Royal College of Physicians

Setting higher standards

Report

of the invited service review to

Salisbury NHS Foundation Trust on 27-28 January 2020

This report is the property of the healthcare organisation responsible for the commission of this invited service review

Contents

1.0 Executive summary

This invited service review was commissioned by Salisbury NHS Foundation Trust (SFT) because of a number of long-standing concerns about their gastroenterology service.

Over the last three years, despite workloads increasing significantly, the consultant workforce has contracted from five [redacted] at present. This has led to an increased reliance on agency locum consultants and neighbouring Trusts.

The [redacted] remaining [redacted] gastroenterology consultant has a very busy and varied workload which, by [redacted] admission, can be unsafe. The majority of [redacted] colleagues agree [redacted] clinical workload is untenable and are concerned [redacted] works across too many sub-specialties to be competent in each field [redacted] cites workload as a reason not to participate in important clinical areas such as multidisciplinary team meetings (MDT) and key performance indicator (KPI) monitoring which is to the detriment of the service and patient care.

There are significant staff shortages in inflammatory bowel disease (IBD), nutrition, histopathology and hepatology and we are concerned that these services are close to the point where they can no longer deliver safe patient care.

We have clinical concerns about the endoscopic mucosal resection (EMR)[1] and gastrointestinal (GI) bleeding services as there had been a number of serious incidents. The EMR concerns highlighted issues with patient selection, consent, and review of histopathology results. Concerns in the GI bleeding service were about assessment, initial treatment and transfer of patients to neighbouring hospitals.

The management structure of the service is not fit for purpose across three different directorates, although we heard clear plans to remedy this and improve accountability. These will partially resolve many of the issues faced by the gastroenterology service.

Issues with teamworking have blighted the gastroenterology service at SFT. Historical disagreements between substantive gastroenterologists and attempts at mediation contributed to several resignations and are the main cause of current staffing problems. The gastroenterology service has garnered a reputation of being dysfunctional and this makes recruitment very difficult.

At present the service depends on the use of locums 7 days a week to help it keep on top of waiting times and deliver the non-elective workload. This is problematic and there are ongoing difficulties between some locums and staff in endoscopy.

[1] A procedure to remove early-stage cancer and precancerous growths from the lining of the digestive tract.

Staff at SFT have mixed feelings about [redacted], some find [redacted] encouraging and helpful whilst others think [redacted] can be obstructive and arrogant at times. Issues with [redacted] communication, record keeping, attendance at meetings and KPI monitoring would suggest that [redacted] does not always collaborate effectively with colleagues. Clearly [redacted] workload and lack of consultant colleagues to assist [redacted] make [redacted] task very challenging, however there must be clarity regarding which key activities [redacted] is expected to take part in and deliver.

Some staff members were critical of the response of senior leadership when issues arise and, in particular, the medical director's leadership. This was characterised by unsatisfactory responses to concerns being raised and not keeping the staffing issues under control.

Several members of staff thought that raising concerns or reporting incidents was, to some extent, futile. In their experience, issues were frequently unresolved and feedback rarely provided. This is a potential patient safety issue and inhibits learning.

[redacted]

Throughout this report, we have captured findings from document review and interview, have drawn conclusions about each term of reference and made relevant recommendations. Implementation of the recommendations will improve the service and the care of patients.

2.0 Introduction

[redacted] medical director and deputy CEO of Salisbury NHS Foundation Trust contacted the Royal College of Physicians (RCP) regarding the gastroenterology service on 10 July 2019. [redacted] discussed the review with [redacted], medical director for invited service reviews (ISRs) at the RCP. Following discussion it was agreed that an ISR of the gastroenterology service at Salisbury NHS Foundation Trust would be undertaken on 27-28 January 2020.

2.1 The terms of reference for this ISR were to:

1. To assess the current service design for the delivery of care of the gastroenterology service, to include a review of activity and workload and current workforce. Consideration will be given to the provision of related specialty services such as endoscopy and management of GI bleeds, focussing on interactions with other medical or surgical specialties.

2. To review the quality of team working within the department and to give a view on whether this supports the delivery of high quality and safe care. Consideration will be given to individual behaviours, multidisciplinary team working, job planning, recruitment, clinical leadership and interactions with junior doctors.

3. To evaluate the quality of governance processes and how this links more widely with the Medical Division and Trust Board level. Consideration will be given to raising and responding to concerns and systems in place to maintain oversight of activity and outcomes.

4. Highlight any new area of concern that arises during the ISR.

2.2 Approach to this review

The RCP consulted the British Society of Gastroenterology (BSG) who nominated specialist reviewers. The RCP convened a review team, including a lay reviewer as set out in section 2.3.

In advance of the review visit, documentation provided by the Trust was examined for the insights it offered in respect of the terms of reference. There was a significant paucity of documents provided by the Trust despite repeated requests from the ISR team. For example, we received a hand drawn organisational chart showing the leadership arrangements for Gastroenterology and accountabilities. During the course of the visit [redacted] the chief operating officer, provided a number of additional key documents e.g. records of escalation of risks regarding the gastroenterology service to the Finance and Performance Board subcommittee.

The review team held face to face interviews with staff during the visit 27-28 January 2020. Details of these have been included in appendix 6.2.

The findings contained in this report are outlined in section 5 and represent a summary of the information gathered by the review team from the documents submitted and the interviews conducted. The findings are organised under the headings of the agreed terms of reference. The information presented sometimes reflects the viewpoints of those individuals being interviewed and where this is the case, it will be made clear; it

will not necessarily reflect the views of the Trust, the RCP or its reviewers. The views of the review team are given as conclusions and where necessary recommendations made in light of these.

2.3 Invited service review team

Name	Role
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

[redacted]

3.0 Recommendations

Timeframe for implementation

In this report we have given an expected timeframe for completion of implementation of that recommendation. These are:

- **Immediate (0-3 months)** – action should be complete within 3 months of receipt of the initial ISR visit feedback letter
- **Short term (0-6 months)** - action should be complete within 6 months of receipt of the ISR report
- **Medium term (6-12 months)** – action should be complete within at least 12 months receipt of the ISR report. Planning for actions resulting from these recommendations should start immediately.
- **Long term (12-24 months)** - action should be complete within at least 24 months receipt of the ISR report. Planning for actions resulting from these recommendations should start immediately.

A summary letter of the initial feedback was sent to the Trust on 25 February 2020 (section 6.3 Appendix 3). This included a series of interim recommendations made to address potential patient safety concerns identified during the course of the visit which are repeated in this main report.

[redacted]

1. Given the serious concerns highlighted by this review at both a service and individual behaviour level, the Trust should share this report with the Care Quality Commission (CQC) and the Trust's General Medical Council (GMC) employer liaison advisor. This report should also be shared with the Trust Board.
   Immediate (0-3 months)

2. The Trust should urgently develop closer links with Southampton and Bournemouth with a particular focus on being able to provide a safely manned GI bleed, hepatology, nutrition and IBD service in the short and medium term. This will require Executive to Executive dialogue and involvement of NHS Improvement and the regional medical director. Formal linked consultant posts between Salisbury and these centres need to be re-explored with support from NHS Improvement.
   Immediate (0-3 months)

3. The Trust should immediately establish the combined Gastrointestinal Unit encompassing GI surgery, GI medicine and endoscopy and this should be led, at least initially, by the gastrointestinal surgeons. This will help to relieve the pressure on the current service in terms of leadership, capacity and workload, improve accountability and focus on the plan for the future gastroenterology service.
   Immediate (0-3 months)

4. The Trust should adopt a much more aggressive and professional recruitment strategy in order to fill the vacant consultant gastroenterologist posts. The Trust should also move forward with recruitment to fill gaps in specialist nursing, histopathology and dietetics some of which may require re-banding to make recruitment attractive.
   Immediate (0-3 months)

5. The substantive consultant should cease working across so many sub-specialties and instead focus on a maximum of one or two. Alternative arrangements for cover of general medical patients need to be put into place, and one option could be a locum general internal medicine consultant, appointed to cover this part of the workload.
   Immediate (0-3 months)

6. The BSG upper GI care bundle[2] for gastrointestinal bleeding should be introduced with immediate effect with a focus on training, resuscitation and risk assessment.
   Immediate (0-3 months)

[2] https://www.bsg.org.uk/clinical-resource/bsge-acute-upper-gi-bleed-care-bundle/

7. The process for taking informed consent should be standardised and clear guidance given to all staff involved in the process. Regular audits should be conducted to assure consistency of approach.
   Immediate (0-3 months)

8. The Trust should ensure that there is consistent and job planned time for gastroenterology representation at relevant MDTs. Any referrals to MDTs should be presented by the referring consultant and, if this is not possible, attendees should be appropriately briefed prior to the meeting and records of any discussions and outcomes detailed in the medical records.
   Immediate (0-3 months)

9. The Trust should consider the results of the 2019 GMC National Training Survey and work with doctors in training and Health Education England to devise an action plan to improve the educational experience within gastroenterology.
   Short term (0-6 months)

10. Due to the breakdown in communication between some of the nursing staff and agency locums, the Trust should work with the agencies to put strategies in place to ensure that working relationships between locums and nursing staff remain cordial and productive.
    Short term (0-6 months)

11. There must be continued Board scrutiny of this service and there should be review of the current assessment of risk based on the contents of this letter. While there are clear performance risks from extended waiting times and financial risks from use of locums and private providers, the clinical risk to patients from poor services should be fully recognised and scrutinised more effectively.
    Immediate (0-3 months)

12. Closer supervision arrangements of the IBD service need to be put into place with immediate effect. At a minimum, there needs to be regular consultant physician and surgeon input into this service and in particular for complex patients.
    Immediate (0-3 months)

13. To encourage and foster a safety culture, all staff should be encouraged to report incidents or raise complaints and timely feedback should be provided on actions taken to address concerns.
    Immediate (0-3 months)

14. All staff should be mandated to update and monitor KPIs to allow the Trust to make service improvements and audit individual performance.
    Immediate (0-3 months)

15. All colonoscopists should adhere to BSG and Joint Advisory Group (JAG) guidance on KPI and quality assurance standards for colonoscopy, paying particular attention to the minimum number of procedures recommended.
    Immediate (0-3 months)

16. The existing clinical governance processes for gastroenterology need to be made more robust. There needs to be:
    a) Attendance from all gastroenterologists at meetings which should be job planned in the clinicians' schedules,
    b) Presentation of cases from all aspects of the GI service including IBD, hepatology and nutrition
    c) Open and honest conversations regarding all complications or adverse outcomes and which considers all possible contributing factors (these should also be completed in a timely way),
    d) Processes in place for reviewing trends, sharing learning and measuring the success of actions arising.
    Short term (0-6 months)

17. All governance documentation, including protocols, standard operating procedures, and terms of reference, should be updated, dated and reviewed, to ensure that the department has a robust suite of governance documentation.
    Short term (0-6 months)

18. All potential EMR cases should be assessed at the Lower GI MDT to ensure patient selection is correct and that surgical resection is not more appropriate.
    Short term (0-6 months)

19. The Trust should ensure that the small number of clinical cases discussed by interviewees in this report are identified and assure itself that these received an appropriate level of investigation to ensure learning and where necessary deliver its duty of candour to patients and their families.
    Short term (0-6 months)

20. The Trust should review its raising concerns policy and the effectiveness of the freedom to speak up arrangements. This review suggests that staff do not always feel this is effective.
    Short term (0-6 months)

4.0 Description of the service

The Gastroenterology Service at SFT undertook 3,005 outpatient appointments and performed around 4,000 procedures in 2018/19. The service is funded to employ 5 full time consultants. However, at the time of the review there [redacted] in post and a part-time, retired and returned consultant on a flexible contract providing assistance with outpatients, endoscopy and upper gastrointestinal physiology There is also 1 specialist registrar and 3 other junior doctor posts linked to the service. In addition, there are specialist nursing posts linked to gastroenterology through the endoscopy service and the cancer multi-disciplinary teams. These specialist nurse/allied health professional roles include an IBD nurse, a hepatology nurse, 2 cancer nurse specialists, a dietician and a number of endoscopy practitioners.

Demand for specialist gastroenterology diagnosis and treatment has been increasing nationally and locally referrals have significantly increased over the last 4 years as illustrated in the table below.

Year	No of referrals
2015/16	2121
2016/17	2342
2017/18	2466
2018/19	3005

This growth represents an increase of more than 40% in the period in question. The gastroenterology service provides on call endoscopy cover for GI bleeds in collaboration with University Hospitals Southampton (UHS) on a 1 in 5 basis but no longer participates in the General Internal Medicine (GIM) on call rota. Currently UHS provide SFT with support to cover 3 slots on the out of hour's rota.

The team takes responsibility for all admissions to Redlynch Ward which is the ward specialising in gastroenterology but also taking a significant number of general medical admissions.

The gastroenterology team also supports the cancer multi-disciplinary team meetings for upper and lower GI and hepatobiliary but regular attendance has proved difficult. It provides 12 sessions weekly in the Endoscopy Unit, 2 of which are for Endoscopic Retrograde Cholangio-Pancreatography[3] (ERCP). The Service also hosts the Bath, Swindon and Wiltshire Bowel screening programme as two of the consultants are fully trained screening endoscopists and there are nurse endoscopists that support that service. The service works closely with the specialist nurses to provide an IBD service, hepatology and nutrition (2 nutrition ward rounds of the hospital per week).

[3]A procedure which helps to determine whether there is a problem with your bile duct system or pancreas.

Currently the service provided is very limited due to a series of departures and subsequent recruitment difficulties. This has led to an increased reliance on the partnership with UHS, increased outsourcing of work and the use of agency locum consultants (at significant cost).

5.0 Findings

5.1 Terms of reference 1

To assess the current service design for the delivery of care of the gastroenterology service, to include a review of activity and workload and current workforce. Consideration will be given to the provision of related specialty services such as endoscopy and management of GI bleeds, focussing on interactions with other medical or surgical specialties.

5.1.1 Operational partnerships

Documentation review

No specific documents were shared before the visit.

Comments from interviewees

We heard that SFT's sustainability and transformation partnership (STP) footprint includes Bath and Swindon. However, with the exception of the bowel cancer screening service, it seems that none of the other clinical pathways or patient flows function with these two hospitals. Furthermore, the distances and travel times from Salisbury to STP partner Trusts are considerably longer than they are to UHS or Bournemouth.

Overwhelmingly, we heard that gastroenterology links are much stronger with UHS and Bournemouth particularly for gastrointestinal bleeding, inflammatory bowel disease (IBD), hepatology, complex radiology and nutrition. There was reported to be limited inter-organisational executive to executive dialogue about the service problems at SFT or involvement of NHS Improvement. We did not explore any other non-GI services and their links within the STP footprint as this was not covered by our Terms of Reference.

Review team conclusion

It would seem that, due to geography and travel times, pathways are in place with UHS and Bournemouth. These need refinement and, in some cases, e.g. GI bleeding, review and Board agreements between the organisations. The STP currently adds little value to the gastroenterology service at SFT and we would encourage the Trust to build further on relationships with UHS and Bournemouth in order to enhance its own service. Stronger links with STP partner Trusts may develop but the time course is likely to be too long to help address the current severe issues SFT are facing with this service. Linked consultant posts with UHS should be reconsidered and Board impetus given to making joint working happen.

Recommendations made in relation to this heading: 2.

5.1.2 Workforce and workload

Documentation review

The following documents highlight the lack of substantive gastroenterologists at SFT as a significant problem:

- A PowerPoint presentation from 26 February 2019 entitled *Gastroenterology Service at SDH, Update for Clinical Governance Committee* states that there is a *'senior medical staffing crisis in gastroenterology'*.

- A report to the Finance and Performance Committee dated 26 March 2019 entitled *Gastroenterology Service Review and plan for Service sustainability referring to the IBD service* states that *'There is also a cohort of patients that may require an outpatient review by a Consultant and as such, one clinic per week for complex IBD (run by a Consultant) is required, as well as support to the IBD MDT meeting'.*

- A report to the Finance and Performance Committee dated 22 October 2019 entitled Gastroenterology Update and Proposal highlights the risk and large cost of relying on a locum consultant workforce: '*A transient workforce of Locum Consultants reduces clinician accountability for results action for patients and general adherence to Trust policy and governance frameworks. Administrative follow up of the majority of outsourced patients is now being managed by the outsourcing company which will reduce the administrative burden on Gastroenterology but it does result in the processes being further disjointed. The appointment of ID Medical for the provision of Locum Consultants to Gastroenterology represents an 800K per annum cost pressure to the organisation as well as an internal locum at the cost of 300K per annum.*

- The *Corporate Risk Register November 19 v6.5 Final @271119* describes, as an extreme risk, *'The inability to provide a full gastroenterology service due to a lack of medical and nursing staffing capacity. This could result in inability to deliver contractual obligation, failure to meet diagnostic standards and failure to deliver cancer standards which may result in patient care, treatment and diagnosis being delayed'.*

- A Board paper entitled *BAF v13.2 for Board Dec 19* which highlights the *'Inability to provide a full gastroenterology service due to a lack of medical staff capacity'*

Comments from interviewees

Workforce

The Senior Management Team is acutely aware of a staffing shortage in the gastroenterology service and acknowledge that there should be a minimum of 6 substantive consultants in order to provide a comprehensive and safe service. They recognise having just one [redacted] consultant in post is unsafe and were concerned about the level of pressure this placed on the consultant and their multi-professional colleagues across the gastroenterology service.

At the time of the review, we heard that use of locums from agency providers, were required 7 days a week to help SFT to meet its obligations in gastroenterology with inpatients, outpatients and ERCP. This comes at a great cost and some staff working within the service expressed concern about the quality of the locums being used and variation of practice which they felt impacted on patient care.

The Senior Management Team were cautiously optimistic that the creation of a GI unit will help with their efforts to recruit more consultants, nurses and other key staff and improve levels of supervision.

Several interviewees told us that there are also significant gaps in staffing at all levels in the Inflammatory Bowel Disease (IBD), hepatology and nutrition elements to the service which also has the potential to compromise patient safety or meant patients were not receiving care in line with what would be considered good practice. This is discussed briefly below and in more detail in section 5.1.3 *Clinical concerns.*

IBD

There was no full time consultant to support the IBD service. As per British Society of Gastroenterologists (BSG) guidance[4] there should be 2.5 full time nurses for the size of the population SFT serves. However, we heard that, at present, the service is run by a part time specialist nurse who, despite [redacted] very best efforts, is struggling to meet the demands placed on [redacted]. Given the complex nature of this patient group and the need for closely coordinated care the service is at best borderline in terms of patient safety and the loss of any one of the small number of staff that deliver the service would make it untenable.

Hepatology

There is only 1 full time hepatology nurse (there should be at least 2) who is supported by the [redacted] consultant who also has a very significant workload. We heard it was an *'extremely disjointed service'* and that the nurse felt *'overwhelmed'.*

[4] https://gut.bmj.com/content/68/Suppl_3/s1

Nutrition

This is again under resourced with only 1 part-time dietician to run the nutrition service and they are also mainly supported by [redacted] consultant.

Workload issues

From the interviews conducted, it would seem that the IBD and hepatology nurses are clearly struggling to meet demand and the same applies to nutrition and gastroenterology in general.

The unanimous view of the staff we interviewed was that the [redacted] consultant, had too many responsibilities and was stretched too thinly. A staff member summed this up quite simply by saying '*we are overloading* [redacted].

On the day that we interviewed the [redacted] consultant, we heard that [redacted] had a ward round of over 50 patients to see (including general medicine) and [redacted] told us that, whilst [redacted] believed [redacted] practice was safe, *'decision fatigue'* would inevitably creep in towards the end of long ward rounds.

Some staff expressed admiration for the [redacted] consultant as the *'last* [redacted] *standing'* and praised [redacted] for [redacted] stamina, tenacity and willingness to help colleagues across a wide range of gastroenterological sub-specialties. However, other colleagues commented that [redacted] '*can't be an expert in everything'* and were concerned that having such a wide range of duties and interests was potentially unsafe. This was further compounded by the view that [redacted] did not have sufficient numbers of procedures for some of [redacted] practice to be considered as consistent with specialty guidance. Please see section 5.3.2 *Oversight of activity and outcomes.*

Review team conclusion

We agree with the view of the majority of staff we met, that having just one full time [redacted] gastroenterologist in post is not sufficient to run the service in an efficient and safe way. This contributes to an excessive workload for [redacted] in particular and all groups of staff from consultants to junior medical staff.

The [redacted] consultant has spread [redacted] working time across several disparate complex subspecialties (hepatology, therapeutic upper GI, endoscopy, complex polypectomy service, and nutrition) whilst also trying to support the IBD service and upper GI cancer service. Our clinical reviewers considered that it would be difficult for anyone to deliver high quality services in all of these domains. Cover for [redacted] consultant during periods of leave would also inevitably have implications for the safety of the service.

Matters are compounded by the gastroenterologists caring for large numbers of general medical patients although they are not on the acute overnight take. Many staff members were concerned that such a wide range of duties was potentially unsafe.

Concerning staffing in IBD, hepatology and nutrition, there are obvious implications for patient safety here (such as patients not getting treatment on time or having sufficient access to consultants) as these roles are clearly under immense pressure and without more recruitment, it is likely that the staff involved will burn out or leave SFT.

Recommendations made in relation to this heading: 2, 3, 4, 5**.**

5.1.3 Clinical concerns

Documentation review

- A report to the Finance and Performance Committee dated 26 March 2019 entitled *Gastroenterology Service Review and plan for Service sustainability* referring to the IBD service states that *'There is also a cohort of patients that may require an outpatient review by a Consultant and as such, one clinic per week for complex IBD (run by a Consultant) is required, as well as support to the IBD MDT meeting'.*

- A report to the Finance and Performance Committee dated 22 October 2019 entitled *Gastroenterology Update and Proposal* highlights issues with the out of hours GI bleed rota which has UHS covering 4/5 slots of the 1/5 rota: *'The main identified risk with this arrangement is that patients who may be actively bleeding, requiring urgent endoscopy intervention would need to be 'blue-lighted' to UHS for treatment – this would cause delay to their care'.*

- The *Corporate Risk Register November 19 v6.5 Final @271119* describes, as an extreme risk, *'The inability to provide a full gastroenterology service due to a lack of medical and nursing staffing capacity. This could result in inability to deliver contractual obligation, failure to meet diagnostic standards and failure to deliver cancer standards which may result in patient care, treatment and diagnosis being delayed'.*

- Emails regarding EMR procedures undertaken by the [redacted] consultant, highlighting inadequate record keeping and histology review.

Comments from interviewees

GI bleeding

Senior management informed us that a recent audit on GI bleeding had raised concerns about processes and pathways regarding appropriate resuscitation and endoscopy management. We heard about 2 serious incidents concerning GI bleeds. In one case, the patient was brought in at 16:30 and it was not clear who would be taking care of [redacted] as it was towards the end of the normal working day. It was then decided that the patient should be blue lighted to UHS and the delay in treatment could have put them at greater risk unnecessarily.

We were informed that, whilst there is said to be a formal agreement in place with UHS, sometimes the transfer of patients occurs without full agreement of the staff on duty and patients then get sent to the emergency department. This has led to some stressful telephone calls for ward nurses and ultimately, a less than ideal patient experience.

The second serious incident concerning a GI bleed involved a patient who died in the endoscopy suite. We were informed that initially this had not been classified as a serious incident, however following presentation of the case at a mortality and morbidity (M&M) meeting, it was decided that it should be. Staff members suggested that the patient had not been reviewed properly or adequately resuscitated before being sent for endoscopy.

We also heard that the national BSG acute upper GI bleed care bundle was not being used and it was felt that this could be an important aid for clinicians and for patient safety.

It is also essential that the BSG upper GI bleed care bundle, which details key interventions to be performed from admissions and within the first 24 hours of care for patients, is implemented immediately. Whilst this has not been implemented in all Trusts in England, given the concerns raised, it is particularly important in this case.

IBD

As highlighted in section 5.1.2 *Workforce and workload*, we heard that following the departure of a specialist nurse, the IBD Service is now run by a part time specialist nurse who is managing approximately 250 patients on biological therapies[5] (including anti-TNF therapies[6] such as adalimumab) and many more on disease modulating drugs.

We heard that consultant input/oversight of this service is limited as the [redacted] consultant at SFT is clearly very busy delivering other aspects of care. We also heard that there is sporadic input from locums and a consultant from another Trust outside of the STP who provide occasional support, however by all accounts, this is inconsistent.

We were informed that this lack of consultant support makes it difficult for IBD patients on biological therapies to be seen on a yearly basis and followed up appropriately as per best practice. Patients also do not receive timely IBD specialist review after being commenced on new biological therapies to assess their response. To mitigate this, the patients are booked into general clinics which were described as being '*hit and miss*'.

Getting patients considered at an IBD Multidisciplinary team meeting (MDT) is also problematic due to the scarcity of gastroenterologists at SFT This will be explored in further detail in section 5.1.5 *Attendance at MDTs.*

[5] https://www.crohnsandcolitis.org.uk/about-crohns-and-colitis/publications/biologic-medicines

[6] TNF inhibitors are drugs that help stop inflammation. They are used to treat diseases like rheumatoid arthritis, juvenile arthritis, psoriatic arthritis, plaque psoriasis, ankylosing spondylitis, ulcerative colitis, and Crohn's disease. They are also called TNF blockers, biologic therapies, or anti-TNF drugs.

Hepatology

As highlighted in section 5.1.2 *Workforce and workload,* there is only one full time hepatology nurse at SFT. The service is supported by the [redacted] consultant who also has a specialist interest in this area.
We heard that it is an '*extremely disjointed service'* with long waiting lists. In order to speed up the process for seeing patients, it was reported that the nurse would often triage the patients first and then present the cases to the [redacted] consultant for advice.

There was reported to have been at least 1 recent case of a late diagnosis of hepatocellular carcinoma (due to long waiting times) which could have potentially been identified and treated earlier if the patient had been under regular surveillance.

We heard that, in order to limit the chances of this happening again, the Trust's I.T. department is currently working on a database to allow the nurse to monitor when patients are due to come back so that they do not go on to develop advanced hepatocellular carcinoma.

We also heard that due to inadequate staffing, outreach clinics and treatment are not available for chronic viral hepatitis and this group of patients, in general, is better served when assessments and treatments are offered closer to their homes.

Histopathology

We heard that this service is provided in-house with a current team of just three full-time histopathologists. This means that there can be delays of several weeks before results are obtained (we recognise that there are national difficulties with waiting times for this service largely as a result of workforce shortages) and we were advised that outsourcing of the service had led to several significant errors and a recall process is currently underway.

Nutrition

We heard that the nutrition service is very stretched. There is only 1 part time dietician and they work in an extended role covering most tube feeding problems, assisting with PEG tubes and managing enteral nutrition.

The [redacted] consultant has a specialist interest in nutrition and we heard that [redacted] provides a good level of support and encouragement to the dietician. If the dietician requires ad-hoc assistance in the interest of *'protecting gastroenterology time'*, they prepare everything for [redacted] so that [redacted] can quickly come and give advice and then return to clinic. However, on occasions when the [redacted] consultant and the dietician are not available, there is inadequate cover which has potential patient safety repercussions.

EMR

We heard that EMR is an area of concern for SFT due to inadequate review of referrals, insufficient consent processes and a lack of data regarding outcomes (please see section 5.3.2 *Oversight of activity and outcomes* for more details).

The EMR service is largely provided by the [redacted] consultant supported by one of the colorectal surgeons.

Some clinicians were concerned about the consent process for EMR as we were told that just a standard consent form (see section 5.1.4 *Informed consent* for more information) for endoscopy when a more detailed one including discussion of risks and benefits would have been appropriate for these higher risk procedures.

We were told about a case where a patient died following an EMR procedure. The patient had a large rectal polyp and suffered a bleed which was tamponaded and then subsequently a perforation occurred. There was some dispute as to whether the patient should have had the procedure given that they were 90 years old and quite frail. However, the operator said that the patient had told them that they could not live with the polyp.

We also heard of at least 1 more case where a patient underwent at least 7 separate EMR procedures. This is unusual as EMRs should be completed in 1 planned session wherever possible. Undertaking 7 EMRs indicates that the EMR technique may be substandard or the patient selection may be incorrect or an alternative procedure should have been offered.

Complex polyps to be treated with EMR are discussed at the colorectal MDT in the presence of the [redacted] consultant or failing that the colorectal surgeon. However, despite this, concerns were expressed regarding the process around the [redacted] consultant's review of referrals and also including histopathology results prior to and post EMR. In addition, inadequate record keeping following the procedures were also reported.

Review team conclusion

Regarding GI bleeds, guidance from the National Confidential Enquiry into Patient Outcome and Death entitled *Time to Get Control? A review of the care received by patients who had a severe gastrointestinal haemorrhage*[7] states that '*Patients with any acute GI bleed should only be admitted to hospitals with 24/7 access to on-site endoscopy, interventional radiology (on-site or covered by a formal network), on-site GI bleed surgery, on-site critical care and anaesthesia. (Medical Directors, Ambulance Trusts and Commissioners)*'.

[7] https://www.ncepod.org.uk/2015report1/downloads/TimeToGetControlFullReport.pdf

In light of this and the serious incidents we were told about, SFT should consider whether it is safe to accept patients with acute GI bleeding or if these patients should automatically be sent to UHS where they have the relevant facilities. At a minimum, there should be clear standard operating procedures regarding the transfer of patients from one hospital to the other.

We were particularly concerned about the IBD service as it is completely under-staffed in terms of nursing and there is no consultant at SFT with a specialist interest in IBD. Having 1 part time nurse responsible for the management of 250 patients on biological therapies with little consultant support, has the potential to be dangerous.

The Trust will need to consider forging closer links with UHS or Bournemouth to provide comprehensive consultant support to the specialist nurse. If this is not possible, it may be safer and more practical to remove the IBD service from SFT and transfer the care of patients to UHS or Bournemouth.

The lack of staffing in the hepatology service is unsafe as, at present, they are unable to accurately monitor and follow up all their patients. It also means that outreach clinics and treatment are not available for chronic viral hepatitis which will put patients at risk of developing cirrhosis and all the complications of chronic liver disease including hepatocellular carcinoma.

More staff are needed as a matter of urgency, failing this SFT should consider transferring the care of hepatology patients to UHS or Bournemouth.

The RCP Improving Quality in Liver Disease Services[8] (IQILS) lays out standards to enable organisations to assess the quality of their services and attempt to progress towards IQILS accreditation. SFT should observe its principles and make appropriate changes with the view to seeking accreditation.

With regards to nutrition, when the [redacted] consultant and nutritionist are available, they are able to keep the service running adequately. However, this is another area where staffing is inadequate to the point of being unsafe for patients. Once again, if the service cannot be improved by having more staff, it may be safer to relocate the care of patients to UHS or Bournemouth.

Deaths are relatively uncommon following EMR procedures, however the death that we were informed about highlighted some rudimental flaws to the process such as a lack of adequate documented informed consent and adequate review of referral notes and histopathology results.

SFT should review the clinical pathway for EMR in order to bring clarity to the process for clinicians and to improve patient safety. Ideally, this should include assessment of all potential EMR cases at the Lower GI MDT to ensure patient selection is correct and, that surgical resection

[8] https://www.iqils.org/Standards

is not more appropriate. There should also be appropriate consent, timely review of histology and prospective audit of outcomes.

Recommendations made in relation to this heading: 2, 3, 4, 5, 6, 17, 18, 19.

5.1.4 Informed consent

Documentation review

No specific documents reviewed

Comments from interviewees

Some staff we met expressed concern that the [redacted] consultant sometimes has a *'flippant'* approach to consent and that, in addition, he did not always adhere to the standard process of completing the World Health Organisation (WHO) check list before [redacted] procedures. This is highlighted to some degree in section 5.1.3 *Clinical concerns*, where it was reported that an elderly patient who died following an EMR procedure was viewed as potentially not having a thorough consent discussion and documentation before their procedure.

Review team conclusion

GMC guidance on consent[9] states: *'You must work in partnership with your patients. You should discuss with them their condition and treatment options in a way they can understand, and respect their right to make decisions about their care. You should see getting their consent as an important part of the process of discussion and decision-making, rather than as something that happens in isolation'.*

We are aware that the [redacted] consultant has many demands of his time, however it is vital that informed patient consent remains a fundamental priority for all clinicians. Relevant guidance should also be part of the suite of protocols and reminders disseminated to staff.

Regarding consent in the endoscopy suite, the Trust should arrange regular audit to assure standards are being met.

Recommendations made in relation to this heading: 7

[9] https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent

5.1.5 Attendance at MDT meetings

Documentation review

- Email from member of staff expressing concern about the [redacted] consultant's lack of knowledge of patients when presenting at MDT meetings.

Comments from interviewees

We heard from several interviewees that gastroenterology is not well represented at MDT meetings. The [redacted] consultant rarely attends MDTs and cites his workload as a reason for not being there. We also heard that there are often delays and inconsistencies with [redacted] patients being put forward for consideration at MDTs and that the notes are often of variable quality. One interviewee said *'sometimes [redacted] asks us to send patients to an MDT but often the patient has already been considered by the MDT'.*

The [redacted] consultant sometimes sends the registrar or a locum doctor in [redacted] place to attend the MDT and some staff advised that they were not always adequately briefed on the patients they should be presenting.

We also heard from an interviewee that a patient (a retired doctor) was concerned that the [redacted] consultant had not discussed the findings of the MDT or the agreed treatment plan with them.

When asked if the [redacted] consultant attended MDTs regularly in the past, when there were more gastroenterologists, we were told that *'this is not a new problem – [redacted] was like that before'.*

We did hear about good practice in MDTs in other clinical areas and, in particular, we were pleased to hear about the colorectal MDT which we were told is effectively chaired by a specialist nurse.

Review team comments

As the [redacted] consultant told us, there are '*too many demands on my time'.* Whilst this is no doubt the case, it is an important element of his role to attend MDTs in order to establish and agree on the best possible treatment plan for [redacted] patients. Delegating attendance to others is feasible provided that they are briefed appropriately and have all the relevant information to hand. However, this should be the exception rather than the rule.

Recommendations made in relation to this heading: 8.

5.1.6 Perspective of the executive team

Documentation review

- The Corporate Risk Register (dated November 19 v6.5 Final @271119) describes, as an extreme risk, 'The inability to provide a full gastroenterology service due to a lack of medical and nursing staffing capacity. This could result in inability to deliver contractual obligation, failure to meet diagnostic standards and failure to deliver cancer standards which may result in patient care, treatment and diagnosis being delayed'.

- Prior to the review, the medical director provided us with a hand written organisational chart and an accompanying email stating that the Trust did not have a chart which represented the *'complexity of a service which is split across three clinical directorates with multiple and confused line management arrangements'.*

- Number of emails regarding clinical incidents and critical of behaviour of consultant gastroenterologists.

- Number of root cause analysis investigation reports. Some of the reports cite staffing within the gastroenterology service as a reason for delayed diagnosis.

Comments from interviewees

All the executive acknowledged the longstanding and severe nature of the problems in gastroenterology. A number of major initiatives had been tried, including a review by Edgecumbe (please see section 5.2.2, *Teamwork*) but had not achieved the desired outcome.

The medical director acknowledged that, when they were appointed, the Trust had also been dealing with a series of other service problems which were prioritised ahead of this one. The lack of improvement in gastroenterology had become a *"wicked issue"* and was why external help was sought.

Review team conclusion

This review was necessary and has highlighted a number of serious clinical and managerial issues. Hopefully, the creation of a GI unit will help with the recruitment of more consultants and make it easier to manage existing team members.

5.1.7 Overall conclusion for terms of reference 1

The STP in relation to the gastroenterology service is almost redundant as links are currently much closer and more productive with UHS and Bournemouth. The STP partner Trusts do not appear to have adequate current resource to support the services in Gastroenterology at SFT.

We would encourage the Trust to build on relationships with UHS and Bournemouth to ensure that there is adequate cover for gastroenterology sub-specialties and staffing is in place.

The current divisional structure with the management of the gastroenterology service spanning 3 different directorates has made it difficult to coordinate service developments and to manage and apply appropriate governance to the service. We would advise the Trust to push ahead with plans for a GI unit as this seems like a good way forward under the management of competent surgery colleagues.

The service is chronically under-staffed and workloads for the [redacted] consultant, the dietician, IBD and hepatology specialist nurses are excessive and have the potential to be unsafe unless immediate action is taken.

Although the [redacted] consultant is clearly very busy, [redacted] still needs to participate actively in MDTs and observe consent procedures. [redacted] enjoys working across a wide variety of sub-specialties, however we believe that it is not possible to do this safely and that it would be better for [redacted] to focus on 1 or 2 sub-specialist areas in which his competencies are strongest.

A range of case anecdotes were reported to us where patients may have received poor care and the current service has a wide range of deficiencies which must be urgently remedied. Many of these were outlined in the immediate feedback to the Trust. However, SFT must assure itself that each patient anecdote reported to us and documented in this report has been properly investigated, learnt from and duty of candour has been met.

Recommendations made in relation to this heading: 19.

5.2 Terms of reference 2:

To review the quality of team working within the department and to give a view on whether this supports the delivery of high quality and safe care. Consideration will be given to individual behaviours, multidisciplinary team working, job planning, recruitment, clinical leadership and interactions with junior doctors.

5.2.1 Management structure

Documentation review

- Prior to the review, SFT provided us with a hand written organisational chart and an accompanying email stating that the Trust did not have a chart which represented the *'complexity of a service which is split across three clinical directorates with multiple and confused line management arrangements'.*

- During the review, we were provided with organograms of the 3 clinical directorates which show that colorectal surgery sits within the surgical directorate, gastroenterology

within the medicine directorate and endoscopy within the clinical support and family services directorate.

- The *Gastroenterology update and proposal for the Finance & Performance Committee* states that the current directorate structure *'causes complication and inefficiency when managing demand and capacity and serves to hinder service'.*

- We were also provided with a document entitled *Proposed services within each new division.* This document gives details of the services which will form part of the proposed divisional structure that is currently out for consultation. This would involve moving from the existing structure of 4 directorates (medicine, surgery, clinical support and family services and musculo-skeletal) to 2 overarching directorates of medicine and surgery.

- The *Gastroenterology Service Strategy* describes the service and the challenges it faces. One of the possible solutions suggested is combining the Gastroenterology and Surgical Teams (Colorectal and Upper GI) into one leadership mode and creating a GI Unit in order '*to improve the cohesion between all gastro-related specialties and provide Gastroenterology with the strong leadership that they require'*

- The *Gastroenterology update and proposal for the Finance & Performance Committee* makes the connection between a new unit and a solution to long standing recruitment problems: Linking Gastroenterology with Colorectal and Upper GI Surgery (who have a good reputation as well operating services at SFT) may also serve to improve opportunity to recruit. Combining services would also give future opportunity to reduce the number of Gastroenterologists required to run the service.

Comments from interviewees

The majority of staff we interviewed were wholly supportive of a restructure of gastroenterology services including moving from a management structure spanning 3 directorates to a new structure where services are contained within 1 directorate. One staff member we met said that the restructure was *'completely needed as at the moment everything takes longer and is more stressful'.*

Almost all the staff we interviewed spoke enthusiastically about the plans for a GI unit and one staff member told us that the new unit *'will unify everyone and give more direction'.*

Staff detailed that the proposed GI unit will be led by the GI surgery team who already play a very active part in the endoscopy unit. They told us that the clinical lead for endoscopy was excellent (a retired and returned surgeon) is working hard to ensure that any issues are resolved promptly and key performance indicators are being closely monitored.

Review team conclusion

The divisional structure spanning 3 different directorates covering endoscopy, surgery and gastroenterology has clearly made it difficult to coordinate service developments and to manage and apply appropriate governance to the service.

The GI surgeons we met appeared to work extremely well together in a cohesive manner, were very engaged in service improvement and seemed genuinely excited about the prospect of working in a GI unit. One of the surgeons told us that '*a functioning GI unit with specialist input from gastroenterology and surgery, is in everyone's interest*'.

We fully endorse the Trust's plans to streamline directorates and set up a comprehensive GI unit led by the GI surgeons. This will provide stronger leadership, closer governance and management oversight of the gastroenterology team. These important structural and managerial developments have the potential to bring about timely and positive changes for the gastroenterology service. However, care will need to be taken to ensure that the medical-surgical interface does not result in a far greater proportion of patients being switched to medical gastroenterology from surgical gastroenterology care as a result of these organisational changes. It will also be important to ensure that the less surgically linked elements of the service such as hepatology are adequately supported and maintained.

Recommendations made in relation to this heading: 3

5.2.2 Teamwork

Documentation review

- Emails of concern about the [redacted] consultant's probity, clinical consultations and ability to work in a team.

Comments from interviewees

Most of the staff we met cited teamwork as the historical cause of many of the problems within the gastroenterology service at SFT.

We heard that a general lack of harmony within the consultant gastroenterology team was the main cause of the current staffing crisis. Many of the staff we interviewed seemed to place the blame on a gastroenterologist [redacted] There was general agreement that teamworking was slightly better following their departure, [redacted]

We were told about previous interventions to improve staff relations which had little success. In fact, several staff members directly associated one such intervention, conducted by Edgecumbe Consulting, with having made matters worse. Some members of nursing staff said

that it was a '*painful experience for everyone';* and that the interviews were rather accusatory and unsupportive. The nurses advised that they were made to feel responsible for '*inhibiting the endoscopists way of working*'.

The Edgecumbe report recommended a change of leadership, regular team meetings and a behaviour code, however, from what we heard, little changed in the aftermath of the review. The views we heard stated that this was mainly due to the inaction of the Trust in following up on the report recommendations and holding relevant people to account for making the necessary changes. As highlighted above, we also heard that some staff were so upset by the review process that they did not engage with the recommendations. Influenced by this and an overall lack of positive change, we were told this led to a number of consultant gastroenterologists leaving SFT to pursue employment elsewhere.

The current gastroenterology team is largely made up of locum doctors working for the private agencies that provide endoscopy services and we heard about several rifts between this group of doctors and the nursing team. We were given an example of the disquiet between the 2 teams: frequently, mid-procedure, in front of even non-sedated or lightly sedated patients, locums would reportedly complain about the quality of the scopes and the reporting database in the endoscopy suite. We were told that, once, following such an incident, the nurses involved had raised the issue of whether it was appropriate to complain in such a way in front of patients. In response, the locum allegedly told the nurses that they were the consultants and should not be challenged in such a way. On the other hand, we also heard about allegations of perceived racism from the locums concerning the behaviour of some members of the nursing staff.

The lead for endoscopy told us that they were concerned by such allegations and tried to bring all parties together in order to resolve any issues, however neither the locums nor their employers turned up to the meeting.

In contrast, we heard that the colorectal team enjoy a strong and productive working relationship. They cover each other when on leave, seek second opinions from each other and respond as a group to incidents. As highlighted in section 5.1.5 *Attendance at MDTs*, a specialist nurse chairs the colorectal MDT which demonstrates a cohesive and flat managerial structure.

Review team conclusion

Teamworking is slightly better following the departure of a gastroenterologist [redacted] who was clearly viewed to be a disruptive influence on the service, however there is still little sense of a 'gastroenterology team' and the [redacted] consultant has little time to concentrate on this aspect of [redacted] role.

SFT will need to work with the locums it employs through private providers to ensure that relationships with nursing staff remain cordial and productive.

The surgical teams lead by example and enjoy productive working relationships. Given the long-standing problems in the gastroenterology team, it seems an ideal opportunity to have this team head up a GI unit and help turn the situation around.

Recommendations made in relation to this heading: 3, 10.

5.2.3 Individual behaviours

Documentation review

- Emails of concern about the [redacted]
- Emails of concern regarding the [redacted] operating policy for EMR, management of data and record keeping

Comments from interviewees

[redacted]

Despite the issues highlighted about the [redacted], the majority of [redacted] colleagues considered [redacted] to be a very able clinician and popular with his patients. Some staff members said that [redacted] would generally try [redacted] best to make [redacted] available to support them even if [redacted] schedule was extremely busy and doctors in training advised that [redacted] always encouraged their learning and ensured that there was a training element to their roles.

In addition to his busy clinical schedule, we heard from a number of sources that the [redacted] has a number of outside business interests which meant that [redacted] was sometimes preoccupied and took phone calls during working hours.

One member of staff said that the stress of [redacted] situation was beginning to show and that, increasingly, [redacted] could be heard saying things like *'yet another thing on my plate'.*

We heard some examples of inappropriate communication from the substantive consultant with nursing staff and surgical colleagues, usually following questions regarding [redacted] way of working. These included statements [redacted] is alleged to have made concerning race and religion. Complaints had been raised about this but staff were uncertain if any action had been taken (see section *5.3.1 Raising and responding to concerns*). As a result, certain members of the team no longer go to [redacted] for advice but worryingly would rather seek counsel from gastroenterologists based at UHS or Bournemouth.

Some of the [redacted] colleagues felt that [redacted] demonstrated a reluctance to be managed and, that as [redacted] is the '*last man standing',* [redacted] is often given too much leeway by the senior management team.

As highlighted in section 5.1.5 *Attendance at MDTs,* the [redacted] attendance and contribution to MDTs has faced some criticism.

We also heard that there had been issues with [redacted] record keeping and that notes on clinical records do not always make sense or sometimes lack important details. This causes confusion for clinician colleagues and delays for patients. There have also been ongoing issues with data for KPI monitoring. Please see section 5.3.2 *Oversight of activity and outcomes* for more details. Some interviewees thought that the [redacted] was part of the problem with recruiting new gastroenterologists. This is because senior trainees had expressed an interest in eventually applying for substantive posts but reportedly had been put off as [redacted] told them that if they were successfully recruited, they may not be able to participate in his preferred sub-specialty areas such as nutrition.

Review team conclusion

Currently there is only [redacted], staff we met had mixed feelings about [redacted] Whilst, they agreed unanimously that [redacted] workload was untenable, some found [redacted] to be difficult to work with but others thought that [redacted] was very supportive and approachable.

We were given examples of poor communication, a lack of engagement with governance processes and problems with patient management. Several interviewees commented that the service would improve and staff would be happier if [redacted] was more closely managed.

Recommendations made in relation to this heading: 3, 4, 5, 8.

5.2.4 Clinical Leadership

Documentation review

No specific documents were shared before the visit.

Comments from interviewees

The clinical director and lead clinician in endoscopy

The clinical director spoke frankly and knowledgeably about the problems faced by the gastroenterology service. [redacted] explained that medicine, on the whole, was experiencing staffing problems and had a 20% consultant vacancy rate.

The clinical director explained that it is sometimes difficult to recruit to a small department as naturally, doctors prefer to work in hospitals where there is less pressure on workload.

We received very positive feedback about the clinical director and lead clinician in endoscopy. Both were described as hard working, committed to SFT and improving care of patients.

Some interviewees we met believed that the [redacted] had been given too much leeway and that this accounted for some of [redacted] negative behaviours, the clinical director conceded that this may be the case but also sympathised with [redacted], to an extent, due to the pressure [redacted] is under.

The [redacted]

Interviewees commented that the [redacted] was not a natural leader. One interviewee said that '*you need to be hard-nosed to lead a department like that'* and they did not think that [redacted] was equipped or motivated to do so. Interviewees also acknowledged that, given [redacted] busy schedule, there was unlikely to be much time for leadership duties.

Some clinicians thought that [redacted] was difficult to manage and that some of [redacted] negative behaviours meant that [redacted] did not always set the best example for the younger doctors.

Review team conclusion

The [redacted] in gastroenterology appears to lack leadership skills and the necessary focus on service improvement. At times, [redacted] is not a team player (as can be seen in section 5.2.3 *Individual behaviours*) and does not always set a good example to less experienced staff.

The situation of poor team working and dysfunction has continued for several years and has not been managed well by the organisation. There has been a lack of control of the service and the reputation of the gastroenterology service has suffered to the point that it has been very difficult to recruit to the vacant substantive consultant posts.

The clinical director was very knowledgeable about the problems and personalities within the gastroenterology service and was clearly passionate about his role. [redacted] and the lead clinician in endoscopy should be supported in their leadership roles. It is likely that the creation of a GI unit will help to provide such support.

Recommendations made in relation to this heading: 3

5.2.5 Recruitment

Documentation review

No specific documents were shared before the visit.

Comments from interviewees

Substantive gastroenterologists

Recruitment is at the heart of the problems of the gastroenterology service. One of the clinicians we met said that the '*main challenge for the service is workforce and our inability to recruit and all the other problems regarding governance all hinge on that'*.

We heard that recruitment to gastroenterology posts is a problem nationally and that the *'toxic'* reputation of the gastroenterology service at SFT makes it extremely difficult to fill the vacant posts.

Some staff believe that the [redacted] is part of the recruitment problem. However, we did meet other members of staff who felt that the [redacted] had good connections with other hospitals in the region and could attract consultants from there.

Staff told us that gaps in rotas are being plugged by using locums provided by 2 agencies which comes at a tremendous financial cost and does not always guarantee good quality of care. There have been some poor experiences with locums and in 2018 there was an issue with one locum who previously worked at SFT, who had a significantly higher than normal complication rate for ERCP and a number of incidents associated with their care.

We were informed that checks on locums are done by the agencies they are employed by as SFT only performs checks on doctors employed directly by them.

We heard that the Trust has a *hard to recruit plan* which features gastroenterology as one of the priority areas. However, we were not told what this plan entails. Until now, The Trust has not considered 'head hunting" or offering incentives for substantive consultants to join the team.

Several of the GI and colorectal surgeons we met believed that the creation of a GI unit might be the solution to the recruitment problem as it would take the focus off the gastroenterology service and candidates would be attracted by the prospect of working alongside the high performing surgery teams.

Recruitment to other roles

As highlighted in section 5.1.2 *Workforce and workload*, we heard that there are also vacancies that need to be filled urgently in specialist nursing roles for IBD and hepatology and for

dieticians. We also heard that some of the neighbouring Trusts were employing equivalent staff at higher bands and as a result, SFT had lost valued staff to them. Given that gastroenterology staff at SFT need to manage the service and operate with greater independence than one would usually expect, it would seem logical to remunerate them accordingly.

Review team conclusion

We were concerned about the locum with the reported high ERCP complication rate. It was not exactly clear what checks were undertaken before [redacted] started working at SFT or what was communicated to the private provider to outline the Trust's concerns.

Although there is a national shortage of gastroenterologists, the Trust on the whole is not difficult to recruit to and Salisbury is generally considered a desirable place to live. SFT has not been able to fill the vacant substantive posts for a significant time now using its current recruitment strategy and it should employ a more aggressive recruitment campaign.

We agree that the prospect of having a GI unit led by the upper GI and colorectal surgeons could help alleviate the recruitment problem as both teams have a good reputation and are led efficiently.

In order to fill the vacant nursing posts in IBD, hepatology and nutrition, the Trust may want to consider re-banding the roles to make them more desirable.

Recommendations made in relation to this heading: 2, 3, 4.

5.2.6 Junior doctors

Documentation review

- *GMC National Trainee survey results 2019* for SFT are quite pessimistic. Results show that for the last 4 years trainee satisfaction in gastroenterology has been in decline and there are a number of red outliers including overall satisfaction, workload and adequate experience.

Comments from interviewees

Doctors in training we met were fairly positive about their experience working within the gastroenterology service but would not necessarily recommend the post to their peers.

The trainee doctors felt that looking after large numbers of outliers on gastroenterology wards was making the ward rounds longer and less relevant to their experience in gastroenterology. They told us that foundation year 1 doctors working within the service were not happy with the long hours that were sometimes necessitated by the large numbers of patients on ward rounds and that this was causing some of them to go off sick.

They agreed that there was a strain on the service that made working at SFT more difficult than at other Trusts they had worked at and cited workload as the main issue. Despite this, they thought that the [redacted] was doing [redacted] best to ensure they had a good experience and this was echoed by comments made by the [redacted]

We heard that foundation doctors had 1 day per week protected time for bleep-free teaching and that it was unlikely that any of the trainees would miss their targets for ARCP.

We also heard that the Trust was in the process of redesigning the education centre including updating the doctors' mess and making it more appealing for more senior trainees.

Review team conclusion

Once again, the lack of substantive consultants is largely to blame for the problems experienced by doctors in training working within the gastroenterology service.

It is discouraging to hear that foundation year 1 doctors in their first placement were already feeling the strain and going off sick and this seems to stem from the long ward rounds featuring large numbers of general medicine patients.

The Trust will need to review the experience of doctors in training within the gastroenterology service as if feedback continues to be poor, it is likely that they will lose the trainees which will only serve to make the situation worse for gastroenterology patients.

Recommendations made in relation to this heading: 9

5.2.7 Overall conclusion for terms of reference 2

Teamwork, or the lack of it, is clearly at the heart of the problems faced by the gastroenterology service at SFT. Historical disagreements between substantive gastroenterologists and attempts at mediation resulted in a number of resignations and the current staffing crisis. It is also cited as being one of the main reasons that the Trust finds it very difficult to recruit to vacant consultant and nursing posts.

At present, the service depends on locums 7 days a week to help it keep on top of waiting times and manage the non-elective workload but this is not without its complications and we heard about ongoing rifts between locums and nurses.

Conversely, the colorectal and GI surgery teams seem to enjoy a cohesive relationship and we believe that they will be able to exert a positive influence on the proposed GI unit in terms of leadership and teamwork.

Staff at SFT have mixed feelings about the [redacted] some find [redacted] encouraging and helpful whilst others think [redacted] is obstructive and arrogant.

Doctors in training were, on the whole, satisfied by their educational experience within the gastroenterology service but advised that workload is too heavy and they were not exposed to much variety in sub-specialty gastroenterology practice as there is only [redacted]

5.3 Terms of reference 3:

To evaluate the quality of governance processes and how this links more widely with the Medical Division and Trust Board level. Consideration will be given to, raising and responding to concerns and systems in place to maintain oversight of activity and outcomes.

5.3.1 Raising and responding to concerns

Documentation review

- Number of emails received regarding clinical incidents and critical of behaviour of consultant gastroenterologists.

- Number of root cause analysis investigation reports. Some of the reports cite staffing within the gastroenterology service as a reason for delayed diagnosis.

Comments from interviewees

We heard about several instances where incidents and complaints (including some of a very serious nature) had been raised by staff which appeared to have not been acted upon or responded to. In some cases, it was claimed that the medical director had been contacted but staff received no acknowledgement, nor did they see any improvements made as a result of raising issues.

To illustrate this, we heard an example of someone raising concerns to the medical director and not getting any response until they escalated it to the CEO of SFT.

We also heard that the medical director had overseen previous investigations into complaints made about a former gastroenterologist. Interviewees felt that the investigations had not been conducted with sufficient gravity and there did not appear to be adequate action taken. Some staff alluded that the medical director did not have matters sufficiently under control.

Clinical incidents

Several members of staff advised us *'we never get any feedback on datix reports'* and this had caused them to lose faith in the system and there appeared to be little point in reporting incidents. We also heard that the raising concerns guardian had been used most recently but staff were unsure of how matters were resolved other than a consultant being seen and then resigning.

Another reason staff cited for their reluctance to report incidents was because in many cases, clinicians had been asked to investigate incidents that they had been directly involved in. Staff felt that this approach has sometimes compromised the investigations and often removed any element of blame for the clinicians involved.

Raising concerns

We heard examples of staff raising concerns about the conduct or performance of clinicians and not getting reassurance that the issues were being investigated or in some cases, any response at all.

Some staff had raised what they saw as important issues with the medical director and alleged that they were informed that she did not have time to meet with them to discuss the problems.

Nursing staff told us that they had been advised to speak up when something did not seem right and that any issues they had raised regarding the conduct of clinicians were always taken seriously by the director of nursing.

We also heard that the nursing teams make every effort to reflect on clinical incidents. They told us that they have a daily meeting called *'2 at 2'* which takes place at 2pm to discuss any learning and actions to take forward.

However, there were clearly failures in this area when it came to a series of concerns raised about alleged inappropriate behaviour of one former consultant. In this case, concerns had been raised over a number of years by different members of staff and various investigations had taken place. This matter is being dealt with by the review team and the Trust separately.

Review team conclusion

We were perturbed to hear about a potentially dangerous culture of staff not reporting incidents or raising complaints as they feel that it is unlikely that their concerns will be taken seriously or acted upon.

This is further compounded by serious incidents investigations often having significant input from the responsible consultant at the review panel stage with the potential for a lack of objectivity.

In order for the service to improve and be safe, this is an area that will require significant attention. The GMC guidance *Raising and acting on concerns about patient safety*[10] clearly states that doctors must '*Take prompt action if you think that patient safety, dignity or comfort is being compromised'.* The lack of timely action in dealing with such issues is, and has been a

[10] https://www.gmc-uk.org/raising-and-acting-on-concerns-about-patient-safety---english-06

significant cause for concern. In this regard, a core principle of GMC guidance has been breached.

Recommendations made in relation to this heading:1, 13, 20.

5.3.2 Oversight of activity and outcomes

Documentation review

- We were provided with some activity data, however it did not paint a true picture of how consultants engage with each other.

Comments from interviewees

We heard from a number of staff that the clinical lead for endoscopy is trying hard to ensure that relevant data is being captured and recorded in the interest of audit, service improvement and securing Joint advisory Group of GI Endoscopy (JAG) accreditation. Important steps have been made in this regard and the unit is now 99.4% compliant.

However, we heard that it is not always an easy task to get the database updated and historically, the clinical lead for endoscopy has experienced some pushback from gastroenterologists as a whole and in particular from the [redacted] in gastroenterology who appears to resent what [redacted] perceives to be an extra layer of scrutiny.

Concerns were previously raised about the attitude of the [redacted] with regards to data collection as [redacted] had been entering inaccurate data on the in-house database under the pretext of being too busy to take the time required to complete the forms properly.

There was also some disquiet about the number of colonoscopies undertaken by the [redacted] in gastroenterology. Anecdotal estimates of the [redacted] activity would suggest that [redacted] numbers fall significantly short of the minimum numbers recommended. *UK Key Performance Indicators & Quality Assurance Standards for Colonoscopy*[11] suggests that an endoscopist should perform a minimum of 100 colonoscopies per year and the *ERCP- The Way Forward, A Standards framework*[12] guidance recommends that there should be a minimum of 75 cases per annum for ERCP endoscopists.

Review team conclusion

It is disappointing that the [redacted] has failed to engage with procedural data regarding KPIs and cites [redacted] workload as a reason for not participating fully. This is not the behaviour expected of a clinical lead or any consultant gastroenterologist and there seems to

[11] https://www.bsg.org.uk/wp-content/uploads/2019/12/UK-Key-Performance-Indicators-and-Quality-Assurance-Standards-for-Colonoscopy-1.pdf
[12] https://www.bsg.org.uk/clinical-resource/ercp-the-way-forward-a-standards-framework/

be a lack of insight on [redacted] part that good governance has the potential to help improve the service.

In modern medical practice, accountability is key and, ensuring that data collection systems are up and running effectively with the buy-in of doctors will only serve to improve the service and bring it closer to JAG accreditation.

The GI and colorectal surgery teams have several years' experience of collecting and auditing data on their procedures and mortality rates and in the words of one of the surgeons *'being scrutinised heightens your awareness'.* We are confident that with the surgeons at the helm, the creation of the GI unit will help to bring the gastroenterology service into line with the surgical specialties in terms of data collection and monitoring outcomes

Recommendations made in relation to this heading: 14, 15.

5.3.3 Clinical Governance meetings

Documentation review

- We received some agendas and minutes of the Endoscopy User Group and the Gastroenterology Clinical Governance Meeting. However, these documents were not provided in any chronological order and it was not always possible to track progress of actions suggested in the minutes.

Comments from interviewees

We heard from the outset that, to date, the main priority for the service has been to recruit more gastroenterologists and this has meant that clinical governance processes have been somewhat limited.

By all accounts, input from gastroenterology is inconsistent and we were told that '*50% of meetings have no gastroenterology presence'*. Once again, clinical workload gets cited for non-attendance, however staff feel that this is a reflection of the [redacted] practice and that he picks and chooses what he is interested in.

We heard from the hepatology nurse that there is not an appropriate forum to present or discuss their patients with other clinicians other than the [redacted] and this was often on an ad hoc basis.

Review team conclusion

Although clinical governance meetings do take place, they need robust input and buy-in from the gastroenterologists for them to be successful.

We also had some concerns about the lack of clinical governance for other elements of the GI service such as IBD, hepatology and nutrition.

The current divisional structure has not helped with clinical governance as elements of the service fall under the management of different directorates. Once again, having a GI unit led by surgeons who have a strong tradition of governance should help to improve this.

Recommendations made in relation to this heading: 3, 16.

5.3.4 Overall conclusion for terms of reference 3

We heard from a number of staff that they considered raising concerns or incidents as futile. This was because, in their experience, very often issues were not resolved and no feedback was provided. This situation is potentially very dangerous as it is not clear if issues are actually being dealt with and it prevents any learning to prevent incidents reoccurring.

We would urge the Trust to take urgent action to change this mindset and reconsider the way that serious incidents are investigated to ensure that there is sufficient objectivity on review panels.

There has evidently been some reluctance from the [redacted] to update and monitor KPIs or attend governance meetings which works against [redacted] accountability and making improvements to the gastroenterology service as a whole. Understandably, [redacted] is very busy, however this is an area that cannot be compromised, and as the [redacted], [redacted] should have a good understanding of the potential benefits to the areas [redacted] de facto leads.

5.4 Terms of reference 4

Highlight any new area of concern that arises during the ISR.

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

6.0 Appendices

6.1 Appendix 1: Documents received and reviewed

Salisbury documentation list

1. Organisational structure – details of service
    - HC endoscopy SOP v3 January 2018

    1.4 cover rota details
    - Bleed rota 2019 v12
    - Consultant rota December 2019
    - Doctors list
    - Endoscopy rota December 2019
    - Junior doctors medicine rota December 2019

    1.5 Appraisals
    - Appraisal output form 22 March 2022
    - CPD 2018/ 2019

    1.6 Protocols-guidelines-pathways
    - Final op pol 1.11 September 2019
    - Questionnaire letter
    - Clinical governance agenda
        - February 2019
        - 9 July 2019
    - Clinical governance meeting minutes
        - February 2019
        - 2 April 2019
        - 9 July 2019

    1.7 Clinic details that support the service
    - Dose rounding pamphlet
    - CNS poster presentation dose rounding 2019

    1.8 Strategic business plans
    - Quality improvement
    - RAC statement for mark

    1.9 Clinical governance assurance systems and plans
    - Clinical governance agenda 2 April 2019

    1.10 Agenda and mins – directorate and clinical governance
    - CGC meeting September 2019

    1.11 Agenda and mins – consultant meetings
    - Endo DMT minutes
        - 6 August 2019

- 15 October 2019
- 17 September 2019
- 18 June 2019
- 19 November 2019
- 21 May 2019

- EUG minutes
  - 11 April 2019
- EMG minutes
  - 16 April 2019
  - 19 February 2019
- Audit list for gastro June 2019
- Endoscopy user group meeting minutes
  - 21 November 2019
  - 20 June 2019

1.12 Most recent Trust board report

- FPC Gastro committee cover sheet template January 2019

2. Details of concern

2.1 Chronology of issues, concerns and actions taken

- Endoscopy complaints October 2017-2019
- Endoscopy concern October 2017-2019
- Themes of endoscopy concerns and complaints October 2017-2019

3. Activity and outcome data

3.1 Activity data

C. Patient experience surveys

- Endoscopy JAG KPI scorecard and web reports

D. Appointment waiting times

- Endo wait times

3.4 Local or national databases

- Gastro risks November 2018

4. Agenda and meeting notes MDT audit MM

- Acute upper GI bleed request form November 2015
- Endo – board safety walk meeting August 2019
- GI bleed pathway

4.1 Clinical audit meeting arrangements

- April 2019 to March 2020
- Letter Salisbury District Hospital 14 August 2019
- GRS action template – action plan
- Demand trends April 2019 – March 2020

4.2 MM meeting arrangements

- Agendas

- 11 April
- 21 February
- 17 January

- Gastro team meeting minutes
  - 18 April 2019
  - 17 January 2019
- Gastroenterology M&M minutes
  - 7 April 2017
  - 19 April 2018
  - 13 July 2018
  - 12 September 2018
  - 13 November 2018
  - 1 February 2019
  - 2 April 2019
  - 9 July 2019
  - 1 February 2018

4.2 Details of recent audits undertaken

- Audit

Documentation received during the Invited service review visit

- Chronology of gastro department
- NTS TA outlier post speciality by Trust/ Board
- Organisational chart
- Invited service review visit 27-28 January 2020 email from [redacted] on 15 January 2020
- Gastroenterology report and recommendations from 2 serious incidents first addressed in July 2018
- RCP service review excel spreadsheet

6.2 Appendix 2: Interviews and visits to clinical areas

27 January 2020 (Day 1)

Time	Event
08.15-09.00	Pre-Invited Service Review meeting: ISR team meet with key Trust personnel for overview of Terms of Reference. [redacted] CEO [redacted] Medical Director [redacted] Director of Nursing [redacted] Chief Operating Officer

09.15-09.45	Meeting with Directorate Managers: [redacted] Directorate Manager - medicine [redacted] Consultant Anaesthetist/ CD [redacted] CFFS Directorate Manager [redacted] Consultant Radiologist
09:45-10:45	[redacted] –Gastroenterologist
10.45-11.15	[redacted] Gastroenterology Secretary
11.15-11.45	[redacted] – ST3 Specialist Trainee
11.45-12.15	[redacted] Senior Sister
12.45-13.30	[redacted] – General Surgeon
13:30-14:00	[redacted] Hepatology Nurse
14:00-14:30	[redacted] UGI Cancer Lead
14:30-15:00	[redacted] IBD clinical nurse specialist
15.00-15.45	[redacted] Foundation Programme Director
16.00-16.30	[redacted] Upper GI Clinical Nurse Specialists
16.30-17.00	[redacted] HR Manager
17:00-17.30	[redacted] Clinical Lead for Endoscopy
17.30	Close of day

28 January 2020 (Day 2)

Time	Event
08.30-09.30	Tour of endoscopy suite and interview with [redacted], Senior Sister Endoscopy
09.30-10.00	[redacted] Alcohol liaison nurse
10.15-10.45	[redacted] - Gastroenterologist
11:00-11:30	[redacted] Clinical Director
12:30-13:00	[redacted] General Surgeon
13:00-13:30	[redacted] General Surgeon
13:30-14:00	[redacted] Clinical Lead (Colorectal)
15.00-15.30	Verbal feedback session to requesting body: [redacted] Medical Director [redacted] Deputy Medical Director
15.30	CLOSE

6.3 Appendix 3: Letter to MD summarising initial feedback dated 25 February 2020

[redacted]
Medical Director
Salisbury NHS Foundation Trust

25 February 2020

[redacted]

I am writing to confirm the immediate feedback that was provided to [redacted] and yourself on 28 February 2020, the final day of the invited review of the gastroenterology service at Salisbury NHS Foundation Trust (SFT).

[redacted]

The review team gathered a substantial amount of information from the interviews held, however we highlighted there was a significant lack of documentation provided in advance of the visit. During, and after our visit, some additional documents were sent to us and we are considering these further. However, on the basis of the information available to us, the review team summarises its immediate feedback as follows:

General feedback

This review was complex and necessary as the gastroenterology service is in a very poor state with significant risks to patient safety and the reputation of the Trust. We found a wide range of problems which now need timely action to ensure patients are safe and this letter contains interim recommendations to address immediate issues.

During the course of our visit we met a large number of people, and several stood out to us, namely: the gastrointestinal surgery team and its clinical leader[redacted] and[redacted] the specialist nurses, a medical secretary,[redacted] (ST3 trainee),[redacted] (clinical director) and[redacted] (radiologist).

Terms of reference 1

Operational partnerships and management structure

STNF's sustainability and transformation partnership footprint includes Bath and Swindon. However, with the exception of the bowel cancer screening service, none of the other clinical pathways or patient flows seem to function with these two hospitals. We heard how the

gastroenterology service at Swindon has extreme pressures. Clinical pathways are strongest with Southampton and Bournemouth and we would encourage the Trust to build further on this relationship in order to enhance their own service. All gastroenterology links are with one or other of these two centres namely for gastrointestinal bleeding, inflammatory bowel disease (IBD), hepatology, complex radiology and nutrition. Travel times from Salisbury to Swindon and Bath are considerably longer than they are to Southampton or Bournemouth although we understand the problems for some Wiltshire patients.

The current divisional structure with 3 different directorates covering one of endoscopy, surgery and gastroenterology has clearly made it difficult to coordinate service developments and to manage and apply appropriate governance to the service.

We fully endorse the Trust's plans to set up an overarching GI unit led by the GI surgeons. This will provide stronger leadership, closer governance and management oversight of the Gastroenterology team. The GI surgery team is very cohesive, engaged in service improvement and excited by the prospect of developing a GI unit. We feel that this important step could bring about timely and positive changes for the gastroenterology service.

Lead consultant

Currently there is just [redacted] gastroenterologist in post assisted by some locums and a part time [redacted] consultant. This contributes to an excessive workload for [redacted] in particular and all groups of staff from consultants to junior medical staff.

The [redacted] has spread [redacted] working time across several disparate complex subspecialties (hepatology, therapeutic upper Gastrointestinal (GI) endoscopy, complex polypectomy service, and nutrition whilst also trying to support the IBD service and upper GI cancer service). Our clinical reviewers considered it would be difficult for anyone to deliver high quality services in all of these domains. Matters are compounded by the gastroenterologists caring for large numbers of general medical patients although they are not on the acute overnight take. Many staff members were concerned that such a wide range of duties was potentially unsafe, for example we also heard that [redacted] had a ward round of 50 inpatients (including general medicine) on the first day of our visit.

Current working pattern of [redacted] (Mondays and Tuesdays) and the definitive locum consultant (Wednesday to Friday) on the gastroenterology ward with multiple handovers is discontinuous and not good for patients or other staff. Cover at the weekends is largely provided by the on-call general medical team.

Key performance indicator (KPI) data for endoscopic procedures was not provided to the review team and [redacted] did not appear to know [redacted] own information regarding colonoscopy. Anecdotal estimates of activity would suggest that [redacted] numbers were about 60 cases. British Society of Gastroenterology (BSG) guidelines state that colonoscopists should perform at least 100 colonoscopies per year, whilst more advanced practitioners should

usually perform at least 150. If the actual numbers are as low as indicated to us then carrying complex work such as EMR of polyps is a concern.

The BSG through the Joint Advisory Group on *Gastrointestinal* Endoscopy (*JAG)* strongly recommend that all endoscopic procedures are recorded on an electronic database and the KPIs for all endoscopists are monitored according to JAG criteria. The clinical lead for endoscopy should be supported in [redacted] work to formally audit the practice of all endoscopists in the Trust including the [redacted] and any locums that are employed within the next 3 months.

Clinical areas of concern

We were particularly concerned about the EMR, GI bleeding, hepatology, nutrition and IBD services.

- EMR service - this is largely delivered by one consultant Gastroenterologist supported by one of the colorectal surgeons. There are concerns about the lead operator regarding review of referrals, adequacy of consent processes and robust data regarding outcomes. We were given evidence of 1 serious adverse event in an elderly patient and heard of at least one case that underwent 7 procedures. Concerns were also expressed regarding the process around the review of histopathology results with at least the potential for significant delays. Audit of outcomes is recommended by the BSG and this is even more important given the concerns that have been raised.

- GI Bleed – we heard about cases of insufficient resuscitation and were uncertain whether these were investigated as serious incidents. The [redacted] provides overnight cover once a week and other nights are covered from Southampton. Patients are being regularly transferred to Southampton by “blue light” ambulance. Whilst we understood a formal agreement was in place, sometimes these transfers occur without full agreement of the staff on duty and patients are sent to the emergency department – this has led to some stressful telephone calls being made to ward nursing staff. There is reportedly inconsistent provision during the day. We also heard that the upper GI care bundle (which details key interventions to be performed within the first 24 hours of care for patients) has not yet been implemented – whilst the BSG recognise this has not been implemented in all Trusts, given the concerns raised, this is particularly important in this case.

- Hepatology – there is only one hepatology nurse who works with the [redacted] to provide what some referred to as only a ‘shoestring’ service. We heard and saw evidence of at least one case with a late diagnosis of Hepatocellular carcinoma who could have potentially benefited from an earlier diagnosis.

- IBD - following the departure of one specialist nurse, the IBD Service is now run by a part time specialist nurse who is managing approximately 250 patients on biological therapies and

many more on disease modulating drugs. No clear understanding, other than a series of short term locum consultants, was given to the medical supervision arrangements of this clinic. This is of very serious concern.

- Nutrition – the nutrition service is very stretched. The [redacted] consultant gives the part time dietician good support and [redacted] works in an extended role covering most tube feeding problems, assisting with PEG tubes and managing enteral nutrition. However, there is inadequate cover for the part time post and insufficient resource in this important area.

Terms of reference 2

Consultant workforce and team work

Three years ago, there were five substantive gastroenterologists at the Trust. One has retired and returned in a limited way but the other three left for differing reasons but all of which revolved around difficulties in team and ways of working. This is despite a number of significant investigations and interventions such as the use of Edgecumbe consulting. We heard that there have been multiple grievances and claims of bullying and harassment, alleged racism and concerns about professional behaviour. All this has resulted in there being [redacted] remaining. Ultimately, having just [redacted] for the size of population and range of treatments offered by the Trust is untenable and puts patients at significant risk despite the use of locums and contracted private agencies. This clearly also puts significant strain on [redacted]

The Trust has been unable to make any substantive appointments to alleviate the situation and we heard that the difficulty in recruitment is due, in part, to the department having a 'toxic' reputation within the region.

Due to the shortage of gastroenterologists, the endoscopy service is supported 7 days a week by two private providers. This comes at a tremendous financial cost to the Trust and, by all accounts, the locums employed by the private providers are of variable quality and most of the staff we interviewed would be keen to bring all services in-house.

We had concerns regarding one particular locum used by the private provider who had previously worked in the service and who had a significantly higher than normal complication rate for ERCP. Furthermore, 2 of these investigations could be potentially regarded as Never Events where they were potentially performed unnecessarily as the patients had previously had them at Southampton. This locum doctor is no longer working at SFT, but it is not entirely clear what communication has happened with the private provider to highlight this potential concern and/or with the locum's responsible officer to ensure that there is scrutiny and oversight of this matter.

Fortunately, the GI surgeons play a very active part in endoscopy unit and the clinical lead for endoscopy is working hard to ensure that, where possible, issues are resolved promptly and key

performance indicators are being closely monitored. [redacted] leadership was commendable. However, there are still rifts between consultants and nursing staff and we heard several accounts of recent disputes between nurses and locums working on the endoscopy unit.

We heard from a number of sources that, as there is only [redacted] gastroenterologist in gastroenterology, [redacted] is given leeway by the senior management team and, as a result, does not always demonstrate professionalism in [redacted] behaviours. We were given examples of poor communication, a lack of engagement with governance processes and problems with patient management. Several interviewees commented that the service would improve and staff would be happier if [redacted] was more closely managed.

Recruitment

The Trust would benefit from a much more proactive approach to recruitment which will require significant investment. In the long term, this investment will be recouped if there is less of a dependence on locums. The proposed GI unit should help with recruitment as the GI surgery team has a good national reputation which could alleviate the stigma attached to the gastroenterology service.

Terms of reference 3

Clinical governance

We heard from the outset that, to date, the main priority for the service has been to recruit more gastroenterologists and this has meant that clinical governance processes have been somewhat limited. The current divisional structure has not helped as elements of the service fall under the management of different directorates.

[redacted] can rarely attend the MDTs of [redacted] specialist areas, has failed to engage with procedural data regarding KPIs and cites [redacted] workload as a reason for not participating fully. This is not the behaviour expected of [redacted] and there seems to be a lack of insight on [redacted] part that good governance has the potential to help improve the service. [redacted] does seem overwhelmed by [redacted] situation and indeed the review team felt that anyone would find [redacted] situation very difficult.

The clinical lead for endoscopy has worked hard to ensure that KPI data is being collected and monitored which will allow for more effective audits. They have also made good progress with moving the unit closer to JAG accreditation.

The proposed GI unit should help to improve clinical governance. The GI and colorectal surgery teams have robust governance and they will continue to support the endoscopy unit and also provide closer governance and management oversight of the Gastroenterology team.

Raising and responding to concerns

We heard of several instances where incidents and complaints (including some of a very serious nature) had been raised by staff which were not acted upon or responded to. In some cases, it was claimed that the medical director had been contacted but staff received no acknowledgement, nor did they see any improvements made as a result of raising issues. Staff on the ground have lost faith in the value of raising concerns and of clear feedback on how matters are resolved. The raising concerns guardian had been used most recently but staff were unsure of how matters were resolved other than a consultant being seen and then resigning.

This has led to a potentially dangerous culture of staff not reporting incidents as they feel that it is unlikely that their concerns will be taken seriously or acted upon. This is further compounded by serious incidents investigations often having significant input of the responsible consultant at the review panel stage with the potential for a lack of objectivity.

Immediate recommendations (to be actioned within 3 months of receipt of this letter)

1. The Trust should immediately establish the combined gastrointestinal unit led by the gastrointestinal surgeons. This will help to relieve the pressure on the current service, improve accountability and focus on the plan for the future gastroenterology service.

2. The Trust should urgently develop closer links with Southampton and Bournemouth with a particular focus on being able to provide a safely manned GI bleed, hepatology and the IBD service in the short and medium term. This will require Executive to Executive dialogue and involvement of NHS improvement and the regional medical director. Formal linked consultant posts between Salisbury and these centres need to be re-explored with support from NHS improvement.

3. There must be continued Board scrutiny of this service and there should be review of the current assessment of risk based on the contents of this letter. While there are clear performance risks from extended waiting times and financial risks from use of locums and private providers, the clinical risk to patients from poor services should be fully recognised and scrutinised more effectively.

4. The BSG upper GI care bundle for gastrointestinal bleeding should be introduced with immediate effect with a focus on training, resuscitation and risk assessment.

5. Closer supervision arrangements of the IBD service need to be put into place with immediate effect. At a minimum, there needs to be regular consultant physician or surgeon input into this service and in particular for complex patients.

6. [redacted] must as soon as possible stop working across so many sub-specialties and should concentrate on a maximum of one or two. There should be

alternative arrangements for cover of general medical patients with perhaps a locum general medical consultant appointed to cover this part of the work.

7. The Trust should adopt a much more aggressive and professional recruitment strategy in order to fill the vacant consultant gastroenterologist posts. The Trust should also move forward with recruitment to fill gaps in specialist nursing and dietetics some of which may require re-banding to make recruitment attractive.

8. To encourage and foster a safety culture, all staff should be encouraged to report incidents and timely feedback should be provided.

9. Given the significance of the concerns, there will be a recommendation made in the final report to share it with the CQC. It is recommended that the Trust starts earlier conversations with the regulator and to share a copy of this letter with them along with an action plan for addressing the interim recommendations.

I hope this letter is clear and helpful in summarising the review team's immediate feedback on these matters at the conclusion of the review visit. The team will now work to prepare and finalise the invited service review report, which will be sent to you as soon as possible.

[redacted]

Yours sincerely,

[redacted]

[redacted]

[redacted]