Royal College of Surgeons of England

ADVANCING SURGICAL CARE

SUPPORT Improvement Collaborative Learning Report

November 2025

THE MPS FOUNDATION

Contents

List of abbreviations

Chole-QuIC – Cholecystectomy Quality Improvement Collaborative

NHS – National Health Service

QI – quality improvement

RCS England – Royal College of Surgeons of England

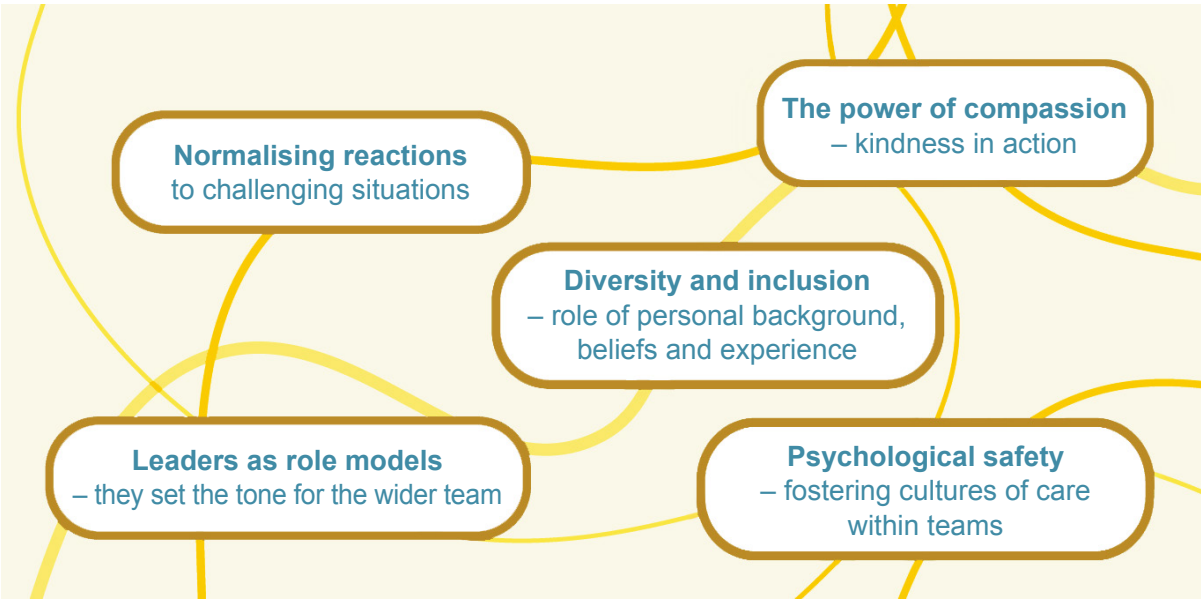
SUPPORT – **SU**rgeon **P**eer-led **Po**st-incident **R**esponse **T**eams

Summary

SUPPORT (SUrgeon Peer-led Post-incident Response Teams) is the Royal College of Surgeons of England's seventh QI (quality improvement) collaborative. The project aim was to enable participating hospital trusts to design, deliver, sustain and evaluate peer-to-peer support for surgeons with a particular focus on support after adverse events in surgical care (both intraoperative and perioperative). This report will outline the key project findings.

- Twelve sites participated in the subscription-based collaborative project. One site was in the Republic of Ireland and the remainder were NHS trusts in England.
- The project built on an existing collaboration with the surgeon wellbeing research team at Bournemouth University, which had led to the RCS England good practice guide *Supporting Surgeons After Adverse Events* (published in 2020).[1]
- The project ran for 18 months from October 2023 (following a pre-launch event in September 2023), and comprised 4 whole-day in-person events at the RCS England headquarters in London, 3 half-day webinars and 5 small group online sessions facilitated by a member of the project team.
- The SUPPORT QI collaborative identified key themes, called 'golden threads'. These threads represent the core principles and values that guided our efforts (*Figure 1*).
- While the majority of the material for the collaborative was produced and delivered by the project team, external experts were invited to deliver specific content throughout the programme.
- Data acquisition and analysis was led by the Bournemouth University team.
- RCS England appointed an innovation and improvement fellow, funded by the Medical Protection Society, for a 12-month period coincident with the collaborative. The fellow led quantitative (data interpretation) and qualitative (structured interviews) analysis of the delivery and progress of the collaborative.

Figure 1: SUPPORT QI collaborative 'golden threads'



"An overdue and required initiative that brings to the fore our shared feelings of vulnerability that we tended to hide as individuals but that as a collective we may hopefully feel more empowered to address"

Site team lead
March 2025

Whole-collaborative photo taken at the SUPPORT QI collaborative celebration event at RCS England in March 2025

1. Background and context

The RCS England QI collaboratives bring together teams from multiple NHS trusts/health boards to focus on a topic area for improvement. This approach has been implemented successfully by RCS England across six previous QI collaboratives, adapting the approach set out by the Institute for Healthcare Improvement Breakthrough Series model.[2] For more information, please visit www.rcseng.ac.uk/qicollaboratives.

RCS England's earlier collaboratives include HandsFirst (focusing on hand trauma care) and Chole-QuIC (focusing on improving care for patients with gallbladder disease). A commonality for all QI collaboratives is in bringing together site teams from hospitals across the UK and the Republic of Ireland to work towards a common area of improvement in surgery using a co-creational approach.

This report focuses on the seventh QI collaborative launched by RCS England: SUPPORT. The SUPPORT QI collaborative ran from October 2023 to March 2025, with the aim of supporting hospital trusts to implement a peer support programme for surgeons following an adverse event.

Adverse events are an inevitable part of surgical practice. The first priority is to care for the patient and their family. There is substantial evidence that experiencing an adverse event can also have a profound impact on a surgeon's wellbeing.[3–5] In work published previously by members of the project delivery team, a survey of 445 surgeons in the UK indicated that a third of respondents reported symptoms such as nightmares, hypervigilance and detachment following an adverse event (symptoms associated with clinically significant levels of post-traumatic stress).[5] Nearly half (48%) of the surgeons surveyed reported anxiety following the adverse event, with many also describing sleep problems, irritability and increased alcohol consumption. Sadly, these findings are in line with a body of research demonstrating the serious consequences for surgeons when things go wrong in surgery, both personally and professionally.[3–7]

Although the impact of adverse events for surgeons is clear, surgeons do not routinely seek support following an adverse event. Surgeons represent 11% of UK medical practitioners but they account for only 4.3% of users of the NHS Practitioner Health programme, which provides access to mental health support for NHS doctors and dentists.[8] Furthermore, even though there is research that peer and manager support are key after potentially traumatic incidents, 42.5% of surgeons reported that they did not talk to anyone at all about their experiences of an adverse event.[5] Surgeons cited lack of support at work and lack of preparedness for the psychological effects of adverse events as key barriers.

While a range of preventive, responsive and specialist interventions could be effectively developed to support surgeons following an adverse event, the SUPPORT QI collaborative focuses specifically on implementing a peer support model. Evidence suggests that this is the preferred support cited by healthcare professionals following an adverse event.[9] This approach is consistent with effective peer support models that have been introduced for healthcare professionals more widely.[10–13] Peer support models have also been introduced successfully for surgeons in the US, with authors suggesting that peer supporters are uniquely positioned to understand the specific experiences of surgeons when things go wrong in surgery.[14,15]

Increasing support for surgeons following adverse events has a number of potential benefits. In addition to improving surgeon wellbeing, supporting surgeons can improve patient safety; surgeons dealing with the aftermath of adverse events are more likely to make subsequent errors.[16,17] Employers also benefit from the financial implications of supporting surgeons; some surgeons report coping with the impact of adverse events by changing roles or leaving the workforce entirely.[18] According to the National Audit Office, the cost of excluding a doctor from work was £188,000 in 2003,[19] a figure that will have undoubtedly grown substantially over the past two decades.

In light of this, in 2020, our team created the good practice guide *Supporting Surgeons After Adverse Events*, developed through collaboration between Bournemouth University's surgeon wellbeing research team and members of the RCS England QI directorate.[1] We launched the SUPPORT QI collaborative to further develop this work and to take proactive steps in helping hospital trusts to implement this guidance to provide peer support for surgeons following adverse events.

2. Design and delivery

Aims and objectives

SUPPORT project aim: to support hospital trusts to design, deliver, sustain and evaluate a peer support programme for surgeons affected by an adverse event

Objectives for site teams: In order to help site teams to build the required skills and understanding to successfully implement a peer support programme, the SUPPORT QI collaborative also focused on the four objectives shown in *Figure 2*.

Figure 2: The four objectives of the SUPPORT QI collaborative

1. **Developing the skills and confidence necessary to conduct effective peer support conversations** – This involved training site teams to understand the psychosocial sequalae that surgeons may face after an adverse event, and to provide support that is helpful, empathetic and validating for colleagues affected by adverse events.

2. **Empowering site teams to implement a peer support initiative in their trust** – Site teams were supported in understanding the practical steps required to design, implement and sustain a peer support programme tailored to their organisational context.

3. **Promoting a culture of care in the trust environment** – This component included psychoeducation on cultivating compassion for both self and others in the aftermath of adverse events, as well as recognising the role of diversity in shaping individuals' help-seeking behaviours.

4. **Challenging prevailing attitudes towards adverse events and seeking support** – This work focused on normalising common psychological responses to adverse events, encouraging leaders to model healthy help-seeking behaviours, and fostering openness and vulnerability when things go wrong in surgical practice.

Process followed

UK-based NHS trusts/health boards were invited to take part in the SUPPORT QI collaborative and given details of the potential benefits of participation (*Figure 3*). In order to join SUPPORT, project sites paid a one-off subscription fee of £10,000 plus VAT, which covered participation in the programme for the 18-month period from October 2023 to March 2025. A total of 12 sites were recruited from the UK and the Republic of Ireland (*Table 1*).

Figure 3: Benefits for sites joining the SUPPORT QI collaborative

- **Continuous support and learning** – 15 months of continuous support, fostering a culture of shared learning and gathering valuable data on the impact of this effort
- **Expert guidance from diverse perspectives** – Led by a multiprofessional team comprising a consultant surgeon clinical lead, clinical psychologists and project managers with invited guest speakers
- **Empowering local capacity and capability** – Each participating site will have a core group that will be part of the SUPPORT collaborative. These local teams will then disseminate their learning locally, building capacity to better support surgeons after harm throughout the UK.
- **Fostering peer-to-peer support** – The collaborative will strengthen RCS England's good practice guidance on *Supporting Surgeons After Adverse Events*[1] and facilitate the exchange of expertise.
- **Driving best practices** – The SUPPORT programme will foster an ecosystem of support that adheres to best practices. We aim to create a unique and robust network for surgeons after adverse events, ensuring that their wellbeing remains a top priority.
- **Involvement in an innovative approach to improving wellbeing in surgeons** and the potential positive benefits this may have for affected clinicians, as well as potentially wider benefits within/across organisations.

Table 1: Sites participating in the SUPPORT QI collaborative

1	Dublin – Tallaght University Hospital
2	East and North Hertfordshire Teaching NHS Trust
3	Guy's and St Thomas' NHS Foundation Trust
4	Mid and South Essex NHS Foundation Trust
5	Newcastle upon Tyne Hospitals NHS Foundation Trust
6	Royal Berkshire NHS Foundation Trust
7	Shrewsbury and Telford Hospital NHS Trust
8	St George's, Epsom and St Helier Hospital Group
9	Stockport NHS Foundation Trust
10	University Hospitals Dorset NHS Foundation Trust
11	University Hospitals Sussex NHS Foundation Trust
12	Wirral University Teaching Hospital NHS Foundation Trust

Sites were invited to a pre-launch meeting in September 2023. The set-up and planning phase took place from October to December 2023, and the live phase of SUPPORT commenced in January 2024, running until December 2025.

During the set-up and live phases, site teams attended three in-person national collaborative meetings to share reflections, learning and progress, and to discuss facilitators and challenges to setting up the peer SUPPORT programme. Sites also attended three half-day webinar events and five online group peer support sessions (with 3–4 sites per group), followed by an in-person celebration event in March 2025.

Sites were provided with an online resource pack for implementing the peer SUPPORT programme as well as a video recorded session outlining how to deliver a peer SUPPORT conversation. Throughout the collaborative, sessions focused on discussion, coaching, facilitated role play and psychoeducational resources, with guest speakers delivering specialist materials on topics such as the medicolegal considerations of peer support.

Project timeline

Figure 4 shows the SUPPORT project timeline. For a full list of the events that took place, see *Table 2*.

Figure 4: Timeline for the SUPPORT QI collaborative

Table 2: Schedule of events for the SUPPORT QI collaborative

Phase	Date	Event	Format
Set-up and pre-launch	December 2023	Webinar 1	Online (Microsoft Teams)
Improvement collaborative – live phase	January 2024	Collaborative in-person event 1	In person
	February/March 2024	Small group peer session 1	Online (Microsoft Teams)
	March 2024	Webinar 2	Online (Microsoft Teams)
	April 2024	Small group peer session 2	Online (Microsoft Teams)
	May 2024	Collaborative in-person event 2	In person
	June 2024	Small group peer session 3	Online (Microsoft Teams)
	September 2024	Small group peer session 4	Online (Microsoft Teams)
	October 2024	Webinar 3	Online (Microsoft Teams)
	November 2024	Small group peer session 5	Online (Microsoft Teams)
	December 2024	Collaborative in-person event 3	In person
Evaluation and reporting	March 2025	Celebration event	In person

Approach

The SUPPORT programme followed the Institute for Healthcare Improvement Breakthrough Series approach,[2] combined with an adapted version of the theory of change framework developed for the Chole-QuIC project.[20] This work aligned with the five components of NHS IMPACT (Improving Patient Care Together):[21]

1. Building a shared purpose and vision
2. Investing in people and culture
3. Developing leadership behaviours
4. Building improvement capability and capacity
5. Embedding improvement into management systems and processes

SUPPORT was the first RCS England QI collaborative to focus on surgeon wellbeing and surgical culture, rather than on clinical areas of care.

Study design

A mixed-methods design was employed to collect quantitative and qualitative data utilising surveys and semi-structured interviews.

- We used a comparative design to measure change in outcomes for site teams from January 2024 to January 2025 (in particular, aspects such as perceived confidence and skill in delivering a peer support programme).
- We hypothesised that implementation of the SUPPORT collaborative would facilitate changes in the wider culture and support-seeking attitudes of surgeons in the participating sites. Consequently, we measured levels of organisational change between March to June 2024 and March to June 2025 in uptake of peer support as well as changes in perceptions of surgeons in the participating organisations.
- Given the need to better understand the perceptions of participating site teams (and specifically, perceived barriers and facilitators to implementing the SUPPORT programme), session-by-session surveys were also completed by site team members. Semi-structured qualitative interviews were then carried out with consenting members of the site teams (*n*=16), recruited between January and March 2025, to explore experiences of participating in the collaborative.

Ethical approval for data collection was obtained from the Bournemouth University ethics committee for all components of data collection. Informed consent was gained from all participants prior to data collection.

Quantitative data collection

Site team survey

Survey data using quantitative Likert-type scales/items were examined to identify any changes in site team members' attitudes, perceived skills and understanding; these data were gathered before participation in the SUPPORT collaborative and at the end of the collaborative (January 2024 and December 2024 respectively). *Table 3* outlines the measures used for the site team survey.

Table 3: Measures used for site team survey

Measures	Construction
SUPPORT aims	
Twelve items to measure the aims of SUPPORT, such as perceived skill, knowledge and understanding of how to set up support, deliver a SUPPORT conversation etc. Items on 5-point Likert scale from "strongly disagree" to "strongly agree". E.g. *"I have the skills to deliver a peer SUPPORT conversation to a colleague after an adverse event."*	Constructed by SUPPORT team
Organisational Compassion Scale	
Measures of perceived compassion to (6 items) and from (6 items) others at work. Items on 5-point Likert scale from "strongly disagree" to "strongly agree". E.g. *"When someone is suffering in my surgical department, I tend to notice the signs."*	Items adapted from the NEAR Organisational Compassion Scale[22]

Self-Compassion Scale (SCS)	
Measures of perceived self-compassion (12 items). Items on 5-point Likert scale from "almost never" to "almost always". E.g. *"I try to see my failings as part of the human condition."*	All items used from the validated SCS[23]
Vulnerability Stigma Scale	
Measures of stigma towards showing vulnerability/seeking support (4 items). Items on 5-point Likert scale from "strongly disagree" to "strongly agree". E.g. *"Showing vulnerability as a surgeon is a sign of weakness."*	Items adapted from the Mental Health Stigma Scale[24]

Organisational survey

In addition, surgical staff employed at participating sites were asked to complete a survey. These data were also collected both at the start and end of the SUPPORT collaborative (March 2024 and March 2025) to measure culture change as well as engagement with peer SUPPORT conversations. *Table 4* describes the measures used for this organisational survey.

Table 4: Measures used for organisational survey

Measures	**Construction**
SUPPORT aims	
Two items to assess the perceived need for/satisfaction with support following adverse events. Items on 5-point Likert scale from "strongly disagree" to "strongly agree". E.g. *"I believe there is a need for surgeon-specific peer-to-peer support after an adverse event."* E.g. *"The current support for surgeons in our trust after an adverse event is adequate."*	Constructed by SUPPORT team
Organisational Compassion Scale	
Measures of perceived compassion from others at work (6 items). Items on 5-point Likert scale from "strongly disagree" to "strongly agree". E.g. *"When someone is suffering in my surgical department, I tend to notice the signs."*	Items adapted from the NEAR Organisational Compassion Scale[22]
Burnout Assessment Tool (BAT)	
Measures of burnout (12 items). Items on 5-point Likert scale from "never" to "always". E.g. *"I feel mentally exhausted."*	All items used from the validated BAT[25]

Vulnerability Stigma Scale	
Measures of stigma towards showing vulnerability/seeking support (4 items). Items on 5-point Likert scale from "strongly disagree" to "strongly agree". E.g. *"Showing vulnerability as a surgeon is a sign of weakness."*	Items adapted from the Mental Health Stigma Scale[24]
Attitudes towards seeking support	
Measures of attitudes towards seeking support (4 items). Items on 5-point Likert scale from "strongly disagree" to "strongly agree". E.g. *"Following an adverse event, as a surgeon I should seek support."*	Created using guidelines from the theory of planned behaviour[26]
Engagement and perception of the SUPPORT initiative	
Items to rate awareness and experience of SUPPORT. Those who indicated having participated in a peer SUPPORT conversation were administered 11 items assessing perceptions of the SUPPORT conversation and 5 items assessing perceived impact of the SUPPORT conversation. Items on 5-point Likert scale from "strongly disagree" to "strongly agree". E.g. *"My peer supporter provided a safe and trusting environment for discussion."*	Items adapted from Hughes' trauma support model[27] and El Hechi's evaluation of a peer support model for surgeons in the US[14]

Qualitative data collection

In order to collect rich qualitative data from site team leads who had taken part in the SUPPORT QI collaborative, semi-structured interviews were carried out with 16 participants to explore their experiences of SUPPORT, and the perceived barriers and facilitators they had encountered in implementing the peer SUPPORT programme. Interviews lasted approximately one hour.

3. Key achievements

One key achievement of RCS England's SUPPORT project was that this QI collaborative was the first of its kind to adapt the QI model to focus on the wellbeing of surgeons rather than patient care. It is novel in emphasising the importance of fostering culture change around seeking support and prioritising care for surgeons when things go wrong in surgery. Although such initiatives have been implemented in the US,[14,15] no such approach has been used in the UK until now. While culture change in healthcare systems can be difficult, we have outlined in the 'Results analysis' section of this report how the SUPPORT programme did in fact lead to some substantial changes in compassion to others, from others and towards oneself for site team members who took part in the collaborative. This is a promising step towards change.

> *"A fantastic learning experience – we have learnt a lot about how we can support our colleagues. However, it is clear that cultural change will be needed to encourage surgeons to come forwards, and discuss their feelings and personal responses to adverse events and complications. This feels like a big step in the right direction!"*
>
> **Site team lead**
> March 2025

Rather than an 'off the shelf' teaching approach, the faculty approached the initiative as a genuinely collaborative effort with site team members, recognising the breadth and depth of both professional and personal expertise in relation to adverse events as well as wider team culture. This included shared exploration of issues and ideas, shared development and testing of the approach, and a shared approach to understanding the impact, strengths and challenges.

Participants fed back that this approach provided opportunities for fostering new connections (both between different trust sites taking part in the collaborative and among colleagues within the same trust), support and encouragement for enablers to change, and validation for some of the challenges that arise in organisational change interventions, such as with the SUPPORT programme. The collaborative approach enabled a process of continuous improvement, which will extend into the next phase of the project, SUPPORT2.

> *"Brilliant way of engaging lots of surgeons across a variety of subspecialties – both new and old – and amazing to see such support for SUPPORT, and the need to recognise that no one is an island or in this alone."*
>
> **Site team lead**
> March 2025

SUPPORT also led to the development of a novel and comprehensive toolkit of modules to help sites set up and evaluate their peer SUPPORT programme. Following the collaborative discussions with the site teams, the project delivery team designed modules covering:

- the needs and aims of the SUPPORT initiative
- the psychology behind SUPPORT
- available support and signposting
- key qualities of a peer supporter
- carrying out a peer SUPPORT conversation and using the checklist
- trauma awareness and understanding responses to adverse events
- managing psychological risk
- supporting peer supporters
- promoting the SUPPORT programme
- evaluating the SUPPORT programme

> *"I feel much more confident now that I have excellent resources and a very clear plan to follow to set up support in my trust."*
>
> **Site team lead**
> March 2025

4. Results analysis

Site team post-SUPPORT evaluation survey

At the last in-person event of the live phase of the SUPPORT QI collaborative (in December 2024), we asked each site team to complete a survey to identify facilitators and barriers to SUPPORT implementation. Eleven site teams completed the survey.

The most frequently cited facilitators for setting up SUPPORT were the backing of RCS England (*n*=9), collaborative working between clinicians (*n*=9) and positive beliefs about the intervention (*n*=9). These were followed by teamwork (*n*=7), the engagement of the site team (*n*=5), positive culture (*n*=5), the adaptability of the intervention (*n*=4) and the quality of the intervention (*n*=4).

With regard to barriers to implementing SUPPORT, responses given by the site teams were lack of time (*n*=9), lack of administrative support/structural characteristics (*n*=5) and insufficient resources (*n*=4).

The teams were also asked: *"Do you feel you have had sufficient time and resources to design, deliver, sustain and evaluate the SUPPORT programme in your trust?"* The possible answers were "yes", "partially" or "not enough". The results are shown in *Table 5*.

Table 5: Site team responses to the question "Do you feel you have had sufficient time and resources to design, deliver, sustain and evaluate the SUPPORT programme in your trust?"

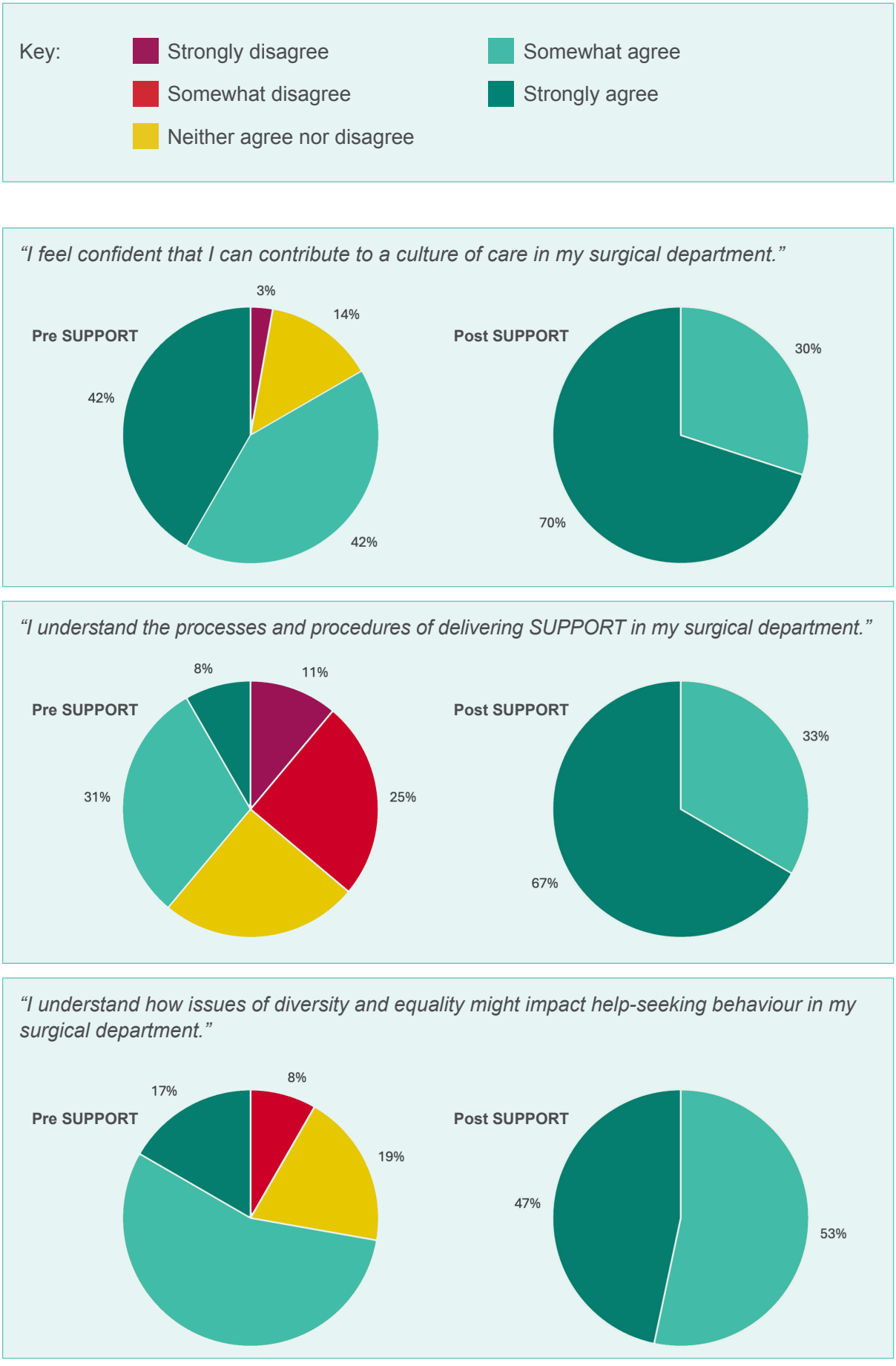
Item	Yes	Partially	Not enough
Design (*n*=11)	4 (33.3%)	5 (41.7%)	2 (16.7%)
Deliver (*n*=11)	2 (16.7%)	7 (58.3%)	2 (16.7%)
Sustain (*n*=10)	1 (8.3%)	4 (33.3%)	5 (41.7%)
Evaluate (*n*=11)	2 (16.7%)	6 (50.0%)	3 (25.0%)

Site team survey: pre-SUPPORT/post-SUPPORT comparison

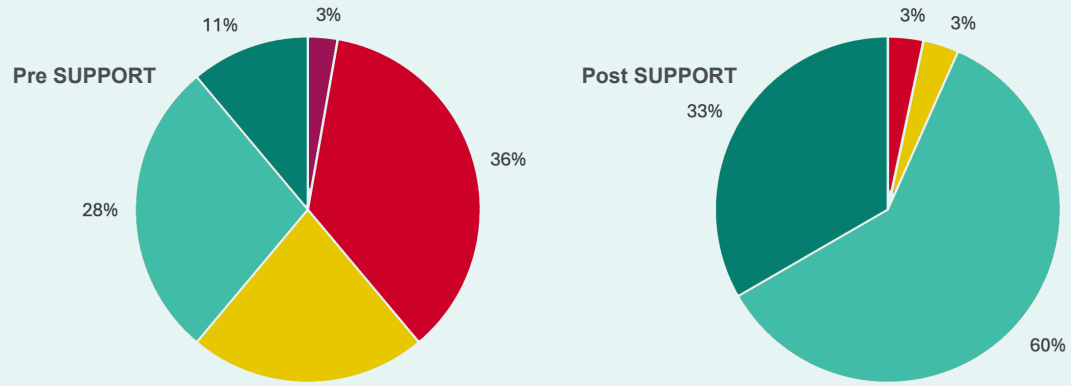
We compared survey responses from the site team members at the start and end of the SUPPORT collaborative. While we received 36 responses from site team members for the pre-SUPPORT survey (in January 2024) and 30 responses for the post-SUPPORT survey (in December 2024), only 17 respondents entered a matching anonymous code at both timepoints to allow us to pair their data. The results presented below are therefore from the total unmatched sample. However, the same findings were observed when re-running the analyses with the matched sample of 17.

There were higher proportions of respondents who "somewhat agree" or "strongly agree" with all items measuring SUPPORT aims after participation in the collaborative (*Figure 5*). This demonstrates that the site teams felt more confident, knowledgeable and skilled around implementing a peer SUPPORT programme in their trust, carrying out a peer SUPPORT conversation and understanding psychological responses to adverse events following participation in SUPPORT.

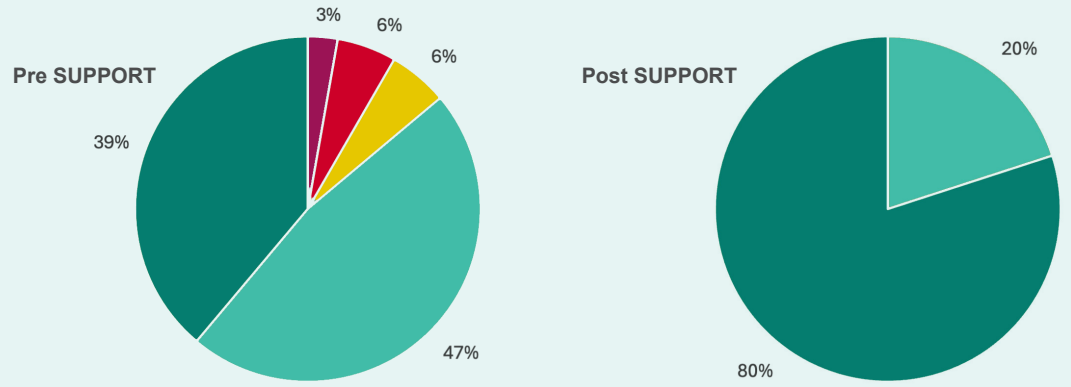
Figure 5: Site team data illustrating changes before and after implementation of the SUPPORT QI collaborative for measures relating to the aims of the SUPPORT programme



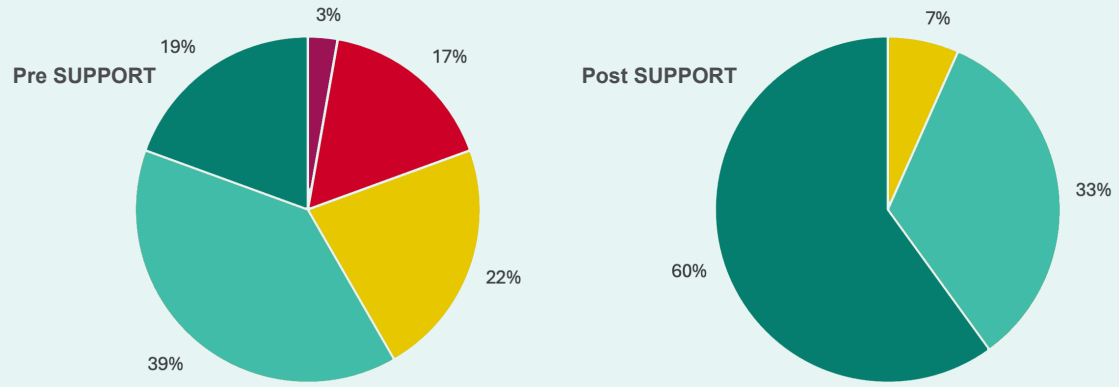
"I understand how to address barriers of seeking support with colleagues in my surgical department."



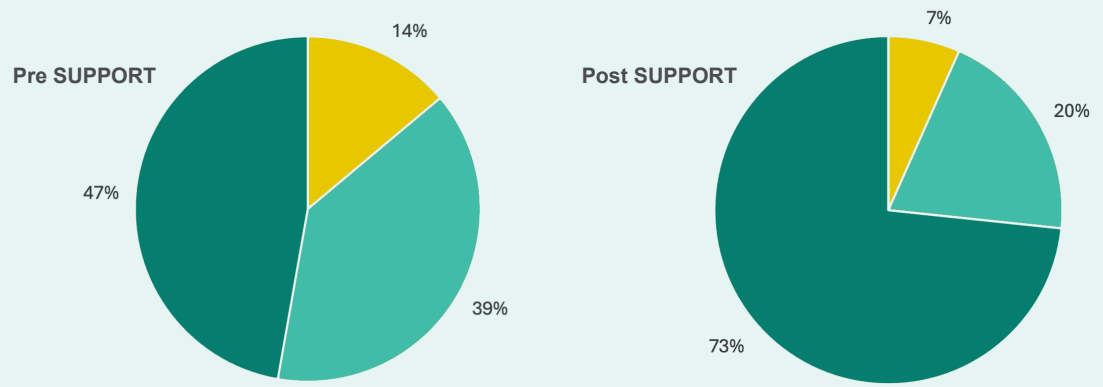
"I am aware of common psychological reactions to adverse events in surgery."



"I have the skills to deliver a peer SUPPORT conversation to a colleague after an adverse event."



"If I were involved in an error or complication during surgery, I would speak to someone."



T-tests highlighted statistically significant changes before and after implementation of the SUPPORT programme in self-compassion (t=-2.46, *p*=0.008), perceived compassion to others at work (t=-4.39, *p*<0.001) and perceived compassion from others at work (t=-3.51, *p*<0.001) reported by site team members (*Table 6*). These findings were replicated with the matched sample (*n*=17). This indicates that participation in SUPPORT fostered a change in culture of compassion for site teams. Although we did not find a statistically significant difference in vulnerability stigma overall, 96.6% of respondents agreed with the statement *"I am comfortable showing vulnerability to my colleagues"* at the end of the SUPPORT initiative whereas only 86.1% had agreed with this statement before implementation of SUPPORT.

Table 6: Comparison of data from the site team surveys administered before and after implementation of the SUPPORT programme

Scale (scale range)	Mean scores (SD)		Mean change	Significance
	Pre-SUPPORT	Post-SUPPORT		
Self-compassion (12–60)	34.61 (6.83)	38.47 (5.70)	+3.86 (+8.0%)	***p*=0.008**
Compassion to others (6–30)	23.19 (3.28)	26.63 (3.01)	+3.44 (+14.3%)	***p*<0.001**
Compassion from others (6–30)	18.61 (5.45)	23.20 (5.09)	+4.59 (+19.1%)	***p*<0.001**
Vulnerability stigma (4–20)	9.92 (2.21)	9.23 (2.74)	-0.69 (-4.3%)	*p*=0.133

SD = standard deviation

Organisational survey: pre-SUPPORT/post-SUPPORT comparison

We collected survey data from surgical staff at participating SUPPORT trusts at two timepoints: pre-SUPPORT (March – June 2024) and post-SUPPORT (March – June 2025). Site team leads were asked to circulate an email advertisement and survey link to all surgical staff in their trusts. There were 153 responses at timepoint 1 (pre-SUPPORT) and 57 responses at timepoint 2 (post-SUPPORT). Of these, only 16 respondents completed surveys at both timepoints. This limits the conclusions we can draw with regard to organisational change.

In the pre-SUPPORT survey, 135 respondents (88.2%) stated that they "somewhat agree" or "strongly agree" that there was a need for surgeon-specific peer-to-peer support after an adverse event. Conversely, only 37 respondents (24.2%) reported that they "somewhat agree" or "strongly agree" that the current support for surgeons after an adverse event was adequate.

In order to examine organisational change, t-tests were carried out to identify any statistically significant differences between pre-SUPPORT and post-SUPPORT data in compassion from others, burnout, vulnerability stigma and attitudes towards seeking support. Given the difficulty with this sample in terms of partially matched data from the pre-SUPPORT and post-SUPPORT surveys, and unequal group sizes, these data were analysed first for the unmatched sample (*n*=210) and then for the matched sample of surgical staff who completed surveys at both timepoints (*n*=16). There were no significant changes between the two survey timepoints in vulnerability stigma or burnout scores. Nevertheless, there was a small improvement in attitudes towards seeking support and also in perceived compassion from others (but for the latter, this was only statistically significant in the matched sample [*n*=16]). *Table 7* outlines the differences between the pre-SUPPORT and post-SUPPORT data from the organisational surveys.

Table 7: Comparison of data from the organisational surveys administered before and after implementation of the SUPPORT programme

Scale (scale range)	Sample	Mean scores (SD)		Mean change	Significance
		Pre-SUPPORT	Post-SUPPORT		
Compassion from others (6–30)	*n*=210	18.89 (6.20)	19.77 (6.21)	+0.88 (+3.7%)	*p*=0.181
	n=16	19.81 (7.78)	22.25 (6.13)	+2.44 (+10.2%)	***p*=0.026**
Burnout (12–60)	*n*=210	27.84 (6.78)	28.33 (7.03)	+0.49 (+1.0%)	*p*=0.323
	n=16	27.94 (7.50)	28.50 (6.49)	+0.56 (+1.2%)	*p*=0.278
Vulnerability stigma (4–20)	*n*=210	10.85 (3.59)	10.86 (3.58)	+0.01 (+0.1%)	*p*=0.491
	n=16	11.44 (3.44)	10.88 (3.59)	-0.56 (-3.5%)	*p*=0.186
Attitudes towards seeking support (5–25)	*n*=210	17.40 (3.98)	18.88 (3.93)	+1.48 (+7.4%)	***p*=0.008**
	n=16	17.63 (3.91)	19.19 (4.00)	+1.56 (+7.8%)	*p*=0.051

SD = standard deviation

Of the 57 surgical staff completing the organisational survey at timepoint 2 (March – June 2025), 6 reported having received a peer SUPPORT conversation and 6 stated that they had "never heard of SUPPORT". Three respondents had been offered support but had declined (with one noting that they were not convinced it would help them and another reporting that they received family support instead). See *Table 8* for a summary of awareness of the SUPPORT initiative among surgical staff.

Table 8: Awareness of the SUPPORT programme among surgical staff at timepoint 2 (post-SUPPORT)

Selected item	Number of staff
I have never heard of SUPPORT	6 (10.5%)
SUPPORT is never mentioned but I know I can request a peer SUPPORT conversation following an adverse event if I need one	13 (22.8%)
I have heard SUPPORT mentioned	18 (31.6%)
I have taken part in a peer SUPPORT conversation following an adverse event (as a supported surgeon)	6 (10.5%)
I was offered a peer SUPPORT conversation but declined	3 (5.3%)
I am a peer supporter for SUPPORT	11 (19.3%)

Four surgical staff provided feedback about their experience of the peer SUPPORT conversation. Although the sample was small, the results indicated general satisfaction with the process of the SUPPORT conversation in terms of feeling listened to, the non-judgemental approach and the timeliness of the intervention (*Table 9*). Feedback about the longer-term impact of the conversation was more mixed, particularly with regard to feeling that emotions were normalised and feeling 'comfortable' returning to their role following the adverse event. This may be due, in part, to the specific context and setting of the conversations that took place. Qualitative feedback from the supported surgeons in this sample indicated that a SUPPORT conversation was more difficult when the peer supporter had a managerial role and when there were interruptions from staff entering the room during the conversation.

Table 9: Feedback from supported surgeons

Item	Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree
My peer supporter provided a safe and trusting environment for discussion	1 (25%)	3 (75%)			
I felt comfortable voicing my concerns	1 (25%)	3 (75%)			
My peer was non-judgemental to what I said	3 (75%)	1 (25%)			
My peer was an attentive listener	3 (75%)	1 (25%)			
My peer supported me in making changes to practice	2 (50%)	2 (50%)			
My peer helped me feel better	2 (50%)	1 (25%)	1 (25%)		
I am satisfied with my experience with my peer supporter	2 (50%)	2 (50%)			
I am satisfied with the programme confidentiality	2 (50%)	1 (25%)	1 (25%)		
I am satisfied with the timeliness of the intervention	3 (75%)	1 (25%)			
I am likely to recommend SUPPORT to colleagues	2 (50%)	2 (50%)			
After receiving peer SUPPORT, I realised that the symptoms or emotions I was experiencing were normal in the circumstances	1 (25%)	1 (25%)	1 (25%)		1 (25%)
After receiving peer SUPPORT, I had a better idea of where I could go for further support	2 (50%)	1 (25%)	1 (25%)		
After receiving peer SUPPORT, I felt that my team cared about my wellbeing	3 (75%)		1 (25%)		
After receiving peer SUPPORT, my team enabled me to get ‘back to normal’ quicker	2 (50%)	1 (25%)		1 (25%)	
After receiving peer SUPPORT, I felt confident about returning to my role		2 (50%)			2 (50%)

"This support mechanism was invaluable to me when I was having a very difficult time at work. I am certain that I would not have been back at work so soon had it not been for this support and I would certainly not have been back operating. I am very grateful for its existence."

Supported surgeon
October 2024

Site team qualitative interviews

Sixteen semi-structured interviews were carried out with SUPPORT site team leads. Interviews were audio recorded, transcribed verbatim and analysed. Reflexive thematic analysis was used as a flexible, structured and reflexive process to identify key themes in the data.[28] Four key themes were explored in the data: the importance of the SUPPORT project, surgical culture, barriers to implementation and facilitators of SUPPORT. Key highlights are described below.

Importance of SUPPORT

Participants described the perceived legitimacy and relevance of the SUPPORT initiative. There was a collective perception of the necessity of the programme, especially when recognising the gravity of the impact of adverse events for surgeons. SUPPORT was cited as important in addressing a longstanding gap in surgeon wellbeing infrastructure, with participants stressing the need to integrate peer support into routine clinical practice. Moreover, SUPPORT was discussed as valuable in addressing stigma around adverse events and accessing support.

"[SUPPORT] *makes it that this is acceptable, and this is normal. Things can go wrong at times, and when it goes wrong, when you are in difficulty, there is help available."* (Participant 8)

Peer support was described as a natural extension of the social aspects of surgical life, and as a non-pathologising and normalising approach. However, co-existence and ability to access psychological support was also highlighted as an important aspect of support.

"You have someone who really gets it, who can provide support, but really understanding your experience, because they've been there before. […] I think that's a really, really positive element of it." (Participant 12)

Surgical culture

Participants discussed the deeply entrenched surgical culture and specifically the fear of being seen as 'weak', 'incompetent' or 'unable to cope' if you seek support as a surgeon.

"The hidden curriculum is you have to be tough, you shouldn't need these kinds of supports and there's something wrong with you if you do." (Participant 12)

Nevertheless, several participants had already observed a shift in culture, which they attributed to implementation of the SUPPORT programme, as well as changes in their own views and behaviours.

"There's a much better recognition now because of this. A lot of people now seem to know about it and understand its importance." (Participant 6)

Cultural change was perceived by several participants as having arisen through the indirect and largely unmeasured impact of the programme. However, some participants described having had many informal conversations but no formal peer SUPPORT conversations in their trusts yet. Participants acknowledged that shifting culture around seeking support would be a gradual process and would take time.

"This is something that, for years, people have worked in a particular way, and then this is actually a bit of a change in the culture, and that takes time." (Participant 14)

Barriers to SUPPORT

Lack of time on the part of the site teams was identified unanimously as a practical barrier to implementation of the SUPPORT programme. Some participants described a sense of inertia in making progress with implementing SUPPORT despite its obvious value. The need for protected time was referenced frequently as a requirement for successful implementation.

"We're all under so much pressure, and time is so short that unless something is urgent and immediate, it doesn't get done." (Participant 1)

Lack of institutional buy-in to the SUPPORT initiative was also cited as a barrier to implementation. Lack of support from some trusts was described as "pushing against a closed door" and was perceived as a "reactionary, rather than proactive" approach to surgeon wellbeing (participant 16). Systemic lack of awareness of the programme more generally at trusts was problematic despite site teams' endeavours to promote SUPPORT in their institutions.

"A practical issue we find is just trying to make sure people know about it. We still haven't completely resolved that." (Participant 13)

Participants also discussed practical barriers to carrying out peer SUPPORT training in their trusts, including the logistical difficulty of getting staff in one place for a training session as well as staff turnover of peer supporters. However, in addition, there was general concern from some participants about being appropriately qualified and skilled to deliver a peer SUPPORT conversation.

"For some reason, we're all a bit scared about saying the wrong thing or doing the wrong thing." (Participant 13)

Several participants highlighted the challenges in identifying adverse events and affected surgeons. There were differing opinions as to whether SUPPORT should be set up on an opt-in or opt-out basis in terms of identifying surgeons who should be offered a peer SUPPORT conversation. Some participants thought that contacting affected surgeons directly may be unhelpful whereas others thought that this needed a proactive approach given that surgeons are less likely to seek support than other professionals.8 There was a sense that the current strategy was not wholly working in identifying appropriate surgeons to offer support.

"I think the main thing […] is feeling like we're missing access to surgeons who really need us, somehow." (Participant 2)

Facilitators of SUPPORT

Many participants described the benefits of having administrator support in setting up the collaborative, as well as discussing the advantages of SUPPORT being an RCS England-led initiative. The latter was linked to external perceptions of the value of the SUPPORT project and was seen as useful in garnering institutional support.

"I think having it led by the College has made a big difference to the impact, both from the surgeons' perspective but also the trust's perspective." (Participant 4)

Financial backing from the trust's leadership team was similarly valued, illustrating the trust's perceptions of the importance of the SUPPORT project. Institutional endorsement of SUPPORT was described as a powerful facilitator to enable the trust to implement the initiative.

"I think probably our managing director's financial support […] I think the fact he has supported it means that it is seen to be valuable." (Participant 12)

Support and collaboration with psychology colleagues was a key facilitator to successful implementation of the SUPPORT programme in organisations where this was possible. In addition to fostering productive working relationships, participants noted how their psychology colleagues brought a different viewpoint and added credibility to the project. Psychologists were described as well placed to advise on the psychology of trauma, help surgeons to develop skills for peer SUPPORT conversations and offer support to peer supporters.

"[Psychology input] could be a recommendation from the outcome of SUPPORT. […] We think that as much as peer-to-peer surgeon support is useful, it needs to be backed up with some more formal psychological support as well." (Participant 4)

5. Lessons learnt

This first phase of RCS England's SUPPORT QI collaborative has demonstrated that surgeons are engaged with the need to support fellow surgeons after adverse events and that they value having a space to consider practical ways forwards with this in mind. We learnt that there is a gap between the significant desire to support colleagues (and the recognised importance of the initiative) on the one hand, and progress in implementing and sustaining this in the complex and pressurised contexts in which colleagues are working on the other. This is common in organisational change initiatives,[9,29] and is perhaps more difficult when the success of the SUPPORT project relies on challenging narratives around surgeons showing vulnerability and encouraging change in support-seeking behaviours.

As other initiatives have shared, culture change in organisations is challenging, and takes time and persistence until the initiative becomes 'the way we do things here'.[29] Through our work with SUPPORT, we have come to recognise that such change is facilitated by a range of enablers, including:

- appointing enthusiastic and committed surgeon champions to be part of project teams
- the value of having an RCS England-badged programme
- the need for senior support (preferably at medical director and surgical clinical director level), championing and ideally role modelling the approach
- having allocated programmed activity time for the project lead(s)
- integrating SUPPORT with existing in-house wellbeing programmes and associated staff (e.g. clinical psychology)
- having clear tasks and timeframes for implementation
- sharing success stories to help generate interest and enthusiasm
- having administrative support for data evaluation and coordination
- having a clear and ongoing communications strategy, for example through:
    - intranet presence
    - screensavers
    - brief refresher talks at clinical governance sessions
    - posters in operating theatres and breakout spaces
    - prompts in operating list 'check-out huddles' and 'hot debriefs', with the offer of 1:1 peer support

We have learnt that as with similar evaluations of support programmes following adverse events,[29] data collection for the SUPPORT project is complex. Although we assumed that hospital trusts would be keen to carry out service evaluation on SUPPORT in their sites, this was not entirely the case owing to the practicalities and time pressures of recruitment. Moreover, we found it difficult to recruit supported surgeons to give feedback via their trusts. In part, this was because of concerns about the need for anonymity of peer SUPPORT conversations and perhaps also because of lower uptake of SUPPORT conversations than we had envisaged initially. Nevertheless, data for the SUPPORT programme are clearly important, and we have made plans to change our approach to permit more timely and accessible feedback from supported surgeons, initiated directly by the project delivery team, as part of the next iteration of the SUPPORT QI collaborative, SUPPORT2.

For SUPPORT2, we recognise the need for allocated programmed activity time for site teams as well as the importance of organisational backing for the success of SUPPORT implementation. With regard to alleviating time barriers identified by site teams and lack of confidence in delivering peer SUPPORT training, we acknowledge that more can be done to facilitate training of peer supporters in trusts/health boards. As part of our ongoing work, we plan to review our approach to peer SUPPORT training, which may include the option for it to be delivered by the SUPPORT faculty (rather than the site teams), and to consider ways to promote culture change around seeking support directly within participating sites. The latter seems particularly key in helping to bridge the gap between the recognised value of the SUPPORT initiative reported by site teams and the challenge of translating this into more tangible SUPPORT outcomes.

6. Conclusions and next steps

RCS England's SUPPORT QI collaborative is the first of its kind in the UK. This first phase of SUPPORT (SUPPORT1) highlighted that there is clear demand for better peer support for surgeons and that surgeons experiencing a SUPPORT conversation gain significantly from this. More broadly, the impact of SUPPORT extended beyond the individual receiving a SUPPORT conversation to the wider surgical workforce.

We learnt that implementing culture change within teams and organisations is complex, and takes time, commitment and resource. A range of enablers were identified, including championing from senior leaders in the organisation as well as the value that was seen in being part of an RCS England-specific initiative.

The process of learning how to implement peer support for surgeons after adverse events continues. The faculty are delighted that the SUPPORT QI collaborative is now recruiting for its next round, SUPPORT2.

Join the SUPPORT2 QI collaborative by completing the form at:

https://forms.office.com/e/bGE5bxkZph

For more information on SUPPORT2, please visit:

www.rcseng.ac.uk/supportimprovement

Acknowledgements

Starting something new is not easy, especially when it explores individual vulnerability and when it interfaces with surgical culture. Any success from SUPPORT is due entirely to the commitment and enthusiasm of the site teams from our 12 participating sites. For their openness, willingness to try new ideas, and desire to see surgeons better supported during and after adverse events, we are in their debt. This gratitude extends to the peer supporters and the wider surgical workforce in the hospitals that they represented.

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For more information, please visit: www.rcseng.ac.uk/supportimprovement

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