Invited Service Review Report

Report on the Hepatobiliary Surgical Service

University Hospitals Bristol NHS Foundation Trust

Review visit carried out on: 25th & 26th February 2020

Report issued: 9th June 2020

A service review on behalf of:

The Royal College of Surgeons of England

Association of Surgeons of Great Britain and Ireland

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1. Introduction and background

On 18th October 2019, Dr William Oldfield, Medical Director and Responsible Officer for University Hospitals Bristol NHS Foundation Trust ("the Trust") wrote to the Chair of the Invited Review Mechanism (IRM) to request an invited service review of the healthcare organisation's Hepatobiliary Surgical Service. The request highlighted some particular areas to be reviewed, including: facilities and resources, team working and interpersonal behaviours, multidisciplinary team (MDT) processes, clinical workload, clinical governance, trainee support, and interactions with management.

The request was considered by the Chair of the RCS IRM and a representative of the Association of Surgeons of Great Britain and Ireland and it was agreed that an invited service review would take place.

A review team was appointed and an invited review visit was held on the 25th and 26th February 2020. 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 four[1] sets of clinical records reviewed.

Overview

University Hospitals Bristol NHS Foundation Trust (UHB) Hepatobiliary (HPB) Surgical Service provides a tertiary service for the local area at two sites: Bristol Royal Infirmary (BRI) for both acute and elective services and St Michael's (STMH) for elective services. Elective outpatients and MDT support is provided in Weston General Hospital (WGH) and Bath Royal United Hospital (RUH).

It was understood that at the time of the invited review visit, three of the seven (six substantive and one locum) consultant surgeons within the hepatobiliary specialty service were working and four were on sick leave. It was also understood that a 0.5 locum consultant HPB surgeon had been appointed a week prior to the review visit and a further full time locum consultant HPB surgeon was due to start at the end of March 2020. Seven surgical registrar posts (plus two vacancies) were supporting the service along with eleven junior doctors. In the wider upper gastrointestinal (UGI) team there were six consultant oesophago-gastric (OG) surgeons; five substantive consultants and one locum.

The consultant on call arrangements were reported to be 1:12 for GI surgery as follows : upper GI and lower GI alternating weeks, HPB and OG sharing the week with a second on call (1:6) for any sub-specialty patients. The surgical registrar on call arrangement was reported to be 1:12 and there was understood to be an expectation of this person being on site at UHB out of hours.

In terms of bed capacity for the service, there were 55 shared dedicated ward beds and 20 ICU and HDU beds shared between surgery and medicine. Theatre resources consisted of a dedicated CEPOD theatre in UHB for the on call team, available 24/7, plus access to an onsite theatre within the BRI for the equivalent of 10 all day sessions every 2 weeks and access to a day case theatre every Monday all day in STMH.

Inpatient theatre lists in BRI used for HPB major cancer cases totalled five whole days per week, alternating between 4.5 one week and 5.5 the next. There was also one whole day-case elective list each week undertaken at STMH.

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[1] Five sets of clinical notes, understood to have been selected for review following concerns being raised, were available for review during the visit. These were listed by the Trust in order of priority and the time available allowed for the first four of these five to be reviewed.

Two outpatient clinics were provided each week for follow up patients, two for new patients plus a clinic every other week in RUH for both new and follow up patients.

The specialist HPB multidisciplinary team (MDT) meeting took place once a week with a time allocation of 90 minutes for discussing on average between fifty and fifty five cases. Mortality and morbidity (M&M) meetings appeared to average approximately four or five per year with a scheduled time for each meeting of three hours. Five audit half days had reportedly occurred in the year before the review visit.

2. Terms of reference for the review

The following terms of reference for this review were agreed prior to the RCS review visit between the RCS and the healthcare organisation commissioning the review.

In conducting the review, the review team will consider the standard of care provided by the Hepatobiliary surgery service, including with specific reference to:

1. The data provided for hepatobiliary surgery outcomes, complications and mortality for both the service and individual surgeons in the context of accepted national and international standards/norms.

2. Preoperative (including patient selection), perioperative and postoperative decision making.

3. If the distribution of specialised low volume complex operations between individual surgeons is appropriate and supports optimal patient outcomes.

4. The reliability and robustness of the data collection and clinical governance processes to address any concerns that arise in relation to perioperative morbidity and mortality.

5. The adequacy of the medical staffing and clinical facilities for the volume of clinical activity undertaken.

6. The effectiveness of the multidisciplinary team (MDT) in ensuring continuous and optimal patient care.

7. Interpersonal relationships within the consultant hepatobiliary surgery team and their interpersonal relationships with the hepatobiliary MDT.

8. The safety and effectiveness of handover and care of patients out of hours.

9. The effectiveness of the hepatobiliary surgery service for the development of surgeons in training.

10. The current interventional vascular radiology support as configured is adequate and does not impact on clinical outcomes.

3. Conclusions

The following conclusions are based on the information provided to the review team from the interviews held, the documentation submitted (appendix A) and the clinical records reviewed (appendix E). 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.

3.1. The data provided for hepatobiliary surgery outcomes, complications and mortality.

The review team considered the data provided for both the service and for individual surgeons, compared to accepted national and international standards/norms.

The apparent lack of systematic collection of unit level outcome data for the HPB surgery service for several years meant that it was not possible for the review team to comment on outcomes and complications and how these compared published data from other similar services. The outcome data which was provided for the review was done so in a piecemeal fashion, the majority of which had been after the review visit. This data was gathered and presented by individual consultant HPB surgeons, which made validation and cross comparison difficult owing to the inconsistencies in the presentation of the data.

The review team made the following comments on the data which was provided:

Pancreas resection data, 2015-2019

The review team's conclusions in respect of the data provided by three consultant HPB surgeons were as follows:

- The mortality rate and post operative fistula rate data was comparable to published outcomes for pancreas surgery.
- The number of completion pancreatectomies was slightly higher than may be expected. This may be explained by the difficulty in accessing vascular interventional radiology.
- The number of cases per surgeon was relatively low at five per annum and below the guidance of twelve per year.

The outcome data for 352 liver resections (for the period end of 2014 – end of 2019) submitted indicated low 30 and 90 day mortality rate. The review team considered that this is consistent with published national and international data.

Overall, the review team were concerned that a lack of systematically organised and routinely collected service outcome data meant that it was difficult to reach any definitive conclusions about the quality and safety of the outcomes of the service at the time of their review visit.

3.2. Preoperative perioperative and postoperative decision making.

The case note review of four of the five cases presented did not identify any mismanagement and the level of care provided appeared to have been appropriate.

The review team commented that the case notes for A3 indicated that the initial sutures, although placed with poor visibility and did succeed in controlling the bleeding, the outcome for the patient could have been catastrophic. When it was realised that the hepatic artery had been occluded, this was remedied.

Preoperative decision-making

The pooled system for theatre listing had been reliant on the effectiveness of the service's Monday morning planning meetings and this appeared to have worked well in terms of discussing patients. However, in the review team's view, there did appear to have been some challenges presented by an apparent reluctance amongst some consultant HPB surgeons to proceed with a particular operative procedure or strategy if they had not been involved with the MDT decision-making.

The review team commented that the patient in case A4 had been seen by a number of surgeons and the notes seen documented that the diagnostic dilemma had been explained clearly to the patient. Further, in their opinion, the notes indicated that, despite differences of opinon between the surgical team, ultimately an appropriate decision for the patient was made.

Post-operative decision making

Whilst it is not unusual for the primary operating surgeon to manage returns to theatre when not on call, the review team were concerned that the apparent lack of trust which had apparently existed within the consultant HPB team had at times contributed to a reluctance by some consultants to allow on call colleagues to deal with returns to theatre.

3.3. The distribution of specialised low volume complex operations between individual surgeons.

The review team considered the question of whether the distribution of specialised low volume complex operations between individual surgeons was appropriate to achieve optimal patient outcomes.

HES data indicated that the activity numbers had been low in more complex cases compared to similar units with similar catchment populations.

With reference to the volume of Whipples procedures undertaken, the reported average of approximately five cases per year per consultant was noted by the review team as falling short of the national minimum guidance of twelve cases.

The review team supported views heard that the pooled system for allocation of cases helps manage waiting times for surgery and equal distribution of cases between surgeons. However, they also recognised that effective communication and trust amongst the consultant HPB surgeons was necessary for this to be successful. The review team noted examples of a lack of cohesion and trust between consultants including differences of opinion arising outside of MDT discussions resulting in a failure to agree on the optimum treatment in individual cases.

It was the review team's opinion that the apparent lack of clarity and agreement regarding sub-specialisation of the consultant HPB surgeons had added to the team working difficulties and opened the potential for "cherry picking" of cases.

3.4. The reliability and robustness of the data collection and clinical governance processes.

The difficulties highlighted by the review team in their ability to compare both the service and individual surgeons' data provided with accepted national and international standards/norms has been outlined in 3.1 above.

The apparent lack of team outcome data for more than five years and the outcome data which was provided being reliant on consultant HPB surgeons' records, has, in the review team's view, limited the reliability, robustness and usefulness of the data collected. The lack of a consistent method of capturing and analysing outcome data, agreed by the consultant HPB surgeons, made it difficult to compare individual surgeons' outcomes as well as overall outcomes for the team. Further limitations of this approach to data collection include a potential lack of robustness

with regard to, for example, independent verification of the data and the range of complications included. These limitations alongside the lack of prospective data collection will have hampered valuable discussion about outcomes, clinical governance and safety assurance.

The review team noted that some work by a consultant HPB surgeon and a trainee had recently begun regarding outcome data collection with the aim of improving both the process and quality of data.

The review team concluded that the current arrangement for M&M meetings was unclear in terms of frequency, scheduling and structure. With regards to the frequency and regularity of meetings, they noted that the minutes of the meetings over the previous three years indicated that, whilst there had been four or five each year, at one point during 2017 and 2018 there had been a period of nine months without any meeting. It appeared to the review team that when M&M meetings had taken place, the quality of discussions had been limited by interpersonal and communication difficulties within the consultant HPB team. It did seem, however, that the presentations given during the meetings in 2018 and 2019, had provided opportunity for discussion of cases and relevant topics areas.

The cessation of consultant team meetings was of concern to the review team as it represented a missed opportunity for the discussion of outcomes and complications within a potentially supportive environment.

3.5. Medical staffing and clinical facilities.

The review team considered the adequacy of the medical staffing and clinical facilities for the volume of clinical activity undertaken.

At the time of the review, when there were three consultant HPB surgeons, the review team concluded that:

- The consultant HPB surgeons had shown dedication and commitment to making the arrangement work.
- The service was under strain because of the volume of work and that this would be unlikely to be sustainable.
- The service provided had contracted in scope and, therefore, at the time of the review, was not of the level which would be expected of a specialist HPB surgery service.
- The situation had impacted the general surgery on call service, elective waiting lists and the acute pancreatitis service. It also relied on other hospital(s) to which some clinical work had reportedly been diverted. It was unclear as to the sustainability of these arrangements.
- Whilst it was suggested that when aspects of patient care that fell outside the areas of expertise of the three surgeons arose it would be possible to seek an external second opinion, the review team considered there maybe practical challenges presented in achieving this.
- Whilst the information provided did not indicate that there had been patient safety concerns, the review team were concerned that, were the current situation to continue for an extended period, there could be the potential for patient safety and care to be affected.
- While the additional 1.5 consultant HPB surgeon posts appointed would likely reduce the strain on the service, it would not return the level of consultant surgeon staffing to the previous number of seven.

The review team concurred with the views expressed to them that 1.5 full time equivalent CNS support for a team of seven consultant HPB surgeons was insufficient.

3.6. The effectiveness of the multidisciplinary team (MDT) in ensuring continuous and optimal patient care.

The review team identified that the specialist MDT meetings appeared to have been under considerable strain. It was apparent that a number of factors and challenges had contributed to this, including that:

- Despite steps being taken to reduce the MDT caseload (including removing benign cyst cases) the ninety minutes set aside for the meeting was insufficient for the volume of cases discussed.
- The apparent inconsistency in the availability of radiology and histopathology reports affecting the quality of the meeting.
- Cases referred from local MDTs in Trusts within the network had reportedly not been presented by the local teams in a consistent manner. This had meant that someone in the specialist MDT then needed to prepare these cases, which had added to the already onerous task of preparing that consultant's own cases for presentation.
- Interrelational difficulties reported between some of the consultant HPB surgeons affected the quality of the meeting. These difficulties were reported to include: a reluctance to participate in discussions, interpersonal friction and conflict, and an unwillingness of participants to consider viewpoints different to their own.

The review team noted that although there appeared to have been some discussion regarding the difficulties identified with the operation of the MDT, review meetings did not appear to have been in place to discuss these matters in a systematic manner. They further concluded that the steps which reportedly had already been taken to improve the current situation were positive, as were the future plans being developed[2].

The arrangement for appointing an MDT lead appeared to have been somewhat ad hoc and lacking a formal process. In the review team's view, this had also contributed to some of the inter-relational difficulties amongst the consultant HPB surgery team.

There appeared to have been some instances of disagreements relating to treatment pathways subsequent to MDT decisions. It was the opinion of the review team that it was unacceptable for these disagreements to be played out in the presence of the patient.

3.7. Team working.

The review team concluded that, individually, the consultant HPB surgeons presented as being hard-working and dedicated to providing the best clinical care for patients. However, the consistently reported interpersonal difficulties within the team had had a significant negative impact on effective communication, trust, and the ability of these individuals to work as a team.

The apparent failure to resolve the inter-personal difficulties over several years had contributed to the situation at the time of the review, which in the opinion of the review team was extremely concerning. It appeared that there had been a complete breakdown in team-working to the point that some members thought that the situation would be very difficult to resolve and reported that they felt unable to work with one consultant HPB surgeon. It was extremely unfortunate that four consultant colleagues had been on sick leave and that this would likely add to the challenges ahead in addressing and resolving the difficulties encountered at the time of the review visit.

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[2] These included: a proforma to record discussions, guidance on protocolisation, consideration of separate MDTs for liver and pancreas, benign and IPMN[2] cases, a triage system for "straight to test," an additional separate forum for discussion of more complex cases, consideration of a CNS leadership role and consideration of ways in which to improve the involvement of trainees.

Many factors were reported as having contributed to the unfortunate situation at the time of the review where it appeared that the consultant HPB surgeons had been unable to work as a team.

In the opinion of the review team, this had been created by a combination of interpersonal and service management issues which had contributed to the diffculties in different ways and at different times over a relatively long period.

Whilst it was difficult for the review team to make definitive conclusions as to the relative individual impact of each of these factors on the current situation, they made a number of observations about this:

- Disagreements, reportedly on the part of one consultant HPB surgeon in particular with their consultant colleagues, appeared to have acted as a barrier to moving forward as a team. These disagreements related to issues such as the historic appointment of additional consultant HPB posts, sub-specialisation, and on call cover.
- Reportedly, as part of the internal investigation following concerns raised in respect of the behaviour of a consultant HPB surgeon towards trainees, consultant colleagues had been invited to comment on the conduct and team working of the surgeon in question. It appeared that the surgeon in question had been made aware of colleagues' responses and had subsequently raised concerns about their clinical practice. Whilst these two events may be unrelated, the review team commented that this chain of events will have likely contributed to antagonsim within the consultant team.
- There had been a lack of systematic collection of unit level outcome data and what was available had been gathered and presented by individual consultant HPB surgeons. This would have made comparisons difficult and, in the review team's view, limited constructive discussion within a consultant team already experiencing difficulties in working in a mutually supportive way. Differences in the collection and presentation of individual outcome data allows differing interpretations, contributing to a need of some to raise concerns about the outcomes of colleagues. This is likely to have contributed to the team working and interpersonal difficulties. The lack of a robust unit M&M meeting also will likely have exacerbated this issue.
- The reports of bullying and an apparent lack of respect for leadership by one particular consultant HPB surgeon had contributed to interpersonal and team working difficulties. There was a widely held view amongst interviewees that the Trust had not adequately dealt with behaviour perceived to have been unacceptable and this is likely to have compounded the difficulties.
- Some elements of service provision appeared to have added to the difficulties in team working and interpersonal relationships. These included the reported increase in cancer cases coupled with increasing elective cancellations. The effectiveness of the pooled patient arrangement relied on effective communication amongst the consultant HPB team and without this tensions became further exacerbated.
- Lack of agreement regarding consultant HPB job plans added further to complications in this area.
- In addition to an apparent lack of a formal process to appoint an MDT lead (as outlined previously in 3.6 above), there did not appear to have been a formal process to appoint a clinical lead for the HPB department. This also led to resentment within the group.
- The lack of consultant team meetings had removed an opportunity for a dedicated time in which the consultant HPB surgeons were able to address and discuss issues.

There were some encouraging signs indicated by the work which had reportedly been initiated a month or so prior to the review (at the time of the interim clinical lead arrangements). These included identifying potential "pressure points" within the team, the introduction of mentoring and support mechanisms for less experienced surgeons, and the efforts being made to find a way to seek and coordinate views of the consultant HPB team.

The review team concluded that there appeared to be good working relationships between the three consultant HPB surgeons working at the time of the review visit, and in the wider MDT team.

3.8. The safety and effectiveness of handover and care of patients out of hours.

The review team were unable to draw definitive conclusions from the information available but concurred with the view that the support for ward nursing staff when two or three consultant led ward rounds occurred simultaneously, was a challenge.

The review team commented that the notes seen for case A1 indicated a breakdown in communication involving the primary surgeon not being informed by the on call surgeon of the intention to re-operate (for a second time). This, in their view, would be standard practice and an expected courtesy. Had this been done, it may have resulted in either the primary surgeon attending the re-laparotomy or a discussion taking place regarding intra-operative care.

3.9. The development of surgeons in training.

The review team concluded that the HPB surgery service had provided opportunities for the development of surgeons in training at a level that would be expected. It was also apparent from what was reported that some members of the consultant HPB surgery team had been particularly supportive and had provided exemplary training.

The review team concluded that the concerns raised initially in 2017 in respect of the support provided for trainees and the reported undermining behaviour by two consultant HPB surgeons, appeared to have been resolved at least in respect of one of the two consultant HPB surgeons concerned. However, they were concerned that from what was heard, the issues did not appear to have been fully resolved in respect of the second.

In the opinion of the review team, a number of factors have had a negative impact on the trainee experience, including:

- The difficulties in interpersonal relationships amongst the consultant HPB surgery team.
- The communication and team working difficulties within the consultant HPB team. These had impacted the effectiveness of the pooled patient arrangement; a system reliant on effective communication. This had also contributed to a lack of clarity regarding overall responsibility of care, particularly in more complex cases.
- Training opportunities being impacted by the workload of the consultant HPB team and the high rate of elective cancellations.
- The lack of an educational supervisor at various points in the past.

3.10. The adequacy of the current Interventional vascular radiology support and any impact on clinical outcomes.

The review team considered the adequacy of the current interventional radiology support as configured and any impact on clinical outcomes.

Urgent, out of hours, interventional radiology was understood, at the time of the review visit, to have been unavailable onsite at the HPB surgical centre. As a result it was reported that HPB patients requiring urgent interventional vascular radiology were transferred to a neighbouring hospital, where they were cared for by a non specialist HPB surgeon. The review team were made aware of difficulties in transferring patients across the city and noted that this arrangement has potential for lack of clarity regarding the overall responsibility of care for the patient. In addition it was recognised that a patient considered not well enough to transfer, may have to

undergo surgery out of hours. It was the opinion of the review team that this may have been responsible for the high rate of completion pancreatectomy observed following a Whipple procedure.

The review team commented that in the notes seen for case A3, when bleeding post-operatively resulted in haemodynamic instability, the patient was considered to be too unstable for transfer to a hospital where interventional radiology is provided. On site availability of interventional radiology would have avoided this situation.

3.11. Other.

The review team were unable to comment on the effectivess of the interim arrangements for the HPB clinical lead as it had been put in place only a day or so prior to the invited review visit. Similarly, the change in Clinical Director had taken place only a month prior to the review visit.

In respect of case A1, the review team commented that the three month wait from patient presentation to definitive surgery, in their view, constituted an unacceptable delay.

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 ensure that a robust system is put in place for the collection of and reporting on surgical outcomes across the service as well as for individual consultant HPB surgeons. The Trust should ensure that in doing this they have access to accurate and timely surgical outcome data to ensure the quality and safety of the service and ensure that urgent action can be taken if these outcomes diverge from acceptable national comparative benchmarks.

2. The current consultant surgeon staffing of three consultant HPB surgeons (plus the 0.5 WTE consultant that had been appointed and the further consultant HPB who was due to start at the end of March) requires careful monitoring in the context of the volume and scope of work that is required to be undertaken by the service and to ensure that the service has capacity to deliver this activity. Any discrepancy arising between current and required staffing levels needs to be urgently addressed and actioned.

3. The Trust should ensure that the conduct and behaviour of all the consultant HPB surgeons is compliant with organisational and professional standards.[3] Deviation from these standards should be acted upon in a timely and appropriate way. A 'code of conduct' document should be drafted explicitly outlining expected behaviour at all times including in meetings, towards colleagues, trainees and all other staff. It should be clearly stated that failure to adhere to an agreed standard of conduct would result in disciplinary action.

4. Interventional radiology services should be available on site 24/7.

5. M&M meetings also require review and steps taken to improve their effectiveness as a forum for discussion, to include but not limited to:

   - Meetings are scheduled appropriately in advance to ensure appropriate frequency and regularity, and at a time which enables all key staff to attend.
   - Meetings should be structured to ensure that agendas are clear and minutes are taken and shared.

   Any work in this area which has started should be taken into account and, where appropriate, built upon. RCS has published tools and templates for M&M meetings[4], which may assist this process.

6. In support of the implementation of recommendations 1, 3, and 5 surgeons and managers should agree appropriate protocols for raising and responding to concerns about:

   - Individual surgical practice.
   - Team surgical practice.
   - Clinical outcomes/complications.

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[3] Such as GMC Good Medical Guidance, Domain 3: communication, partnership and teamwork
[4] Royal College of Surgeons of England morbidity and mortality meetings tools and templates.

7. The Trust should review and agree each of the consultant surgeon's job plans to ensure that the provision of a comprehensive and transparent core on call service in which all consultant surgeons play an equal part. Alongside this, sub specialisation needs to be agreed such that that all surgeons have an appropriate, manageable, agreed workload, which enables relevant skill sets to be recognised and maintained.

8. Consultant meetings should be reinstated at a time which ensures that all consultant HPB surgeons are able to attend.

9. Arrangements should be put in place to promote and develop team working, including but not limited to, joint operating, peer to peer mentoring and cross covering.

4.2 Recommendations for service improvement

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

10. Following recommendations three and six above, the work already begun, led by the interim clinical lead, should continue and be supported. This work should include but not be limited to:
    - Identifying potential "pressure points" within the team.
    - Mentoring and support mechanisms for less experienced surgeons[5].
    - Seeking and coordinating the views of the consultant HPB team.
    - Supporting the recently appointed educational supervisor.

11. The Trust should consider making any consultant HPB surgeon positions, which have been locums for longer than a year, substantive, in line with RCS guidance.[6]

12. There should be a comprehensive review of the MDT meetings, with particular consideration given to the following:
    - A systematic process for bringing together information and proposals from discussions and meetings which have taken place recently as part of reviewing MDT meetings.
    - Based on the volume of cases reported at the time of the review visit, the ninety minute time allocation for the meeting needs to be extended to reduce pressure and facilitate meaningful discussion.
    - The process for the appointment of the MDT chair and this person's roles and responsibilities need to be formalised.

    An action plan needs to be agreed and responsibilities for taking this work forward made clear

13. The current CNS staffing for the service should be reviewed and consideration given to preparing a business case for additional post(s).

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[5] The Royal College of Surgeons of England provides guidance on mentoring.
[6] Locum Surgeons: Principles and standards. RCS 2011.

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.

14. Following recommendation one, consideration should be given to the development of a database to support quarterly governance reviews and the determining of associated staff levels and other resources required. This should include consideration of the appointment of a data clerk to provide dedicated support.

4.4 Responsibilities in relation to 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 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 content 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.[7]

4.5 Further contact with the Royal College of Surgeons

Where recommendations have been made that relate to patient safety issues the Royal College of Surgeons 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 College 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 College's Invited Review service may also be able to provide this assistance.

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