niche
HEALTH & SOCIAL CARE CONSULTING

An independent investigation into Urology services at University Hospitals of Morecambe Bay NHS Foundation Trust

Appendices

November 2021

Investigation Lead Partner: Mary-Ann Bruce, Niche Health & Social Care Consulting

Appendices to the Final Independent Investigation into Urology Services at University Hospitals of Morecambe Bay NHS Foundation Trust Report: November 2021

Niche Health and Social Care Consulting is an independent management consultancy that specialises in supporting health care providers with all issues of safety, governance, and quality, including undertaking independent investigations following very serious incidents.

Our Final Report has been written in line with the Terms of Reference as agreed with NHS England for the Independent Investigation into Urology services at University Hospitals of Morecambe Bay NHS Foundation Trust. This is a limited scope review and has been drafted for the purposes as set out in those Terms of Reference alone and is not to be relied upon for any other purpose. The scope of our work has been confined only to the areas set out in the Terms of Reference and a wider review may uncover other areas of concern.

Events which may occur outside of the timescale of this review will render our report out-of-date. Our report has not been written in line with any UK or other (overseas) auditing standards, we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information.

Different versions of this Report may exist in both hard copy and electronic formats and therefore only the final, approved version of this report should be regarded as definitive.

Niche Health and Social Care Consulting
4th Floor, Trafford House
Chester Road
Old Trafford
Manchester
M32 0RS

Telephone: 0161 785 1000
Email: enquiries@nicheconsult.co.uk
Website: www.nicheconsult.co.uk

Contents

APPENDIX 1 – TERMS OF REFERENCE (PHASE 1 OUTPUT) 4
APPENDIX 2 – EMPLOYMENT DETAILS SENIOR MEDICAL STAFF 10
APPENDIX 2A – EMPLOYMENT DETAILS KEY SENIOR EXECUTIVE STAFF 11
APPENDIX 3 – EXTERNAL REPORTS 12
APPENDIX 4 – STRATEGIC INITIATIVES 24
APPENDIX 5 – KEY EVENTS IN COMMISSIONING AND NATIONALLY 27
APPENDIX 6 – COMMISSIONING STRUCTURES 2000-2021 30
APPENDIX 7 – CONTRACT MONITORING MEETINGS 31
APPENDIX 8 – CCG GOVERNANCE STRUCTURE DIAGRAMS 33
APPENDIX 9 – CCG REFERENCES TO UROLOGY JULY 2009-NOV 2019 34
APPENDIX 10 – MBCCG QUALITY ASSURANCE HEAT MAP FOR UROLOGY – JULY 2020 37
APPENDIX 11 – GLOSSARY OF ABBREVIATIONS 38

Appendix 1 – Terms of Reference (Phase 1 output)

Phase Two Reporting [Section One]:

Section One of our report will be distributed in draft form during the summer of 2020. This will enable the Trust to undertake any validation checks on the quantitative 'hard' data which will be used to underpin our fieldwork and report. This report will remain in draft, for limited distribution, until the collation of the (draft) final report, later in the year. This section will also contain any early analysis of any gaps in controls which will need addressing at an earlier stage than the final report (our full report will provide a definitive assessment on current controls assurance). Report Section One will include:

1. Quantitative analysis of clinical data, outcomes measures and harms.
    1. Establishment of patient cohort, demographic, and Trust context.
    2. Analysis of adverse incident numbers (including near-miss incidents and catastrophic outcomes including suicides) (106 cases as at 8.4.2020).
    3. Conversion to incidents/RCAs/hard data.
    4. Defined analysis of mortality.
    5. Patients who experienced issues within <24, <36, <1 week(s) of discharge (via GP, community, or formal readmission rates).
    6. Analysis of patient experience outcomes.
    7. Delayed diagnosis analysis.
    8. Outcomes between different consultants.
    9. Comparative data between different UHMB sites.
    10. Vacancy rates, staffing levels, sickness and absence, turnover, recruitment.
    11. Analysis of financial impact upon the Trust and CCG.
    12. Analysis of the impact upon activity, waiting lists and other providers.
2. An indication of the current controls within the Urology department and whether the Trust should be seeking additional assurances on quality and safety.
    1. Is this service currently being closely monitored at all levels?
    2. Are there issues currently within the culture of this department which might give rise to sub-optimal care or communication?
    3. Is this department currently working in-line with the appropriate clinical guidelines set for Urology?
    4. Are there any concerns about the resilience of this service whilst this investigative activity takes place?

Phase Two Reporting [Section Two]:

3. Individual care and treatment reviews and patient stories.

This section of the report will detail individual patient stories and provide a background on care and treatment. This will include a summary of each case including a description of care, outcome/harm, investigative inputs, and current case status. Cases will be written in an anonymised format to protect the identities of

patients. (We will cite individual patient contributions where we have their permission – their own patient stories will only be identifiable to them and their families).

Phase Two Reporting [Section Three]:

4. Background to the Urology service and timeline of key events.
    1. History and operational context of the Urology service (2000-2019) including facilities, location, capacity, and outline of clinical competencies (was there a shortage in clinical skill resulting in tertiary referrals from the Trust?).
    2. Commissioning of urology services by the CCG(s).
    3. Establishment of a full timeline of key events.
    4. Description of key roles (tenure and inputs).
5. Governance in relation to individual roles including recruitment, job-planning, and revalidation.
    1. Timeline of recruitment to the team – processes and impact.
    2. Process for Consultant appraisals, revalidation and CPD – effectiveness and probity.
    3. Management of internal clinical capability and MHPS processes including sharing outcomes appropriately with Consultant colleagues and appropriate others.
    4. Job planning and expense claims management.
    5. On-call protocols, evidence of doing on-call and consultant contracts.
    6. Balance between private and NHS work – agreements, enforcement, and Choice policy arrangements.
    7. Managing consultant leave, absenteeism, and private practice.
6. Clinical governance and clinical care within the Urology department across the timeline of events.
    1. Referral processes and allocation to consultants under RTT (including tertiary referrals and stent register).
    2. Clinical review and pooling of patients, clinical oversight, continuity, and clinical handover practices.
    3. Outpatient management and practices including follow-up arrangements and impact on primary care.
    4. Theatre listing, appropriateness of patient selection (clinical risk assessment).
    5. Pre-operative practices and consent and conveyance of risk to patients.
    6. WHO Surgical Safety Checklist completion and audit.
    7. Post-operative care practices, ward-based monitoring (deteriorating patient, NEWS 1 and 2) and escalation.
    8. Processes for the application of NICE guidance and other clinical standards, targets, and trajectories such as PSA, Cancer RTT and clinical tolerances applied.
    9. Clinical benchmarking and clinical audit – internal and external performance, action taken on outlying indicators.

   10. Mechanisms for identifying and monitoring clinical issues such as delayed diagnosis, delayed follow-up, incidents, re-admission rates, test-results, mortality, and subsequent action taken to address concerns.
   11. Communication with patients, standard communications, communications on risks, follow-up communications and communications on adverse outcomes.
   12. Communications between colleagues, including other departments, primary care, community services and other professional groups.
   13. Local ward-based meetings, attendance and overall effectiveness, engagement between nursing and medical staff.
   14. Primary care liaison in routine care, emergencies and obtaining advice.
   15. Management of MDTs including membership, attendance, decision making, outcomes and behaviours in meetings.
   16. Clinical leadership within Urology.

7. Clinical and operational governance at the Care Group level including actions to improve services.
   1. Involvement of clinicians in key meetings/decision making/meeting culture/terms of reference and monitoring of attendances.
   2. Clinical and managerial leadership and support, continuity, and quality of handover.
   3. Quality, finance, and performance reporting to include financial management, monitoring and oversight of activity (e.g. per Consultant session, additional activity sessions and contracts).
   4. Oversight of serious incidents at Care Group level.
   5. Approach to and management of inquests including resultant actions, implementation, and monitoring of improvements – assurance on completed actions.
   6. Local change management and service improvement interventions.
   7. Admin support, processes, and communications.
8. Board leadership, awareness and scrutiny including an assessment of the effectiveness of corporate governance.
   1. The knowledge and awareness of the Trust Board in relation to issues within Urology including the sequence of events which led to the Royal College of Surgeons Review.
   2. The quality and extent of challenge in relation to escalation. Levels of assurance given to the Trust Board.
   3. Role of the Council of Governors and Trust response to concerns raised.
   4. Impact of legacy reputation and profile.
   5. Restructures, rationale, implementation, and impact.
   6. The quality of reporting to the Trust Board including benchmarking of clinical incident reporting (internal and external).
   7. Trust approaches to identifying patients who have been harmed; Being Open and Duty of Candour.

8. Use of risk registers, local, divisional, and Trust-wide and decisions taken in response to the escalation of risk.
9. Oversight of external reviews (e.g. Royal College of Surgeons Report), monitoring, implementation and testing of changes made.
10. Trust strategy, vision and values and the proliferation into services.

9. The quality of information, information governance, reporting and Duty of Candour.
    1. GDPR, confidentiality and SARs.
    2. Sharing information between health partners.
    3. Quality of record keeping (now and then).
    4. Handling and resourcing of internal communications.
    5. Duty of Candour application.
    6. The authenticity of email correspondence re PR, the IT security arrangements in place in 2014 and present and reliability of services and email archives (outsourced to Cyber Security teams).
10. Governance surrounding Incident management and investigations assurance.
    1. Appropriateness of reporting (by Consultants and other staff).
    2. Thematic review and management of same causal factor analysis of incidents (and complaints).
    3. Quality of serious incident investigations and RCAs (including templates used) including quality control and governance processes (SIRI Panel).
    4. Involvement of family, witnesses/staff (including in theatre), feedback to family and staff.
    5. Training of staff to undertake investigations.
    6. Conversion of complaints to incidents.
    7. Process and quality of complaints responses and completion of actions.
11. Management oversight and management interventions across the timeline of events.
    a) Care Group/service manager level:
        1. Oversight of the Urology service, concerns raised, action taken, and support given.
        2. Clinical leadership roles, clarity, appointment, and support.
        3. Processes for managers holding clinicians to account (e.g. for behaviour, clinical practice, late starts).
        4. Communications with urology staff (including theatre teams) over restricted practice and return to work after suspensions.
    b) Executive level:
        5. Role of individual Executives in relation to escalating issues in Urology.
        6. Communications between Executives about escalating issues within Urology.

7. Action and interventions at an Executive level within Urology.
8. Executive Team culture.
9. Role of the Medical Director and Medical Directorate.

c) Human resources:

10. Timeline of HR interventions.
11. Culture, capacity, and capability within the HR Team, including leadership, turnover, and complaints.
12. Actions to address workforce issues in Urology.
13. HR/service handling of adversarial conduct/poor clinical practice and re-training, HR management of employment tribunals.
14. HR involvement with Medical Director re GMC and performance issues.
15. Role of the Medical Directorate and liaison with HR on issues of concern.
16. HR Policy effectiveness and Policy implementation, audit and testing of HR policy and procedural documents.

d) CCG level:

17. Engagement with commissioners in relation to pathway design.
18. Awareness of CCG into issues within Urology, including SIs, complaints, and adverse outcomes.
19. Role of CCG in oversight of urology, enhanced monitoring mechanisms (including sharing of external reports with CCG).
20. Change in commissioners and impact on service.

12. Raising concerns, service-evaluation and responsiveness to concerns raised (internal and external).

a) Internal:

1. The timeline and detail of concerns raised by patients and families.
2. The timeline and detail of concerns raised by UHMB staff (including any Union involvement).
3. Concerns which were being raised externally to the department and subsequent handling.
4. Role and impact of the bullying champion, SID and FTSUG.
5. Responses to concerns raised and the effectiveness of interventions.
6. Continuing internal profile of urology within the Trust.

b) External:

1. The timeline of concerns raised within and externally to the department, for example tertiary providers, primary care and through audit and peer review.
2. Concerns raised to the CQC and by the CQC through inspection.

3. Ownership of and response to internal and external reviews (e.g. RCS Report), quality of action planning, monitoring, implementation, testing of changes made and assurances to the Trust Board/regulators.
4. Role, approach, and robustness of external urology RCA reviewer.
5. Press and public profile, impact, and handling of the media.
6. Intelligence from Healthwatch and other consumer champions.
7. Involvement of the police and Coroner.
8. Involvement and advice from the GMC, NMC, NCAS, NHS England and NHS Improvement.
9. The role of legal firms in Whistleblowing cases.

13. The behaviours and conduct of individual members of staff as well as culture within the department.
    1. Conduct issues raised formally by staff.
    2. Conduct issues raised formally by patients.
    3. Clinical collaboration (MDT's and patient pooling), relationships and impact on the service.
    4. Consultant power, autonomy, and independence.
    5. Individual practice and culture within theatres, clinics and on the wards.
    6. Relationships between nursing, allied health professional and Consultant staff.
    7. Fear and intimidation in the department.
14. Inclusivity and diversity within the department and the Trust with an assessment of how allegations of racism were handled.
    1. Claims of racial (sexist or any essentialist) discrimination at the Trust.
    2. An analysis of overt or hidden bias or behaviours.
    3. Historic and current actions to promote inclusivity and diversity including positive action.
    4. Handling of individual cases, actions taken by the department/Care Group/Trust and impact of interventions.
    5. Analysis of partisanship based on ethnicity, professional group, sex or other essential characteristic and impact upon services.
    6. BAPIO (role and development), Unions and other representative groups engagement, remit, and activity.

Phase Three

A summary of the issues raised, a summary of causal factors and the development of recommendations for improvement.

We will provide an overarching summary of all investigative outcomes. This summary will distil the key findings of the investigation into 'causal factors' against which we will provide a full set of action oriented recommendations. This summary will be utilised at the outset of the report as an Executive overview of findings.

Appendix 2 – Employment details senior medical staff

The table below details the employment dates of senior Urology medical staff in post between 2000 and the present date.

Date	Individual and title
10.01.2000	Consultant Urologist 2 (Consultant) appointed
23.10.2000	Consultant Urologist 3 (Consultant) appointed as Locum (substantive April 2001)
05.07.2004	Consultant Urologist 4 appointed
04.09.2006	Consultant Urologist 5 appointed
02.10.2006	Consultant Urologist 5a appointed
13.07.2007	Consultant Urologist 1 (Consultant since 1977) retired
24.09.2007	Urologist 6 (Specialty Doctor) appointed
04.01.2008	Consultant Urologist 5a (Consultant) left the Trust
16.06.2008	Consultant Urologist 7 appointed as Locum (substantive September 2009)
03.08.2009	Specialty Doctor 1 appointed
01.03.2010	Locum Consultant (in post since 1989) left the Trust
18.03.2010	Specialty Doctor 2 appointed
04.01.2011	Consultant Urologist 9 appointed
01.08.2011	Specialty Doctor 3 appointed
01.10.2012	Consultant Urologist 8 (Specialty Doctor) appointed (from General Surgery)
28.05.2013	Specialty Doctor 2 left the Trust
07.08.2014	Specialty Doctor 4 appointed
20.02.2015	Consultant Urologist 4 left the Trust
11.05.2015	Consultant Urologist 10 appointed
02.02.2016	Specialty Doctor 1 left the Trust
07.03.2016	Specialty Doctor 5 appointed
31.08.2016	Specialty Doctor 5 left the Trust
26.09.2016	Consultant Urologist 3 (Consultant) left the Trust
03.11.2016	Consultant Urologist 8 appointed as Locum Consultant (from Specialty Doctor)
01.04.2017	Consultant Urologist 11 appointed
28.09.2018	Consultant Urologist 2 (Consultant) left the Trust
06.06.2019	Specialty Doctor 6 appointed
01.03.2021	Consultant Urologist 7 left the Trust

Appendix 2a – Employment details key senior executive staff

The table below shows the individuals in post in key Executive Director roles between 2000 and the present date. Identifiers are used below if individuals are referenced in the report. Where an individual is not referenced no code has been assigned.

Chief Executive Officer	
01.04.1999 to 31.10.2006	Chief Executive 1
01.10.2006 to 30.06.2007	(Acting/seconded)
01.01.2007 to 24.02.2012	Chief Executive 2
25.02.2012 to 18.03.2012	(Acting)
19.03.2012 to 27.07.2012	(Interim)
01.08.2012 to 31.03.2018	Chief Executive 3
01.04.2018 to present	Chief Executive 4
Director of Human Resources/Workforce/Organisational Development	
01.12.1993 to 28.02.2007	HR Director 1
01.03.2007 to 01.09.2007	(Acting)
01.02.2007 to 01.07.2007	(Acting)
02.07.2007 to 01.07.2012	Substantive post
11.10.2012 to 30.06.2013	(Interim)
01.07.2013 to present	Director of People and Organisational Development
Medical Director	
1998-November 2001	Medical Director 1 (overlapping roles during 2001)
May 2001 to 31.03.2006	Medical Director 2 (overlapping roles during 2001)
01.04.2006 to 31.03.2012	Medical Director 3
01.04.2012 to 31.12.2014	Medical Director 4 (Interim until 29.10.2012)
01.01.2015 to 31.08.2019	Medical Director 5
01.09.2019 to 31.10.2021	Medical Director 6
Chief Nurse/Quality Director	
12.09.1994 to 30.09.2003	Substantive post
03.09.2003 to 29.10.2006	Substantive post
29.10.2006 to 01.08.2008	(Acting)
04.08.2008 to 30.06.2013	Substantive post
01.07.2013 to 30.09.2013	(Acting)
01.10.2013 to 30.11.2013	(Acting)
02.12.2013 to 10.9.2021	Chief Nurse 1
Executive/Director of Governance	
2013	(Agency appointment)
30.9.2013 to 31.3.2019	Director of Governance/Executive Director of Governance
1.4.2019 to 23.9.2021	Substantive post (Director not Board position)
1.4.2019 to 10.9.2021	Chief Nurse 1

Appendix 3 – External reports

<table>
<tr><th>Date</th><th>Event</th><th>Key points to note</th></tr>
<tr><td>July 2011 (published September 2011)[1]</td><td>CQC inspection</td><td>CQC undertakes a review of compliance due to concerns associated with maternity and finds the Trust “was not meeting one or more essential standards”. It takes enforcement action against the Trust and issues a Warning Notice.</td></tr>
<tr><td>October 2011</td><td>Major Incident report (SHA)</td><td>Failings in outpatient follow-up processes
Failings with the introduction of Lorenzo and its impact
Results in Monitor action
Poor RCA quality in index event
Results in commissioning of Helen Bellairs Report</td></tr>
<tr><td rowspan="2">October 2011</td><td>Monitor intervention</td><td>Monitor finds that the Trust was in significant breach of its Foundation Trust authorisation due to governance failings in maternity and paediatric services.</td></tr>
<tr><td>Grant Thornton</td><td>The Trust commissions Grant Thornton to undertake a review of regulatory decisions and activity at UHMB. We do not have a copy of this report.</td></tr>
<tr><td>February 2012</td><td>Helen Bellairs Report: ‘Investigation into Follow-up Outpatients Backlog at UHMBFT’</td><td>Commissioned on the instruction of Monitor – this found:
Failing to recognise the problem. The Trust had focused on the introduction of Lorenzo and the partial booking system. It had failed to undertake any investigation, despite problems with individual patient journeys and some complaints. Issues were clouded by assurances that the problems were being addressed.
False assurances. When the backlog was first identified it was perceived as an administrative issue and even complaints failed to identify the patient safety implications. The Trust was assured that it was being managed. However, assurances were not matched by the delivery of any solution.
Other issues ‘drowned out’ the follow-up issue. The 3 main issues detailed below were identified as distracting from the growing backlog:-
- The cancellation of out-patient appointments.
- Waiting times for appointments leading to the centralising of booking away from the Trust.</td></tr>
</table>

[1] Onsite inspection dates provided with publication date in brackets

		- GP concerns regarding communications. The length of time taken to receive clinical letters and the sending of these letters to the senior partner, not the referring GP. • Divided management of outpatient booking, with no one taking overall responsibility. • Shortage of staff and staff capacity. Staff reported that they did not have the capacity to handle the volume of bookings, and the introduction of Lorenzo slowed them down further. • The arrangements and organisational culture which appears to support passing on responsibility and then absolving oneself. • Clinical disengagement, consultants felt disenfranchised from the process. • Failure to undertake proper risk and impact assessments of changes to booking system leading to chaos and complaints. • No systematic demand and capacity work undertaken. • Delayed or protracted solutions and a failure to implement plans to resolve the issue. • No holding to account. • Poor governance and risk management systems which failed to identify or address the problem.
January 2012 (published July 2012)	CQC inspection	• CQC publish the findings of their inspection. This was triggered by maternity concerns but "*focused on emergency care and the Trust's governance and management systems*." • The report found that "*patients remained at risk of poor care, particularly those patients in accident and emergency and other parts of the hospital that provided urgent care*". • The report also noted that since November 2011, the Trust had not had a Director of Operations or a Chief Operating Officer. While the role of Chief Operating Officer was vacant, it was covered by members of the Executive Team including the Director of Nursing. A Chief Operating Officer was appointed in April 2012. • The report also refers to a past external review report, conducted by H&H Bellairs Consulting Ltd and published by Monitor in February 2012, which "*highlighted*

		concerns of a similar theme to those identified following other external reviews conducted within other areas of the Trust. These included: failure to recognise the problem; shortage of staff and capability; organisational culture; clinical disengagement; change to booking arrangements without a full risk and impact assessment; no systematic capacity and demand work; delayed or protracted solutions; no real system of holding people to account; and poor governance and risk management."
February 2012	PwC Governance Review	• Prompted by Monitor finding the Trust to be in breach of its terms of authorisation. • Concluded that the Trust's "*governance processes and systems are inadequate*". • Also, poor level of challenge, scrutiny, and debate at Board/committee level; inadequate Board reporting on performance, safety, and risk; failure of the Clinical Quality and Safety Committee to provide assurance to the Board; a need to develop skills of all BMs; focus of the Executive Team is operational and reactive; clinical leadership roles poorly defined and clinical leadership is weak; the Trust is not a clinically-led organisation and clinicians are not sufficiently engaged on performance, governance, and risk; divisional accountability is weak and divisional governance is underdeveloped (it is not clear who is responsible for governance at a divisional level); "*The Trust approaches improvement planning in an ad hoc and reactive manner*"; and weak risk management culture.
May 2013	PwC review of progress against February 2012 report	Improvements include: • Eight new Board appointments. • A new risk management system and greater focus on staff responsibility for reporting incidents. • Redevelopment of the BAF and CRR . • Appointment of an interim Director of Governance and Company Secretary. • Strengthening of Clinical Director posts. Remaining areas of concern: • High numbers of vacancies, staff sickness and use of interim staff adversely effecting progress. • Board reporting still does not enable Board/committee line of sight to specialties and divisions.

		• Divisional governance arrangements are still inconsistent. • Board and divisions need to develop skills to analyse, manage and mitigate risks.
May 2013	Divisional Governance Review	• Scope was to ascertain progress on recommendations relating to divisional governance arising from the PwC Governance Review. Key findings include the need to standardise divisional governance, the need for a central governance team, the need to develop quality metrics to strengthen division performance accountability, divisional quality performance dashboards should be developed, risks should be reviewed regularly at divisional meetings. Key findings in the review were: 1. No consistent structure of clinical governance and risk management across the divisions. 2. No consistent use of names for committees, boards, meetings, or forums 3. Terms of Reference whilst available for each committee, Board, meeting, or forum have been completed but again there is no consistency and there are distinct gaps in some. For example, reporting responsibilities, annual review of terms of reference. 4. No consistency in the format of the governance report or dashboard and in the format of the risk registers as presented at each divisional meeting. 5. There are clear schedules of meetings for most meetings but there is a lack of rigour in actually holding the meetings with frequent cancellations or apologies being offered. 6. There is a poor record of attendance by key personnel at some meetings as highlighted in the appendices. *Summary: Little progress has been made on divisional governance since the PwC report. There remains a high degree of inconsistency and there are signs that governance meetings are not taken seriously (low attendance).*
June 2013	Grant Thornton – The CQC re Project Ambrose Report	• Grant Thornton report titled “The CQC re Project Ambrose” is published in June 2013. • The report finds *“evidence of the apparently deliberate suppression of an internal report entitled “Summary of the internal review of the regulatory decisions and activity at UHMB*”, *which was commissioned by senior management in October 2011... the alleged decision to suppress it may constitute a broader and on-going*

		cover-up." The report concludes that there were a number of failings in the CQC's oversight of the Trust.
September 2013	CQC inspection	• CQC undertake a follow-up review following their July 2012 inspection. • The most material finding in the follow-up is the "*failure to implement a cultural change programme across the organisation that promotes an identity of a fully merged trust. The programme of change needs to engage all staff and articulate what the expectations are of individual staff".*
October 2013	GMC RLI visit and report	• The report alerted the Trust to the need to review on-call and also ensure an appropriate educational experience for junior doctors in job plans, coupled with a clear process for concerns to be raised about education. The Executive Management Group notes suggest a defensive reaction to the report's more negative findings.
November 2013	Grant Thornton Review of progress against governance action plan (from PwC in May 2013)	• The report stated: *Overall, the progress described in this report is significant, although new structures and processes will need time to become embedded before their effectiveness can be judged*. Eight recommendations were made.
February 2014 (published June 2014)	CQC inspection	The inspection concludes that the Trust is 'Inadequate'. (Well-led = I; Safe = I; Responsive = RI). Key findings: • High turnover of senior leadership. • Poor incident reporting, management, and sharing of learning. • Governance systems have been strengthened by dividing clinical services into five clinical domains and appointing substantive clinical leaders to each division. • There was no clear strategy for the future provision of services across the trust, The strategic plans and risks were not well known at ward of team level. • Little evidence of a cultural change programme and a disconnect between staff and management and the Board.
March 2015	Impact Consulting Psychologists review of the MDT in Urology	• Impact Consulting Psychologists were commissioned in May 2014 by the Chief Operating Officer to review the Multi-disciplinary team (MDT) in Urology given the conflict in the Urology department and that there had been discipline and grievance issues. This identified organisational, geographical, environmental, work related

		stress, clinical governance and group dynamic issues. Their workshops concluded in March 2015.
March 2015	NHS Employers	• Report commissioned by the Trust to support them in responding to Sir Robert Francis' Freedom To Speak Up review. Key areas for improvement included: - not enough options for raising a concern except through immediate line manager - managers often respond by acknowledging that the raiser of the concern has done the right thing but what follows in terms of management of the process, support and quality of the feedback does not feel like that - the stress of raising a concern can be compounded by feelings that nothing will happen as a result of raising a concern - although several staff members reported good team relationships, there were indications of some powerful 'cliques' existing within teams which impacted on the ability and ease in which to raise concerns - close family and friend connections can make it difficult for a person to raise a concern if related to a person or service who their manager has a close relationship with - witnessing or experiencing bullying behaviour was a theme in some discussions, "*raising a concern can lead to intimidation, harassment, victimisation, isolation and exclusion, causing stress to the individual raising the issue and sometimes those around them*" - there was also a discussion about whether certain groups of staff are treated differently – in particular BME staff – either consciously or unconsciously - many staff commented about not feeling safe when raising or thinking about raising a concern, this was described as constantly wondering what would happen to them as a result of raising the concern - an overwhelming feeling that the resolution of concerns takes too long with no sense of urgency displayed by managers - some staff cited 'underlying issues' and 'known dysfunctional teams' which needed to be explored to have the issues surfaced and resolved, "*a feeling that nothing happens until something goes wrong*".
March 2015	Kirkup Report	The Maternity Investigation report was published. Key issues included:

		• Substandard clinical competence of clinicians involved (midwifery, paediatrics and obstetrics) • Pursuit of normal birth at any cost with insufficient recognition of risk • Dysfunctional team working • Inadequate clinical investigations including reliance on poor quality internal governance systems • External oversight was inadequate during the process of seeking foundation trust status and a development approach was used. This included CQC, Monitor, PHSO and NW SHA. • Governance concerns – listed themes in Table 12 in Section 10.
May 2015	PHE Breast screening	• The report includes findings in relation to the need to ensure adequate inclusive leadership, for strengthened team working, refresher training, and strengthened audit of the service.
September 2015	Monitor intervention	• A letter to Monitor shared with the Board in response to the enforcement actions states "*The Trust is continuing to make efforts to clear the patient backlog, especially in Maxillofacial, Urology and General Surgery*. There is no evidence that the Board sought assurance in relation to potential harm because of the patient backlog.
November 2015	Grant Thornton Well-led Governance Review	Key findings include: • A lower overall rating for 6/10 areas (which in our view is, in itself, indicative of too much optimism/too little Board-level self-awareness). • The report did not find any areas to be amber/red or red and states *"there appear to be no glaring gaps in the Trust's governance arrangements".* • The need to keep Executive Director capacity under review. • Divisional risk registers need to include target dates. • Oversight of divisional compliance with NICE guidance should be strengthened. • Medical colleagues' participation in quality governance (for example, in conducting root cause analyses and attending divisional governance and assurance group (DGAG) meetings should be continually promoted), with the impact of recent initiatives such as written communication following non-attendance monitored.

		• Need to strengthen sub-group reporting to committees. • The purpose and definition of a 'rapid review' should be explicitly communicated to all divisional leadership teams. • Notes of the patient safety summit meetings should include reference to any actions taken or planned as an immediate response to the incidents under consideration. • The new central governance lead post should be used to improve the consistency of DGAG meetings across divisions. • Board members should be encouraged to consider all departments, not just inpatient wards, when visiting any of the Trust's locations. The report was presented to the Board at an away day on 12.11.15. The report does not, however, go to a formal Board meeting. *This is poor governance. The report has a low profile consequently and there is no record of the Board's reaction to the report*.
December 2015	Monitor intervention	• Monitor announced that the Trust is no longer in 'special measures' following a CQC inspection. • A revised enforcement undertaking is applied to the Trust which includes powers to ensure that an improvement director remains at the Trust for a further six months to help implement the recommendations from the Kirkup report.
	CQC inspection July 2015 (published December 2015)	• CQC rates the Trust 'Requires Improvement' with no domains rated 'inadequate'. • Several areas for improvement and associated breaches of regulations are referred to in the report. It found that further improvement was required in relation to engaging with BME staff due to the Trust's latest WRES results. • It also found that *the pace at which the required management changes were being implemented was slow and had become very protracted*. This was specifically in relation to the review of the breast screening service.
	RCS Review of Urology	• Quality Committee are informed that the RCS will review Urology in January 2016 but no context given for the review
January 2016	RCS Review of Urology	• The Board are first informed of the RCS Review as part of the Medical Director's report to Board. This states that the findings were positive about many aspects of the service and that the formal report would be available in late February. This is not captured as an action and there is no Board in February 2016. There is no reference to Urology in the March 2016 Board.

		The reference to the RCS report also takes place at a meeting during which the Kirkup report and action plan is on the agenda. It is possible that the Board loses sight of the RCS report which was available but not shared with the Board in February 2016 and the only feedback it receives in relation to the visit is the statement that its findings were positive overall. This is also the case for the Quality Committee.
March 2016	RCS Review of Urology	• The Medical Director, Deputy Medical Director and Divisional Medical Director for Surgery met to discuss the actions from the RCS report (which formed the Urology Action Group but was never minuted). Nothing was reported or escalated outside of this meeting (Urology Action Group) (i.e. to EDG, TMB, Quality Committee, or Board). The SIRI panel was left to receive action plans and updates but this was not the appropriate forum and it did not receive appropriate updates.
May 2016	RCS Review of Urology	• The actions/areas of focus in the RCS Review are indirectly reported to the Quality Committee via the SIRI Panel Quarterly Report. There is no evidence of discussion at the Committee about Urology and the SIRI Quarterly Report reads as though the actions relating to Urology arose from an internal thematic review rather than an external visit.
July 2016	Grant Thornton Well-led Governance Review	• The Public Board receives an update on progress against the recommendations in Grant Thornton's Well-led Governance Report. The report itself is dated March 2016. There is a four month delay between the report being compiled and being presented to the Board which raises significant questions about the validity of its content but also the nature of accepted assurance at Board. • The report states that progress is green (defined as on track to delivery against agreed timescale) against recommendation 5: *"Medical colleagues' participation in quality governance, for example in conducting root cause analyses and attending divisional governance and assurance group (DGAG) meetings should be continually encouraged and required, with the impact of recent initiatives such as written communication following non-attendance monitored".* • It also states progress is green against recommendation 9: "*The purpose and definition of a 'rapid review' should be explicitly communicated to all divisional leadership teams."* • The evidence used to justify a green or blue rating is weak. For example, one of the recommendations was in relation to strengthening senior strategic leadership

		capacity to ensure that there is a clear statement of vision for the Trust. This action is 'blue' on the basis that a senior appointment has been made, however, the impact of the action on achieving the overall goal (i.e. a clear vision) is not referred to. • It also states that *the new central governance lead post should be used to improve the consistency of DGAG meetings across divisions* and that *Notes of the patient safety summit meetings should include reference to any actions taken or planned as an immediate response to the incidents under consideration.*
October 2016 (published February 2017)	CQC inspection	• CQC rates the Trust as 'Good' overall. The 'safe' domain is found to be 'requires improvement'. • The report finds that the Trust has "*significantly improved*".
April 2018	Internal Well-led review of governance	The Director of Governance undertakes an internal review of governance using the Well-led Framework and the 2015 Grant Thornton report as a baseline. This is presented to the Quality Committee on 16.04.2018. Key findings in the report are: • BMs have strong experience but there has been significant churn in membership; a key action is a Board Development Programme for 2018. • Concerns about Board capacity in the face of a demanding agenda. • There is a leadership development programme in place and 21 leaders have attended. • It provides positive assurance in relation to risk management, QI, SI management and Board reporting via the WESEE format. *"WESEE is a simple and robust integrated reporting mechanism that begins with ward/area managers and escalates to divisional governance and management meeting through the organisation via the Governance structures and any issues requiring escalation are reported through to Quality Committee. Information is cascaded back through to staff on the front line so that all staff know how they and their areas are performing in all aspects of NHS life".*
June 2018	Internal Well-led review of governance	The Board undertakes a self-assessment against the Well-led framework. This is largely positive with all KLOEs rated green. The narrative indicates some areas of improvement, but it is not clear what is being done to address these. These include: • "Middle management role as leaders needs exploring."

		• "Improvement area includes development of BME network." • "Board awareness of top 5 risks needs to be rehearsed."
November/December 2018 (published May 2019)	CQC inspection	• The rating of the Trust went down to 'Requires Improvement'. The safe, well-led, and responsive domains are rated as RI. • The report was positive about staff understanding their responsibilities in relation to reporting incidents and Duty of Candour, as well as action taken because of incidents. • Adverse findings included: - Limited evidence of non-executive director (NED) challenge and documenting actions agreed to address adverse performance from the non-executive team within the minutes of board meetings. - Limited evidence to suggest governors held NEDs to account. - Tendency for presentations rather than reports at TMB. Actions were not clear. - Pace of actions/implementation was slow. The Private Board in March 2019 considered several contextual responses drafted by Directors and the Company Secretary as part of the Trust's factual accuracy response. The tone of these in general is that of defensiveness and making a case for the report being overly negative and not reflective of the sustained change made by the Trust.
September 2019	Deloitte Well-led Review	The developmental well-led review included: • Positive findings in relation to the format of the BAF and IPR (the latter including more SPC and forecasting), and a range of activities to support governors. • Priorities and plans could be clearer. • Use of the BAF could be enhanced. • Greater debate and scrutiny from the Board of key risks. • Need to clarify process for escalating risks and issues. • Council of Governor's effectiveness should be reviewed annually.
December 2019 (published March 2020)	CQC inspection of Maternity/Children's Service	The developmental well-led review included: • Leaders did not consistently operate effective governance processes throughout the services.

		• Actions taken to mitigate risk were not always identified or actioned in a timely way. • The services collected data and analysed it. However validated data was not easily accessible to all staff to allow them to understand performance, make decisions and improvements. • We were not assured that processes to monitor equipment competencies were effective.

Appendix 4 – Strategic Initiatives

Strategic arrangements and provision is provided through two groups:

1. **Lancashire and South Cumbia Integrated Care System (ICS)**
   - Covers five Integrated Care Partnerships (ICPs), also known as local delivery plan areas.
   - Population of 1.7m, making it one of the largest ICSs in the country.
   - Monthly ICS Board, supported by a Programme Management Board. The Chief Executive is the representative from UHMB.
   - A joint committee of CCGs to help co-ordinate commissioning decisions and actions across the ICPs and ICS.
   - Focus of the ICS:
     - make faster progress on reform of the four priority areas (urgent and emergency care, primary care, mental health and cancer services),
     - manage improvements within a shared financial control total across CCG and provider partners,
     - integrate services and funding within a single health system.
2. **Bay Health and Care Partners**
   - Made up of a range of local health and social care services working together across North Lancashire, South Cumbria and Furness with a shared vision: *"To see a network of communities across Morecambe Bay enjoying great physical, mental and emotional wellbeing, supported by a health and care system that is recognised as being as good as it gets."*

'Better Care Together' (BCT) is a review of health services being carried out by 10 health and care organisations across Morecambe Bay including Morecambe Bay CCG. Key timelines for this and other Trust strategic initiatives include:

Date	Initiative	Detail
June 2014	BCT	BCT Strategy submitted to NHS England and Monitor. The 'Bay' area is identified as one of the national vanguard sites.
July 2014	BCT	The Board agrees to form an internal team dedicated to development and implementation of the BCT strategy.
October 2014	BCT	Refreshed BCT is submitted to NHS England and Monitor, along with a 2-year delivery plan. This forms the basis for the Trust's own strategy.
May 2015	BCT	National New Care Models team visits the Trust.
September 2015	BCT	The Trust is asked to deliver two outline business cases (OBCs) linked to the BCT programme as well as its five year strategy. Each OBC has to cover the follow five points:

		- the Strategic case – the case for change - the Economic case – optimise value for money - the Commercial Case – commercially viable - the Financial Case – financially viable - the Management case – can be delivered successfully We note there is little emphasis on quality and safety in this regulatory ask.
October 2015	BCT	The Board receives the *Better Care Together Progress report* which notes that Urology is included in the next phase of pathway redesign projects.
November 2015	Quality Improvement Strategy	The Board approves a new Quality Improvement Strategy 2016-19; this includes the new Patient Safety Summit as a key part of the Trust's quality approach.
	Listening into Action ('LIA')	The Listening into Action scheme 'supporting a culture of learning and development across the bay' will facilitate open and honest debate commencing with the Big Conversation on 9 December 2015 to surface ideas for development of a fundamentally different approach to delivery of training nearer to, and more aligned with, service delivery.
May 2016	BCT	BCT Memorandum of Understanding (MoU) is signed. It sets out the high-level implications for leadership, decision making and governance during the 'shadow' period. The MoU was not a formal binding agreement but did include a Mandate to support shared decision making.
May 2017	BCT	A report to Quality Committee notes that Patient-Initiated Follow-Up (PIFU) will be introduced to Urology as part of BCT plans.
May 2018	ICP	Private Board receives a paper titled *"Proposals for a Governance and Assurance Framework for Bay Health and Care Partners (BHACP) Integrated Care Partnership (ICP)"* This builds on the May 2016 BCT MoU. The new framework proposes the creation of a Senior Leadership Team (SLT) that will be held to account by the Partnership Board comprising system CEOs, Chairs and Leaders; The SLT will have accountability for delivery of the BHACP Strategy and the Five Year Financial Recovery Plan and their SRO responsibilities.
September 2018	Trust Strategy	EDG consider a strategy refresh roadmap to set the original 2015-2020 strategy in context. The refreshed document would sit alongside rather than replace the BCT Strategy that was created with partners to plan future healthcare in Morecambe Bay.

December 2018	Trust Strategy	EDG receives a paper setting out the Trust's approach to engaging with staff on the Strategy. Team Talks are a key feature of the engagement process, but it also includes tea and talks, emails to Trust membership, CEO briefings, a cascade system into Care Group Management teams, intranet pages asking for feedback from staff, staff side meetings.
January 2019	Trust Strategy	EDG considers a Hospital-based Clinical Services Strategy. The relevant paper states *"it is now over four years since the publication of the Better Care Together Strategy; over this time there has been considerable change in the landscape of the NHS, established ICP and ICS are now in place; the NHS funding gap has increased with the financial gap for Bay Health Care Partners now at £70 million and Healthier Lancashire & South Cumbria estimated at £572 million by 2020/21. At the same time, we continue to see the demands on our services increasing whilst we battle with the challenges of recruitment and our estate. We recognise that running services across multiple sites produces duplication and is not the most efficient way to deliver care."*
November 2019	BCT/ICP	The Private Board receives the draft BCP Strategy v2 which is overseen by the BHCPs.

Appendix 5 – Key events in commissioning and nationally

Key events in commissioning and nationally in relation to Urology 2000-2021.

Year	Event
2000-2005	• Publication of the NHS Cancer Plan[2] by the Department of Health (DH) in 2000. This was an investment strategy to bring together the prevention, screening diagnosis, treatment and care for cancer and introduced national cancer standards on waiting times for diagnosis and treatment It introduced multi-disciplinary team (MDT) working and regionally led peer reviews. The plan specifically aimed to increase the number of Urologists to tackle waiting lists for prostate and bladder cancer and invest in specialist cancer nurses. • The Prostate Cancer Risk Management Programme[3] was introduced in 2001 which has since been updated and continues as guidance for GPs. • Cancer networks were established to plan the strategic commissioning and provision of cancer services. Funding was allocated for a lead GP for cancer in each Primary Care Trust (PCT) to support the development of cancer networks. • Cancer Services Collaboratives (CSC) (currently known as the Cancer Alliances) were rolled out across the country to support the redesign of cancer pathways, working with MDTs to improve cancer services locally. • In 2002, "Improving Outcomes in Urological Cancers"[4] was published by the National Institute for Clinical Excellence (NICE). The guidance was to be implemented over the next five years and was led by the cancer networks supported by the CSC. • Morecambe Bay PCT and Cumbria PCT were established in 2002 and responsible for commissioning most of the services provided by UHMBT. Strategic oversight of the performance of PCTs was through the Cumbria and Lancashire Strategic Health Authority (SHA). • April 2005, Practice Based Commissioning (PBC) was introduced to give GPs more influence on the commissioning of services.

[2] https://www.thh.nhs.uk/documents/_Departments/Cancer/NHSCancerPlan.pdf
[3] https://www.gov.uk/guidance/prostate-cancer-risk-management-programme-overview
[4] https://www.nice.org.uk/guidance/csg2

	• In 2005, Choose and Book was introduced for outpatient appointments.
2006-2010	• The Transforming Community Services national policy was introduced in 2008. • Cancer Commissioning Guidance[5] and a supporting toolkit were published by the Department of Health in 2009 as part of the Cancer Reform Strategy of 2007 and World Class Commissioning. • The public inquiry into the failings at Mid Staffordshire NHS FT was announced in June 2010.
2011-2013	• January 2011, the DH published "Improving Outcomes: A Strategy for Cancer"[6]. It recommended the use of NICE's Improving Outcomes Guidance as a key element of commissioning. • July 2011, the DH published an update to the 2009 Cancer Commissioning Guidance[7]. • The Francis Report was published in February 2013 (Report of the Mid Staffordshire NHS FT Public Inquiry). The report highlights whole system failure with major implications for all health services.
2013/14	• April 2013, North Lancashire CCG and Cumbria CCG were established. NHS England was responsible for specialised commissioning and oversight of CCGs, with regional and local offices.
2015/16	• In June 2015, Choose and Book was replaced by NHS e-Referrals. • In October 2015, NHS England introduced a policy for the monitoring, management and incident reporting of long cancer waits ('backstop policy').
2016/17	• October 2016, the Cancer Alliance in Lancashire and South Cumbria was established in response to the publication "Achieving World Class Cancer Outcomes: A Strategy for England 2015-2020."
2017/18	• April 2017, following boundary changes, Morecambe Bay CCG and North Cumbria CCG were established. Each CCG held their own contracts with UHMBT but worked closely together on the quality agenda. • Lancashire and South Cumbria Sustainability and Transformation Partnership was established – Healthier Lancashire and South Cumbria.
2018/19	• Morecambe Bay Integrated Care Partnership was established known as Bay Health and Care Partnership.

[5] https://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093160.pdf
[6] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213785/dh_123394.pdf
[7] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/153603/dh_128690.pdf

2020/21	• Refreshed quality framework for Morecambe Bay CCG. • GIRFT publish 'A framework for re-establishing and developing Urology services in the COVID-19 era' in September 2020 and a self-assessment tool for Trusts.

Appendix 6 – Commissioning structures 2000-2021

Time Period	Structures
April 2000 – March 2002	Morecambe Bay Health Authority North West Regional Health Authority
April 2002 – September 2006	Fylde PCT Wyre PCT Morecambe Bay PCT (MBPCT) Cumbria PCT (responsible for commissioning for Cumbria residents) Lancashire and South Cumbria Strategic Health Authority (SHA) Practice Based Commissioning (PBC) introduced in 2005
October 2006 – March 2013	North Lancashire PCT (NLPCT) following merger of Fylde PCT, Wyre PCT, and part of Morecambe Bay PCT Cumbria PCT (responsible for commissioning for Cumbria residents) NHS North West (SHA renamed) NHS North of England (from 2011) World Class Commissioning programme introduced in 2007
April 2013 – March 2017	North Lancashire CCG Cumbria CCG (responsible for commissioning for Cumbria residents) NHS England (Specialised Commissioning) Lancashire and South Cumbria Sustainability and Transformation Partnership (STP)
April 2017 – present	Morecambe Bay CCG (MBCCG) North Cumbria CCG Morecambe Bay Integrated Care Partnership (previously Bay Health and Care Partners) part of Lancashire and South Cumbria ICS

Appendix 7 – Contract monitoring meetings

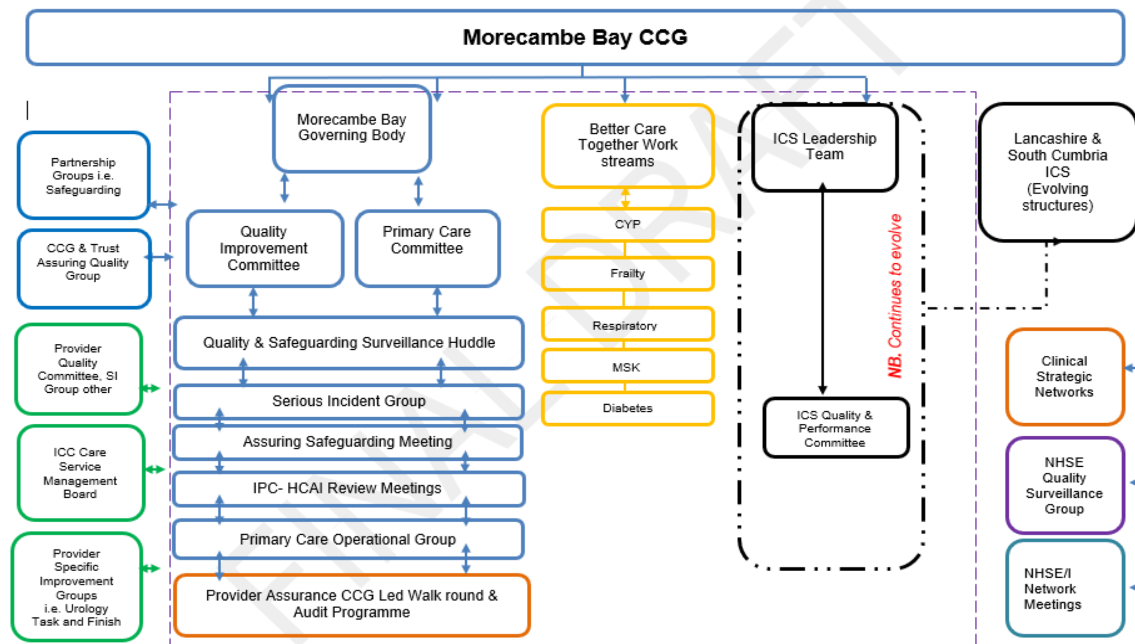
Period	Quality Performance	Finance and Activity Performance
2009/10	**North Lancs PCT** Clinical Quality & Performance Review Meeting	**North Lancs PCT** Finance, Activity, and Information Review Meeting
	Cumbria PCT Service & Quality Review Sub-Group	**Cumbria PCT** Contract Review Group
2010/11	**North Lancs PCT** Clinical Quality and Patient Safety Assurance Meeting	**North Lancs PCT** Finance, Activity, and Information Review Meeting
	Cumbria PCT Service & Quality Review Sub-Group	**Cumbria PCT** Contract Review Group
2011/12	**North Lancs PCT** Clinical Quality and Patient Safety Assurance Meeting	**North Lancs PCT** Finance, Activity, and Information Review Meeting
	Cumbria PCT Quality sub-group Clinical Review Groups (time limited)	**Cumbria PCT** Finance Information and Performance Sub-Group
2012/13	**North Lancs and Cumbria PCTs** Contract Quality and Performance Meeting	**North Lancs PCT** Finance, Activity, and Information Review Meeting **Cumbria PCT** Finance Information and Performance Sub-Group
2013/14	**Lancs North and Cumbria CCGs** Contract Quality and Performance Meeting	**Lancs North CCG** Finance, Activity, and Information Review Meeting **Cumbria CCG** Finance Information and Performance Sub-Group
2014/15	**Lancs North and Cumbria CCGs** Contract Quality and Performance Meeting (note: assumed to run until November 2014) Assuring Quality Meeting (from December 2014	**Lancs North CCG** Finance, Activity, and Information Review Meeting **Cumbria CCG** Finance, Information and Activity sub-group
2015/16	**Lancs North and Cumbria CCGs** Assuring Quality Meeting	**Lancs North and Cumbria CCGs** Finance, Information and Activity Sub-Group
2016/17	**Lancs North and Cumbria CCGs** Assuring Quality Meeting (to September 2016) Quality Assurance Group (from November 2016)	**Lancs North and Cumbria CCGs** Contract Business Meeting
2017/18	**Morecambe Bay CCG** Assuring Quality Meeting	**Morecambe Bay CCG** Contract Business Meeting
2018/19	**Morecambe Bay CCG**	**Morecambe Bay CCG**

	Quality Assurance Meeting (to August 2018) Assuring Quality Group Part A (from September 2018)	Acute and Community Contract Meeting
2019/20	**Morecambe Bay CCG** Assuring Quality Group Part A (to December 2019) Assuring Quality Group (from January 2020)	
2020/21	**Morecambe Bay CCG** Assuring Quality Group (to July 2020) Assuring Quality Meeting (from August 2020)	**Morecambe Bay CCG** Acute and Community Contract Meeting

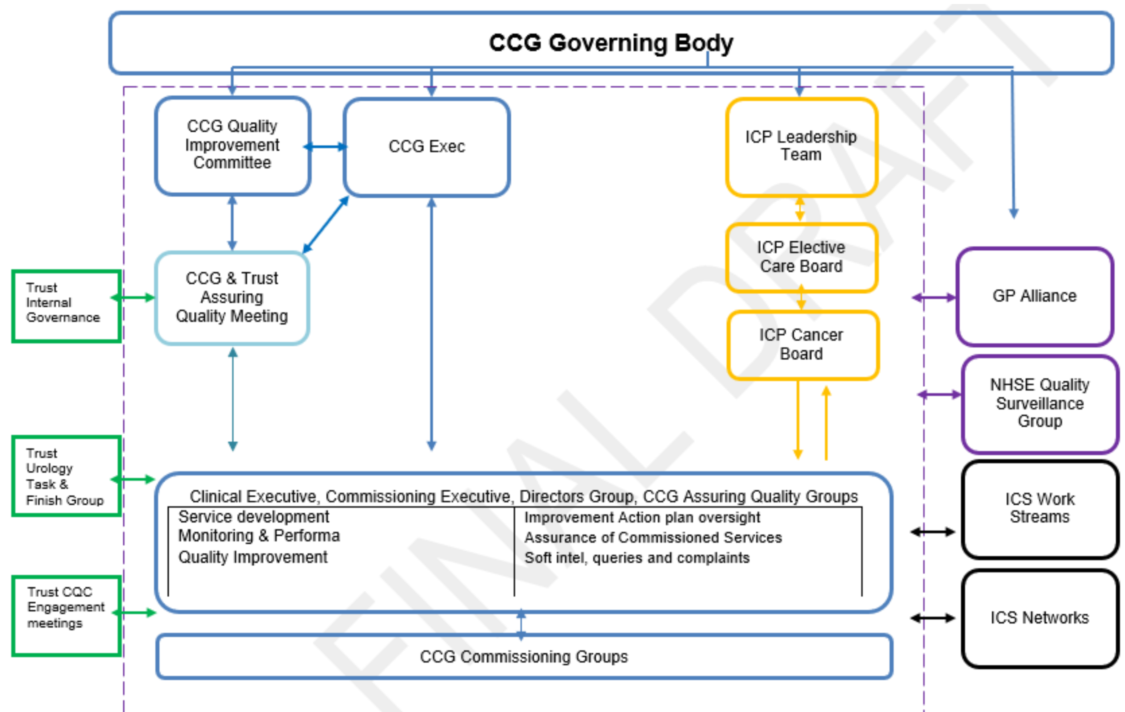
Appendix 8 – CCG governance structure diagrams

MBCCG's current quality governance arrangements are set out in the Quality Improvement, Assurance and Accountability Framework for the CCG (version 0.10) which was presented to the Quality Committee in August 2020. The structure diagram provided in this paper is set out below.

MBCCG Quality Assurance System – June 2020



MBCCG Quality Assurance System for Urology – June 2020



Appendix 9 – CCG references to Urology July 2009-Nov 2019[8]

Dates	Reference
Contract Quality and Performance Group	
July/Aug/Sep/ Oct/Dec 2009/Feb 2010	Urology MDT attendance and clinical oncologist cover was queried. October 2009 – Urology MDT performance dropped considerably for surgeons, specialists, and the radiologist.
Dec 2009	1 Urology incident identified but this related to a medicines' management issue in Primary Care. NPSA Alert relating to female catheters being used in males – no questions if an issue at UHMBT
Jul 2010	Cancer Peer Review Report for Morecambe Bay locality, risks, or serious concerns. Local Urology MDT part of peer review. "Urology was rated green" with no immediate risks or serious concerns. Minimal detail in this two-page report or evidence for the judgement made.
Jun 2012	Cancer Peer Review for Urology identified concerns on identification of patients for discussion at MDT, access to Clinical Nurse Specialists and notification within 24 hours to GP of serious diagnosis.
Feb 2013	A report on the Outpatients backlog refers to a significant number of Urology patients in the priority cohort, including the index case (Patient 64).
Nov 2013	Concern raised about why Urology patients were waiting six weeks for follow-up appointments. This was appropriately followed up and a response provided by the Clinical Lead at the meeting in December – the issue was due to staff sickness and had not impacted on cancer patients; a business case had been submitted to increase staff capacity in Urology.
Mar 2014	New NICE guidance on Urology mentioned on prostate cancer and Medical Director to liaise with Consultant Urologist 5 on this.
Apr 2014	Performance: Urology mentioned as underperforming on RTT. Outpatient backlog – information provided by specialty. For Urology 143 patients past tolerance for appointment – due to significant consultant sickness a number of patients booked into the last week in March had to be cancelled, these patients to be re-booked into clinics – comprehensive description of actions being taken.
Jun 2014	Urology – local audit recommendations, Mid Urethral Tape Audit – Streamlining of Trust guidelines. Patient pathway to be modified. Audit of recurrent UTIs. Audit highlighted unnecessary cystoscopies with recurrent UTIs in females. Recommended cystoscopy only with persistent haematuria and re-audit in 12 months. Summary for year at back of report shows for each specialty – for Urology there is one audit in August 2013 for which

[8] We reviewed all papers to end of May 2019 (prior to whistleblowing events). CCG requested additional references to be added in August and November 2019

	concern expressed but report provides no detail on reason for this.
Jul 2015	A patient refused access due to being out of area referral. Issue that Urology is under pressure as now pick up all cases whereas previously General Surgery would have picked up.
Oct 2015	Urology issues update: *Deputy Director of HR noted that due to changes in training over the past 10-15 years, all emergency Urology work was undertaken by Urologists rather than General Surgeons and there were a low number of trainees coming into the service. Royal College of Surgeons and the British Association of Urology Surgeons had been asked for guidance, noting that increased specialisation does not serve rural populations well. The RCS was undertaking a clinical record review, service review, talking to staff, reporting in February. Does not show as outstanding action.*
Nov 2015	Trust response to Coroners letter (Urology) and Trust actions – Medical Director 5 provided an overview and confirmed that the Urology Department had formulated an action plan and had sent a letter to all clinical staff detailing the actions that must be taken and addressed.
Jun 2016	Clinical audits relating to Urology, paper on incidents relating to testicular implants – 18 patients recalled – actions to be taken by Trust for patients regarding testicular implant incidents. No evidence yet that CCGs had asked about changes in practice/lessons learned as a result, just expressed concern – reassurance not assurance referred to in incidents.
Mar 2019	Operational Performance Report is in the appendix so hidden away in the papers. Some specialty analysis – 62 day waits trends shown, issues in Urology relating to failed implementation of prostate pathway – analysis by cancer type but Urology consistently red compared to other categories.
Quality Improvement Committee (Morecambe Bay CCG)	
Dec 2017	Never Event – “since the last QIC meeting a Never Event had occurred. A patient attended the Urology Department at RLI for an outpatient follow-up appointment and had a procedure undertaken but this was on the wrong person. This was being reviewed and the catalogue of errors being investigated.”
May 2019	“Urology has made significant changes to the prostate pathway after a ‘One-Stop’ Clinic to determine next steps, which will shorten the pathway. The benefit on the 62-day pathway should be reported from September. Presently these benefits are not being realised, due in part to radiology slots and surgical and radiotherapy in house counselling. Further work has been developed including nurse triage and scan prior to appointment.”
May 2019	RTT report in May 2019 showed 2017/18 and 2018/19 RTT performance by specialty. For 2018/19, the median wait for Urology was 6 weeks which was similar to average wait across all specialties (6.5 weeks, range 3-13 weeks).
August 2019	Assuring Quality Meeting. Matters arising re: high waiting list figures

	XX queried the extent of missed issues and the significance of their impact was discussed. XX shared that the Trust is going through the backlog and whilst no one specific specialty was identified, a Urology theme was picked up and a thematic review on these patients is underway. A harms form has been completed on each patient to check whether patients need to remain on a waiting list and if any harm is found they are going through SIRI. **ACTION:** XX requested figures and XX shared that Quality Committee in September will pick up this issue and XX will Invite XX to attend. XX to provide XX with an email update around the missed cancers.
Nov 2019	Quality Committee 2019 Annual Assessment for CCG Commissioner Cancer Services. Enhanced surveillance provider action recorded – Urology and Oncology clinics continue to be parallel rather than joint, indicating non-compliance. Action to establish barriers to joint clinic (possible limitations around clinical oncology) and indicate options to implement.
Nov 2019	XX provided a verbal update and said the Terms of Reference for the Royal College of Surgeons Review have now been agreed and signed off. Notification has been received from NHS England and NHS Improvement that a company called Niche have been appointed to undertake the independent investigation review. The Oversight Group will continue to oversee the learning and application.

Appendix 10 – MBCCG Quality Assurance Heat Map for Urology – July 2020

Key:

Score	Description
3	**Full Assurance** - No outstanding assurance actions, effectiveness evidenced. effectiveness evidenced.
2	**Moderate Assurance** - Some assurance has been provided with evidence of effectiveness, although there are some outstanding actions
1	**Minimal Assurance** - Minimal assurance provided, limited evidence of effectiveness with multiple outstanding actions.
0	**No Assurance** - No assurance provided, no evidence of effectiveness with multiple outstanding actions.

Areas of Assurance Action	**Overall CCG Assurance Score - January 2020**	**Overall CCG Assurance Score – February 2020**	**Overall CCG Assurance Score – April 2020**	**Overall CCG Assurance Score – July 2020**	**Movement this Reporting Period**
RCS Action Plan – overall Interfacing Action Improvement plans across the Trust	2	2	2	2	↔
Identification of thematic/ Recurring issues (relating to organisational memory)	2	2	2	3	↑
Staff confidence to raise concerns via the appropriate route	1	2	2	2	↔
RTT; Breach of national standards 62 day (8.4) & 62 day (9.4), Standard not met of Zero tolerance to 52 week waits	1	1	1	1	↔
Medical vacancies in urology	1	1	1	1	↔
Case For Change – out of hours cover to ensure safe service	2	2	2	2	↔
Stent related Incidents 2015-17 (no robust follow up process for stent removal)	2	2	2	2	↔
Failure to follow up on Results (primarily radiology - Some of relate to Urology).	2	2	2	2	↔
RLI higher rate of surgical complications in nephrectomy surgery 2016 (14.59% risk adjusted) compared to the national average (2.51%)	1	1	1	REMOVE	
Mortality SHMI data August 2018 – July 2019 (UHMBT is within expected mortality range for Urinary Tract Infection and Cancer of the Bladder).	2	2	2	2	↔
Follow up beyond Indicative Review Date	2	1	1	2	↑
Serious Incidents-Urology	2	2	2	2	↔
Tertiary patient pathways	0	1	1	2	↑
Feedback via complaints and comments and FFT	2	3	3	3	↔
Incidents and Concerns arising via Media Alerts (The CCG becomes aware of a number of incidents via media alerts)	3	3	3	3	↔
Individuals named within publication	3	3	3	3	↔

Appendix 11 – Glossary of Abbreviations

Acronym	Definition
AAS	Additional Activity Session
ADoP	Assistant Director of Operations
AMD	Associate Medical Director
APH	Abbey Park Hospital
AQM	Assuring Quality Meeting
BAF	Board Assurance Framework
BAME	Black, Asian and Minority Ethnic
BAPIO	British Association of Physicians of Indian Origin
BAUS	British Association of Urological Surgeons
BCT	Better Care Together
BM	Board members
BMA	British Medical Association
CAESG	Clinical Audit and Effectiveness Steering Group
CBU	Clinical Business Unit
CCG	Clinical Commissioning Group
CEASG	Clinical Effectiveness and Audit Steering Group
CI	Clinical Incident
CNS	Clinical Nurse Specialist
CoG	Council of Governors
COO	Chief Operating Officer
CPCC	Central Patient Choice Centre
CPD	Continuing Professional Development
CQC	Care Quality Commission
CQPG	Contract Quality and Performance Group
CRR	Corporate Risk Register
CSM	Clinical Services Manager
CSU	Clinical Service Unit
CV	Curriculum vitae
EDG	Executive Director's Group
eGFR	Estimated glomerular filtration rate
ESP	Enhanced Support Programme

Acronym	Definition
NCAA	National Clinical Assessment Authority
NCAS	National Clinical Assessment Service
NCCCG	North Cumbria Clinical Commissioning Group
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NED	Non-Executive Director
NICE	National Institute for Clinical Excellence
NLPCT	North Lancashire Primary Care Trust
NPSA	National Patient Safety Agency
NRLS	National reporting and learning system
NSSG	Network Site Specific Group
OD	Organisational Development
PA	Programmed activity
PALS	Patient Advice and Liaison Service
PBC	Practice Based Commissioning
PCT	Primary Care Trust
PHSO	Parliamentary Health Service Ombudsman
PIP	Performance improvement plan
PLICS	Patient Level Information and Costing System
POTTS	Physiological Observations Track and Trigger System
PSA	Prostate-specific antigen
PTL	Patient tracking list
PwC	PricewaterhouseCoopers
QIC	Quality Improvement Committee
RCA	Root cause analysis
RCS	Royal College of Surgeons
RLI	Royal Lancaster Infirmary
RMO	Resident Medical Officer
RTT	Referral to treatment
S&CC	Surgical and Critical Care
S&CCG	Surgical and Critical Care Group
SAR	Subject Access Requests

EUA	Examination under anaesthetic
FCE	Finished Consultant Episodes
FGH	Furness General Hospital
FOIA	Freedom of Information Act
FPC	Finance and Performance Committee
FTSUG	Freedom to Speak Up Guardian
GAD	Guaranteed access dates
GI	Gastrointestinal
GIRFT	Getting It Right First Time
GMC	General Medical Council
HR	Human Resources
HSCA	Health and Social Care Act
ICU	Intensive care unit
ICS	Integrated Care System
IPR	Integrated Performance Report
IQPR	Integrated Quality and Performance Report
IRD	Indicative review date
ITU	Intensive Treatment Unit
KPI	Key performance indicators
LNC	Local Negotiating Committee
LNCCG	Lancashire North Clinical Commissioning Group
LoS	Length of stay
MBCCG	Morecambe Bay Clinical Commissioning Group
MDT	Multidisciplinary team
MHPS	Maintaining High Professional Standards
MPTS	Medical Practitioners Tribunal Service
MUST	Malnutrition Universal Screening Tool
SGAG	Surgical Governance and Assurance Group
SHA	Strategic Health Authority
SI	Serious incident
SIRI	Serious Incident Requiring Investigation
SMB	Senior Management Board
SOF	Single Oversight Framework
SOP	Standard operating procedure
SPA	Supporting professional activity
StEIS	Strategic Executive Information System
STP	Sustainability and Transformation Partnership
SWOT	Strengths, Weaknesses, Opportunities, Threat’s Analysis
TCS	Transforming Community Services
TMB	Trust Management Board
TPN	Total Parenteral Nutrition
TRUS	Transrectal ultrasound
TURP	Transurethral resections of the prostate
UBM	Urology Business Meetings
UHMB	University Hospitals Morecambe Bay NHS Foundation Trust
UOG	Urology Oversight Group
UQOC	Urology Quality Oversight Committee
UT&FG	Urology Task and Finish Group
VTE	Venous thromboembolism
WAC	Workforce Assurance Committee
WC	Workforce Committee
WGH	Westmorland General Hospital
WLI	Waiting list initiative

Niche Health and Social Care Consulting
4th Floor, Trafford House
Chester Road
Old Trafford
Manchester
M32 0RS

Tel: 0161 785 1000

www.nicheconsult.co.uk

Niche Health and Social Care Consulting Ltd is a company registered in England and Wales with company number 08133492

niche
HEALTH & SOCIAL CARE CONSULTING