to raise standards to the best.

The review team were aware that those surgeons resistant to a move towards a county-wide service have recently retired and that the Trust management were confident that the remaining consultants at both the Alexandra and Worcester Royal Hospital were on board to integrate the general surgery service. The review team were pleased to hear from staff at all levels very positive and supportive comments about the prospect of sharing good practice with Worcester Royal general surgery team. There was an overall sense of willingness by staff to improve the service. The exception to this was the accounts heard from the Middle Grade doctors who were seemingly unsure about where they fitted in.

The review team were concerned that the Middle Grade doctors were a somewhat isolated and possibly undervalued group. There was an overall sense that the emergency service had relied heavily on them and yet they had no voice within the Trust and were not being engaged in the process of reconfiguration. The review team were of the view that it had been expected of the Middle Grades to follow the management decisions and new pathways and yet as key members of ground-level out of hours staff they had not yet seen the proposed surgical pathways a week prior to its implementation, nor been involved in its synthesis.

The review team heard that there was an absence of team working arrangements between radiologists and surgeons, with joint meetings between these groups having disappeared.

The same applied to team working between anaesthetists/intensivists and surgeons. The review team considered that some degree of structured interaction would be of clinical benefit and likely to benefit the service as a whole.

Workforce

The review team were concerned about the current workforce in place and more specifically about the continuity of care being provided by a service that is relying heavily on locum consultants, bank agency staff and good will. The review team are sympathetic to the fact that the Trust has struggled to attract staff with the reconfiguration plans on going and uncertainty about how the service will be delivered and were reassured to hear confirmation that two consultant appointments, as well a further six month locum position, had recently been made.

The review team were not provided with the full details for the reasons as to why the surgical trainees were removed from the Alexandra site but were of the view that with the county-wide programme the gradual re-introduction of the trainees (from the Worcester Royal) would have a positive influence on the current service being delivered.

Clinical Governance

The review team have been explicit in their concerns about the clinical governance systems previously in place at the Trust. It was regrettable that the Trust had only been alerted to concerns about the emergency service from members of staff at ground level and that it was only following these concerns that a review of mortality data was undertaken. The review team considered that this indicated a significant flaw in the ability of the Trust's governance mechanisms to alert them to concerns at an early stage.

The review team concluded that the audit meetings were ineffective as they did not look more closely at outcome data. They understand that Name redacted has done some considerable work to develop templates for the future audit meetings that will look more closely at the data and that in the future these meetings will take place jointly with the Worcester Royal. The review team also understand that the Trust has plans to submit data to additional national audits such as the NELA database. These changes were considered positive new measures.

The Trust's system for looking at Datix incidents and complaints did not look at overall trends and the effectiveness of actions undertaken to address any issues raised. The review team did not consider this to be acceptable.

The review team appreciate that the Trust now have a new reworked governance structure in place. However, while on paper this looks satisfactory the infrastructure's effectiveness will be determined by its ability to pick up on concerns and trends in a timely manner. Because of this the review team considered that the Trust will need to closely monitor and

review these processes.

The review team were concerned to hear that some of the surgeons and other members of staff did not regularly have appraisals. With revalidation now in place this will require immediate attention by the Trust. The review team did not see any appraisals and so could not comment on the quality of the appraisals themselves.

Job planning was clearly an issue for the Middle Grade doctors who it was reported were continuously being told at the last minute to report at different clinics and different hospitals. The review team were reassured that this would be one of the priorities to be addressed by the Trust.

The review team considered that the Trust had a good strategic plan but appeared to be at risk of losing the engagement of their staff on the ground-level in relation to its implementation. The review team were of the view that communication across the different levels was poor.

Any other concerns

The review team were of the opinion that the Trust still needed to give further consideration to issues of patient access and communication, pathways for emergency paediatric cases, complex Upper GI and Acute Bowel Obstructions.

Monitoring capacity and demand will also be crucial, including the consideration of whether there is a potential requirement for a two surgeon on-call system.

9. Recommendations

The following recommendations are for Worcestershire Acute Hospital NHS Trust to consider.

Prioritised patient safety actions for the Trust

With the new surgical pathway being put in place the review team did not find any immediate causes for concern about the safety of the current general emergency surgical service at the Alexandra Hospital. However, there were a number of areas that the review team considered would require immediate and ongoing attention from the Trust. Recommendations to address these areas have been provided below.

<u>New surgical pathway for emergency patients</u>

1. The Trust should closely monitor and review the effectiveness of the new surgical pathway for the management of general emergency surgical patients. It is important that any problems with the pathway are responded to in a timely manner.
2. The Trust should ensure that any changes to the surgical pathway are effectively communicated to all members of staff that use the pathway. The Trust should consider whether, for its own reassurance, mechanisms for ensuring that staff have read and understood the pathway are introduced, such as a sign off on a register.
3. Capacity and issues such as the availability of ambulances to transfer patients should be closely monitored to ensure that this is not having an adverse impact on patient care.
4. The Trust need to closely monitor and review the outcome data available to them and respond to any causes for concern in a timely manner. This should be reviewed once a month as a minimum.

<u>Delivery of the general surgical service</u>

5. The Trust needs to update the delivery of the current general surgical service at the Alexandra so that this meets current national standards. The number of procedures undertaken laparoscopically is likely to improve with the updating of equipment, however, increasing the number of procedures undertaken as day cases and establishing an Enhanced Recovery programme still requires further work.

<u>Emergency surgical provision</u>

6. The Trust should ensure that there is consistently senior input out of hours. If it is not already the case, the 'consultant of the day' provision should be extended to seven days a week as well as through the night. Senior input must be available during nights and weekends.
7. The Trust should ensure that there is senior input available out of hours to middle grades and that middle grades are proactive in identifying complications and

consulting senior doctors

8. The Trust should review the care pathways for complex upper GI and acute bowel obstructions to ensure that any patients who require emergency procedures without delay are not being operated on outwith the skill set of the on-call consultant and are being referred to neighbouring Trusts if required.
9. The review team supported the interim measures that the Trust introduced for the emergency service at the Alexandra hospital, however, the Trust should monitor the uptake of these and ensure that there are consequences for those who do not adhere to them.
10. A pathway for reporting concerns about the emergency surgery service needs to be developed. Establishment of the Clinical Lead for Emergency Surgery will be crucial to this.

Post-operative care

11. The Trust should undertake work with the middle grade doctors to identify any training needs they may have. It is considered that the middle grades should have attended either the RCS ATLS (Advanced Trauma and Life Support) or CcRISP (Care of the critically ill surgical patient) in the past and should maintain their skills and keep up to date in these areas in particular. It is expected that they should be shown to be competent in six months.
12. The Trust should review the current protocols for requesting scans out of hours to ensure that there are no unnecessary delays in establishing diagnosis. e.g. double checking requests from middle grade doctors with the consultants.
13. Adoption of pathways such as the amber pathways by all staff needs to be addressed. Consideration should be given to introducing these as part of mandatory training.
14. The number of forms required for insulin prescriptions for diabetic patients needs to be reviewed and unambiguous protocols for care of diabetic patients need to be in place.
15. The Trust should establish an Enhanced Recovery Programme at the Alexandra Hospital.
16. End of life care and decision making was highlighted as a concern in Name redacted's review; the Trust should give further consideration to ways to improve this provision and whether any additional training needs to be given to staff to address these concerns.

Team working

17. Establishment of a county-wide team has begun with some of the Worcester Royal surgeons starting to operate at the Alexandra site. Work needs to be done to ensure that this is an inclusive programme and requires the full input of the Alexandra consultants.
18. The Trust should ensure that there is a forum for the views of middle grade surgeons to be heard and that they are more actively involved in departmental meetings with

attendance mandatory. Consideration should be given to assigning a mentor to each of the middle grades. Active steps are needed to improve the morale and functioning of this group, on which the surgical service so much relies.

Workforce

19. Now that the reconfiguration plans have been agreed, the Trust needs to continue to put in place a stable workforce to provide the general and emergency surgical care.

Audit and Outcomes

20. The Trust needs to establish a template for the audit meetings and ensure that these are looking at key datasets such as HSMR, NELA and NBOCAP.
21. The consultants should be free of any elective commitments during audit meetings with annual attendance for each member agreed (it is suggested this should be around 60 per cent), and progress against this discussed during their appraisal.
22. Audit meetings should involve staff from all levels to ensure that they are aware of the outcomes of the department and areas that require improvement.

Clinical governance

23. The governance structure in place for addressing complaints and dealing with SUIs needs to be reviewed. It is important that these are being handled in a timely manner and any backlogs of Datix incidents are dealt with. Any actions taken to address issues arising from these should be logged and reviewed. There are a number of Department of Health policy documents on matters such as how to investigate an SUI and the reporting of never events and the Trust should review their current processes to ensure they are in line with current best practice.

24. The Trust should not view complaints and incidents as single events. Work should be undertaken to look at any potential trends in this data. In the interests of patient safety, sufficient resources need to be allocated to enable this to be performed effectively.
25. Adherence to pathways such as the amber pathway should be addressed. The Trust should regularly review any pro formas that are used to monitor its use and take action accordingly with those who do not comply.

Appraisals

26. It is important that the Trust addresses their current completion rates for appraisals and ensures that each of the consultant surgeons are having annual appraisals.
27. Review of incident outcomes by the named clinician is a fundamental component of the appraisal process for medical staff and ensures that reflective practice is undertaken. The appraisal process should therefore review any complaints or Datix incidents that are relevant to the individual along with actions taken to address any issues.

Job Plans

28. The job planning for the middle grade doctors needs to be reviewed. Six weeks rolling notice of work plans should be given to this group.

29. The consultant job plans will need continuous monitoring and review as the reconfiguration process continues to ensure that there is a smooth transition. The Trust should ensure that the Alexandra consultants will not encounter any clashes which would prevent them from attending key meetings such as audit, MDT and M&M meetings.

Communication

30. The Trust needs to improve communication across the current structure. It is clear that the Trust has a vision for the service but they will need to engage their staff in the process of implementation of these plans in order for it to be a success and to operate safely.

Patients

31. The priority for the Trust should first and foremost be patient safety but the Trust should not lose sight of the needs of its catchment population and in particular transportation issues for relatives as well as patients.

Responsibilities of the Trust in relation to the recommendations of this report.
This report has been prepared by The Royal College of Surgeons of England and Association of Surgeons of Great Britain and Ireland under the IRM for submission to the Worcestershire Acute Hospital NHS Trust. It is an advisory document and it is for the Trust concerned to consider any conclusions and recommendations reached and to determine subsequent action. It is also the responsibility of the Trust to review the content of this report and in the light of these contents take any action to protect patient safety that is considers appropriate.
Further contact from the Royal College of Surgeons following final report.
Where recommendations are made that relate to patient safety issues, the Royal College of Surgeons will follow up this report with the Trust to ask them to confirm that the Trust has addressed these recommendations. The College's Lead Reviewer may be available to support this process. Where the College is not satisfied that these recommendations have been addressed within a reasonable period of time following the issue of the final report, the College, the Association and/or the Reviewers reserve to themselves the right to disclose in the public interest but still in confidence to a regulatory body such as the General Medical Council, or the Care Quality Commission or any other appropriate recipient, the results of any investigation and/or of any advice or recommendation made by the College, the Association and/or the Reviewers to the Hospital. The College will also contact the Trust to carry out an evaluation of its services following the issue of the final report.

Signatures of reviewers

Names redacted

10. Appendices to the Report

11.1 Appendix 1 – Brief biography of the reviewers

Names and content redacted

11.2 Appendix 2 – Summary of feedback sent to Trust

Mr Mark Wake
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31st January 2014

Dear Mr Wake,

As you are aware a Royal College of Surgeons (RCS) invited review of the general emergency surgery service at the Alexandra Hospital took place from 23-24 January 2014. The review team meet with Mr Graham James, Divisional Medical Director, Mr Chris Tidman, Director of Finance (on behalf of Penny Venables), representatives of the commissioners and you on the afternoon of Friday 24th January 2014 to provide some initial feedback on their findings. Given the current work being undertaken by the Trust the review team considered it would be helpful to summarise their initial feedback to the Trust in writing in advance of their production of their report.

<u>The general emergency surgery service</u>

The review team commended the Trust on the steps they had taken to introduce measures to address concerns over the HSMR (Hospital Standardised Mortality Ratios) data. It was reported that these measures included preventing the consultants from undertaking elective work whilst on-call, introducing a twice daily consultant ward round and working with the nursing staff to increase their awareness and confidence in escalating concerns over deteriorating patients. The review team understand that following the implementation of these measures the Trust has seen their HSMR rates fall within the accepted confidence

limits. The review team were reassured to hear this but highlighted to the Trust that as it would be almost impossible to determine if these measures alone had been the reason for the reduction in mortality rates it would be important for the Trust to continually monitor this position.

Emergency surgical care provided to patients at the Alexandra Hospital site

It was reported to the review team that as of the 3rd February 2014 the Trust is intending to implement a new surgical pathway for an interim period of around six to nine months whilst the process of wider hospital reconfiguration was on-going. This pathway would see those patients presenting in the Alexandra Accident and Emergency Unit with a suspected Acute Bowel Obstruction and/or Peritonitis being assessed on site and transferred to the Worcester Royal Hospital (bypassing A&E) to receive emergency surgery or on-going surgical management. The review team understand that should a situation arise where the patient being transferred required critical care then an anaesthetist would travel with the patient. If the patient was not in a condition to be transferred the consultant on-call at the Worcester Royal Hospital would attend to treat the patient.

The review team were satisfied that this new pathway was appropriate in circumstances but explained that they were unable to completely reassure themselves that the implementation of this pathway was completely safe based on the following points:

- Communication – whilst the review team commended the Trust for the speed with which they had developed the interim surgical pathway, they were concerned to hear from a number of front line staff (to include critical care staff, consultants in emergency medicine, middle grade doctors and nurses) that they had not yet seen the interim surgical pathway, were unaware of the specifics of this and felt unsure about what they would be required to do in particular circumstances such as when a patient was unfit for transfer. The review team understand that the Trust did not wish to share the pathway with staff until the final version was signed off (it is understood that this will be finalised imminently). The review team emphasised in the feedback session that it would be critical for the Trust address this as a matter of urgency in order to ensure that staff are clear and confident on the pathway so that a situation

does not arise where there is confusion amongst staff that could impact on patient safety.

- Ambulance transfers – the review team were informed by senior managers that the Ambulance service were aware of the intended interim pathway and requirements of the service for the transfer of emergency patients from the Alexandra to the Worcester Royal. However, the review team highlighted concerns held by staff that these links would not be in place for the 3rd February with some interviewees giving accounts of patients who as recently as last week had to wait over forty-eight hours for a transfer.

  The review team heard during the feedback session that responsibility for communication with the Ambulance service was currently being taken forward by another member of staff and that you would check how far the communication had gone. The review team would consider that prior to the 3rd February, it is crucial for the Trust to be assured that these links are in place in order for the interim pathway to succeed in maintaining patient safety.

- Capacity – the review team heard from some consultant surgeons that essential to their sign-up and agreement to the implementation of the interim surgical pathway was that the issue of capacity was addressed. The review team were reassured to hear from Penny Venables, Chief Executive that the Trust had 'ring-fenced' beds at the Worcester Royal Hospital for those patients being transferred from the Alexandra Hospital and that the emergency patients will take priority over elective patients.

The review team consider that these issues require the immediate attention and action from the Trust prior to the implementation of the interim surgical pathway on the 3rd February 2014 in order to ensure patient safety is maintained.

Finally, it was acknowledged that the new arrangements may cause transport difficulties for relatives accompanying or visiting the patient and that the review team considered this would require further review by the Trust as they continued to develop new plans for the service.

<u>Clinical Leadership</u>

The review team understand that with the plans for the development of cross county care for emergency patients that **Redacted name and job title (relating to new role)** . Having interviewed a number of the staff at the Alexandra Hospital, however, the review team highlighted to the Trust the divergent accounts from staff as to who they would go to if an issue or problem arose, with some staff seemingly unaware that a Clinical Lead role for Emergency Surgery even existed. The review team would consider that in order for the interim pathways to succeed it would be important for staff to be acutely aware of who they should approach if problems arise and that this should be addressed immediately.

Clinical Governance

During the feedback session the review team expressed their concern about the current clinical governance systems in place and their capacity to provide continuous monitoring of the quality of outcomes of the service. The review team acknowledge that the Trust is working to address this issue but would stress that as a priority the Trust needs to ensure that any changes to the service, to include the implementation of the measures adopted to address the HSMR data and the interim surgical pathway are being continuously monitored and reviewed. It is also essential that any adjustments to the pathway based on performance data are being made in a timely manner.

Diabetes

The review team highlighted conflicting accounts by senior managers and ground level staff as to the resolution of concerns relating to the management of patients with diabetes. It was reported by senior managers that they considered that this issue had been addressed and yet staff reported that they were continuing to raise concerns as to the number of forms required in relation to insulin prescriptions for diabetic patients which they considered caused potential for confusion. The review team considered that this concern needed to be immediately reviewed by the senior managers.

I hope it has been helpful for you to receive this initial feedback for your consideration and action. The College will now work to produce the full invited review report, which will be sent to you as soon as possible and likely within the next six to eight weeks.

Yours sincerely

Name redacted