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

Final Report

November 2021

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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 and NHS Improvement 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Events which may occur outside of the timescale of this review will render our report out-of-date.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 Final 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.

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Contents

LIST OF TABLES, DIAGRAMS AND GRAPHS

1. Foreword

1.1 Providing high-quality care means putting patient safety at the forefront of every action and decision made in the provision of health care services. To achieve this requires the conditions of close cooperation, good communication and the application of effective systems, processes and controls - through good governance. This investigation will describe a complex and evolving set of circumstances where these conditions were not met and which played-out negatively over many years, resulting in uncontrolled legacy.

1.2 A primary objective of this investigation has been to seek a full and validated understanding of any patient harms or clinically untoward outcomes in Urology. Particularly, but not exclusively, to validate concerns raised publicly in the 'whistleblowing' publication *Whistle in the Wind*. What we found is a multi-faceted set of contributory issues which cannot, in many cases, be singularly applied to individual Consultant failings.

1.3 When placed into context, it is clear that there have been multiple individual, team, organisational and regulatory shortfalls which have resulted in a systemic failure to deliver good urological care at all times. We cannot conclude on the full extent of harm in the department, although it is likely that many patients received good care as evidenced in our current case review.

1.4 However, this report shows the culmination of individual, team and organisational failings has resulted in instances where poor care has been delivered leading to potentially premature deaths, significant harms, and distress to patients and staff. Particularly, this report draws upon our review of aspects of 523 individual patient cases. This review of cases informed the themes and concerns raised in relation to clinical care and governance.

1.5 We have focused upon the intrinsic nature of these failings and the impact that these have had upon individual patients and families. We were unable to determine whether this department benchmarked negatively when compared to the national average, as relevant outcome data is simply not available for comparative purposes. For example, clinical complications in Urology care.

1.6 Good Medical Practice[1] guidelines set out what is expected of a good doctor which includes establishing and maintaining good partnerships with colleagues. The failure to demonstrate collaborative working, respect and fair treatment and demonstrate awareness of how behaviour may influence others within and outside the team were key failings amongst many in the Consultant team. Holding Consultants to account as a team for failings against these guidelines is the preserve of the Responsible Officer (RO)[2] [3] [4] accountable to the Board and closely

[1] https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice
[2] https://www.legislation.gov.uk/uksi/2010/2841/made
[3] https://www.legislation.gov.uk/uksi/2013/391/regulation/3/made#regulation-3-3

[4] The Role of Responsible Officer, Closing the gap in Medical Regulation – Responsible Officer Guidance (26.7.2010) states: all designated healthcare organisations will be required to nominate or appoint, resource and support a Responsible Officer. In the NHS in England this will be a senior licensed doctor, usually sitting on the Board. Paragraphs 4.27 and 4.28 sets out relationships with the Board:
4.27 The Responsible Officer has a relationship with, and is accountable to, the GMC on matters in connection with fitness to practise, including ethical issues. The Responsible Officer should also be directly accountable to the organisation's Board or the highest level of management.

aligned with the Medical Director but poor control of this role has resulted in a weak response to team dysfunction.

A legacy of mistrust

1.7 Clashes within the Consultant body in the Urology department at the Trust started as far back as 2000 and can be attributed to a range of factors including issues of personality, background, governance, training and variations in clinical approaches. It is clear that some Consultant Urologists, for various reasons, elected not to communicate or work as a team.

1.8 The Urology team at the Trust is not the first clinical team nationally to have experienced significant departmental dysfunction; however, this case is distinctive in terms of the extent and polarisation of the fallout, the drawing in of the media and regulators, the cost to the public purse, the cost to individuals on a personal and professional level, as well as the cost to the ongoing reputation of an NHS Trust which has struggled considerably, over many years, with aspects of governance and care quality.

1.9 Concerns started to be raised by the whistleblower in particular and were based upon a belief that sub-standard care was being delivered by another Consultant. The reporting of these concerns increased over time but created an imbalance in the data as reporting became targeted at specific individuals. There was basis to many of the concerns, however, some went on to be misreported or reported in a reductive way over time. This led to an imbalance of views forming and increasing adversity between the whistleblower and his colleagues.

1.10 The organisation did not always respond to the concerns raised with interventions which were decisive, validatory or equitable. Allegations of discrimination and racism were an additional (sometimes resultant) complicating factor and concerns, ill feeling and poor behaviours were allowed to escalate over time to an intractable level.

1.11 The legacy of past failings may have had an unstated influence on how the Trust handled the emerging problems within this department. Particularly, that they had previously been criticised for the way that staff had not been enabled to speak out on matters of care quality and bullying (Kirkup et al. 2015 report) due to inter-professional and hierarchical jealousies. This report directly, in our view, challenged the organisation's ability to have difficult conversations around race, as well as handling and validating concerns raised by staff. Additionally, the organisation had (and has) a very complicated geographical operating agenda. Reputation management, with an emphasis on positive news, would appear to have been a factor for this organisation, which has spent a large part of the last decade in quality turnaround, enhanced monitoring and under the media spotlight. The organisation has had a difficult balance to manage between inaction and overreaction.

1.12 A tendency by the organisation to apply measured, incremental, but ultimately ineffective approaches in response to concerns in Urology led eventually to one

4.28 Key relationships for the Responsible Officer at Executive Board level will be with the Chief Executive, Director of Human Resources and Director of Nursing or their equivalents. Within the organisation, the Responsible Officer will relate closely to the organisation's medical management, appraisal and clinical governance infrastructure.

Consultant self-publishing a whistleblowing book. Some of the cases raised in this book were based on justifiable concerns, indeed, even a single case as described could justify a concern being raised. However, this independent investigation has found that the book was based on an inaccurate version of the facts in over half of the cases described.

1.13 Some cases have been reported both internally and externally as 'true facts' and have been used in a variety of key settings including at the Trust, at Coroner's Court, with the General Medical Council (GMC), at employment tribunal and ultimately, and extensively, in the media. The use of identifiable patient information on some occasions in these settings, requires reflection to understand how patients and families can be protected from such unexpected disclosures in future. In this case, it took several years for the dysfunction to play out (indeed, it is still being played out in the media). Viewpoints have become polarised and subjective; reduced to 'good' and 'bad'. Behaviours have become partisan and even bereaved families have been drawn into 'personal' and 'political' matters, which has perhaps been one of the more concerning aspects of this investigation.

The formation of public views

1.14 Of concern is some of the rhetoric surrounding public reporting. Three 'Asian' doctors have been repeatedly identified in the media, on occasion referred to collectively as 'foreigners'; and have become the subjects of a local media panic. Their race has frequently been referred to as a factor, either as a determinant or, at the least, as worth attention and this is concerning.

1.15 It was undoubtedly the job of the Trust to ensure that valid, reliable and independently assessed information was used as the baseline for all onward action. Failing to do this has meant that individual Consultants have been vilified in public - extensively in local media - but also in national and global media, where they had no public right of reply unless they too engaged the media in a campaign. The Trust did make some efforts to investigate cases, however, investigations and reviews were not of sufficient quality or scope and were ultimately unable to form a definitive and penetrating view. This allowed the distillation of individual and subjective viewpoints to develop. The Trust, to this day, has not been apprised of the full events in some of the cases and in consequence key officers were unable to provide a correct version of events in response to enquiries.

1.16 This is particularly manifest in the index case (which is a case we have reviewed in detail as part of this investigation) where the publicly available version of events is neither an accurate nor a complete reflection of the actions of all the individuals involved. This has led to discriminatory, adverse and disproportionate consequences for some Consultants but not for others who were equally involved. The failure to get to the facts of the case suggested an environment where individuals can express their views without any accountability and with no mechanism to stop inappropriate messaging from evolving into a media campaign.

1.17 Additionally, there were system issues that contributed significantly to the challenges. These include the competitive career and development path for Consultants within this department, the development of territorialism in clinical workload, and the limited opportunities for developing new surgical techniques and specialisms. The geographical challenges of retaining emergency services on two sites also required significant regular travel. It introduced inequity in distribution of workload and travel. Private work incentivised the wrong behaviours at times and,

additionally the operational practice of ‘pooling’ patients crystallised existing workplace fractures.

Governance issues

1.18 A governance system with no clear reporting line of sight from specialty level to the Board has ultimately meant inadequate oversight of these issues and performance and has negatively impacted on patient safety.

1.19 A series of weaknesses in medical management has resulted in a ‘Swiss cheese effect’ whereby systems designed to support and manage medical staff have failed to effectively address the dysfunction in the team.

1.20 Regulators (the CQC, the GMC and NHS England[5]) jointly had opportunities to respond at earlier stages to emerging statements about the service. The Care Quality Commission (CQC) received identifiable information but were unable to share specific details having been asked to keep it anonymous and to protect the identity of the individual concerned. NHS England, when contacted, did not respond to concerns of whistleblowing when approached through the Chief Executive’s office. When GMC processes were involved, some cases were protracted in the extreme and focussed only on individual Consultants’ involvement in relation to individual events, which contributed to the ongoing mistrust and relationship difficulties by not examining the wider dysfunctional issues at play that affected individual performance. A multitude of commissioning reorganisations contributed to a lack of focus at sub-specialty level and insufficient processes for assurance on the quality of Urology services.

1.21 There are serious questions which the NHS, its regulators and professional bodies must ask in relation to the challenge of ensuring that information in the public domain, including whistleblowing concerns, is accurate and reliable so as not to allow the potential for the process of whistleblowing to become weaponised. The subject of whistleblowing is deeply problematic for the NHS and efforts, in all good faith, to ensure a culture of openness and accountability might well have left the Trust hidebound and unable to deal with allegations without being seen as behaving in a persecutory manner themselves; this is an uncomfortable truth that may be applicable more widely.

1.22 There is, of course, evidence to support the view that some whistleblowers and those reporting under the PIDA (1998) have been disadvantaged in the NHS and public sector; it is clear that a number of staff in this case may have also been impacted by the concerns and the manner in which they have been raised and addressed. Whistleblowing must not be seen as an end in itself; indeed, the very act of whistleblowing should only ever be utilised as a last-line of defence as the first-line defence should always be organisations who are supported to have an open reporting and learning culture. More should be done nationally to enable these mechanisms of governance to work effectively long before whistleblowing occurs but, when it does, significantly more work must be done to support this process if it is to offer any form of reliable resolution for all parties. Reforms might include ensuring a fully independent investigation of significant and material whistleblowing concerns from the outset.

[5] 15 Improvement aligned and then merged between 2019 and 2020

1.23 In this case, what started out as attempts by the whistleblower at raising concerns became a deeply traumatic experience and one which has had a significant and stressful impact on all involved. This trauma, combined with uncertain handling of behaviours in the team by the Trust (including through the application of appraisal/revalidation and MHPS[6] processes), may have contributed to subsequent attempts at trying to validate the facts being alleged as 'persecutory', 'victimising' or engaging in a 'witch-hunt'. This includes this independent investigation where, at times, there has been a vociferous rejection of any emerging views which do not concur with individual views or 'facts' previously expressed. This is almost certainly because of the total cumulative breakdown of trust between parties and a total lack of confidence in good-handling and impartiality.

1.24 This case provides every single justification for the NHS to ensure that accurate insights are gained, and that firm and decisive interventions are made when concerns (whether they be whistleblowing or not) are raised. This might involve difficult conversations about race and culture and indeed, in some cases, might challenge the essence of clinical approaches and even professional hubris.

1.25 In our view, the root cause of the polarity in the team was the failure at all levels to investigate issues and allegations robustly. This included difficulties experienced by regulators and commissioners in seeking definitive responses (partly through reliance on information provided by the Trust, partly through reassurance (not assurance) from the activity of other external parties, and partly through the limited remit or application of their powers). This resulted in patients and staff being impacted and distressed through inaccurate information being provided on numerous occasions. Fundamentally, this has prevented service improvement.

1.26 This root cause was the key factor that led to confused responses in relation to concerns being raised over the years. There is a distinct lack of clarity as to when a concern was adequately addressed when raised or not, when concerns became protected disclosures and whether whistleblowing became justified. A failure to follow Trust policy as regards incident reporting, grievance management and raising concerns/Freedom to Speak Up (FTSU) and whistleblowing contributed directly to the sequence of events which led to this investigation.

1.27 We hope that this investigation will definitively support the process of resolution and, in the work undertaken by the independent team across the lifespan of this investigation, that where improvements to governance and clinical practice are required, that these will be implemented and sustained, not only within this Trust but across the NHS.

Niche Health and Social Care Consulting

November 2021

[6] MHPS - Maintaining High Professional Standards 2005
https://webarchive.nationalarchives.gov.uk/ukgwa/20130123204228/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4103586

2. Introduction

2.1 The main purpose of an independent investigation is to ensure that serious and catastrophic incidents can be investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services can be made. The underlying aim is to identify common risks and opportunities to improve patient safety and to make recommendations for organisational and system learning.

2.2 This report sets out a lot of numbers and references. We are acutely aware in anonymising this public report that each number and reference represents a patient or loved one. We offer our sincere sympathy and condolences to all patients and families affected by this report. We would like to express our thanks for their helpful participation, directly or indirectly, in this investigation.

2.3 We would like to express our thanks to the NHS staff and other health professionals who assisted us during our fieldwork with openness, candour, and a willingness to learn and improve. We hope that the recommendations from this case are diligently enforced and monitored through the Trust Board and the NHS more widely and used to underpin improvements in both patient safety and the working environment of its employees.

2.4 We are very grateful for the support provided to the investigation by the Trust, the Clinical Commissioning Groups, the Royal College of Surgeons, the Care Quality Commission and the General Medical Council and acknowledge the significant effort and diligent attention of staff involved particularly at a time impacted by the national pandemic.

Background to the investigation

2.5 Niche Health & Social Care Consulting Ltd (Niche) were commissioned by NHS England and NHS Improvement in November 2019 to carry out an independent investigation into Urology services at University Hospitals of Morecambe Bay NHS Foundation Trust (the Trust). This arose from a request for support by the Trust following internal and public concerns, media attention and the publication of a book *Whistle in the Wind*. Niche is a consultancy company specialising in patient safety investigations and reviews.

Scope

2.6 The scope of the investigation was developed through a detailed first phase involving over 60 interviews with current staff, previous staff, a journalist, several patients, and a wide range of relevant stakeholders. This provided a free-ranging and open opportunity for interviewees to raise any concern or to provide a view to inform the wider scope.

2.7 We undertook a survey of GPs across the two Clinical Commissioning Groups (CCGs) involved in commissioning services, a separate survey of over 700 Trust staff involved directly or closely with the current provision of Urology services (with a response rate of 35%) and a high-level document review of key reports relating directly to Urology including the Royal College of Surgeons' (RCS) Invited Service Review report published in January 2016. We were approached directly by individuals with perspectives of their experiences of the Trust.

2.8 The Terms of Reference were published following this exercise on 27 May 2020 on the Trust's website. They are included in Appendix 1 of this report.

Approach and methodology

2.9 A review of this nature can take an extended amount of time. We agreed with NHS England and NHS Improvement, as commissioners of the investigation, to provide an assessment of whether services were currently safe in the early part of our investigation. We therefore provided an early assessment of the controls currently operating in the Trust as regards to Urology provision. We also undertook an on-site assessment of the care of patients through a current case records review. On completion, these interim reports were provided confidentially to NHS England and NHS Improvement and to the Trust to provide early insight into any immediate changes required to current governance controls or improvements needed in patient care.

2.10 The Current Controls Assessment Report was provided in final draft in October 2020. The Current Case Review Report, involving a review of 138 cases cared for during August and September 2020, was provided in final draft in March 2021. In December 2020 we provided the Trust with a draft quantitative analysis of key data to underpin the findings of this report. This has been updated subsequently.

2.11 On being commissioned by NHS England and NHS Improvement, the wider investigation commenced with an expectation that 29 cases identified in the published book needed to be considered and would form the cases of interest. We requested the investigation reports for these patients and for any other case subject to an investigation.

2.12 One case in particular required a full forensic investigation, and this case forms the index case. The key findings of this case are included in this report, but the full report will remain private and confidential (due to its personal nature).

2.13 Through our document and data review the cases of interest list grew. The additional cases identified were drawn from an analysis of clinical procedures, incident lists, root cause analysis (RCA) investigations, serious incident (SI) documentation, claims against the Trust, Parliamentary Health Service Ombudsman (PHSO) investigations, mortality reviews, complaints, internal concern reports, cases brought directly to our attention by patients, staff or other individuals and cases arising from our review of a wide range of documents.

2.14 The number of cases of interest to the investigation has therefore grown to 523 cases (nine could not be linked to individual patients and three did not identify any issues of note). We have not investigated all these cases exhaustively, but we have examined the relevant documentation provided in each case, including some case notes, to draw together the themes presenting over the last two decades. The anonymised summaries of our patient case reviews have been provided to NHS England and NHS Improvement and to the Trust as the evidence base for our clinical and governance related findings and to support onward action.

2.15 In specific cases, we drew any immediate concerns to the attention of the Trust. We worked with the Trust to develop and regularly share with them our master list of cases of interest to support the provision of appropriate and relevant documentation for review and to enable the Trust to act where required. As our review developed, we shared insights into emerging themes when we considered this was appropriate.

2.16 We requested an extensive list of documentation. The subsequent information set provided for the investigation from all parties extended to over 26,000 documents (several million pages of information and data). The information was logged using

MS Teams by the Trust using unique referencing and was directly accessed by the investigating team. The information set is too extensive to detail in this report and archiving arrangements will be agreed with the Trust.

2.17 An investigation of this type by its nature is significantly more forensic than other investigation types in searching for information, communications, records and data to support a fair and balanced assessment. The Trust made every endeavour to respond to significant requests for data not typically used in day to day operations. We requested a substantial amount of email evidence including onward communications throughout our investigation. In particular, this approach identified new information in relation to the index case through email evidence that meant that a more accurate version of events in this difficult case came to light.

2.18 Some of this evidence has been rejected by the whistleblower as ‘fake’. In order to assure ourselves of the reliability of all the email evidence collated we commissioned two independent forensic IT consultancy teams to provide an assessment of the IT and cyber security environment of the Trust and therefore the probity of the email evidence. They concluded that there was no evidence to indicate that emails could not be relied upon for the purposes of this investigation.

2.19 We are aware that this matter was referred to the police by the whistleblower via Action Fraud. However, we understand the case has now been closed. It is our view that this issue is indicative of the mistrust between parties that has been built up and sustained over time.

2.20 We interviewed, met and spoke with over 120 people either as part of the scoping of the review, the investigation into the index case, during our on-site case review, as part of the Current Controls Assessment Report or to inform our wider findings. Board members were interviewed in relation to their roles as were some previous Board incumbents. In addition, current and previous relevant Board incumbents were provided with the opportunity to comment on our draft findings through the factual accuracy processes applied in finalising this investigation. We have spoken with all Consultant Urologists employed at the Trust and other key members of the current and previous Urology team. We met with past and present governors and spoke with individual staff who wished to make themselves known to the team. We received a small amount of anonymous information. We spoke directly with ten patients or families about their specific cases.

3. Key Findings

Context

3.1 University Hospitals of Morecambe Bay NHS Foundation Trust provides Urology services across a catchment area covering Morecambe Bay and parts of Cumbria. Services are provided from three main sites: Furness General Hospital (FGH), Royal Lancaster Infirmary (RLI) and Westmorland General Hospital (WGH). Core Urology services have been delivered in the following locations since April 2013:

- day case and elective surgery at RLI, FGH and WGH; and
- outpatient clinics at RLI, FGH, WGH, Queen Victoria Hospital and Ulverston.

3.2 Urology services are part of a network for the provision of cancer services through a Cancer Alliance covering Lancashire and South Cumbria. In line with National Institute for Clinical Excellence (NICE) guidance[7], defined complex urological cancer cases should be referred to a specialist cancer centre. Local multidisciplinary teams[8] (MDTs) work with network MDTs[9] to make decisions about the best treatment options for individual patients.

3.3 In 2000, the Trust provided a wide range of minor and major procedures in relation to Urology care. It was a high performing team and they introduced the One Stop Clinic model as the service was keen to extend its reach over a wider geographical area. By 2008 the team was recognised in an award for innovations such as pooled waiting lists and rapid diagnostic clinics. Over time, however, more specialist procedures became centralised, as was the focus across the NHS, to ensure that these procedures were conducted with the appropriate level of skill and expertise. Alongside this, further development of the National Cancer Plan resulted in the formation of networks to ensure that clinicians worked in alliance to provide access to aspects of care in the most appropriate setting.

3.4 Whilst introduced in 2005 by the Cancer Plan, from around 2009 the changes resulted in the shift of most major procedures being conducted away from the Trust and, at present, the Trust Urology service provides routine cancer care in conjunction with East Lancashire Hospitals NHS Trust (ELHT) and Lancashire Teaching Hospitals NHS Foundation Trust (LTHFT). All specialist procedures (radical prostatectomy, cystectomy, partial/radical nephrectomy and nephro-ureterectomy) are referred to ELHT (Blackburn) with radiotherapy provided at the Royal Preston Hospital (LTHFT). The Christie NHS Foundation Trust receives penile cancer referrals.

3.5 Centralisation of complex Urology has increasingly deskilled the team at the Trust. Appropriately, more complex surgery and cases are undertaken in other centres in line with national approaches. The team need close working relationships with tertiary referral centres to ensure patients are referred promptly and when they are discharged from tertiary centres that there is ongoing dialogue to facilitate high-quality active surveillance and monitoring.

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[7] https://pathways.nice.org.uk/pathways/bladder-cancer/managing-muscle-invasive-bladder-cancer

[8] Local MDTs are hospital service based multidisciplinary teams organised by cancer site which discuss and decide on treatment options

[9] Network MDTs are Cancer Alliance based multidisciplinary teams organised by cancer site which discuss and decide on treatment options when cases are referred from Local MDTs.

3.6 There were attempts by Consultant Urologists to introduce a lead for each cancer type within the Urology department in 2015. This was resisted by some and never revisited. This has been detrimental by not facilitating an element of responsibility and accountability/authority levels for engaging across the team for specific pathways.

3.7 The development of sub-specialties would be an appropriate approach to building on clinical interests, attracting new Consultants and providing an element of specialism appropriate to the needs of the population supporting a core Urology and diagnostic cancer service.

Key data

3.8 The Urology service provides care in relation to one in four cancers (27%) in the region which relate to the bladder, prostate and kidneys. Three in four patients are male. There is a significantly higher prevalence of bladder and renal cancers for males and females in this area than the England average. Prostate and testicular cancer prevalence is also slightly above average.

3.9 The service income is stable at between £6m and £7m per year and is provided through lead commissioners at Morecambe Bay Clinical Commissioning Group (CCG). The service is loss-making in that it costs more to deliver than the income available. There are no dedicated Urology beds; instead they form part of the surgical bed base at both FGH and RLI. This adds to the lack of profile of Urology provision and impacts on the alignment of nursing resource and skills to support it.

3.10 Urology demand rose steadily between 2000–2008 but largely stabilised from then onwards in respect of new patients, outpatient activity, GP referrals and procedures conducted. Emergency work rose year-on-year and now accounts for an average of 10 referrals through the Emergency Departments per week. The average length of stay has reduced markedly in the last 20 years largely due to less complex work being undertaken and the introduction of day case activity.

3.11 Theatre activity is based around core urological procedures involving inserting and changing stents, undertaking diagnostic biopsies and resections of tumours of the bladder and prostate. A small amount of more specialist work involves paediatric cases which is mainly orchidopexy[10] (Urologists undertake emergency paediatric cases where necessary; elective paediatric cases are currently attended to by General Surgeons), some Andrology[11] and, until recently, nephrectomies (which largely stopped at the Trust in 2017).

3.12 Cancer waiting times are key for this service but have been deteriorating. Since the introduction of these standards in 2015 there have been increasing breaches of both 62 and 104 day referral to treatment targets. Urology has been the predominant specialty in the Trust for these target breaches, in particular for prostate cancer.

3.13 Emergency theatre activity involves between 200–220 cases per year (four cases per week). Most of this emergency work is completed outside of normal working

[10] Orchidopexy - the removal of a testicle that has not descended or moved down into the scrotum. Usually required where the testicle has not descended by eight months of age.
[11] A medical specialty which deals with the male reproductive system and urological problems found only in men. It is the direct male equivalent of gynaecology.

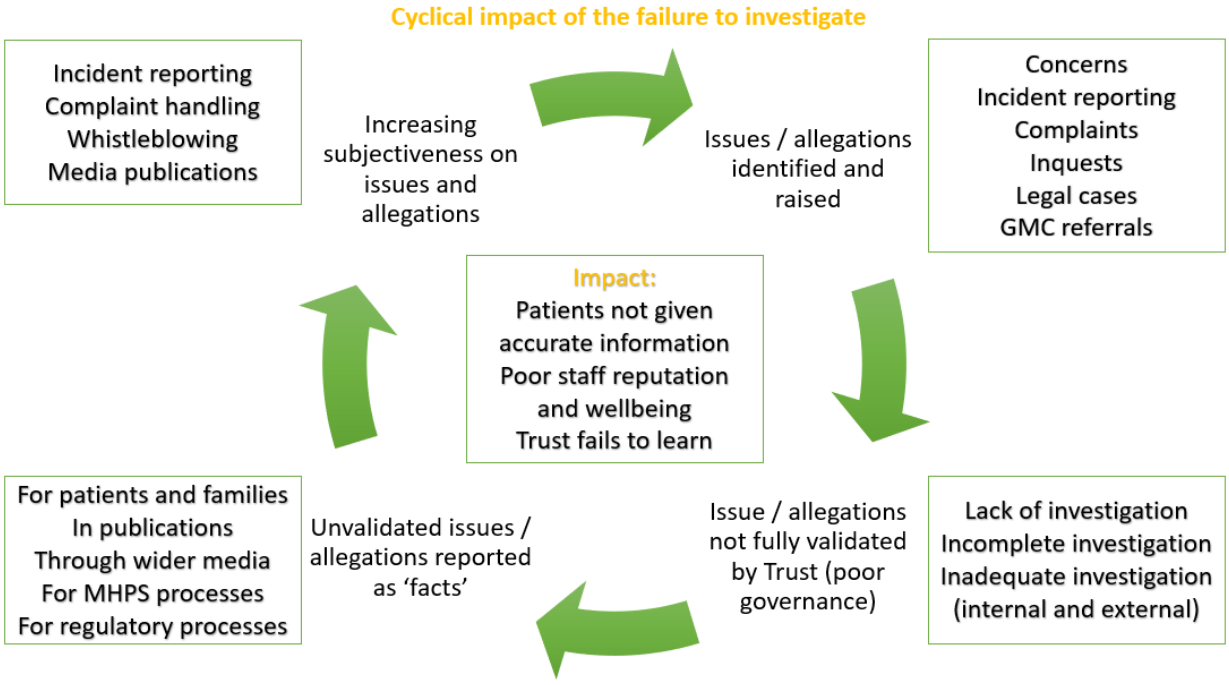
hours due to difficulties accessing theatre space in normal hours. An increasing proportion of this work is being carried out by locum staff.

3.14 Over the period covered by this investigation there has been a steady increase in the medical and clinical nurse specialist resource recruited to Urology. The Consultant body increased from three to seven whole time equivalents by 2016. There are now six (including a Locum) Consultant Urologists in post as of 2021. This remains above the British Association of Urological Surgeons (BAUS) recommended numbers for the population. The impact of the increase in this resource was eroded by periods of absence and restricted practice amongst the Consultant staff. Capacity and demand planning has been weak, and backlogs of patients have developed. In order to respond to the increasing backlog, additional activity sessions (AASs) have been undertaken by Consultant Urologists and senior medical staff. There were approximately 580 AASs during 2019/20 (averaging 10 sessions per week) adding additional costs to the service. Urologists incurred greater additional cost to the Trust through AASs than the rest of the surgical body. Urologists also appear at the higher end of Consultant pay over each of the last seven years.

The root cause underlying the development of concerns in Urology

3.15 The diagram below shows how the root cause of the polarity in the team was the inability at all levels to investigate issues and allegations robustly. This included regulators and commissioners and resulted in patients and staff being impacted and distressed through inaccurate information being provided on numerous occasions. Fundamentally, this has prevented service improvement.

Diagram 1 - Cyclical impact of the failure to investigate



3.16 This root cause was the key factor that led to confused responses in relation to concerns being raised over the years. There is a distinct lack of clarity as to whether concerns were adequately addressed when raised or not, when concerns became protected disclosures and whether whistleblowing became justified. A failure to follow Trust policy as regards incident reporting, grievance management

and raising concerns/FTSU and whistleblowing contributed directly to the sequence of events which led to this investigation.

A dysfunctional team

3.17 Problematic relationships started between the Clinical Lead and the newly appointed Consultants in 2000. From the mid-2000s difficulties between Consultants, partly driven by private practice, partly through concerns over competency and partly from personality clashes, began to take its toll. Periods of stress, poor health and wellbeing, compounded by individual restricted practice, all contributed to a cycle of increasing stress, demand and capacity concerns.

3.18 The significant problems that some of the individuals in the Urology team have had in working together over the last 20 years is an underlying cause of the patient safety related findings in this report. The failure to robustly manage the relationships, the lack of effective reporting processes and the limited investigation of concerns raised has had a lasting effect on team function, professional engagement and the tolerance of poor behaviours.

3.19 A key difficulty that was not addressed was the increased pressure experienced by individuals and the way this manifested in their behaviours and impacted on the team. Not addressing the stress and wellbeing of some staff and continuing to tolerate the behaviours demonstrated, however extreme, meant that the root causes of these manifestations were not fully acknowledged despite being articulated. This alongside other key failings directly resulted in whistleblowing allegations and wide ranging consequences for all involved.

3.20 A fundamental failure to respond to concerns of discrimination is also a key failing throughout. Multiple microaggressions, biased reporting and, at times, unsubstantiated allegations have sustained a perception of discrimination and racial undertones. The tensions eventually led the Urology team to become divided along ethnic lines. In the words of one previous executive this was a '*boil that needed lancing*' or in the words of another '*not just a boil but a huge operation'*.

3.21 There were undoubtedly failures to act competently and professionally at times by several Consultants. There is evidence of harms and near misses through some procedures being conducted or not conducted as well as poor clinical decision-making. However, the way concerns were raised, managed, investigated and audited enabled similar poor governance processes to become the norm within the department and left inappropriate behaviours unchallenged.

3.22 Whilst concerns were being raised in respect to patient safety issues, at times the way in which these were reported became bipartisan, inappropriate and were not in line with Trust policy. Some incidents that should have been reported were not.

3.23 Conflict between staff which was poorly managed in the past left a legacy of ongoing mistrust which will need to be finally and completely resolved if this is to become a sustained, effective team.

2014 - a pinnacle year

3.24 2014 was the pinnacle year whereby a crescendo was reached in the environment, in relationships, and in the context of the organisation within which the Urology team were working. This environment contributed directly to the failings in the index case described in our interim reporting and other harms identified in this report.

3.25 Individual inappropriate behaviours and difficulties in relationships had become extreme. The long-term nature of the 'noise' in Urology reached the relatively new Executive team early in that year.

3.26 The intervention of the Executive Directors Group (EDG) came in commissioning 'Impact - Psychology for Business' (Impact), an established consulting firm, to work with the multidisciplinary team in June 2014. This was an opportunity for change but the subsequent failure of individual senior Urology clinicians to respond to this direct and supportive intervention is of considerable concern and was a key missed opportunity to ameliorate the dysfunction.

3.27 Even as Impact sought to identify the concerns through confidential interviews and develop codes of conduct and rules for professional behaviour within the team, individual members continued to brief against each other. Inaccurate incident reporting and expressions of discrimination continued behind the scenes which undermined the attempts to bring the team together. Whilst there were genuinely held views to support incident reports, the content of email communications and claims of discrimination, the resulting investigations were weak and lacked transparency which enabled mistrust to continue unabated. Human resource (HR) processes largely failed to effectively manage grievance processes and concerns of discrimination.

3.28 The index case we have investigated in detail developed over this timescale and it is our view that by the time of the inquest in mid-2015 the underlying maelstrom affected the accuracy of reporting and oversight. This has directly led to years of difficulty in seeking the definitive picture of what went wrong in this case and the inability to resolve and learn from other critical incidents.

3.29 During 2014 other key cases were reported which were not adequately investigated and remain, even now, inaccurately narrated.

Impact of dysfunction on others

3.30 Whilst this report focuses largely on the medical aspects of Urology it must be recognised that the dysfunction at this level has had an impact on nursing staff and other team members.

3.31 Junior doctor support is not dedicated to Urology and is shared with General Surgery. A history of the difficulties of junior doctor training arrangements described by a prior Medical Director is summarised in the footnote below[12]. We have repeatedly seen through medical records the challenges junior doctors have

[12] Whilst major teaching hospitals have had a fully staffed Urology department providing emergency and elective care for 40 years or more, it is only in the past 20-25 years that many other hospitals offering emergency urological care have had sub-specialisation in Urology. Prior to this, varying levels of urological care were offered by general surgeons in a District General Hospital and as and when a Consultant Urologist was appointed, local arrangements were made for emergency admissions. This was required because a consultant appointment was seldom, if ever, accompanied by the concurrent appointment of the numbers of junior staff in Urology required to provide a dedicated team delivering both elective and emergency urological care. A common arrangement was for the junior surgical team on call to assess and manage admissions overnight referring to the Consultant Surgeon or Consultant Urologist on call as appropriate, with handover to the Consultant Urologist(s) as soon as possible thereafter. Since about 2000, the exposure to formal urological surgery during training by general surgeons has dwindled and [so some] have declined to accept responsibility for any emergency urological admissions as a consultant. In units such as UHMBT where there will be no higher specialist trainees in Urology, this poses a major problem, which is highlighted by the review. A junior staff emergency rota for Urology that is working time compliant would require [six] junior doctors and have cover for holidays and other absences, […] Focusing both in-patient Urology and emergency admissions for Urology on a single site, with a dedicated specialty bed allocation, would seem to provide an opportunity that would go a long way towards giving a structural and geographical focus to the specialty, that might improve training opportunities for specialty doctors..[…].

faced in accessing, liaising with and carrying out the instructions of senior colleagues.

3.32 The role of the Clinical Nurse Specialist has developed over the last 20 years with recruitment into this role. We have observed an element of bipartisan behaviour develop in this group (and amongst other nursing staff in theatres and on wards) along the same Consultant divisions described in this report. This has impacted the relationships individual Consultants have had with the wider team including potentially exacerbating some behaviours; for example, undermining colleagues by reporting back to other Consultants on concerns instead of using the incident reporting system. This has given the impression of 'eyes and ears' being directed towards the performance of a small number of Consultants and resultant reporting, in particular, in respect of attitudes.

3.33 Administrative staff have also taken the brunt of poor clinical working. We have observed medical secretaries being blamed for failures whilst dealing with new systems. There has also been a lack of dedicated Urology administrative resource and failures of systems like dictation for letters and dependence on fax machines for referrals.

Outcomes and harms

3.34 We cannot conclude that patients were safe within the Urology service at all times in the last 20 years. There were clearly incidents that point to significant harms, but the reporting systems and monitoring of harms means that a definitive picture cannot be secured. National comparative data does not provide an insight into patient safety within the specialty. We have, however, identified 520 cases where actual or potential harm occurred. A key concern is the combined failure to consistently report and robustly investigate patient safety incidents and concerns as they arose, through whichever source these were identified. This has directly led to the Trust not fully understanding the totality of events at this sub-specialty level. Equally this is the case in individual cases which in turn has meant that the Trust have been unable to confidently respond to the repeated allegations being asserted in a range of communications including the media.

3.35 We examined information in relation to 523 patients identified between 2000-2020 and reviewed a wide range of supporting documents[13]. We found that some of the cases had not been reported through the appropriate systems.

[13] These figures do not include all cases involved in either the Prostate Biopsy recall in 2005 or the Testicular Implant recall in 2015.

3.36 The table below summarises, by year, 511 of the 523[14] cases of interest.

Table 1 - Cases of interest by category 2000–2020

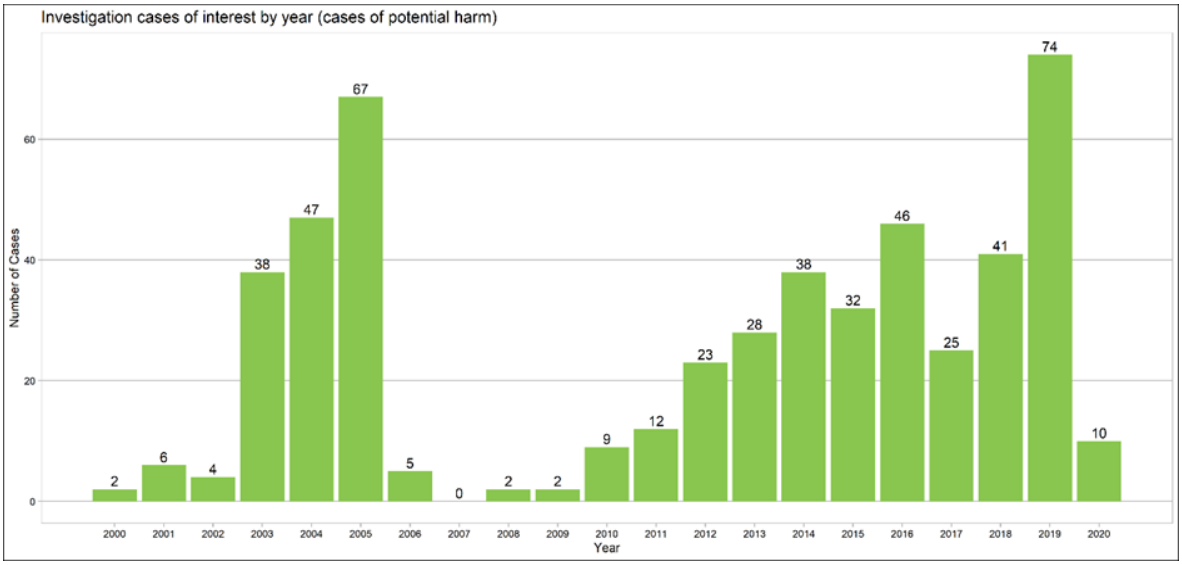
Year	Clinical Concerns	Incident only	Incidents - breach 104 days	Incidents RCA	Incidents StEIS	Never Events	Complaints	PHSO	Claims	Mortality Cases	Coroner/ Inquest	External Reviews	Other	Total
2000	0	0	0	0	0	0	0	0	0	0	1	1	0	2
2001	1	0	0	0	0	0	2	0	0	0	1	0	2	5
2002	1	0	0	0	0	0	2	0	0	0	0	0	1	3
2003	21	0	0	0	0	0	15	0	2	0	0	0	0	17
2004	38	0	0	0	1	0	3	0	5	0	0	0	0	9
2005	63	0	0	0	0	0	1	0	3	0	0	0	0	4
2006	2	0	0	0	0	0	1	0	2	0	0	0	0	3
2007	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2008	0	1	0	0	0	0	0	0	1	0	0	0	0	2
2009	0	0	0	0	0	0	0	0	2	0	0	0	0	2
2010	0	5	0	0	0	0	1	1	1	0	0	1	0	9
2011	0	1	0	1	1	0	0	1	1	0	1	1	5	12
2012	0	7	0	1	0	0	1	0	6	0	0	5	3	23
2013	0	11	0	1	1	1	1	0	3	0	1	8	1	28
2014	1	8	0	5	3	1	2	1	6	2	0	6	3	37
2015	0	12	0	6	1	0	1	0	5	3	1	0	3	32
2016	0	22	0	10	2	1	0	0	3	4	0	1	3	46
2017	0	14	0	1	5	1	0	1	1	1	0	0	1	25
2018	0	10	10	2	7	0	1	0	6	0	0	0	5	41
2019	0	21	15	8	10	1	10	0	6	0	0	0	3	74
2020	0	2	1	0	1	0	1	0	4	1	0	0	0	10
All	127	114	26	35	32	5	42	4	57	11	5	23	30	511

3.37 The table allocates a category to each case identified[15]. We view each of these as an opportunity for intervention to improve processes and pathways. Whilst some investigations did occur, many were insufficient. At times key events (Parliamentary Health Service Ombudsman (PHSO) cases, Never Events[16] and 104 day breaches) were not reported to the Board. Our view is that poor governance and ineffective investigations resulted in repeated failures to enable the Urology department to flourish and ultimately to prevent and reduce the risk of further patient harm.

3.38 We can see that the number of cases of interest mirrored the problems within the team. There were two distinct waves with a largely complete absence of events between 2007 to 2009. The lack of cases in this period could be due to a failure to report incidents, better team working or reduced clinical risk – it is not possible to establish which. The peak in 2019 is partly due to the impact of historical enquiries and an increase in contacts and complaints raised following external publicity. The graph below shows the cases of interest by year.

[14] Some cases were not considered harms once the review had taken place and others could not be identified to individual patients.
[15] Each case may sit in more than one category but we have assigned the highest level of category where appropriate e.g. PHSO is of a higher order than a complaint as it is a complaint that has resorted to resolution through the PHSO. The difference between the 523 cases reviewed and the 511 in the table is either the case could not be identified to a specific patient or was a procedure of interest that did not identify any concerns.
[16] Never Events are a set of defined events under the Serious Incident Framework that should not occur in the NHS if all procedures are correctly followed. There are specific events defined as Never Events for different healthcare settings and their occurrence is considered to be entirely preventable because guidance of safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Graph 1 - Cases of interest by year reviewed by the investigation team



3.39 There is no evidence that these events resulted in significant changes to working practices or learning that led to improvements in practice.

3.40 Key themes from our review of the above cases are summarised below.

Referral processes and timely diagnostics

3.41 The Urology service is responsive to initial cancer referrals. The One Stop Clinic model (introduced in 2006) has worked well and is largely effective in seeking early diagnosis. There were some aspects that could be improved which we identified in our Current Case Review Report but the introduction of this model was a positive development, and this has been sustained to the benefit of patients across the area.

Follow-up and review

3.42 We highlighted in our Current Case Review ongoing problems in relation to patients being followed up in a timely fashion and ensuring that patients on long-term pathways were seen within required timeframes. Too many have been lost to follow-up, were impacted by delays in diagnosis or treatment, and have suffered actual or potential harm as a result. This is closely aligned with issues in relation to a lack of continuity of care by the Consultants. These were aspects that featured strongly in the index case and directly impacted the outcome for the patient. This is mainly the situation in cases where the Urology department shares the care of a patient through tertiary referrals in more complex cases requiring care that exceeds the responsibilities of the department.

3.43 Essentially, new patients are prioritised over follow-up patients by the systems in place. The difference between how new cases are seen quickly and how existing patients experience delay may also be driven by system targets which prioritise the importance of seeing new referrals over the management of patients who are already under the care of the Trust. The balance of pathways for new patients and the need to redesign follow-up pathways to match capacity and demand is apparent.

Continuity of care

3.44 The model in Urology was of pooled care between Consultants with no named individual Consultant responsible for a given patient. If there is one aspect of care

in the Urology department that needs to change it should be a focus on the lack of continuity of care that arose from the pooled model. If this is not possible, there is a need to ensure enhanced support to administrative teams to implement and use systems and processes to help the Consultant team. There was a need for improved communication to ensure patients were seen by a consistent team and followed-up on time. This did not happen and difficulties in the team were exacerbated by having no named Consultant, poor handover and a lack of clear responsibility at a senior medical level. This includes practical arrangements such as not having a dedicated office base to facilitate team engagement.

3.45 The move to largely pooled working (although seen as an innovation on introduction) has resulted in patients being seen by many different team members with individuals delivering care at a given point in time but with nobody taking overall responsibility for resolving the patients' issues. Multiple cases show the entire team being involved throughout a given patient's care. In the context of the team dysfunction, poor handover and communication this has been to the detriment of patient care. This is less a concern if patients follow short well-defined pathways (i.e. haematuria referral) but if they have unusual results or the diagnosis is unclear or the treatment options are complicated it is not understood who is responsible for resolving the issues and there has been delay and obfuscation in many cases.

3.46 In other units with a team approach it is the named (specialist) nurse who directs care and advocates on behalf of the patient. Despite using multidisciplinary notes it is very difficult to see the effective input of the specialist nurses throughout our review. We do not doubt the important and central role played by the specialist nurses, but they need to be supported, their role made more visible and developed further by both the clinicians and the Trust.

3.47 We identified a range of further consequences and system risks for patients perpetuated by the team issues explained above. We describe these in more detail in section 8. These are:

- procedural complications in relation to stenting, cystoscopy and bladder perforation;
- emergency surgery being conducted predominantly out of hours;
- divisive on call arrangements across a wide geography;
- poor documentation and consenting practice;
- pathway problems leading to delayed care and treatment;
- handover problems;
- failure of MDT processes; and
- long waiting times and delays in making tertiary referrals.

Management support and clinical leadership

3.48 The role of the Urology Clinical Lead is significant as described in the extensive job description covering a wide range of responsibilities. In reality, it is required to be performed alongside a full-time clinical responsibility which sets unrealistic expectations even in normal circumstances. The Urology Clinical Leads did not receive sufficient support and guidance from HR, the Responsible Officer or the Medical Directors in handling extremely difficult personnel issues. Whilst some

conflict resolution training was provided and two Clinical Leads were able to access an NHS Leadership course (one in 2017), these were too late in the day. Other leadership programmes have since been made available from August 2018 but were paused due to Covid-19.

3.49 Management support to Clinical Leads has been weak. Clinical Leads have been expected to manage highly complex tensions in a poorly functioning department without a dedicated and consistent Urology Clinical Service Manager until 2018. A maximum of a day per week was an inadequate time allocation for the incumbent to address, with any degree of rigour, the lack of systems and processes within the department and to manage senior clinicians.

3.50 The Clinical Leads were themselves, at times, the subjects of investigations, grievances, or accusations. This was complicated by the personal allegiances that influenced professional relationships potentially compromising or complicating their actions or decisions. These relationships were also seen to interfere with fair process and gave rise to perceptions of bias. Given the Clinical Leads from 2003–2016 were in this position and had stronger personal and professional alliances and relationships with some members of the team than with others, this left clinical leadership impotent. This impacted their ability to address individual concerns especially when this involved very difficult subjects relating to accusations of discrimination, racism and differential treatment.

3.51 An expectation of the role is to 'foster a culture that values respect, teamwork and excellence in all aspects of the delivery of patient care'.

3.52 However, clinical leadership failed partly due to the lack of recognition of the personal allegiances between incumbents over 13 years and the perceived conflict of interest this created. This is particularly the case as the line management function could not reasonably and objectively be delivered. It was a clear responsibility to harness effective team working and whilst Consultant Urologist 5 acted appropriately and in a balanced manner, perceptions of bias undermined his intent. This individual was pulled in two directions as clearly evidenced by a request not to be a witness in an employment tribunal against his colleague, whilst also having to address the accusations of discrimination from other colleagues directed at the team.

3.53 The role of the Responsible Officer (RO) is to be accountable for the local clinical governance processes in a Trust focusing on the conduct and performance of doctors. Duties include evaluating a doctor's fitness to practice and liaising with the GMC over relevant procedures[17]. Medical Director 3 was appointed as RO for the Trust in 2011. On appointment of new Medical Directors between 2012 and 2020, the RO role and duties were retained by the previous Medical Director 3. However, we can see no evidence that this decision was formally approved, recorded or revisited by the Board after the initial decision to appoint to the RO role was made in 2011.

3.54 This was an important role but the responsibilities from 2012 were internally and informally divided between the appointed RO and the Medical Directors. This meant that there was restricted oversight of Consultants' conduct and performance

[17] https://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/06/ro-guidance-draft.pdf and https://www.england.nhs.uk/medical-revalidation/ro/ro-faqs/

as information was not all held in one place. Between them, the RO and Medical Directors were aware of the extent of dysfunction in the Urology team but failed to objectively assess the need for decisive intervention. This was partly due to the informal separation of duties, in that the RO took responsibility for Appraisal and Revalidation processes and Fitness to Practice/GMC referrals, with the Medical Directors leading MHPS (internal investigation) processes. This resulted in some aspects of the regulations not being effectively delivered. In particular, the RO guidance[18] specifies that the RO has a duty to investigate the causes of concerns about a doctor's performance, and where necessary, to initiate action to address wider systems or team issues that result in poor performance. No one took responsibility for this through these arrangements.

3.55 We also understand that access to the Board was limited to the Medical Director only (despite recommendation 6 of the Pearson Review published in January 2017[19] which highlighted the need for Board level reporting and challenge). The RO was, instead, asked to report via the Workforce Assurance Committee. In addition, not all Medical Directors in post between 2012 and 2019 had undertaken RO training[20] and despite the updated regulations in April 2013 the value of this training was missed individually and corporately. Ultimately, there was a failure by both roles to jointly reinforce GMC guidance in relation to the conduct required of doctors despite liaison with the GMC Employer Liaison Advisers. The tri-partite combined impact was ineffective in Urology.

Job planning, capacity management, AASs and appraisal

3.56 Alongside line management, job planning and appraisal are key processes for supporting Consultants to deliver their contractual obligations and reflect on the manner and competence with which they deliver their work.

3.57 Capacity management enables the service to plan and should inform job plans which should facilitate manageable workloads and reduce the need for AASs.

3.58 All these processes failed to support service delivery, hold individuals to account or identify and manage the dysfunction and the resultant consequences for individuals and the organisation.

3.59 Job planning is the contract through which line managers should manage Consultants. Job planning has been weak in Urology. Attempts to agree job plans have been resisted or have failed to be approved. There has been no demand or capacity planning to an effective level to address perceived capacity concerns, inequitable workload, and travel concerns. This has directly driven the persistence

[18] The Role of Responsible Officer, Closing the gap in Medical Regulation – Responsible Officer Guidance. Paragraph 4.21 (26 July 2010) RO guidance states in reference to Regulation 16(4)(h)(iv):
If an investigation confirms a valid concern, the root cause should also be traced. Many cases of apparent poor performance of an individual may in fact be due to a dysfunctional team or a wider organisational system. The Responsible Officer has a duty to investigate the causes of concerns about a doctor's performance, and where necessary, to initiate action to address wider systems or team issues that result in poor performance.

[19] https://www.gmc-uk.org/-/media/documents/Report_of_Sir_Keith_Pearsons_review_of_revalidation.pdf_69136669.pdf
Recommendation 6 ROs should report regularly to their board on the learning coming from revalidation and how local processes are developing. Boards should challenge their ROs as to how they are learning from best practice and how revalidation is helping to improve safety and quality.

[20] Medical Director 5 had undertaken this training in the Department of Health prior to appointment between 1 April 2013 and 31 August 2014 but evidence cannot be provided. The RO at the time had not been required to attend update courses. After the regulations were updated, the ROs were not required to attend any refresher courses and we are informed there were not any specific courses available to attend.

of AASs which has driven the cost of the service up and has been an incentive for additional pay for all concerned. As a result the service is loss-making and, despite the AASs, patients were still subject to backlogs and delays.

3.60 We address the additional cost to the service driven by AASs throughout the report. We believe the use of AASs had become endemic in the department (and also widely within the Trust) creating an expectation of additional pay and reward but which has not impacted on reducing patient backlogs and delays in follow-up care. Both clinic sessions and AASs were sometimes not full. A lack of attention to these areas of capacity management again drove further demand for AASs.

3.61 AASs were also used inappropriately to increase the reward of one Consultant when there were changes to his job plan, but this was done without appropriate approval and transparency. The confusion that subsequently arose over the signed job plan, additional programmed activities (PAs) and the use of AASs to arrive at a level of reward for a job change contributed to the difficulties experienced by the Clinical Service Manager in approving claims for AASs that did not take place. This lack of clarity and the ensuing delay in trying to understand what had happened had a direct impact on the judgement of constructive dismissal at the employment tribunal of the Consultant concerned.

3.62 The recognised geographical challenges in the Trust have not been openly acknowledged and addressed when it comes to expectations of Consultants and the fair recognition of time required to travel to direct clinical care sessions. This directly impacts on time available, has led to genuine difficulties of punctuality, additional pressures on Consultants between sessions and whilst on call as well as allegations of lack of availability during on call. There were also patient safety risks arising from travel for the provision of emergency care at FGH. These issues have been an underlying theme of clinical incident reporting and grievances between team members for many years.

3.63 Appraisal processes for the Consultants failed to appropriately escalate the stress that was clearly expressed within them. The appraisal process sits outside line management and patient safety functions as a separate professional validation exercise which is largely confidential. In this team, the recognition of the wellbeing concerns being raised during this process might have supported the identification of the extent of distress at an earlier stage and informed appropriate interventions. We regard this as similar to safeguarding processes whereby some confidential information, when patient or staff safety is at risk, requires action to be taken. There is a key opportunity to develop the appraisal process when being signed off by the Responsible Officer to identify dysfunctional teams or individual wellbeing concerns that require actions by the employer.

Medical management

3.64 There were a series of systems and processes in place to support and manage medical staff in the Trust. However, weaknesses in each of these processes has had a cumulative impact on managing the dysfunction in the Urology team. The lack of attention given by the Board to the role of the RO and lack of an explicit recognition of the role, alongside the informal division of duties with the Medical Directors has meant that the Board could not be fully assured that the regulations were being implemented effectively.

3.65 The lack of communication, at times, between the RO, Medical Directors and the Director of HR and OD has led to fragmented oversight of the myriad of issues

facing the Urology team. A cohesive plan of action could not be developed as a result as no one department had the full picture.

3.66 These limitations at Board level were compounded by departmental weaknesses including ill-defined line management, poor and inconsistent approaches to job planning, a lack of support to Clinical Leads, weaknesses in the resolution of grievances, some inadequate investigations and MHPS investigation outcomes not being shared amongst the team.

Governance and Board oversight

3.67 There are many lines of defence that apply to keep a service safe and ensure that if one line of defence fails others are there instead. The divisional and departmental management arrangements were unable to hold individual clinicians to account for their behaviours, investigate reported concerns sufficiently well, apply Trust policies and good practice or instigate change in delivery pathways. Successive Trust Boards failed to identify the impact on patients, staff and quality of service of the significant dysfunction amongst senior medical staff and the wider disquiet in the Urology team. Successive commissioners of the service also failed to focus adequately on what it was commissioning and the quality of that contract. Regulators collectively failed to comprehensively hold the Trust to account and seek robust assurance (rather than reassurance) through their own intelligence systems to ensure patients in Urology were safe, doctors held to account for their actions and staff were listened to at a sub-specialty level. The failures at all these levels resulted in patient harm, increased distress, media attention, individual and organisational reputational damage and most importantly a failure to improve services when things go wrong.

3.68 Prior to September 2019, Urology was very rarely discussed at Board or Quality Committee. It was a service which afforded very little attention from the Board. However, throughout this period all Medical Directors were aware of the tensions in the department and the various disciplinary processes that were ongoing as well as at least one Non-Executive Director, Chief Executive 1 and, later, a Chairman. However, this knowledge did not translate into a Trust level response to dealing with the consequent underperformance of the department through several Board changes.

3.69 From 2013 to 2015 the Trust was heavily distracted by the process of the maternity investigation and, thereafter, by the need to respond to external criticism following the Kirkup Report[21] and there was a strong focus on a positive narrative to demonstrate improvements as a result. We view this as a key period in which this focussed attention led to concerns about other services being missed. The desire to respond to the criticism and demonstrate improvement had an overwhelming impact on whether negative messages were heard or tolerated. Unfortunately, this was a key time in the development of the problems in Urology and the almost complete change in very senior managers and Executives at this time resulted in lost organisational memory.

3.70 The Royal College of Surgeons (RCS) Invited Service Review in 2016 was a key missed opportunity by the Trust to set the team back on track as it set out clear

[21] - https://www.gov.uk/government/news/morecambe-bay-investigation-report-published

recommendations and helpful insight. The focus of the review was to some extent constructed by the department itself to focus on specific incidents largely aimed at individuals. The drivers for the invitation to the RCS related to concerns about the team's conduct (including Consultant Urologist 2's performance) and some of the findings arising from RCA1 in the index case referenced in section 4. Whilst the Medical Directorate was involved in signing off the terms of reference, the identification of other incidents to be considered was driven by some individuals in the department more than others. The outcome did result in a detailed and helpful report for the department, however, it also resulted in a continued internal narrative that problems were the result of individual failings around specific incidents. Whilst these specific incidents were appropriate to investigate further, there was an underlying belief within the Urology team that failings rested with individuals and this impacted on the failure to implement improvement actions required by the collective team. Leaving the implementation of the actions to the oversight of the Serious Incident Requiring Investigation (SIRI) panel further enforced that view.

Board opportunities for intervention

3.71 A Trust Board cannot be sighted on all issues, all the time. However, in our view, there are four subjects that should be regularly and consistently reported to the Board. These are:

- All external reports and reviews in full.
- A detailed analysis of inpatient deaths by speciality/sub-specialty in line with Learning from Deaths guidance.
- A detailed understanding of all litigation and legal proceedings by specialty/sub-specialty.
- Employee relations reporting.

3.72 We found cases where the Board as a body had not been provided with the full reports of external reviews - including the PHSO Complaints Report in 2012 which highlighted the inadequacy of the complaints process at that time in response to concerns from four patients and the RCS Invited Service Review Urology Report in 2016. Summary presentations which provided an overly positive spin on the results were discussed but did not give insight into the full findings.

3.73 As reported in our Current Controls Assessment Report in October 2020, we remain of the view that Learning from Deaths processes as set out in the Health and Social Care Act regulations were weak at department and Trust level. Since September 2017, the Trust was required to have a policy for this and to be able to identify inpatient deaths. Whilst this was possible at a Trust level and the Medical Examiner role has now been introduced; we have not yet seen evidence of a specialty/sub-specialty focused mortality review process[22] that examines patient experience in line with Learning from Deaths guidance. A new Learning from Deaths Policy was introduced in September 2021.

3.74 We are not confident that the Trust can currently and reliably identify inpatient deaths by sub-specialty and that individual departments can be held to account for

[22] The Trust state that specialty mortality reviews have been in place since July 2021. Urology inpatient deaths remain difficult to identify although the Medical Examiner reviews all deaths.

reviewing these. In Urology this is partly due to it being a service that receives referrals from admitting specialities and not being a primary specialty. However, in the case of Urology, the small numbers involved should result in high-quality review and examination across the team. The medical examiner system was introduced within the Trust from June 2020.

3.75 Litigation claims are reported to the Board, but there was no overall analysis of these, by specialty/sub-specialty or over time. There was no evidence the Board was sighted on the number of claims in any given specialty, provided with comparative information or any sense of the timeliness or outcomes from the cases (other than where cases were settled).

3.76 There has been insufficient reporting to the Board on the extent of employee relations issues including tribunals, whistleblowing, grievances, suspensions, restricted practice and referrals to professional bodies. This has left the Board with a limited oversight of the risks that are presented to the Trust in relation to senior medical staffing difficulties. Oversight of employee relations is a weakness that the Board itself recognised during 2019 and an employee relations report was subsequently added to the rolling private Board agenda. This report seeks to give an insight into 'hotspots' at the Trust, however, there remains scope to further triangulate its content and the discussion it provokes with other signs of service risk, such as rising incident numbers and complaints.

Lack of specialty focus

3.77 The Trust and the divisional structure have not focused on the performance of this individual specialty and there is no evidence that a specialty focus formed the basis of clinical quality monitoring. Trust-wide and care group data is used at Executive and Board level, but the data has not been triangulated on a specialty or sub-specialty basis.

3.78 Whilst the care group was responsible for triangulating operational data, they failed to address sub-specialty-based issues with the responsibility falling to the Clinical Leads. Given the relationship tensions and legacy of difficulties it was insufficient to rely on this role to enact the level of improvement required in such challenging circumstances. The Urology specialty was a small sub-specialty of surgery that was overshadowed and underrepresented on agendas and given insufficient dedicated review and management support outside of the surgical grouping.

Failure to investigate adequately

3.79 The quality of investigation reports has been poor. This is particularly concerning after efforts during 2011/12 in the wake of a major incident in relation to outpatient backlogs as well as maternity services. Concerns relating to the Urology case which triggered this incident resulted in significant attention being paid to supporting the quality of the RCA report involved at that time. The recommendations also involved providing help to the Trust from the NHS North West Strategic Health Authority (SHA) to improve the standard of RCAs. However, no impact of this effort can be demonstrated.

3.80 We consider that the failure to report all incidents (including complaints, claims and other concerns) and to investigate thoroughly, share the findings and implement change has directly contributed to the perceived need to whistle blow using other channels. This was made worse because all senior Urology staff were

involved in multiple complex cases, so nobody was conflict free and able to detach from the emotional consequences of a complaint, incident or poor outcome.

3.81 In our review of cases of interest, we have identified that the quality and robustness of RCA investigations and the application of incident grading and monitoring of the quality of investigations including SI reports was inadequate. We also highlighted this in our Current Controls Assessment Report following our initial review. The wider review has corroborated this assessment. At times, investigations were not undertaken when they should have been and, in our view, there was differential treatment depending on who reported the incident and insufficient recognition of each incident report on its own merits. This has led to differential treatment between Consultants, the likely under reporting of incidents that should have been logged and a lack of robust thematic review of any consequence.

3.82 The RCAs that were undertaken were compromised by:

- a lack of independence, with the department investigating itself including where relationships could clearly not sustain such requests;
- a lack of external rigour where required;
- a lack of underpinning training or experience;
- limited evidence of patient and family engagement and of Duty of Candour[23]. Some reports have never been shared;
- no evidence that actions appropriately followed from the investigations and would resolve the issues if implemented; and
- no evidence of the monitoring of actions being completed either within the department, care group or through the SIRI panel.

3.83 The SIRI panel did not function as an effective arrangement for ensuring that serious incidents were thoroughly investigated. It accepted poor quality reports and did not take a role in ensuring that actions were carefully articulated and subsequently monitored. The standard of what was accepted as a report in the context of an inadequate investigation process was poor and it has failed to be the backstop it should be.

3.84 We cannot see how the role of the SIRI panel aligns with that of the Quality Committee. The SIRI panel should be focused solely on the production of high-quality serious incident reports and resulting actions and should be the quality assurance function for this.

3.85 We cannot be confident that the Duty of Candour regulation has been applied adequately at the Trust. There has been a lack of family engagement, examples of cases which have not had harms reviews and of individual cases where there is no final response provided. Other cases demonstrate a lack of inclusion in investigations and this leads us to conclude that there have been repeated failings to be open with patients and families.

[23] Duty of Candour regulation was introduced for NHS Trusts in November 2014. https://www.gov.uk/government/publications/nhs-screening-programmes-duty-of-candour/duty-of-candour

Triangulating the learning from and handling of complaints, incidents and claims

3.86 A key issue that led to the whistleblowing allegations has been the failure to triangulate the themes arising from complaints, incidents and claims at a specialty/sub-specialty level.

3.87 The Trust did not have an effective mechanism by which it learned from patient feedback and then disseminated that learning across the workforce. It was not clear that all cases were discussed at departmental level and how that fed into the care group or Board.

3.88 We have seen limited evidence of a systematic approach to clinical audit linked directly to complaints, incidents or claims to ensure there were no other similar cases nor has there been adequate thematic review.

3.89 Complaint responses to patients were at times significantly delayed. In one case during our review, we requested the Trust provide a final response to a complaint that had not been provided a year after the complaint had been made. In another case a patient had been promised an independent investigation which has not transpired. We are also concerned about the lack of clarity and completeness of when and what is shared when medical records are requested by the patient or deceased relatives.

3.90 Whilst nearly all the incidents that were reported were appropriate, the process of subsequent investigation was flawed as described above. Incidents were reported haphazardly, not in keeping with Trust standards, used emotive language at times and were sometimes reported by nursing staff at the behest of Consultants.

3.91 We are particularly concerned that on multiple occasions the events of incidents were not reported accurately. Key issues were left out or there were attempts to focus on one aspect of care within the broader care provision with the intention of implicating an individual Consultant. These inaccurate reports undermined the integrity of the incident reporting system; poor quality investigations that followed at times facilitated inaccurate and biased versions of events to be maintained.

3.92 Incidents in relation to Urology are often logged by different departments and the system had not been used in sufficient detail to identify the totality of incidents until this investigation requested detailed reporting.

3.93 There were repeated opportunities for intervention using well-established systems and processes, however, these were not applied and therefore failed to be effective.

3.94 The failure to use the incident reporting system for events surrounding claims meant 50[24] potential or actual claims were not logged for early investigation or thematic analysis.

Commissioning of Urology services

3.95 Core Urology services are not commissioned to a service specification. This is common practice in the commissioning of acute services which in the main, are commissioned using a pathway approach from referral to treatment and discharge. Activity planning is therefore based on points of delivery (inpatient spells,

[24] This was between 2003 and 2020. However, 34 claims were not logged as incidents between 2010 and 2020 (i.e. after the introduction of incident reporting processes into the NHS in 2010 by the National Patient Safety Agency (NPSA)).

outpatients (first/follow-ups), day cases etc.). This approach does limit commissioners' ability to understand the drivers of service performance and ask the right questions about quality. The Trust's operational policy for Urology 2018/19 now sets out services, care pathways and MDT requirements and would be a useful reference for commissioners.

3.96 Commissioners have struggled to embed a robust governance framework for the quality oversight of the Trust. Arrangements have not been effective in identifying red flags and potential systemic issues in Urology. Upon refreshing the framework in 2020, Morecambe Bay Clinical Commissioning Group (MBCCG) referred to these challenges:

'The CCG collective capacity has often been steered to respond to external motivations such as, inspection and regulation and targets and performance with little resource left to bring about improvement 'from within' and 'across' the system.'

3.97 Until alerted by the whistleblowing concerns in 2019, commissioners have had limited involvement in Urology services or insight into emerging problems. Commissioners' attention has been absorbed by urgent issues in maternity services as well as the Care Quality Commission (CQC) and other external scrutiny of the Trust. The issues in Urology surfaced to them in July 2019 and then became the main topic of discussion at CCG quality oversight forums. There have clearly been efforts to re-establish effective quality governance and the framework was refreshed in November 2019, with the latest version set out in a paper which went to the Quality Improvement Committee (QIC) in August 2020.[25]

3.98 The significant changes in commissioning structures over the last ten years have been a barrier to the embedding of effective governance and relationships with the Trust. The continued fluidity with the emergence of the new Integrated Care System (ICS) and CCG reconfiguration may add distraction and create more distance between commissioners and front line services.

3.99 Commissioner quality assurance systems have been ineffective as an early warning system to identify serious issues and systemic failures in Urology which, as a sub-specialty, has been relatively inconspicuous. Factors contributing to this are the absence of specialty specific information which has not been routinely requested by commissioners, as well as a lack of probing on the issues which have surfaced periodically in Urology. There has been no mechanism to draw together pockets of intelligence into a cohesive picture of the sub-specialty.

3.100 Clinical safety and cultural issues emerged in Urology with several alerts including a significant Urology patient recall in 2005 (prostate biopsies), a Never Event in 2015 resulting in another recall (testicular implants), various external reports on Trust governance failings and the RCS Invited Service Review report in 2016. However, the broader implications of these warning signs were not addressed by commissioners.

3.101 Intelligence through serious incident reporting has not been available. The focus has been on numbers of incidents rather than any qualitative commentary and there has been no analysis at specialty/sub-specialty level. Reports on key themes

[25] Quality Improvement, Assurance and Accountability Framework for the CCG v0.10, June 2020

and learning have been of a poor standard and limited in their scope. Similarly, commissioners have had no effective process in place for spotting systematic failures in Urology through complaints monitoring, partly due to the poor quality of information received from the Trust.

3.102 There is no evidence of commissioning led pathway redesign for Urology. The Elective Care Board has been the 'engine room' for elective care and cancer services improvement, however, its focus has been on cross-cutting projects such as outpatient management and 18-week targets; Urology services have not featured in its work programme.

3.103 There were no indications of any meaningful engagement with the local Urology Network and Cancer Alliance or use of Urology specific guidance to inform commissioning. These were potentially missed opportunities to gain an alternative insight into the drivers of service performance and the challenges for Urology services.

3.104 Urology is now an area of focus in the Better Care Together (BCT) Strategy, however this is a reactive response rather than informed planning. Commissioning intentions for Urology and oversight of associated BCT workstreams remain ill-defined.

3.105 Quality governance structures set out in the CCGs revised quality assurance framework are complicated and somewhat disjointed. The Elective Care Board is no longer part of the CCG assurance framework, yet this is one of the few existing sources of insight at specialty level. There remains a risk of fragmented assurance, blurred responsibilities and, importantly, key issues could still be missed.

3.106 Commissioning oversight of Urology has been considerably strengthened since summer 2019 because of a 'deep dive'. Joint Trust/CCG groups now examine Urology specific information and oversee delivery of action plans and performance improvement. Reporting on progress has been through the NHS England and NHS Improvement led Urology Oversight Group until December 2020 and the CCG provided a comprehensive update to this forum. This report could be improved in terms of focus and clarity, but it is a good step forward for commissioning oversight of this specialty. A System Improvement Director is now in place.

3.107 Our main concern is the sustainability of these arrangements in view of the many competing pressures on CCG and Trust resources and the logical assumption that a similar level of scrutiny may need to be replicated in other specialities. The transition to the ICS will need to ensure any momentum is not lost.

Regulators and external bodies

3.108 Regulators were aware of concerns on an individual Consultant basis throughout this period through the National Clinical Assessment Authority (NCAA) and at times the General Medical Council (GMC). However, our main criticism is the hugely extended timescales involved in responding to referrals particularly to the GMC. In one case it was four years before the GMC closed a patient's family's complaint and currently a referral made in November 2017 continues four years later.

3.109 We are also concerned that doctors are not informed of all complaints against them and nor are their employers (the GMC views some complaints raised to them

as not requiring any action). As a result, there is no single perspective of the totality of concern of an individual doctor shared amongst all relevant stakeholders and the doctor themselves. Whilst we accept that at times referrals may need to be anonymous, this investigation is concerned by the level of vexatious reporting between Consultant Urologists. This has led to lengthy investigations which have been stressful for all concerned.

3.110 The RCS was called three times - once in 2002 for a rapid review which was clear and responsive, but its recommendation was not taken up; then for an invited clinical record review in 2015 which looked at cases from 2013-14; and again in 2016 when the Invited Service Review occurred. The 2016 report was advisory, clear and insightful. However, whilst an action plan was developed, the recommendations were not effectively implemented or reported to or monitored at Board level. The Trust did not approach the RCS for a follow up service review to confirm its recommendations had been addressed and to ensure its members continued to deliver a safe service. The RCS report was shared with the CQC by Consultant Urologist 3 in April 2016 and not by the Trust. The RCS notified the CQC that they had undertaken an Invited Service Review as part of information sharing to inform pre-inspection planning in August 2016. The updated action plan was shared by the Trust with the CQC in August 2016. However, the report was not shared with the Board and the action plan was not progressed through the Urology Action Group which had been set up to implement the actions arising from it.

3.111 NHS England and NHS Improvement were contacted directly by Consultant Urologist 3 in 2016 in relation to his concerns. However, NHS England's Chief Executive's office initially failed to respond and then redirected him to the Care Quality Commission (CQC).

3.112 The NHS England and NHS Improvement regional office did seek assurance in 2017 that cases raised by Consultant Urologist 3 had been investigated but were too easily reassured thereafter. Medical Director 5 had undertaken a review of actions in relation to these cases but these were not adequate in our view as they were based on poor investigations at the time.

3.113 The CQC were informed on several occasions by Consultant Urologist 3, albeit anonymously, of concerns in the department. They were in contact with the Trust but there is no evidence that they sought to examine the quality of investigations or test any of the cases in question. Whilst the CQC were aware of Consultant workforce challenges there was no other sub-specialty inspection focus evident in relation to the patient safety issues arising at the time.

The legacy of conflict

3.114 The two decades of allegations and counter-allegations have taken their toll on all involved. The team is beginning to rebuild. However, this means that they must redouble efforts to improve processes, attract high-calibre staff and improve their own wellbeing to deliver services.

3.115 However, the underlying relationships, including those external to the Trust, remain and this may well continue to undermine some of the individuals within the team. This is a significant risk to the speed with which the team can move on.

The impact of Inaccurate reporting on individual and organisational reputations

3.116 The inaccuracy of reporting on some cases described in the public space is of concern. The book published in 2019 contains descriptions of events that are not always accurate and leads the reader to make conclusions that this investigation does not corroborate. This investigation may go some way to reducing the inaccurate and repeated assertions being reported.

3.117 The 29 cases as described in the book have been reviewed in this investigation and 25 have been linked to known patients (a further patient has not been identified although details of the case are available). In our view, whilst ten of the descriptions are broadly commensurate with the events as described in medical records, 16 were not accurate. The full course of events in all cases was also not provided.

3.118 Inaccurate reporting in the media and in the book combined with the complete absence of, or the poor standard of investigation by the Trust has impacted the Trust's ability to respond publicly and ensure that its staff and patients are fairly represented. This has also led directly to reputational damage both for the clinicians who have been named and for the Trust. There are four cases which have been repeatedly recycled in the media for public consumption despite some not having been robustly investigated.

3.119 There were clearly areas of concern in relation to the Urology department; however, the validity of repeated whistleblowing about events covering 20 years and the continued promulgation of incorrect versions of those events calls into question the role of the whistleblower. In this case, despite some investigations being undertaken, at times forensically (by, for example, the GMC, external reviews and legal processes), apparently protected disclosures continue to be made regardless of the commissioning of this independent investigation.

3.120 Other serious cases which have involved patients being treated by the Urology team have been identified through this investigation. Our overall conclusion is that the cases highlighted in the book have focused attention on the alleged failings of some specific individuals rather than others and less so on the wider performance of the Urology department or the Trust.

3.121 Repeated assertions and incorrect narrative continue to harm individuals through reputational damage and presents a continued risk to patient and staff safety through fear of the consequences of speaking up. Individuals have been left to respond to the above assertions and the GMC has had to apply processes that have at times then resulted in the dismissal of allegations. The full version of events, upon which all sides can rely, is not available in some cases.

3.122 The employment tribunal for Consultant Urologist 3 confirmed that there was no evidence of the NHS causing deliberate detriment to the employment of the whistleblower in this case; in our view there is clear evidence of efforts to hear his version of events after he left the Trust in 2016 despite concerns about the motivation behind his reporting.

Responding to publicity

3.123 There has been significant media attention paid to aspects of the Urology department since Consultant Urologist 2's suspension was leaked to the media by a staff member in 2005. Appropriately, the Trust did not comment on confidential issues, but no action was taken to respond to the appropriateness of the article. In

2011, Consultant Urologist 3 was the subject of a media story in relation to a complaint made by a patient and he took personal direct action through his solicitors to have the article removed.

3.124 The employment tribunal involving Consultant Urologist 3 from 2016 to 2018 attracted extensive media attention, including in relation to the alleged failings of other Consultants. Private (patient and staff) information found its way into the public domain through this route. Many of the alleged incidents were then repeated in the book published in 2019.

3.125 Consultant Urologist 2, Consultant Urologist 7 and Consultant Urologist 9 were subsequently the subject of repeated news articles both locally and globally. The situation was complicated by some of the reports being inaccurate in their narrative but extensively promoted by the author.

3.126 The Consultants were provided with a briefing on defamation from the Trust's legal advisors and interpreted this as advice to not take any action ('*it will settle down'*). While there were some supportive press releases from the Trust, the facts of each case should have been established, particularly when referencing serious incidents and avoidable death, to ensure that they were fully sighted on harms caused. Also, so that patients and their families were not unnecessarily distressed and detriment to the individuals concerned was minimised. Fully informed, counter-communications would then have been possible.

3.127 We are also concerned that the references in the media to 'Asian' doctors had racial undertones and should have been challenged directly at the time by the Trust as race was irrelevant to the events whether true or otherwise.

3.128 We recognise that NHS organisations can be in an invidious position and do not wish to be seen to victimise whistleblowers or release personal information about individual cases, but there is also a right for staff to be supported by their employers when accused of alleged wrongdoing so publicly.

4. Interim reporting

This section sets out our early findings which were provided to the Trust and NHS England and NHS Improvement prior to this final report being published. Improvements may have subsequently been made by the Trust in response to these interim findings and this section may not reflect the current position on publication of this final report.

4.1 In line with the terms of reference published in May 2020, we reported on our findings at key milestones during this investigation to support the early implementation of actions to improve clinical care and governance processes. We set out below the summary findings arising from the interim draft reports provided to date to the Trust and NHS England and NHS Improvement. The associated recommendations are set out from page 49. These are the:

- Current Controls Assessment - Final draft report October 2020
- Current Case Review October/November 2020 - Final draft report March 2021
- Quantitative Analysis - Initial draft report December 2020
- Index Case Report - Final report November 2021 (Draft March 2021)

Current Controls Assessment October 2020

4.1 The first part of the Urology investigation was a review of the current controls in place in 2019/20 within the Urology department and whether the Trust should be seeking additional assurances on quality and safety. This was not an exhaustive report but aimed to highlight areas of current concern to enable the Trust to undertake early interventions.

4.2 The key lines of enquiry for the Current Controls Assessment were:

- Is the service currently being monitored at all levels?
- Are there issues currently within the culture of this department which might give rise to suboptimal care or communication?
- Is this department currently working in line with the appropriate clinical guidelines set for Urology?
- Are there any concerns about the resilience of this service whilst investigative activity takes place?

4.3 The staff we spoke with during interviews were very motivated to deliver high standards of care to their patients and we found some areas of improving practice.

4.4 There were, however, findings which led us to conclude that, without immediate intervention, the current controls applied to the Urology service did not ensure that a safe and effective service was provided to patients. The most material of these findings included:

- Insufficient line of sight from the Urology department to the Board with key risks that are not always identified or monitored effectively, along with a lack of clarity around performance accountability.

- Dynamics between a small number of senior clinicians that remain dysfunctional thereby presenting risks to a safe and effective clinical working environment, particularly given that Urology patients continue to be 'pooled'.
- Inadequate departmental management and Trust level monitoring of Urology mortality reviews which inhibits proper learning from inpatient deaths.
- The approach to incident investigation lacks rigour and independence. There is limited thematic reporting of complaints, litigation and incidents, or follow-up of reviews which have taken place. A reduction in incident reporting is of some concern (even in the context of Covid-19).

4.5 A number of improvement areas have previously been brought to the attention of the Trust by independent parties including:

- The Report of the Morecambe Bay Investigation - Dr Bill Kirkup CBE (2015)
- Well-led Governance Review - Grant Thornton LLP (2015)
- Invited Service Review of the Urology Service - Royal College of Surgeons (2016)
- Get it Right First Time (2018)
- Care Quality Commission inspection (2019)
- Developmental Well-led Review - Deloitte LLP (2019)
- Urology Department External Review - York Teaching Hospitals NHS Foundation Trust (2020)

4.6 Themes presented in these reports which are still issues in the department today include:

- unclear and ineffective governance structures and risk escalation routes;
- a need to strengthen performance reporting;
- an inadequate mortality review process;
- a lack of systematic identification of underlying themes in incidents, concerns, and complaints; and
- a slow pace of action and slow implementation of improvement, even in areas of the Trust known to be high risk.

4.7 The lack of action taken to address these areas and ensure sustained improvement is indicative not only of challenges with the local application of controls but also in broader governance and assurance mechanisms at a Trust-wide level.

4.8 The findings aligned to our key lines of enquiry include:

Is the service currently being closely monitored at all levels?

4.9 Several groups and committees have been established in response to historic concerns which focus on Urology; however, these currently lack clear reporting lines and should be reviewed to ensure terms of reference are met and risks are adequately escalated from the service to the Board.

4.10 While some efforts have been made to strengthen performance reporting in relation to Urology, further steps are required both in terms of content, structure and the scrutiny applied to reports, including the Safe Today[26] Report. Corporate performance reporting omits a few good practice features, such as a balanced scorecard enabling the reader to identify links between different areas of performance and early signs of risk. Corporate monitoring of Urology performance currently relies on proactive escalation, which is lacking, rather than on automated, triangulated assurance.

4.11 Steps have been taken by the Trust to provide greater senior management support to Urology in the form of the Enhanced Support Programme (ESP), although this is now stretched across four services. Criteria for entry and exit from this support mechanism has been agreed; however, the absence of a robust performance and accountability framework for Urology as well as weaknesses in departmental and care group governance structures, do not enable effective escalation of issues and risks from the service to the Board.

4.12 Staff have said that they know how to identify and report a risk, but we have found that there are some risks which have not been captured on the risk register e.g. dysfunctional team working, 104 day breaches. Risk registers have not been routinely reviewed at departmental or care group level, and the profile of Urology risks at care group and Board level is too low when compared to the risk profile.

4.13 In line with an open reporting culture incident reporting had been increasing in 2018-19 but this has significantly reduced in the context of Covid-19.

4.14 Our review of recent Urology incident investigations showed a lack of rigour and independence, with some of the staff who undertake the investigations not having had recent (and in some cases any) training. This presents a continuing risk to patient safety.

4.15 The monitoring of reportable concerns is predominantly focused on key performance indicators (KPIs). There is a lack of important thematic analysis of complaints, litigation, incidents and Patient Advice and Liaison Service (PALS) information, with little evidence that undertaking same causal factor analysis is valued as a mechanism to identify and swiftly respond to emerging risks. The follow-up of actions from previous thematic reviews cannot be evidenced.

4.16 There is no stand-alone Learning from Deaths Policy in the Trust and, although under review, the latest procedure on mortality review does not sufficiently set out the process and has not been adequately implemented in Urology. There is no clear link between mortality reviews at departmental level with those at Trust level. It is of particular concern that the Trust has not been able to identify inpatient deaths readily and accurately within Urology. The number of inpatient deaths in Urology is minimal and this supports the view that all Urology inpatient deaths should be individually reviewed and discussed at departmental and Trust mortality meetings.

[26] The Safe Today report is a regular summary of performance in the Urology department introduced in October 2019 on the request of the CEO for the Urology Task and Finish Group and has been further developed since then. A balanced scorecard has been added to the Safe Today report from October 2020 when this issue was initially raised in our Current Controls Report.

Are there issues currently within the culture of this department which might give rise to suboptimal care or communication?

4.17 A cultural transformation project (InterBe work commenced November 2019) is being delivered by an external provider in response to the concerns identified within the Urology department. Staff feedback about this process is positive, however, our review has confirmed that a small number of relationships remain fractured and at times staff are not seen to be held to account for poor behaviours; this has been described by staff as the single greatest risk to patient safety and resilience of the service.

4.18 There is a lack of confidence in the strength of leadership in the department and the capacity to deliver sustained improvement. Some progress has been made to strengthen this leadership; however, the forum for the triumvirate (Clinical Lead, Clinical Service Manager and Matron) to meet was paused during Covid-19 and clinical representation at key Urology governance meetings is limited.

4.19 Day-to-day communications are improving with the introduction of Urology team meetings, but the culture of the department does not yet support the open sharing of learning.

Is this department currently working in line with the appropriate clinical guidelines set for Urology?

4.20 The lack of named Consultants and continued pooling of patients presents an ongoing risk for Urology patients' safety, particularly in the presence of fractured relationships. Pooling is seen by clinicians predominantly as a drive for efficiency and some patients are seen by multiple Consultants throughout their patient journey, which is less than optimal. The Trust is aware that this is an issue and has been for six years; greater urgency is required to secure ways in which this could be resolved.

4.21 There is currently no satisfactory emergency cover two weekends in four at Furness General Hospital (FGH). A new out-of-hours emergency care model has been agreed and has the support of most staff in the department, but its implementation has been delayed[27].

4.22 Out-of-hours emergency care has been an ongoing issue for at least eight years and has been raised by the Royal College of Surgeons (RCS) in 2016, Getting It Right First Time (GIRFT) in 2018 and continues in 2020. The proposed model still does not have sign up from commissioners as the model remains temporary and a consultation on a more permanent solution is yet to be undertaken.

4.23 The operating model in Urology continues to be reliant on clinicians undertaking a significant number of additional activity sessions (AASs), often within time scheduled for administration or for supporting professional activities in job plans. There is a significant lack of control and oversight of AASs to manage costs, monitor allocation to clinicians, and assess the impact of undertaking AASs on job plans and wellbeing.

[27] A new on call process went 'live' on 31 October 2020.

4.24 An on-site review of cases to be undertaken in October/November[28] this year (2020) will provide detailed insight into the current quality of care and adherence to clinical guidelines.

Are there any concerns about the resilience of this service whilst this investigative activity takes place?

4.25 Recent, enhanced focus on the department, including for this investigation, has affected staff morale and patient confidence in the Urology service; however, over 250 staff completed our survey and over half of these remain proud of the service and are confident in its future.

4.26 The Trust has supported the review by providing over 20,000 documents and supporting staff to attend for interview.

4.27 Whilst recognising the additional workload that our review has had on some staff, we do not have any immediate concerns about the impact that our investigation is having on the resilience of the Urology service. However, action must be taken to address some governance issues which will be affecting staff and patients.

Priority actions

4.28 Within this report we propose a range of priority actions to mitigate the areas which we saw as key risks to the safety and quality of the service provided by the Urology department. Specific patient-oriented actions were addressed on site and have not been repeated here. In addition to this we have made further recommendations. (See section 5).

Current Case Review March 2021

4.29 We undertook a case note review for patients discharged from Urology during August and September 2020. We reviewed a sample of 138 cases from a full list of inpatients and outpatients. A team of clinical reviewers examined current hard copy and electronic notes on site in two one-week periods in October and November 2020.

4.30 Overall, the case review conclusions can be summarised as follows:

- The One Stop Clinic functions well and is a good model of care. The Radiology department is also very responsive, with comprehensive tests undertaken quickly; it is a department that caters for a patient's needs well. The team were impressed by the quality of these services.
- However, beyond initial assessment in the One Stop Clinic, some patients are not being followed up, decisions are not taken quickly or with continuity of care. There appears to be a lack of clinical engagement with follow-up characterised by an over-reliance on patients being traced administratively and key actions not being monitored.
- Operational and administrative leadership compensates for weak clinical engagement to some extent but patients still risk being lost to follow-up within a pooled system, with poor communication when there are delays in enacting clinical decisions.

[28] This was undertaken - see interim reporting on Current Case Review

Queries and escalation of cases whilst on site

4.31 Where the reviewers felt that immediate action needed to be taken or where further information was required, we made enquiries or escalated to an appropriate individual whilst on site. These were responded to by the Trust at the time of the concern being raised. The team raised 24 queries whilst on site (17 in October and 7 in November): two cases were not related to Urology issues and were incidental findings; one case was a query regarding whether onward follow-up had been booked; a further two were queries regarding onward care. We therefore escalated a total of 19 Urology cases (14% of the sample) (13 in October and 6 in November).

4.32 A summary of the overall ratings made in the outpatient and inpatient samples is shown below:

Outpatient case review

- 38 outpatient cases were reviewed: 63% (24) of cases were assessed as adequate or good care; 37% (14) as poor or very poor care.
- There were positive lessons in 13 cases regardless of rating, and negative lessons in 20 cases.

Inpatient case review

- Of 94 inpatient cases we scored 90[29]. Overall, 83% of cases were assessed as adequate or good care; 17% as poor or very poor.
- There were positive lessons noted in 41 cases and negative lessons in 47 cases.
- The combined scores for the 14 (of 90) cases of people with a mental illness, learning disability or with dementia or confusion demonstrated that 64% of cases were adequate/good or excellent care and 36% were poor or very poor; suggesting a poorer overall experience amongst this group of patients.

4.33 Reviewers assessed the quality of record-keeping in each case. The overall ratings are shown below:

Record-keeping

- The record-keeping review across the sample (n = 123) showed that the majority of records were rated as adequate or good (77%). 23% (28) were assessed as poor.
- It was not possible to assess individual Consultant performance given the pooled nature of the service.

Areas of good practice

4.34 There were clear areas of good practice which are noted below:

- The One Stop Clinic model is timely, prompt and undertakes investigations efficiently.
- There are timely and responsive radiology interventions.

[29] Some could not be completed from the records available

- There were examples of compassionate care, clearly articulated management plans, interspecialty working and good coordination of care.

Areas of concern

4.35 The Trust also identified specific actions as a result of individual cases.

4.36 We made a number of recommendations to improve the safety and quality of care in the Urology department in response to the areas of concern identified from the detail of individual comments from reviewers. There is a need to repeat a case note review to establish if planned changes in practice are being embedded before actions are signed off. (See section 5).

4.37 Our main concerns related to:

- fluid balance monitoring - particularly given the specialty involved;
- mortality review - recent practice and oversight;
- the need for named Consultants for complex patients;
- consent practice;
- capacity and best interest decision-making and recording in line with the Mental Capacity Act 2005;
- the use of Lorenzo[30] to optimise its effectiveness; and
- the recording of ethnicity given the need to record ethnicity to support Covid-19 research.

Index Case Report key findings April 2021

4.38 The index case refers to one patient who died in early 2015. This case has been referenced in a variety of publications, in media reporting and has been the subject of internal and external debate. It was a key event which led to the commissioning of this investigation. We extend our condolences to the family of this patient and empathy for the difficulties caused by poor governance processes following this death. There were more cases of concern over this period, but this case is illustrative of almost all the clinical and governance failings highlighted in this report, including its impact on patients and their families.

4.39 This case however occurred during a time of maelstrom for the Urology department. In June 2014, Executive Directors had commissioned a psychology consultancy to work with the Urology multidisciplinary team after concerns were raised to them about the functioning of the team. Over the next year interviews and workshops were conducted to help the team improve their relationships. However, behind the scenes a blame culture and accusations of discrimination persisted. Poor governance processes and delayed human resource (HR) responses meant that the issues raised were not tackled. By the time the inquest for this patient took place in mid-2015 relationships were so poor that it became impossible for the sequence of events to be fully and transparently investigated. The Executives did not return to evaluate the impact of their interventions and the Board became

[30] Lorenzo is the Trust's Electronic Patient Record (EPR) system

distracted by external reviews and the maternity issues identified by the Kirkup Report. A key opportunity to make changes in the department had been lost. In our view, this directly impacted on patient care and the subsequent events in this case and delayed implementing improvements. We describe these below.

4.40 We are particularly concerned that the sequence of events in this case has not been accurately described in various publications and in the media. We consider that a revised and accurate version of events has now been provided in the full report to NHS England and NHS Improvement, the Trust, relevant individuals and to the family.

4.41 Our key findings in relation to the index case are set out below:

Clinical care

4.42 Throughout our investigation we identified several missed opportunities which, had they been recognised, and a different course of action followed, may have affected the outcome for the patient and the experience of the family, including in the seeking of answers to their questions after the patient died.

4.43 We identify these key missed opportunities as:

1. There was a significant and unacceptable delay in managing the patient's diagnosis, in securing discussion about the care options at the network MDT meetings and in referring the patient to the regional centre at the Royal Hospital Preston for treatment.
2. There were repeated delays in reporting scan results which lengthened the overall diagnostic and treatment timeline.
3. There were repeated delays in arranging a cystoscopy and stent change, a lack of active consideration to the need for the stent to remain in place, and a failure to consider alternatives such as a nephrostomy. This was compounded by a lack of arrangements for advance booking for monitoring cystoscopies from one procedure to the next.
4. There was a failure to review the patient's abdominal X-ray prior to discharge and to ensure that the patient was fit to go home.
5. There was a failure by the General Surgical team to recognise the patient's deterioration and to refer earlier to Urology.
6. There was a failure by the General Surgical and Urology teams (despite sharing the same ward) to liaise on multiple occasions and to take a rounded view of the patient's needs. This was compounded by there being no formal process for referral between clinical teams and a practice of communicating via the medical records.
7. There was a lack of communication between Urologists including a failure to handover from one Consultant to another on two separate nights.
8. There were repeated failures to take the patient to theatre on four consecutive days for a stent change.
9. There was a failure to talk to the patient's family about the risks of operating, particularly on the day of his stent change, and, in the absence

of the family, to seek a second opinion as to best interests given the patient's inability to consent.

Governance and complaints handling

10. There was a failure to report the patient's death (or the circumstances leading to this) as a clinical incident.
11. There was a failure to accurately capture the circumstances of the patient's death in both the contemporaneous death summary and the sudden death report to the Coroner.
12. There was a failure to pick up the shortfalls in the patient's care through the embryonic mortality review processes in place at the time of the patient's death. There was also no subsequent review of this death in any departmental or Care Group Mortality and Morbidity meeting. The Urology department had a wholly inadequate mortality review process and did not review each inpatient death (even though the numbers were small).
13. There was a failure to review the statement that went to the Coroner from the Urology Consultant to ensure it was a factual summary of the care that was given by this and other teams.
14. There was a failure to more robustly coordinate the subsequent orders of the Coroner to ensure that instructions were fully understood by all concerned and actioned to completion. However, the instruction to discuss the case at the Mortality and Morbidity meeting was superseded by the incident investigation process and communicated and agreed with the Coroner. In our view, it was appropriate not to discuss the case at the Mortality and Morbidity meeting initially, to allow the investigation to proceed and then follow normal processes which should have involved a discussion of the findings with all involved.
15. There was a failure to ensure full, robust investigations in both RCA 1 and RCA 2, including a failure to engage with the family to identify their questions and provide precise answers to their concerns on both occasions. This was contributed to by a limited scope of relying on case notes.
16. There were repeated failures to precisely respond to statements made by a Consultant Urologist as regards the facts of the case. This resulted in some inaccurate statements becoming considered factually correct, but which were misdirected. Hindsight bias has clearly been applied throughout this case.
17. There was a lack of decisive action and corporate leadership by the Board and the care group when allegations of medical negligence began to emerge in writing and thereafter in a range of communications between Consultant Urologists. These were serious accusations that needed far greater attention and priority for investigation and action at Board level.
18. There was a failure to recognise a series of increasing concerns and requests for information from the family as a compound complaint, to record this formally and then to follow appropriate processes so that resolution could be achieved through the Trust or by onward referral to the Ombudsman. Some concerns were protracted (for both the family and

some clinicians) and continued to remain fully unanswered for several years.

19. The recommendations resulting from both RCAs were weak. We could not see what process was used to develop the actions which do not align fully to the recommendations listed in the reports. Whilst progress has been made against some of the actions, some are yet to be completed; this is despite some of these being clearly required at least five years ago.

Early update on actions taken in response to interim reporting

4.44 The next phase of this investigation proposes an assurance review following this report. However, due to our early interim reporting and recognition in the Trust that focused effort was required to address the outstanding RCS Invited Service Review recommendations and to support team improvement, key changes should be recognised at this point. Support from the Good Governance Institute was commissioned following the issue of our current controls assessment and there has been ongoing assistance with many of the governance related recommendations raised by this investigation and other reviews.

4.45 This section reflects some of the Trust's comments on actions taken so far but the extent to which these are embedded and sustained will be assessed in the proposed assurance review in approximately 12 months' time. We have been advised by the Trust that some of the recommendations made have already been addressed. These will need to be confirmed and include:

- 24-hour microbiology cover on all sites was introduced in 2016.
- Out-of-hours cover for interventional radiology (for nephrostomy) in Urology was considered across the integrated care system in 2018 and is now available out of hours. (However, this remains an ongoing issue with some delays in transferring emergency patients to Royal Preston Hospital which is the new emergency arrangement).
- Standard operating procedures for theatre access and management of the infected obstructed kidney were updated in 2019. These are currently subject to audits.
- Since 2019 the triage of patients on the two week wait pathway includes a CT Urogram, pre-One Stop Clinic attendance.
- Sepsis guidelines and training have formed part of medical induction since 2020.
- A newly appointed department mortality lead trained in structured judgement review. We understand that with the introduction of the medical examiner in early 2020, all Trust deaths have been subject to scrutiny.
- Flexible cystoscopies are now undertaken at all One Stop Clinics (by adding RLI in October 2020).
- Electronic handover was introduced in Urology using RCS guidelines and was rolled out to FGH in November 2020.
- An e-Consultation/interspecialty request pilot was carried out in December 2020 and the Trust is working with two other sites on the bleep replacement strategy to support instant senior doctor to senior doctor notifications. At present referrals remain via phone calls.
- Named Consultant rota went live in January 2021.
- An updated standard operating procedure (SOP) was put in place in March 2021, with a generic email box for communication with tertiary centres.

- Development of a stent register function in Lorenzo to record insertion and removal of stents with an alert notification in place to minimise delays in changing them. This went live in May 2021.
- Revised consent policy signed off in May 2021 including consent for emergency cases without capacity. Electronic consenting via iPad is being piloted in Endoscopy services.
- Signed off agreement in relation to on call arrangements and cover for emergency care at FGH.
- A review of job plans completed.
- NEWS2[31] is monitored in the Trust through an electronic process in Lorenzo with a centrally held function that enables alerts for any patient with high scores to be identified and immediate attention escalated.
- More transparency through the Safe Today Report on additional activity sessions (AASs).
- An independent investigation team with external support was commissioned in October 2020 to move the team's investigation quality to an improved state. Training and oversight of investigations and reporting has been provided. This team has now been disbanded and the function transferred back into the care groups and Trust systems.
- A new Learning from Deaths Policy was introduced in September 2021.
- The Trust has implemented a proforma for 104-day review that incorporates a formal harm review. The NW long wait harm review policy has been released (October 2021) and the Trust is undertaking a gap analysis of current processes and will adopt the NW approved approach: North West Guideline: Managing Long Waiting Cancer Patients.
- New business cases for additional equipment are being progressed including for: a stack system at RLI for a planned new Urology Unit when this is realised; upgraded suction equipment for RLI; and a proposal for buying two SERRES irrigation machines (FGH/RLI).

4.46 The InterBe[32] transformation programme undertaken over the last 18 months has now ended. The feedback session was recorded and shared with us. It was heartening to hear the profound responses from many in the team in recognising the legacy of the difficulties they have all experienced, the need to let go of historical challenges and the recognition of the impact the dysfunction of some of the senior individuals has had on the wider team and its ability to deliver services. The Urology team consists of more than just Consultants and there has been inclusion of a wider team including nursing, administrative and managerial staff in the efforts to transform working. There is still much to do but there is a much greater team recognition of the need for kindness towards each other, with teamwork and listening featuring

[31] NEWS2 - the latest version of the National Early Warning Score - a calculation based on points to establish if a patient is deteriorating and inform escalation decisions. It combines patient observations to trigger an escalation protocol for a deteriorating patient.
[32] InterBe are an organisation inspired by The Order of Interbeing, founded by a Buddhist monk based on the belief that of interconnectedness and that change does not occur in isolation. They were commissioned by the Executive Team in 2019 to help transform the way the team worked together.

heavily. One particular action has made a difference - having an office base. Whilst there is still a need for a team base at RLI, the base created at FGH appears to have played a major role in enabling the team to work better. Combined with 'whole team' meetings which were valued, and which the team wish to continue, there is a sense that everyone in the team plays a key role; administrative support is particularly essential to ensure continued team working and in supporting care pathways.

4.47 We have also seen an improvement in reporting through the Safe Today Report which has addressed some of our early recommendations.

5. Recommendations

We set out the recommendations made throughout this investigation in chronological order of reporting referencing Trust, NHS England and NHS Improvement, CQC, GMC, RCS and commissioner responsibility.

We have provided our view in the tables below on whether there is the potential for wider learning from our recommendations outside the Trust's Urology specialty (i.e. whether other services may also have similar challenges). We have provided our assessment of this potential to support learning across the Trust as well as the wider NHS.

Recommendations arising from interim reporting

Trust recommendations arising from the Current Controls Assessment Report issued in final draft on 23 October 2020

No.	Recommendation	Priority	Potential for wider applicability than Urology
R1	**Recommendation 1 - Oversight of Urology through Trust governance structures** Reporting lines need to be clearly articulated in the terms of reference for each of the groups and committees which have been established for oversight of the Urology service and depicted in an organogram. Links to the Urology department, care group, committee and Board governance structure should also be confirmed.	H	Yes (Trust)
R2	**Recommendation 2 - Quality and safety data in the Integrated Performance Report** The quality and safety data in the Integrated Quality and Performance Report (IQPR) should be expanded to include trend and thematic analysis. Key quality and safety metrics should be included in a new upfront performance dashboard and hotspot reporting should include more detailed analysis on key risks.	M	Yes (Trust)

R3	**Recommendation 3 - Performance framework for Urology** Introduce a performance and accountability framework which clearly sets out the approach to corporate and care group scrutiny of Urology and, where necessary, support from the Enhanced Support Programme (ESP).	M	Yes (Trust)
R4	**Recommendation 4 - Urology audit** The newly appointed Urology Audit Lead should have dedicated and experienced support to provide best practice guidance on conducting audit and governance meetings. The terms of reference and agendas for the audit meeting should be drawn from best practice in other Urology services.	H	Yes (Trust)
R5	**Recommendation 5 - Safe Today Report** The Safe Today Report should be received at department and care group level before presentation to UT&FG and UQOC[33]. It should also be developed further to provide more appropriate measures of assurance with: • inclusion of an overarching scorecard to enable the reader to understand performance 'at a glance'; • a reduction in the narrative analysis throughout the report; • greater emphasis on prospective performance through the use of early warning indicators and forecasting in order to allow timely identification of deteriorating performance; • more same causal factor analysis of complaints, litigation, incidents and Patient Advice and Liaison Service (PALS) feedback; • an expansion of the quantitative and qualitative data relating to patient and staff experience, including patient feedback in the form of real time and retrospective data collection, staff pulse surveys and a wider range of workforce metrics (e.g. turnover, appraisals, training, use of agency staff, staff sickness, as well as concerns raised by staff).	M	Yes (Trust)

[33] Urology Task and Finish Group and Urology Quality Oversight Committee

R6	**Recommendation 6 - Meeting administration** Meeting administration must be improved. This should include: • a review of the ToR for all meetings at departmental and care group level to ensure they are in date, aligned to the objectives required of the meeting, and also other key meetings, with agendas planned to reflect these; • the introduction of standardised templates for agendas, minutes, and action logs; and • the provision of training for individuals with minute-writing responsibilities and all minutes should be reviewed by the relevant Chair before distribution.	M	Yes (Trust)
R7	**Recommendation 7 - Risk registers at service, care group and Trust level** The challenges currently being faced by the Urology service should be reviewed to determine whether the risks are sufficient to warrant inclusion on the service, care group or Corporate Risk Register (CRR) or the Board Assurance Framework (BAF); this includes the difficulties with on call cover at Furness General Hospital (FGH) and continuing fractured relationships as a patient safety risk. Departmental and care group meetings should include risk as a standing agenda item and the risk profile of the service should be reviewed at least quarterly.	H	Yes (Trust)
R8	**Recommendation 8 - Quality of investigations in Urology services** All reported incidents and complaints received in relation to Urology services should, for a period of at least 12 months, be investigated by a dedicated independent team outside the department which has access to independent Urology advice. This would remove pressure on the existing team to investigate each other and provide room to work on relationship development. It would also help to set a standard for future high-quality investigations. [This recommendation related to incidents and complaints requiring investigation not all cases].	H	Yes (Trust)
R9	**Recommendation 9 - Thematic review** Quality performance reporting should include thematic and same causal factor analysis of complaints, litigation, incidents, and PALS information to ensure that lessons can be learned, and actions taken to prevent recurrence of the same. Themes should be discussed at departmental, care group, and committee level with a clear focus on actioning improvement.	H	Yes (Trust)

R10	**Recommendation 10 - Mortality review (Link to R15 and R26)** Every inpatient Urology death must have a case review conducted by Consultant Urologists with external support in using structured judgement review (SJR) methodology (Royal College of Physicians) or other recognised case note review methodology and be subject to Trust level scrutiny (as per Trust Policy). Every death must then be presented without exception to a Urology mortality meeting. These should be separate from audit and multidisciplinary team (MDT) meetings until such time that mortality review becomes an accepted and business as usual activity.	H	Yes (Trust)
R11	**Recommendation 11 - Professional relationships** Intelligence from the InterBe meeting in August 2020 should be used to assess the severity of concerns associated with relationships between senior clinical staff to determine whether issues can be resolved or if other remedial action needs to be taken.	M	No
R12	**Recommendation 12 - Pooled model of patient care** • There is an urgent need to review the pooling of patient referrals and the way in which patients are allocated to, and reviewed by, clinicians in Urology to ensure that continuity of care is optimised. • There should be clear procedures for allocating patients against specific pathways (including in line with Cancer MDT guidance). Any subsequent changes to management plans should be agreed with the named Consultant/an appropriate clinician especially if there are clinic cancellations or delays to treatment.	H	Yes (Trust)
R13	**Recommendation 13 - Monitoring of additional activity sessions (AASs)** Introduce a robust policy and controls to retrospectively and prospectively review AAS activity in the Urology department, including a quarterly analysis of the number, value, and justification for AASs undertaken on a clinician-by-clinician basis.	M	Yes (Trust)

Trust recommendations arising from the Interim Current Case Review Report issued on 8 March 2021

No.	Advised action	Priority	Potential for wider applicability than Urology
R14	**Recommendation 1 - Fluid balance monitoring** Fluid balance practice should be audited and a programme of high-quality recording put in place for Urology patients.	H	Yes (Trust)
R15	**Recommendation 2 - Mortality review (Link to R10 and R26)** • Following on from our recommendation on mortality review in our Draft Current Controls Assessment Report, the Trust must develop a robust mechanism for identifying deaths by speciality using both admission and treatment function codes and other identifiers. This should include deaths up to 30 days post-discharge. • The HOGAN[34] and National Confidential Enquiry into Patient Outcome and Death (NCEPOD)[35] scoring arising from mortality reviews must be subject to audit and further scrutiny within the Trust. • All NCEPOD or HOGAN scores of 2 or above should give rise to further review by the Trust, investigation where appropriate and the potential need for Duty of Candour processes.	H	Yes (Trust)
R16	**Recommendation 3 - Named Consultants** • Named Consultants, for complex patients, should be introduced in Urology. This should include non-cancer patients. Complex cases without a diagnosis should be discussed at MDT or Radiology meetings. • Clinicians should be allocated clinical responsibility for the oversight of pathways including by cancer type to develop greater ownership and to drive improvements in services. (See R54(E)).	H	Potential (Trust)

[34] HOGAN - A standardised scoring following a retrospective case review on a 1-6 scale to assess preventability
[35] NCEPOD - National Confidential Enquiry into Patient Outcome and Death grading - a grading system following mortality review to grade care from good practice to less than satisfactory

R17	**Recommendation 4 - Capacity and best interests: applying the Mental Capacity Act 2005** • Capacity assessment and best interest decision-making should be improved through audit, training, and best practice examples. • An enhanced focus should be given to people presenting with dementia or confusion and those with a learning disability. • A thematic review examining the pathway, management and replacement of suprapubic catheters should be undertaken.	H	Yes (Trust)
R18	**Recommendation 5 - Consent** • Consent for operations must be completed on every occasion. Any consent not completed correctly must be reported and investigated to improve practice. • Consenting practice should be subject to audit and should include whether the patient dated the consent and the practice of confirmation of consent where the operating surgeon is different from the consenting surgeon. • Theatre staff should be alerted to our concerns regarding consenting practice and be authorised to report all incidents where consent is not compliant with expected practice.	H	Yes (Trust)
R19	**Recommendation 6 - Lorenzo** • All scan and clinical results should be acknowledged by the requester. Clinicians should be trained on the use of Lorenzo to ensure that they are aware of how to complete this activity. • It should be made clear to all staff in which part of Lorenzo key documentation should be filed to reduce the amount of time spent finding key clinical information. • A record of stent register status should be clearly marked and visible.	M	Yes (Trust)
R20	**Recommendation 7 - Recording of ethnicity** • The sample provided does not include information on ethnicity other than White or Unknown/Mixed. The Trust should examine whether it is recording ethnicity in its records in line with expected practice. https://www.england.nhs.uk/wp-content/uploads/2015/03/monitrg-ehi-pos-paper.pdf	M	Yes (Trust)
R21	**Recommendation 8 - Case note review** • There should be a repeat case note review (100 cases) in 12 months (Autumn 2022) to assess if improvements have been sustained and embedded.	M	No

Trust recommendations arising from the in-depth investigation into the index case

No.	Advised action	Priority	Potential for wider applicability than Urology
R22	**Recommendation 1 - Improving the pathway for bladder cancer diagnosis** • Where appropriate, conducting a flexible cystoscopy on the day of attending the One Stop Clinic would make this a truly one-stop service. • Patients meeting the two-week wait criteria with visible haematuria and normal estimated glomerular filtration rate (eGFR) should be triaged to have a CT Urogram prior to attending clinic to streamline the service. • Patients requiring ongoing monitoring following chemotherapy/radiotherapy should be referred back via the MDT to a named Consultant at the Trust, on completing their therapy, who is then responsible for co-ordinating on-going care (e.g. in this case, being clear about the rationale for examination under anaesthetic (EUA), biopsy, cystoscopy and stenting). The MDT will need to ensure there is a clear management plan and processes put in place to ensure Urology actions are implemented. This will also allow time to plan dates for surgery to meet required timescales. • Lancashire and South Cumbria Cancer Alliance follow up protocols should be agreed and followed. • All patients should be listed on the stent register. If they are transferred to another Trust with the expectation that the stent is removed, this should be explicitly stated; if patients are transferred into the Trust with a stent in situ, they should be added to the Trust's stent register.	H	Yes (Trust/Cancer Alliance)
R23	**Recommendation 2 - Clinical monitoring** The Trust should continue to embed good practice and use of: • Venous thromboembolism (VTE) assessment. • Nutrition, hydration and associated food/fluid balance monitoring must be enforced as fundamental standards. Use of the Malnutrition Universal Screening Tool (MUST) should be audited at specified intervals to ensure scoring and onward actions are appropriate.	M	Yes (Trust)

	• Total Parenteral Nutrition (TPN) guidelines should be reviewed and monitored to ensure that this option is considered early for all patients who are at risk of malnutrition. • The Trust should monitor the recent implementation of the electronic NEWS2 charts to ensure that the new system is successful in identifying and responding to deteriorating patients. • Access to formal on call microbiology advice out-of-hours should be provided.		
R24	**Recommendation 3 - Standard operating policies and procedures** The Trust must ensure the following are up-to-date and subject to regular audit: • the identification and management of Urosepsis and obstructed kidneys; • the identification and management of sepsis and the deteriorating patient; • the management and registration of stents; • handover of patients between on call Consultants; • consenting guidelines, including actions to be taken when patients cannot consent and when emergency surgery is required; • interspecialty referral processes; and • recording decisions made when a patient is referred to Intensive Treatment Unit (ITU), the escalation of capacity issues and a clear protocol regarding options when ITU is full.	M	Partial (Trust)
R25	**Recommendation 4 - Nephrostomy service** • The Trust and Clinical Commissioning Groups (CCGs) should review arrangements for out-of-hours nephrostomy provision, including over bank holidays and emergency cover. • The arrangements that have been put in place should be assessed to ensure that standards for accessing nephrostomy provision out of hours and for returning patients to the Trust are appropriate, agreed, and form part of a standard operating procedure that is audited to confirm compliance.	H	Yes (ICS)
R26	**Recommendation 5 - Mortality review (Link to R10 and R15)** • Any post-operative death should be subject to rigorous and contemporaneous case review and monitored at Trust level. This would also help support accurate reports to the Coroner if required to be written some months post death. • Death summaries and sudden death reports to the Coroner should be audited for quality and accuracy.	H	Yes (Trust/National)

	• Every inpatient death within the Surgical and Critical Care Group (S&CCG) should be reported and subject to case review, this review should be shared within the department and at Trust level. • Every inpatient death in Urology services and other surgical specialties should be discussed in departmental meetings. • Every inquest involving the Trust must include consideration of whether an incident might have occurred that requires investigation and to prepare statements and reports in an adequate timeframe. • Statements to Coroners written in relation to whole episodes of care involving a team or a Trust service should be subject to validation by legal or corporate services to ensure that all parties have a right of reply (where needed) and that statements made are accurate. This is distinct from an individual health care professional providing a witness statement solely in relation to their own input. • Failures in care identified as a result of producing a Coroner's statement must be reported as an incident and any named individuals given a right of reply. • The Trust's Providing Statements to the Coroner Standard Operating Procedure should be revised to include the above. • The Trust must assure themselves that the Providing Statements to the Coroner Standard Operating Procedure is being complied with. Statements should differentiate between fact and opinion. In addition, there should be a clear indication of how the statement has been compiled. • The Trust should ensure that records are retained post-death and copies made for the purposes of review and investigation to mitigate the risk of retrospective entry. [The Medical Examiner role was introduced in the Trust in April 2020; this function should be assessed against the above recommendations].		
R27	**Recommendation 6 - Managing complaints and compound family questions** • The Trust's Management Procedure for the Investigation and Resolution of Complaints should be reviewed to ensure advice is clear on the handling of persistent/compound complaints that are not vexatious. • Repeated approaches/compound questions from a family in relation to concerns in care, including the death of a loved one, should be formally logged as a complaint.	M	Yes (Trust)

	• These cases should be allocated an appropriate single point of contact or family liaison officer to manage the process and support the family. These cases should also be flagged and carefully monitored as they have potential for extended resolution timescales. • Any case involving an inquest or complaint from a family should also be reviewed to determine whether it should be recorded as an incident(s). Any subsequent investigation and complaints processes should be managed in a coordinated fashion. • Compound complaints often arise once medical records are provided as these may be incomplete (due to archiving and multiple patient record systems). The Trust should ensure that full sets of medical records are provided at the outset of the request in line with existing Freedom of Information Act (FOIA), Subject Access Requests (SAR) and Access to Health Records Policies. • Clear guidance on sharing the medical records of deceased patients with families should be set out to ensure that relatives are provided with requested information promptly and in line with the appropriate legislation. • When FOIA or SAR include requests for email-based information, all searches should be formally logged and centrally managed so that the Trust has a full record of searches available to them.		
R28	**Recommendation 7 - Consultant relationships (Link to R65(E))** • The Trust should pay particular attention to any grievance raised by a Consultant or senior medical member of staff about another peer. Prompt and diligent investigations should be undertaken to ensure that the basis of concerns is fully understood and properly actioned to resolve peer-to-peer difficulties and concerns in a transparent and effective manner. • The Board should be made aware at an early stage of any specialty where relationships may be failing as this is a key patient safety marker. The Board should monitor actions to achieve improvement. This should be undertaken via the Employee Relations Report. • The Medical Director should be informed of any concerns about Consultant relationships (as Responsible Officer).	H	Yes (Trust)
R29	**Recommendation 8 - Triggers for external investigations** • Terms of reference for all externally commissioned investigations should be scoped individually and quality assured to ensure that patient/family questions are included and that specific Trust concerns are addressed. (This principle should be followed for all root cause analysis (RCA) and serious incident (SI) reports undertaken internally in line with good practice).	H	Yes (Trust)

	• The Trust should develop a set of triggers for external investigations to be undertaken including when departmental dysfunction is apparent. • The Trust should revisit its tolerance for requesting external support in investigations.		
R30	**Recommendation 9 - Clinical records in the form of emails (Link to R34(E))** • The Trust should add all Consultant staff email accounts to their Very Important Persons (VIP) list for a period of seven years once employment is ended. • The Trust should revisit its record-keeping policy as regards the use of email communications between clinicians containing clinical information. This should include: - clarification of what is an acceptable use of email in sharing patient specific clinical information, both internally and externally, to the Trust (including in clinical networks); - ensuring that where patient specific clinical information is shared by email (if appropriate) that these communications are retained as part of the clinical record; - revisiting the Trust email archiving policy, in light of the above, to ensure that emails can be retrieved where necessary (for example for SAR purposes); and - that all professionals should record the fact that an onward communication has been made within the clinical record.	H	Yes (Trust/ICS/ National)
R31	**Recommendation 10 - Clinical dispute resolution** • The Trust should introduce a mechanism of escalation, separate to the existing grievance and Freedom to Speak Up processes, whereby clinical disputes (in MDTs, between individuals or within departments) are formally mediated and resolved. The responsibilities for professionals involved in the event to engage in this mechanism of escalation should be made clear. This should be supported by a formal policy and should detail timescales for reporting, arbitration, resolution, and the trigger for the involvement of independent clinical adjudicators. Processes to report into other forums (such as Clinical Governance, mortality review, Ethics Committee and Revalidation) should be made clear within this policy.	M	Yes (Trust)

NHS England and NHS Improvement recommendations in-depth investigation into index case

No.	Advised action	Priority	Potential for wider applicability than Urology
R32(E)	**Coroner's statements** NHS England and NHS Improvement should develop guidance for Trusts and NHS organisations more widely in relation to the following aspects of recommendation 5 (R26) above: • Statements to Coroners written in relation to whole episodes of care involving a team or a Trust service should be subject to validation and where a statement includes or implies failures in care all individuals named should be given a right of reply. This is distinct from an individual health care professional providing a witness statement solely in relation to their own input. • Where failures in care are identified as a result of the production of a statement and a new incident is reported, the Coroner should be informed to determine if an investigation report will be required for any further proceedings. • Trusts must assure themselves that their policies in relation to providing statements to the Coroner are being complied with. Statements should be based on fact rather than opinion and there should be a clear indication of how the statement has been compiled.	H	Yes (National)
R33(E)	**Clinical practice** NHS England and NHS Improvement should consider what relevant guidance could be developed for Trusts and NHS organisations more widely in relation to recommendations 1–8 made in this report and how these lessons might be shared. The learning from this report would be of benefit to the wider NHS community through an anonymised case study which will be developed from this case.	M	Yes (National)
R34(E)	**Clinical records and email communications** NHS England and NHS Improvement should decide whether more guidance is needed in relation to the uses and retention of email correspondence (or other electronic communications) as part of health records and any regional or national implications of recommendation 9 above.	M	Yes (National)

Recommendations arising from the wider investigation

Trust recommendations

No.	Advised action	Priority	Potential for wider applicability than Urology
R35	**Review Niche patient case studies** The Trust should review all Niche case studies in priority order to contact patients in respect of Duty of Candour or ensure appropriate investigations have been completed to a high standard and actions have been implemented.	H	No
R36	**Urology pathway priority management** • There is a need to redesign follow-up pathways for Urology patients to match capacity and demand to prevent backlogs and balance this with the faster response for new referrals. Clear protocols for long-term active surveillance which ensures cases are appropriately seen at the right intervals are required. • Advance booking for long-term surveillance procedures should be introduced (including stent replacement and cystoscopy) and audited to ensure delays are minimised.	H	No
R37	**Capacity and demand modelling in Urology** The Trust should undertake a capacity and demand modelling exercise (including the use of PLICS information) to provide an up to date baseline for the service and to support job planning. This should include: • Medical staffing levels • Junior staffing resources • Administrative resource • Nursing skills and a clinical nurse specialist role review	H	No
R38	**Revisit and align all reporting policies** The Trust should revisit and recommunicate the following policies to ensure that the purpose is clear, that they are aligned to each other and that they are workable for staff to readily follow and apply	M	Yes (Trust)

	when escalation is required. This should include a flow diagram so staff can see which policy to follow in which situation. • Incident reporting • Raising Concerns • Grievance management • Whistleblowing • Freedom to Speak Up		
R39	**A specialty focus** The Trust should identify key specialty metrics that enable focus on harms to be triangulated in subspecialties of the Surgical and Critical Care Group (S&CCG). This should include: • A single monthly report on claims, incidents, Parliamentary Health Service Ombudsman (PHSO), Never Events and complaints with a cumulative analysis of themes arising. • At least biannual thematic reviews (regardless of whether complaints or claims are upheld) to understand any concerns being raised at the earliest possible opportunity. • An annual reconciliation of claims and complaints and their conversion to incident reports should be undertaken to ensure all patient safety concerns are logged through the incident reporting process for learning. • Learning and sharing relevant patient safety issues arising from MHPS investigations (which should be logged as incidents where appropriate). • Use of the annual GMC National Trainee Survey results to ensure information on junior doctors' experience is considered as part of these metrics.	M	Yes (Trust/ICS)
R40	**Implement clinical audit programme (Link to R4, R9, R14, R18, R25, R41, R47)** A standard should be set for each of the following against which a clinical audit programme should be implemented: • Handover quality • Emergency surgery including access to and use of theatres out of hours • Emergency transfers from FGH to RLI • Stent register compliance • Results review and acknowledgement • MDT referrals, implementation of actions, attendance and quality of behaviours • Out-of-hours support from junior doctors	M	Partial (Trust)

	• Ward round management • Consenting practice • Continuity of care • Harms as a result of delayed follow ups and IRDs • Application of National Institute for Clinical Excellence (NICE) guidance		
R41	**Cancer MDT management** The Trust, with the Cancer Alliance, should: • Agree and implement new Standards of Care (SoC) in line with the advice of the Streamlining MDT Meetings guidance. • Clarify the expectations of core members at both local and network MDTs and the expectation for named Consultant Urologists to present their cases. A deputy role for the chair of the local MDT should be put in place. • Ensure that all core members attend the MDT as agreed above. • Audit the new processes to ensure alignment with the introduction of the named Consultant. • Ensure responsibility for actioning decisions made at the local MDT is maintained within the Trust. • Ensure there is clarity for responsibility for actioning decisions made at the network MDT. • Ensure that professional behaviours are demonstrated at both local and network MDTs and confirmed through observation and transparent feedback on a regular basis for all attendees.	H	Partial (Trust/Cancer Alliance)
R42	**104 day cancer breach root cause analysis** • Ensure all 104 day cancer waiting time breaches are subject to a root cause analysis (RCA) and thematic reviews are acted upon to ensure pathway problems are properly identified and improved. • The Trust should follow the newly released (October 2021) North West Guideline: Managing Long Waiting Cancer Patients	M	Yes (Trust)
R43	**Emergency theatre access** • The Trust should monitor the use of emergency theatres out of hours in Urology (building on the analysis provided in this report) to establish whether the existing Standard Operating Procedure (Theatre Access) is effective in changing the pattern of practice highlighted by this report. • This should be examined in the context of whether some emergency theatre demand could be reduced through the provision of ward based facilities.	H	Partial (Trust)

R44	**Patient handover** Handover of patients between Consultants should include: • a formal handover arrangement between Consultants for out of hours cover. • a handover for patients who are transferred between Consultants.	H	Yes (Trust)
R45	**Managing team dysfunction** A uniform approach should be applied to team dysfunction. This should include: • Clear communication from the Trust re the service strategy, goals and objectives - particularly around behavioural standards • Holding to account against professional standards in Good Medical Practice • Sustained visible leadership and "sponsorship" from the Board • Intelligent review of patient outcomes and harms • Follow-up, monitoring and review to ensure that behavioural improvements are sustained.	H	Yes (Trust)
R46	**Duty to monitor staff wellbeing** The Trust has a duty to monitor staff stress levels and wellbeing and to intervene to support and understand the underlying issues before burn out affects patient care. The Trust should develop a cultural dashboard to identify key metrics that can provide early warning of team stress e.g. Occupational Health referral, employee relations concerns, engagement scores.	H	Yes (Trust)
R47	**Appraisals for medical staff (Link to R40)** • Appraisals may identify colleagues who are having difficulties and a protocol should be put in place to safeguard staff when concerns are apparent. • The Responsible Officer should explicitly monitor appraisals which may demonstrate team dysfunction as a means of early warning and to instigate remedial interventions. • Specialty interests with key outcome measures at unit level should be agreed. Individual Consultants should be given lead responsibility for specialist areas with outcomes linked to the clinical audit programme and fixed into appraisal processes.	M	Yes (Trust)
R48	**Engagement with Consultant body** • Engagement by executive and non-executive members of the Board with the Consultant body should be examined and options provided to facilitate increased opportunities for interaction. • This should include a clear programme of engagement at sub-specialty level over a rolling programme. This should be in addition to existing Medical Advisory Committee meetings.	H	Yes (Trust)

R49	**Trust Management of Royal College reports** • The Trust should inform regulators (CQC and NHS England and NHS Improvement) and commissioners of any plans for external reviews for quality and safety concerns, including Royal College Invited Service Reviews as soon as they are confirmed. This will ensure that regulators and commissioners can take this into account in their assurance activity in real time. • Advisory reports from the Royal Colleges should be shared, in full or in summary where appropriate, by the Trust with the Trust Board. • The Trust should formally inform the regional or local NHS England and NHS Improvement team, the Care Quality Commission and relevant fitness to practice investigations conducted by the GMC and commissioners of relevant Royal College reports and share these where appropriate. • Transparent action plans arising from all Royal College reports should be developed by the Trust, shared with the Trust Board and formally monitored through the Trust Quality Committee.	H	Yes (Trust)
R50	**Clarify role of governors and escalation mechanisms** • Governor training and induction programmes should be revisited to confirm that methods for escalating concerns are clearly set out and understood. • Procedures for escalation should include processes for resolution where governors remain dissatisfied with responses to issues raised.	M	Yes (Trust)
R51	**Institutional memory** Formal handover procedures should be in place for all incoming and outgoing Board members (including postholders with committee chair roles). These handovers should include employee relations issues and sub-specialty summaries.	M	Yes (Trust)
R52	**Media articles** Revise advice and guidance on dealing with media articles that name individuals and provide support to ensure an appropriate right of reply is sought (also in line with GMC guidance on responding to criticism in the media[36]).	H	Yes (Trust)

[36] https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/confidentiality---responding-to-criticism-in-the-media

Commissioner recommendations arising from wider investigation

No.	Advised action	Priority	Potential for wider applicability than Urology
R53(C)	As part of the work underway to establish system governance, commissioners should agree shared mechanisms to enable proactive commissioning and visibility of the Trust's services at specialty/sub-specialty level.	H	Yes (ICS)
R54(C)	• Alternative mechanisms for specialty/sub-specialty level scrutiny as part of routine assurance processes should be examined, for example cyclical deep dives as part of an annual work plan led by commissioning managers for scrutiny by quality assurance forums. The heat map approach (as in Appendix 10) developed by the CCG provides a useful model for this purpose. • The CCG should add an analysis of complaints/concerns/incidents from GP practices at a specialty level on at least an annual basis as part of this scrutiny.	M	Yes (ICS)
R55(C)	A reporting template should be developed which brings together quality, activity, and performance information at a specialty level. A programme of reporting at this level should be agreed with the Trust, with frequency of reporting for each specialty to reflect jointly agreed priorities. This should provide a single source of reporting to all relevant governance groups. The Safe Today report provides a sound basis for development.	M	Yes (ICS)
R56(C)	Terms of reference for all quality assurance forums should be explicit about specific areas of focus, reports to be considered and how issues should be monitored. Key Issues Reports should be used for escalation. An issues log should be maintained which identifies concerns with departments/specialties involved and this should be shared, populated and reviewed at key governance forums.	M	Yes (ICS)
R57(C)	Internal audit should test the efficacy of CCG assurance at a Trust specialty level as part of its annual work programme.	M	Yes (ICS)
R58(C)	The CCG should ensure that its contractual requirements with the Trust relating to incident reporting, and as set out in the Quality Schedule to the latest contract (2021/22), are met.	M	Yes (ICS)

NHS England and NHS Improvement recommendations (in association with the Trust where relevant) arising from the wider Urology investigation

No.	Advised action	Priority	Potential for wider applicability than Urology
R59(E)	**Protecting patient confidentiality** Examine ways in which confidential patient information is appropriately anonymised for the purposes of employment tribunal hearings. Guidelines should include: • advice to healthcare professionals on the use of patient information in these proceedings in line with Good Medical Practice guidance and GMC guidance on the use of personal information; • advice on the relevant GDPR and Data Protection regulations and the right to protect private information for both patients, their families and other individuals; • information relating to circumstances where patients do consent to the use of their personal information being used; and • the application of how Duty of Candour applies in such circumstances.	H	Yes (National)
R60(E)	**Never Event review** Revisit the Never Events cases highlighted in this review and ensure that the Trust applies rigour to all possible Never Events reporting.	M	Yes (National/MHRA)
R61(E)	**Learning from Deaths** Consider a revision to the Learning from Deaths guidance to ensure that patient records on death are suitably managed in original form by professionals to reduce the risk of posthumous amendment.	M	Yes (National)
R62(E)	**Networked support for team development** NHS England and NHS Improvement and the CCG should seek stronger working relationships between the Trust and tertiary centres to support Consultants in facilitating the provision of sub-specialty services at the Trust.	M	Yes (Trust)

R63(E)	**Development of safe services and specialist interests** A Urology strategy should be developed involving all key Urology medical staff and other relevant healthcare professionals to set the context for the following actions: • The Trust should undertake an equipment stocktake for Urology and plan into the capital replacement programme the need for cystoscopes, bipolar diathermy and suction equipment both in the short term and over the medium term or consider lease options. • Examine, with the Trust and CCG, the development of Urology sub-specialisms building on Andrology and stone services, the management of superficial bladder cancer, local anaesthetic transperineal biopsy work and paediatrics. • Examine, through the provider collaborative network, the viability of Urology provision across two sites and its associated support services in the long term should be examined in respect of future provision at Furness General Hospital. Formal consideration of centralising inpatient and emergency Urology services on one site should be revisited. This should include options for dedicated ward based facilities.	M	No
R64(E)	**Regulation and oversight of team dysfunction (Link to R65(E))** • NHS England and NHS Improvement should discuss the lessons learned from this review with the Care Quality Commission and share them with the National Quality Board or similar regulatory oversight group, in respect of the failings to resolve the long standing dysfunction in this team. • NHS England and NHS Improvement should provide clear guidance about what external support might be available to Trusts from the regional medical directors' teams and the advisory options when there is team dysfunction emerging. • Regulatory activity should review the effective functioning of the Responsible Officer role in regard to managing concerns where team dysfunction may be apparent. • Guidance should include ensuring Trusts are encouraged to seek early support where team dysfunction may put patient safety at risk.	H	Yes (National)
R65(E)	**Guidance and support to Responsible Officers from NHS England and NHS Improvement Regional Medical Directors** • NHS England and NHS Improvement should ensure that guidance to ROs is up to date and a final version is in force to include the 2013 RO regulation amendments and learning since the role was introduced.	H	Yes (National)

	• Regional Medical Directors should use this investigation as a case study to reinforce escalation processes for Responsible Officers who may be facing conduct difficulties within their medical workforce. • The North West Regional Medical Director should share this case study with other Regional Medical Directors to reinforce the importance of the RO role, appointment processes and the lessons learned from this investigation. • Good practice should be shared between Trusts to provide clarity on the best approaches for dealing with and escalating behavioural and conduct issues that are impacting on patient safety in line with Good Medical Practice. • The Trust Board should revisit its understanding of the role of the RO and assure itself that there is clarity of duties between the Medical Director (now as RO) and the wider team in exercising duties to meet the RO regulations.		
R66(E)	**Whistleblowing** Guidance on setting up appropriate governance processes should be developed to support intractable whistleblowing cases. It should aim to provide resolution to concerns and facilitate learning in relation to patient safety.	M	Yes (National)
R67(E)	**Assurance review** NHS England and NHS Improvement should commission a Phase 5 review (Autumn 2022) in line with the Terms of Reference to include assurance on key elements such as: • continuity of care; • named Consultant; • MDT management; • follow-up patient pathways; • the quality of incident reporting and investigations; • team development opportunities; and • mortality governance. to establish if implemented changes have become embedded and are sustainable.	H	No

National recommendations to advisory and regulatory bodies

No.	Advised action	Priority	Potential for wider applicability than Urology
R68(N)	**Role of the GMC in relation to team dysfunction** The GMC should reflect on this investigation. They should: • seek to understand how and if team dysfunction issues impact on fitness to practice investigations. • whether the role of medical managers and their fitness to practice (in relation to their management function) have been sufficiently considered in this case. • ensure that GMC guidance in relation to the RO regulations is up to date and considers the 2013 amendments to the regulations and learning since the role was introduced. • indicate to Trusts that the GMC Connect dashboard can be made accessible to Medical Directors as well as the RO team.	H	Yes (National)
R69(N)	**Enforcement and follow up of actions from Royal College Invited Service Reviews** Invited Service Reviews should include: • clear expectations for Royal College Invited Service Review reports to be shared, in full, by the Trust with the relevant Trust Board; • expectations for when Royal College Invited Service Review reports should be shared, in full, by the Trust with regulators; and • clarity about the implementation of action plans arising from Invited Service Reviews to enable the Royal College to be satisfied that recommendations have been fully addressed to end their active involvement.	M	Yes (National)
R70(N)	**Sharing of information between regulatory bodies** The effectiveness and intention of the Emerging Concerns Protocol https://www.cqc.org.uk/what-we-do/how-we-work-people/emerging-concerns-protocol should be revisited in the context of the findings of this case. The inclusion of additional signatories (e.g. Royal Colleges, NHS England and NHS Improvement) should be considered. This may be the most appropriate process to improve information sharing.	M	Yes (National)

R71(N)	**Assessing the effective role of the Responsible Officer in Well-Led assessments** The role of the RO and its development since the introduction of this function in 2010 should form a regular and consistent part of examination as part of internal and external Well-Led and governance reviews.	M	Yes (National)
R72(N)	**Testicular Implant Recall** NHS England and NHS Improvement should share the findings from the testicular implant recall exercise with relevant bodies and agree the next steps at a local or national level.	H	Yes (National)

6. Demographic and contextual data

6.1 We produced a detailed quantitative assessment of the Urology department through an analysis of a wide range of data provided by the Trust and on NHS websites. The draft analysis was provided for confirmation of factual accuracy to the Trust and NHS England and NHS Improvement in December 2020 and subsequently updated to underpin our findings.

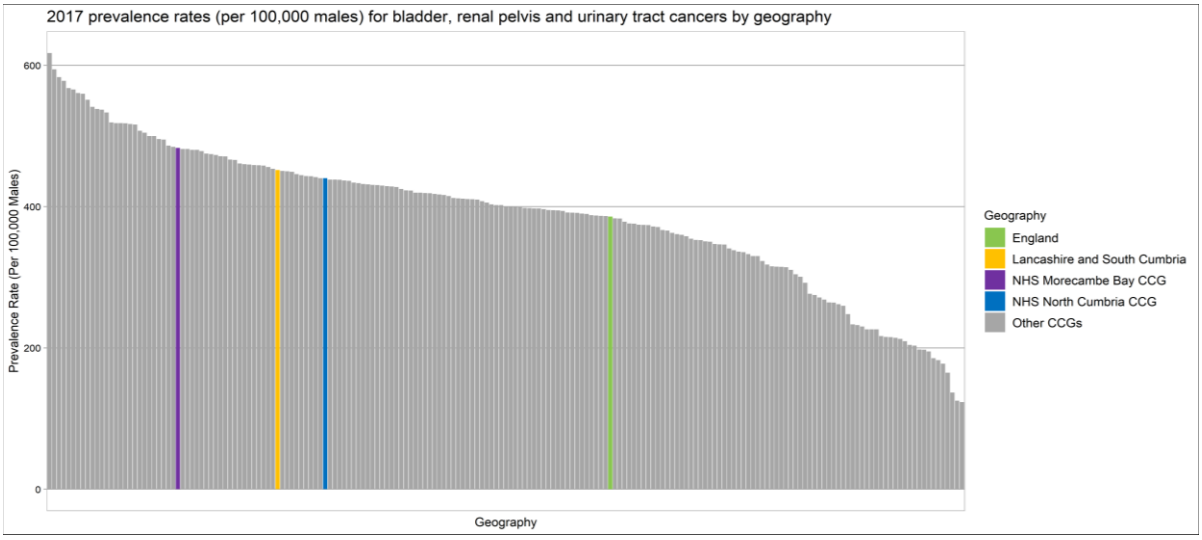
6.2 The key points arising from this analysis are set out below. Urology care encompasses diseases of the kidneys, bladder, and prostate, including incontinence, impotence, infertility, cancer, and reconstruction of the genitourinary tract. It delivers services for both male and female patients, although approximately 75% of referrals are male and 25% female.

Prevalence data

6.3 Key characteristics of the population served by the Urology department are:

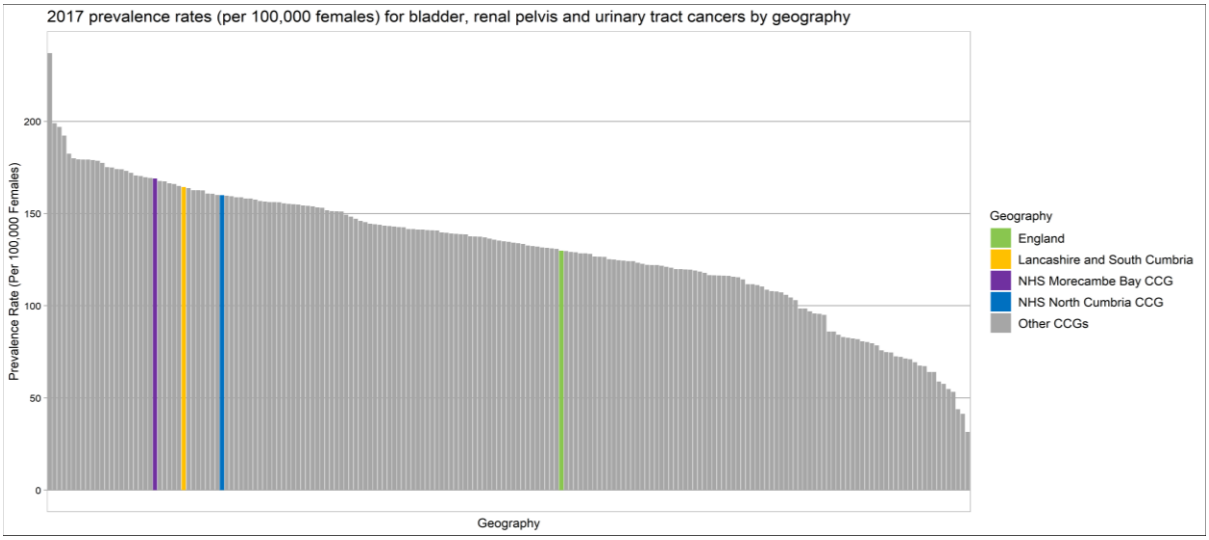
- On average an older population than the rest of England with a greater percentage of the population over 50 years
- Deprivation levels (a driver for poorer health outcomes and higher incidence of some cancers) are similar to the England average.
- Bladder, renal pelvis and urinary tract cancers have a higher prevalence in the catchment area for males than the England prevalence rate.
- The graph below shows Morecambe Bay CCG (MBCCG) had the 28th highest prevalence rate for male bladder, renal pelvis and urinary tract cancers amongst all (191) CCGs in 2017. North Cumbria CCG (NCCCG) had a lower prevalence rate (58th of all CCGs) than MBCCG, but it was still higher than the rate for England.

Graph 2 - Prevalence rates for bladder, renal pelvis and urinary tract cancers (males)



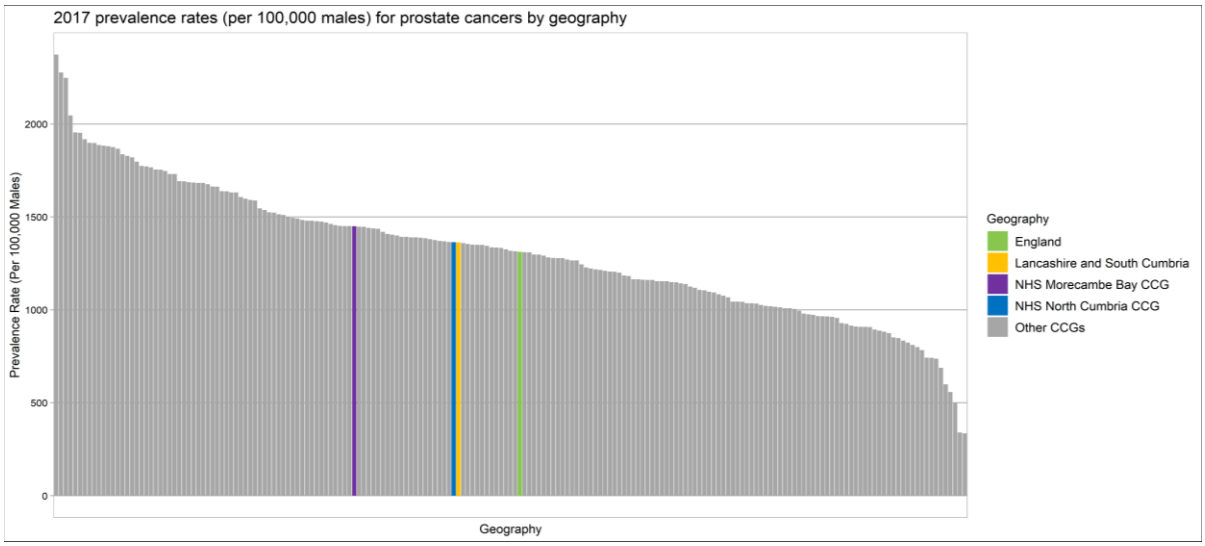
6.4 Bladder, renal pelvis and urinary tract cancers have a higher prevalence in the catchment area for females than the England prevalence rate. The graph below shows MBCCG had the 23rd highest prevalence rate for female bladder, renal pelvis and urinary tract cancers amongst all CCGs in 2017. NCCCG had the 37th highest prevalence rate which was also higher than the rate for England.

Graph 3 - Prevalence rates for bladder, renal pelvis and urinary tract cancers (females)



6.5 The prevalence of prostate cancers per 100,000 population is higher than the England prevalence rate and higher in the MBCCG catchment area than NCCCG.

Graph 4 - Prevalence rates for prostate cancers



- Testicular cancer prevalence is higher in the catchment area than the England prevalence rate.
- Bladder, renal pelvis and urinary tract cancers make up 7.9% of all cancers in the MBCCG catchment area. This is slightly higher than the England percentage. NCCCG also has a slightly higher percentage of these cancers than across England.
- Urology services deal with up to 27% of all cancer types in the resident population which is comparable to the England position.

Income data

6.6 The total income to the Trust for the Urology service is approximately £6.5m. This is divided between emergency care, day case surgery, inpatient care and outpatient income. The table overleaf shows this information:

Table 2 - Trust income by point of delivery grouping (£000's) 2008-2020

Trust income by POD grouping (£000s)

Grouping	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Day case	£2,257	£2,075	£2,411	£2,433	£1,592	£1,792	£1,714	£1,936	£1,877	£1,891	£2,056	£2,190
Outpatient	£1,696	£1,607	£2,161	£2,636	£2,871	£2,632	£2,510	£2,234	£2,316	£1,786	£1,799	£1,813
Elective	£1,601	£1,808	£1,853	£1,564	£1,452	£1,311	£1,429	£1,543	£1,507	£1,269	£1,174	£1,075
Non Elective	£448	£693	£784	£1,279	£1,239	£1,090	£1,280	£1,363	£997	£1,294	£1,397	£1,740
Total	**£6,002**	**£6,182**	**£7,209**	**£7,911**	**£7,155**	**£6,826**	**£6,933**	**£7,076**	**£6,697**	**£6,240**	**£6,426**	**£6,818**

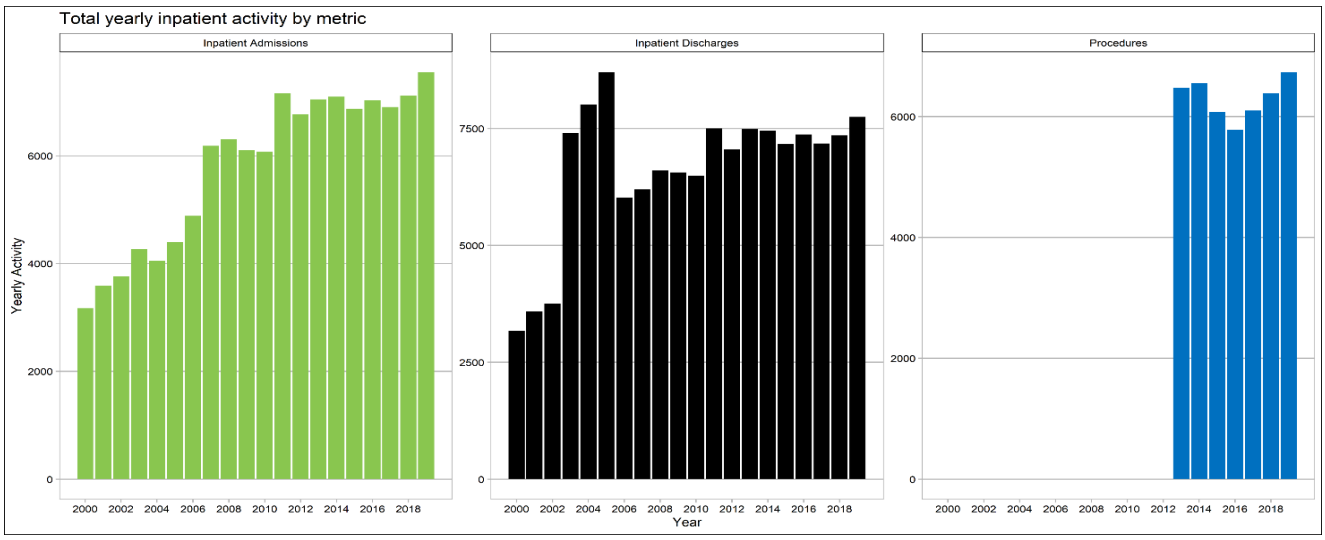
6.7 Income has remained relatively stable over the last 12 years.

Activity data

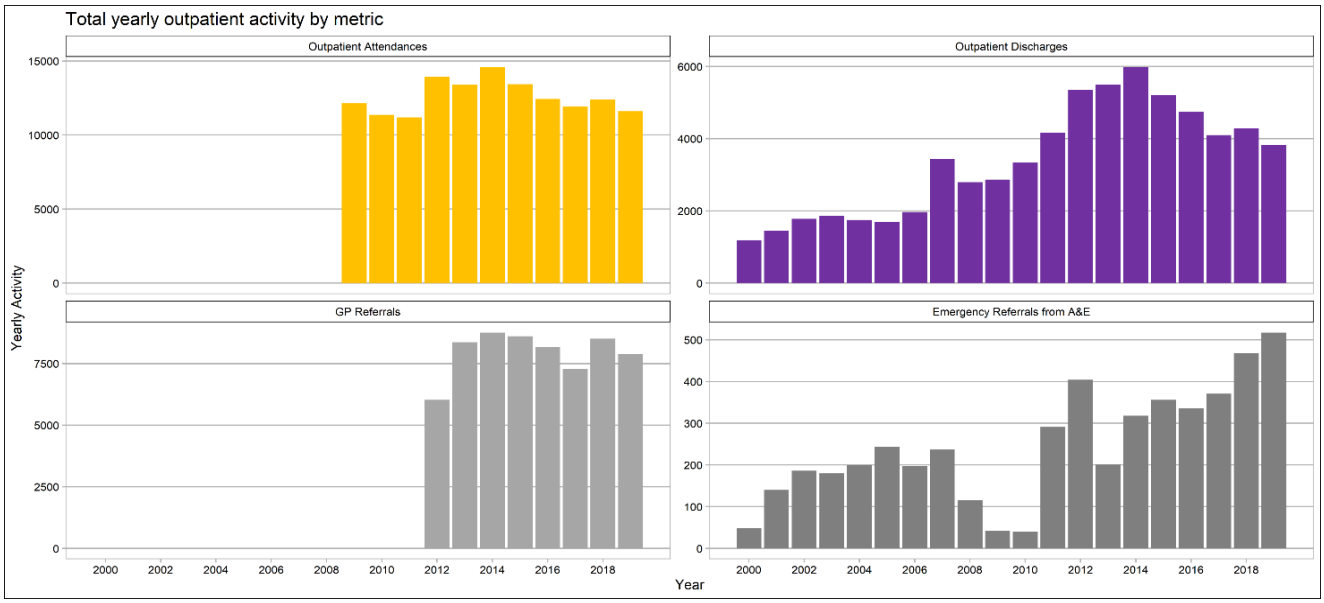
6.8 The service currently has approximately 7000 Finished Consultant Episodes (FCEs) per year and this has been largely stable over the last decade.

6.9 The activity in the Urology service from 2000 to 2019 is shown in the table below:

Graph 5a - Activity in Urology 2000-2019 (Inpatient and procedure activity)



Graph 5b - Activity in Urology 2000-2019 (Outpatient and referral activity)

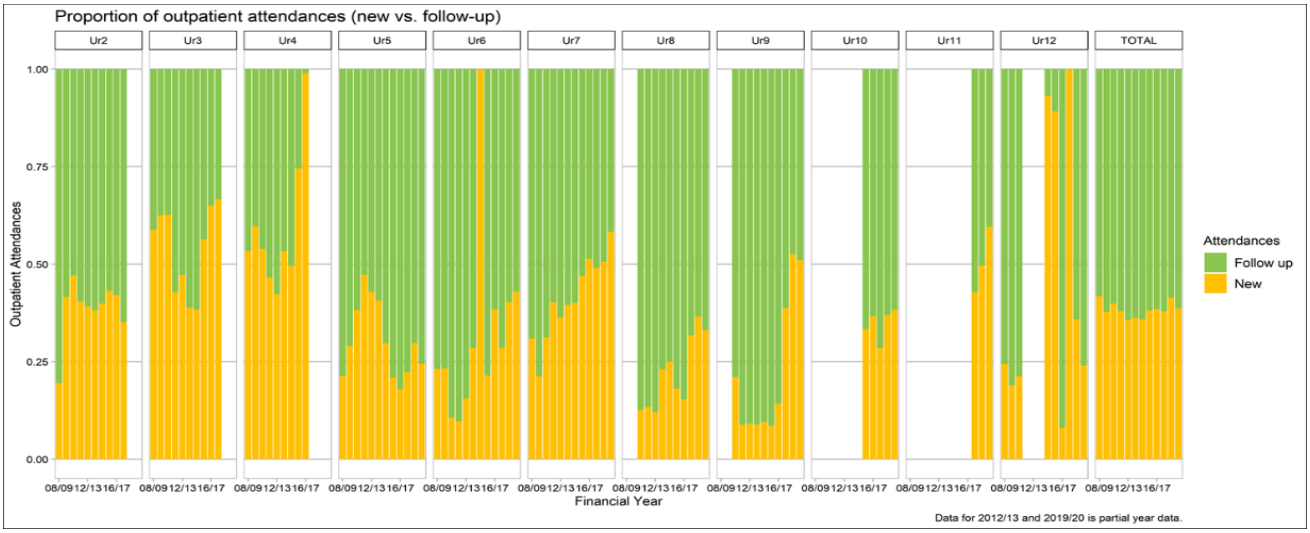


6.10 Inpatient activity rose steadily from 2000 to 2008, admissions increased further in 2011 and activity then remained relatively steady to 2019. Procedural data was only available from 2013 but like inpatient activity has remained largely steady.

6.11 Outpatient activity has been largely stable over the last ten years with total attendances of 11–14,000 including just under 5000 new outpatients per year (100 per week).

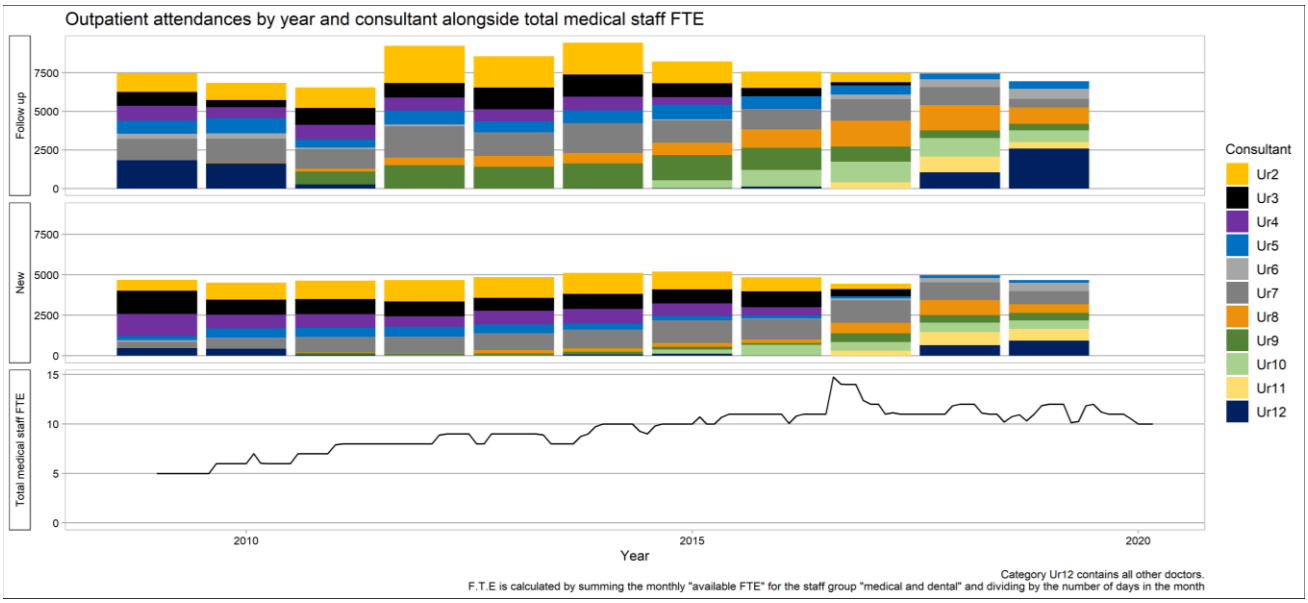
6.12 Graph 6 below shows new to follow-up ratios by Consultant and in total. The chart shows variable practice between Consultants, but the data is less reliable than other data sets due to the pooling of patients and with no named Consultant. The last ten years has also seen a stable level of GP referrals into the service, patients being discharged from the service, and a relatively stable number of procedures being performed across the Urology medical and nursing team.

Graph 6 - New to follow-up appointment ratios in outpatients



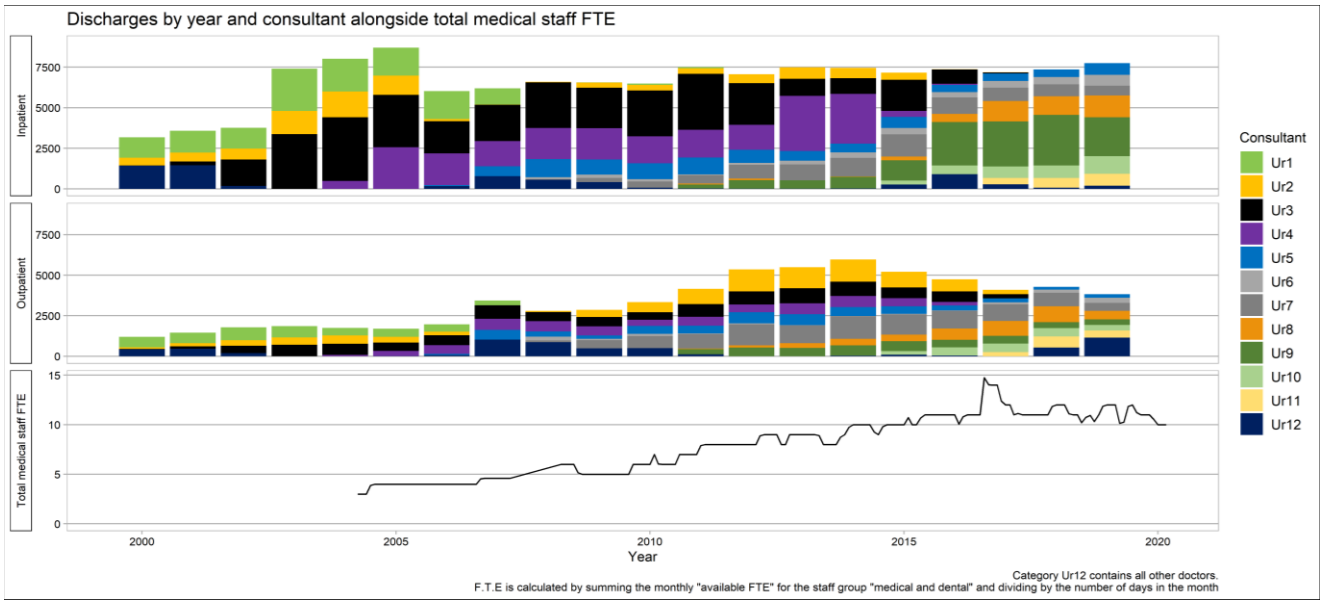
6.13 The table below shows outpatient activity relative to the increase in the workforce over the same period. The workforce increased at a higher rate than the activity. The data is provided per Consultant but, as above, this split may not be reliable as there was a pooled arrangement in place with no named Consultant.

Graph 7 - Outpatient attendance by year against workforce increase



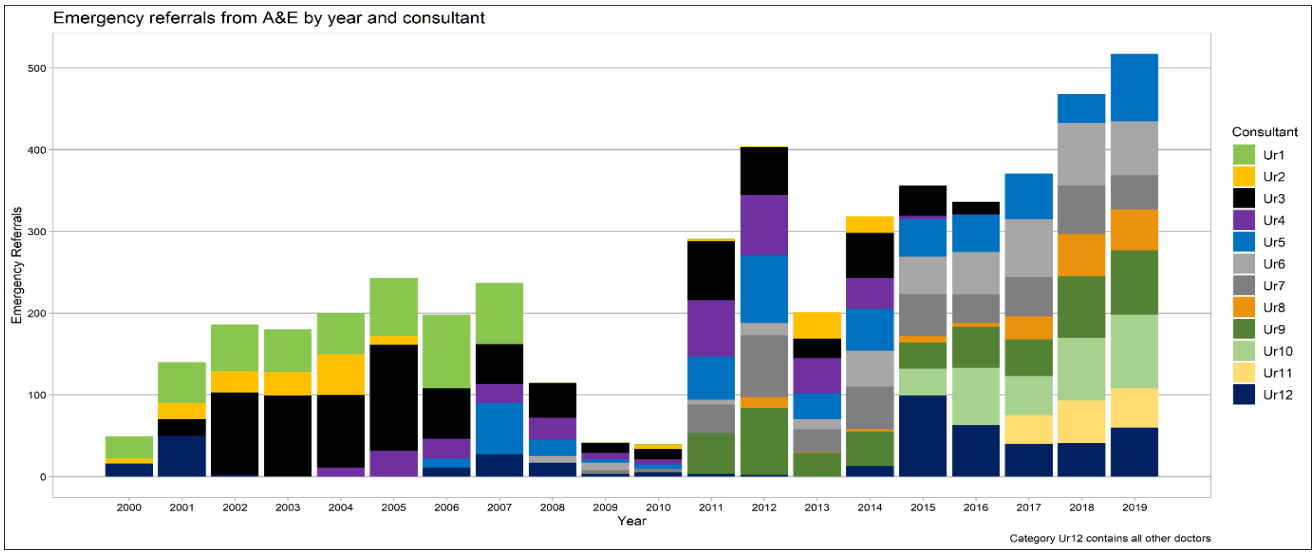
6.14 Discharge activity is shown below. The inpatient discharge activity shows the similarly stable nature of inpatient demand. Whilst there was an increase in outpatient discharges between 2012–2014, these are reducing. This may be due to the active surveillance required to monitor patients over the long-term for some types of cancer or to a less active validation process/increasing backlog. The data is shown per Consultant but may not be an accurate record of activity.

Graph 8 - Discharges by year from outpatients



6.15 Emergency referrals from the Emergency Department have steadily increased with a 60% increase between 2014-2019. (3-4 cases per week). The gap in 2009-2010 relates to an IT failure and cannot be filled but there has been an increase from an average of 300 referrals per year in 2011-2017 to approximately 500 per year in 2018-2019. This currently forms an average of nine to ten emergency cases per week. Evenly distributed this is between one to two emergency referrals via the Emergency Department per Consultant per week. The chart below shows the emergency referral data by Consultant. This data is more reliable than previous data sets as the on call Consultant is usually the named Consultant in these cases. The referral workload appears relatively evenly distributed between Consultants with Locum Consultants (Ur 12) taking a similar share in later years.

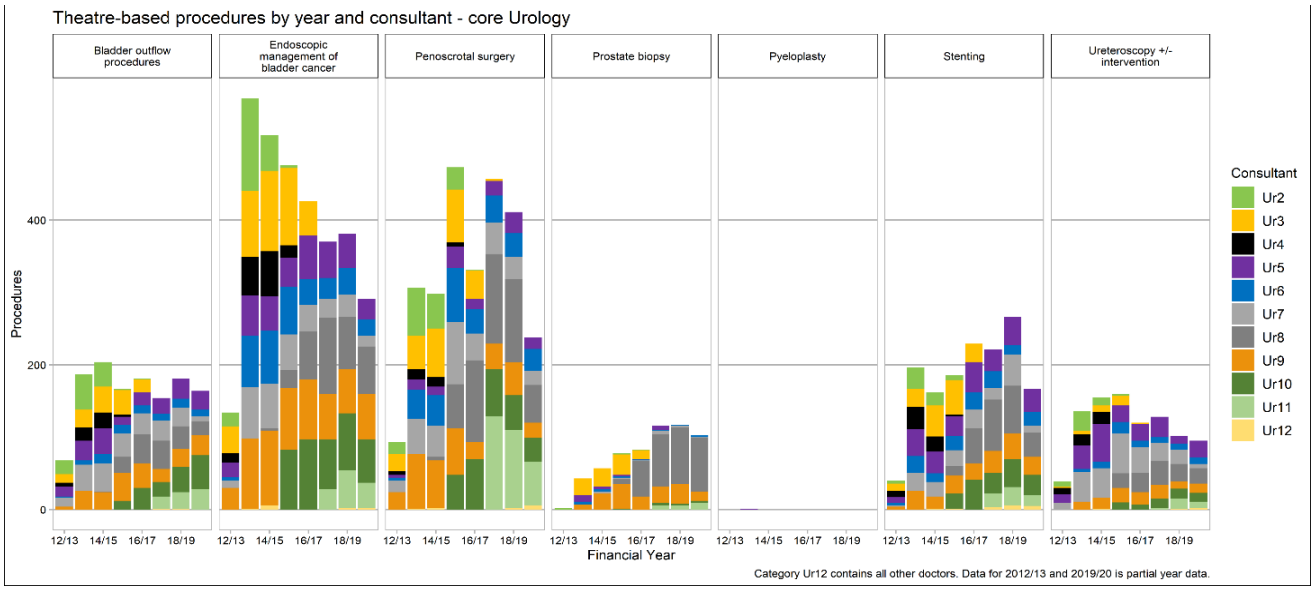
Graph 9 - Emergency referrals to Urology



6.16 In relation to procedures, many are carried out by the nursing staff in relation to catheter management and minor procedures. Approximately 1,400 core Urology theatre-based procedures are conducted annually by Consultants and senior medical staff (27 procedures per week/4-5 procedures per Consultant per week).

6.17 The most common theatre procedures conducted by senior medical staff are shown in the table below. These relate to transurethral resections of the prostate (TURP), inserting and changing stents, examining and taking biopsies of the bladder using flexible or rigid cystoscopes, and bladder resections. These are core Urology techniques. Penoscrotal surgery, also a core Urology procedure, is one of the more common procedures undertaken.

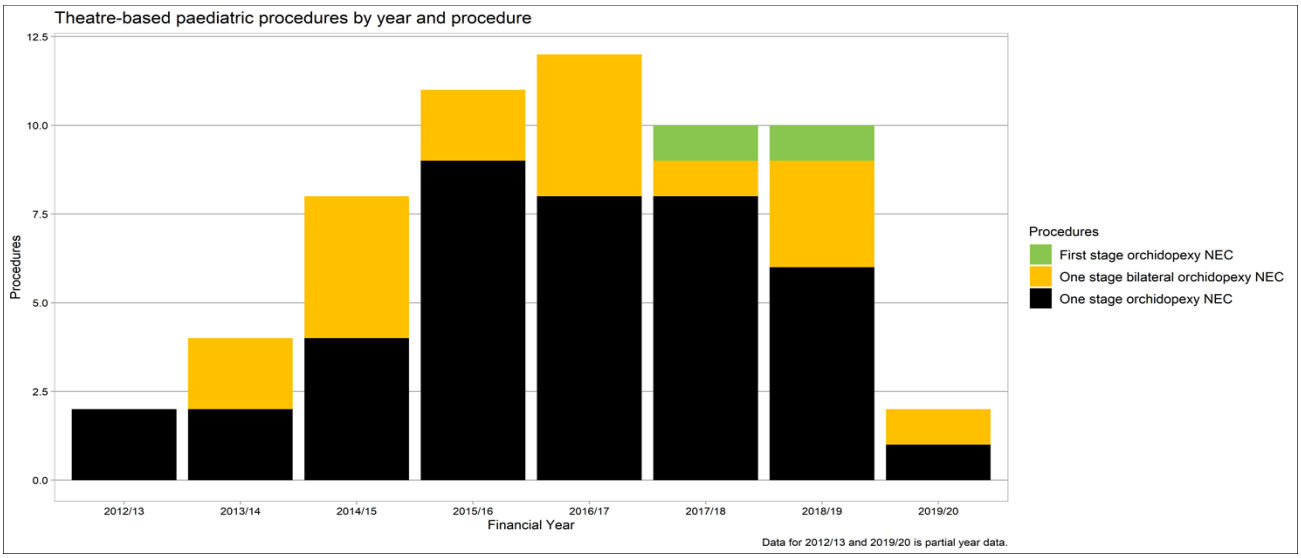
Graph 10 - Theatre-based procedures



6.18 Special interest surgery amounts to, on average, 85 procedures annually (1-2 per week).

6.19 A small amount of paediatric work (orchidopexy) was being conducted; however, this is no longer carried out by the Urologists as the numbers are too small to justify. In emergency cases it may be appropriate for Urologists to perform procedures (especially in the case of testicular torsion). See chart below:

Graph 11 - Paediatric procedures by year



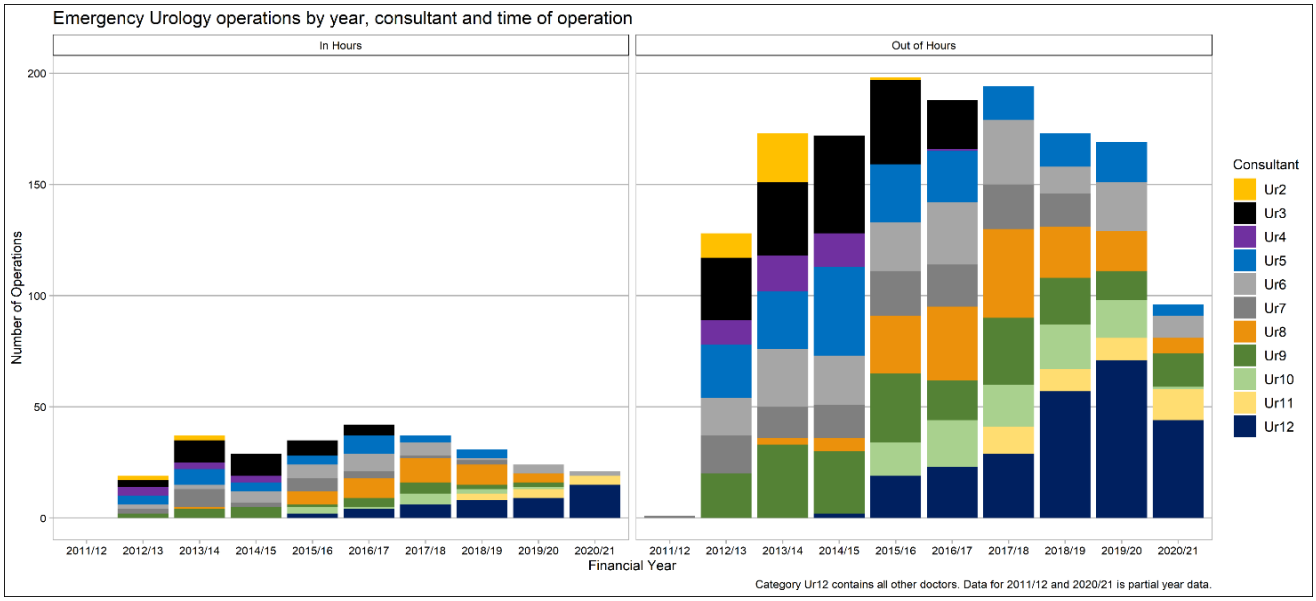
6.20 Approximately 100 circumcisions and a small number of vasectomies are performed each year.

6.21 Major procedures should not have been carried out in small numbers at the Trust (some of these may be coding errors). The number of nephrectomies and nephroureterectomies was small (15-20 per year) and probably only sufficient for one surgeon to maintain a specialism, but it was divided between too many surgeons to remain safe. A service relying on one surgeon would not be resilient and it is appropriate that this service has now stopped.

6.22 The management of specialist Urology procedures needs to be actively monitored and developed.

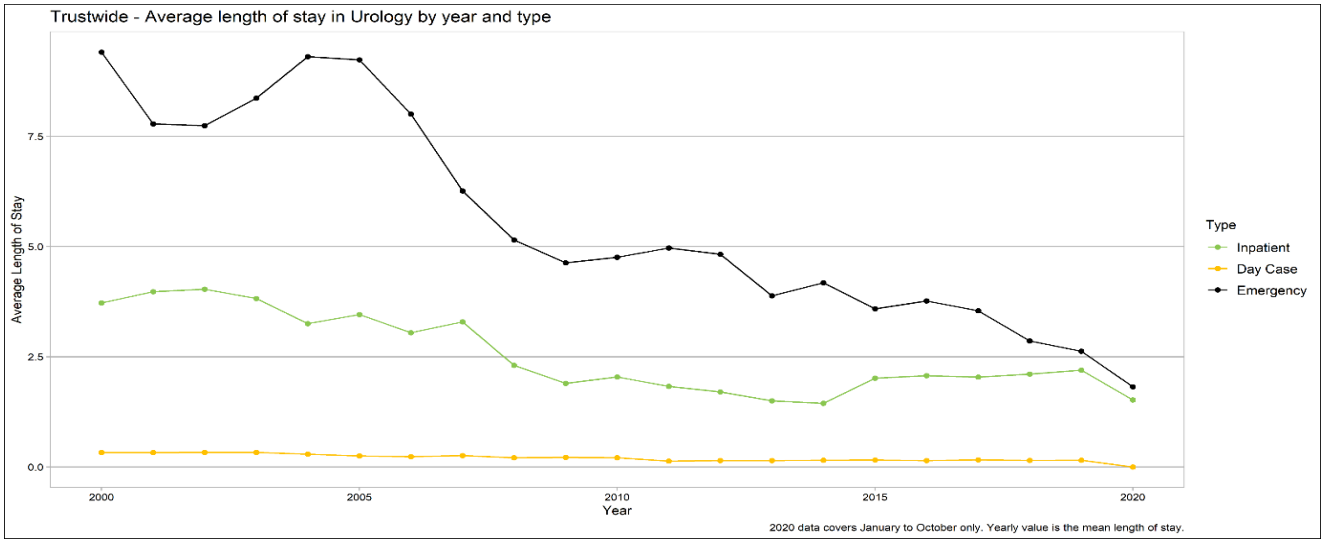
6.23 Emergency theatre activity is shown below between 2012 and 2019. What is clearly shown is the amount of emergency activity that is being undertaken out of normal working hours and the increasing amount of emergency work being undertaken by non-core Urology team members i.e., agency or locum staff.

Graph 12 - Emergency Urology operations by year



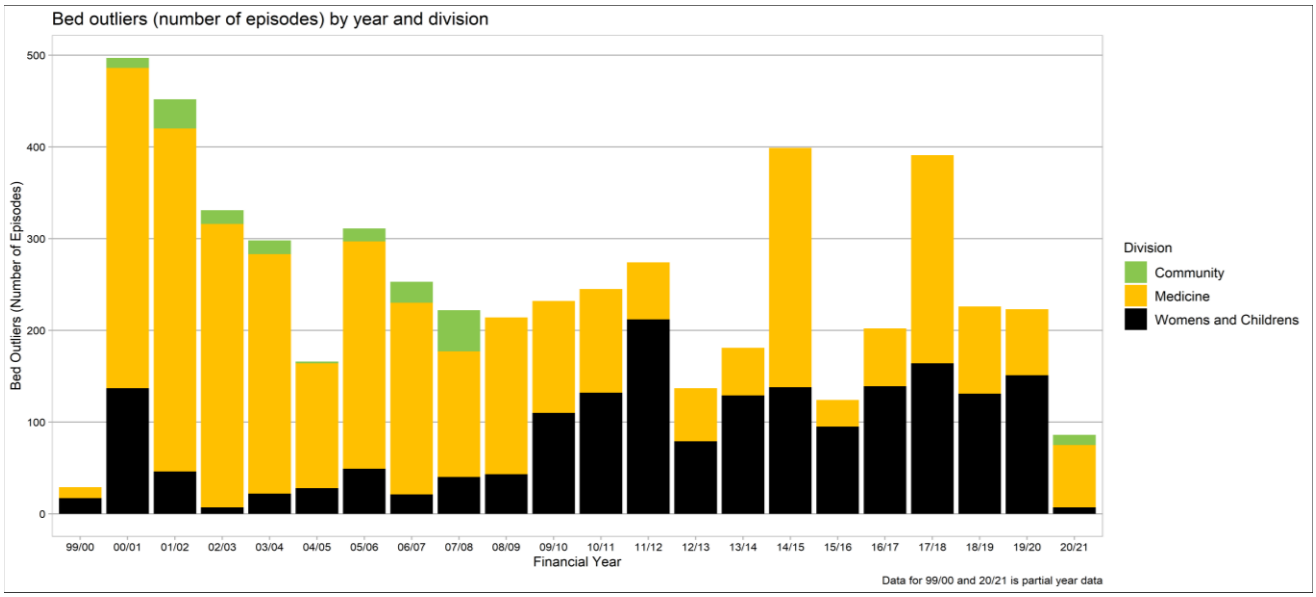
6.24 The average length of stay (LoS) for inpatients (elective and emergency patients) has reduced markedly since 2005 to two days which is in line with expected practice. (Complex cases have been increasingly referred to tertiary centres leaving a greater proportion of day case activity in the Trust). Day case surgery continues for most procedures. Length of stay at Furness General Hospital (FGH) is marginally higher than Royal Lancaster Infirmary (RLI). See chart below for whole Trust LoS in Urology.

Graph 13 - Average length of stay in Urology



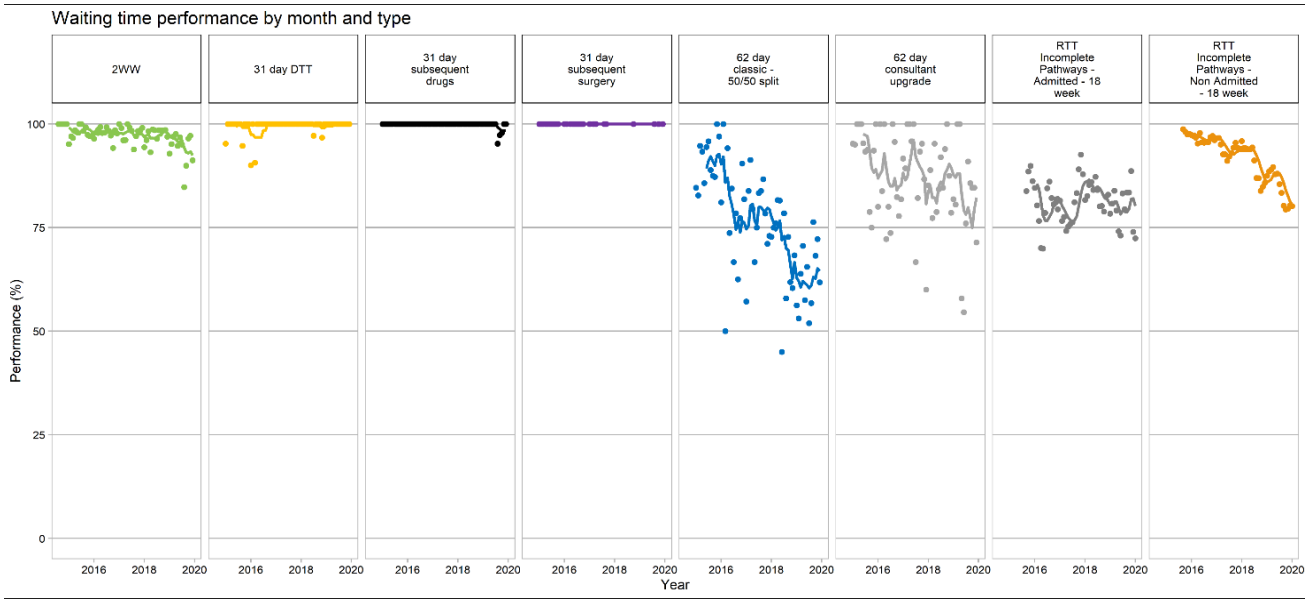
6.25 There are no dedicated inpatient beds for Urology. Beds are shared with the General Surgeons at both RLI and FGH. A lack of dedicated beds means that Consultant ward rounds have to include several wards and those on call have to establish where patients are situated (this can be challenging especially when there was poor handover in place). Outliers (when beds are not available on the surgical wards) tend to be dominated by female patients who are placed in gynaecology wards. The outliers on gynaecology wards have shifted from occupying medical beds over the period. See chart below:

Graph 14 - Bed outliers 2000-2020



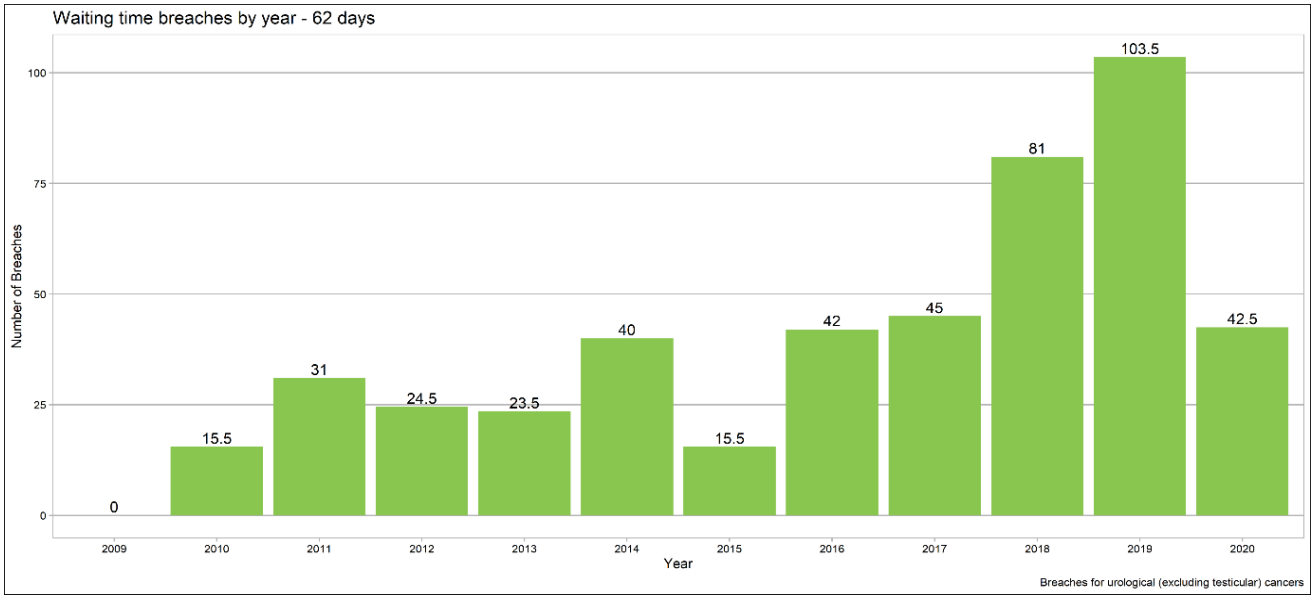
6.26 Cancer services centralised for Urology in 2005, and the Urology team were required to ensure patients were cared for in the best centre for their needs and through tertiary referrals. The graph below shows that the initial referral process has always performed well and where patients need relatively straightforward care, they receive prompt attention. Performance declines where pathways become extended and shared care is required.

Graph 15 - Waiting time performance 2015-2020



6.27 Cancer waiting times impacted on patients through breaches of 62 and 104 day targets. The increasing number of breaches in Urology is shown in the graph below:

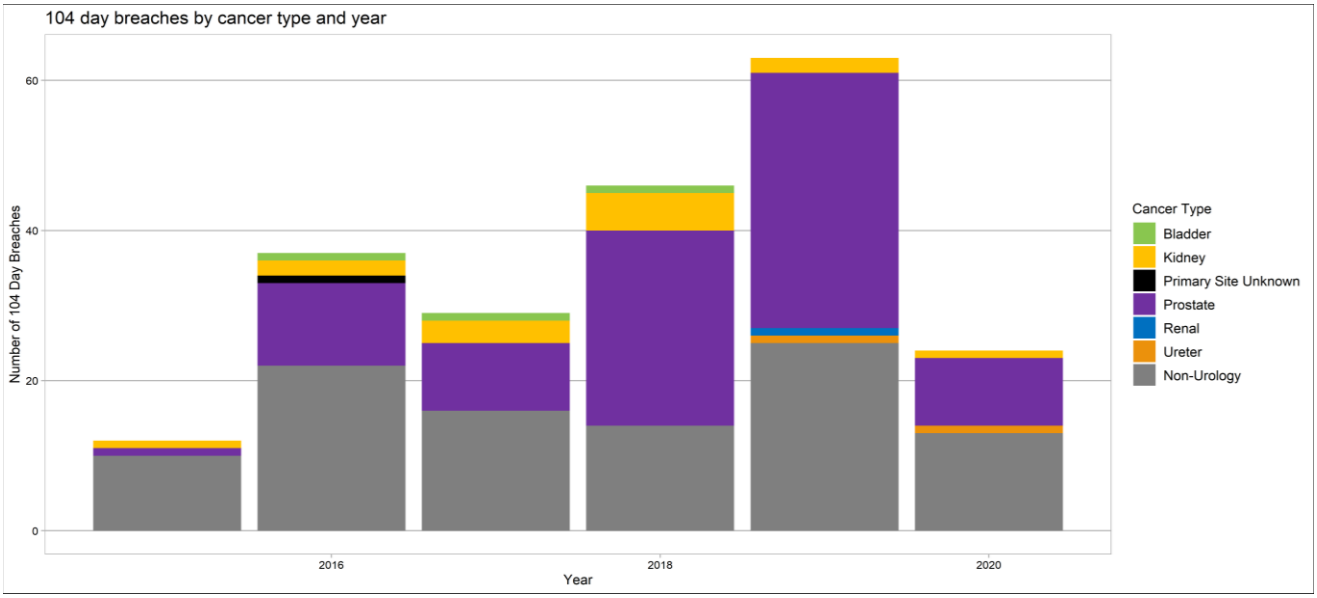
Graph 16 - Waiting time breaches in Urology 2009-2020



6.28 The number of 62 day cancer breaches in Urology have increased over time.

6.29 The number of 104 day cancer target breaches across the Trust are shown below - as can be seen, the Urology service makes up the bulk of the 104 day breaches in relation to the prostate pathway. This increased from 2015 onwards.

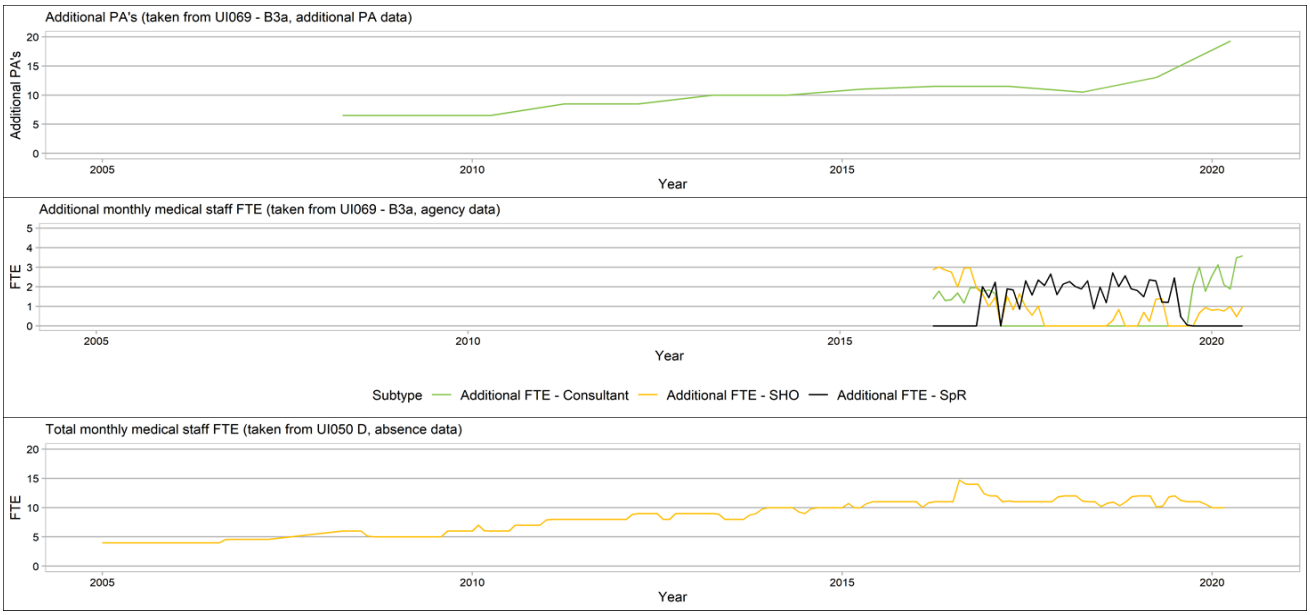
Graph 17 - 104 day breaches all tumour sites



Workforce and capacity data

6.30 There are now five substantive Consultant Urologists in employment at the Trust covering a population of 320,000 (plus a full time locum). The British Association of Urological Surgeons (BAUS) guidelines recommend one Consultant to 80,000 population. Consultants are now supported by four middle grade staff including one Associate Specialist. The training of junior doctors is through the surgical rotation with junior doctors shared with the General Surgical team. The chart below estimates the amount of medical staffing in the Urology department. This has increased over the last 20 years and additional locum staff as well as additional programmed activities (PAs) have been agreed in response to capacity concerns despite a largely stable workload.

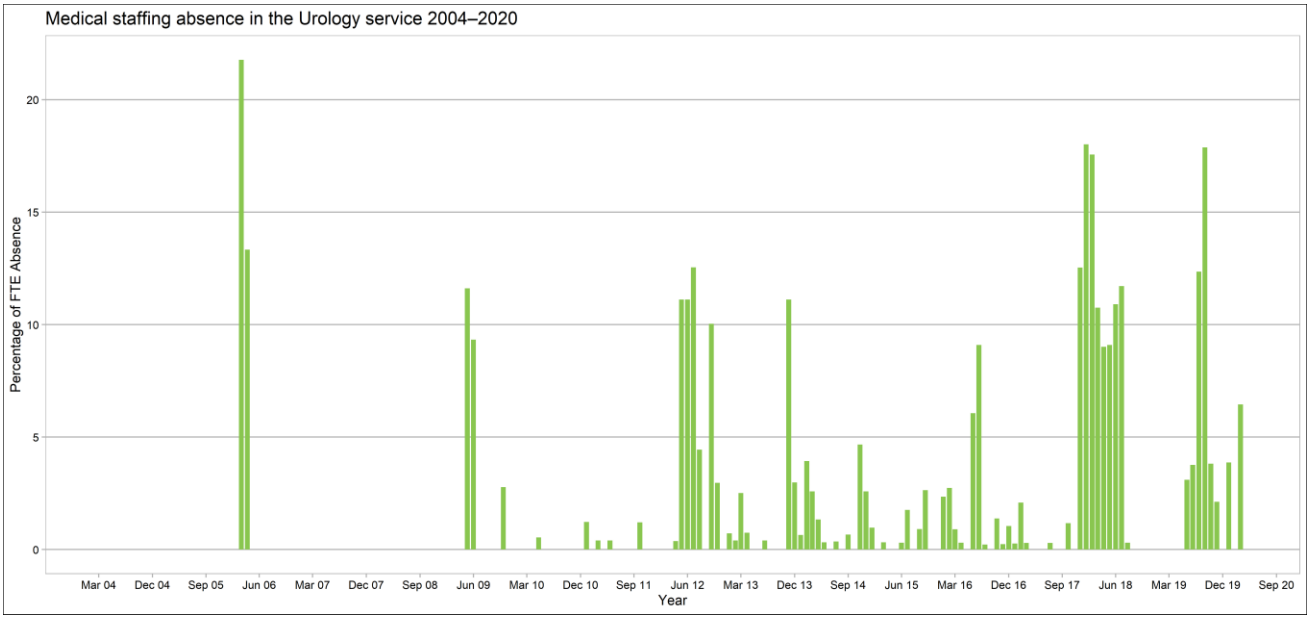
Graph 18 - Medical staffing 2005–2020



6.31 However, this increase in capacity does not account for sickness levels or restricted practice (the Trust found difficulty in providing data to support a complete picture of medical resourcing in Urology). The graph below shows the extent of absence of

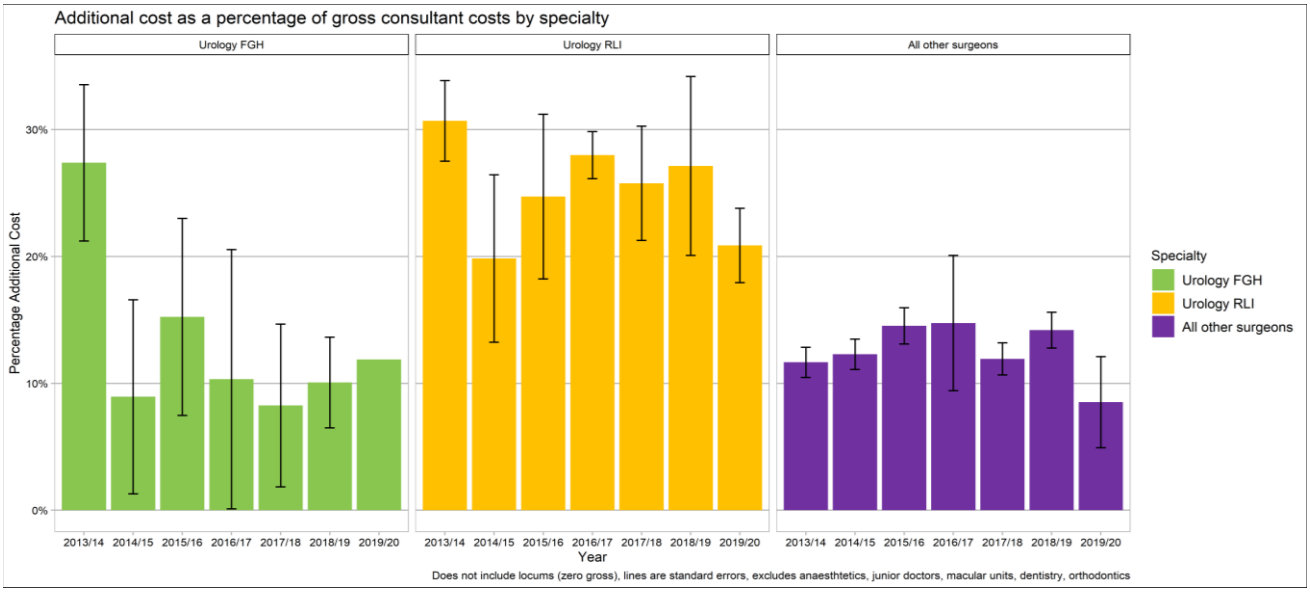
medical staff in the Urology service over the period for all reasons. At times this peaked to over 30% of available hours.

Graph 19 - Medical staffing absence in the Urology service 2004–2020



6.32 In addition to the locum staffing support to the core team and the increase in the number of programmed activities in job plans, the team have also been paid to undertake additional activity sessions (AASs). These are paid as an extra to the core job plan. We have examined the cost to the service of these additional payments to baseline Consultant costs to try to quantify the impact. Urologists have been paid a significant proportion of income through these sessions and are amongst the highest reimbursed surgeons in the Trust over the last seven years (see chart below). In comparison with the remainder of the surgeons in the Trust, Urologists appear to be undertaking proportionately more AASs.

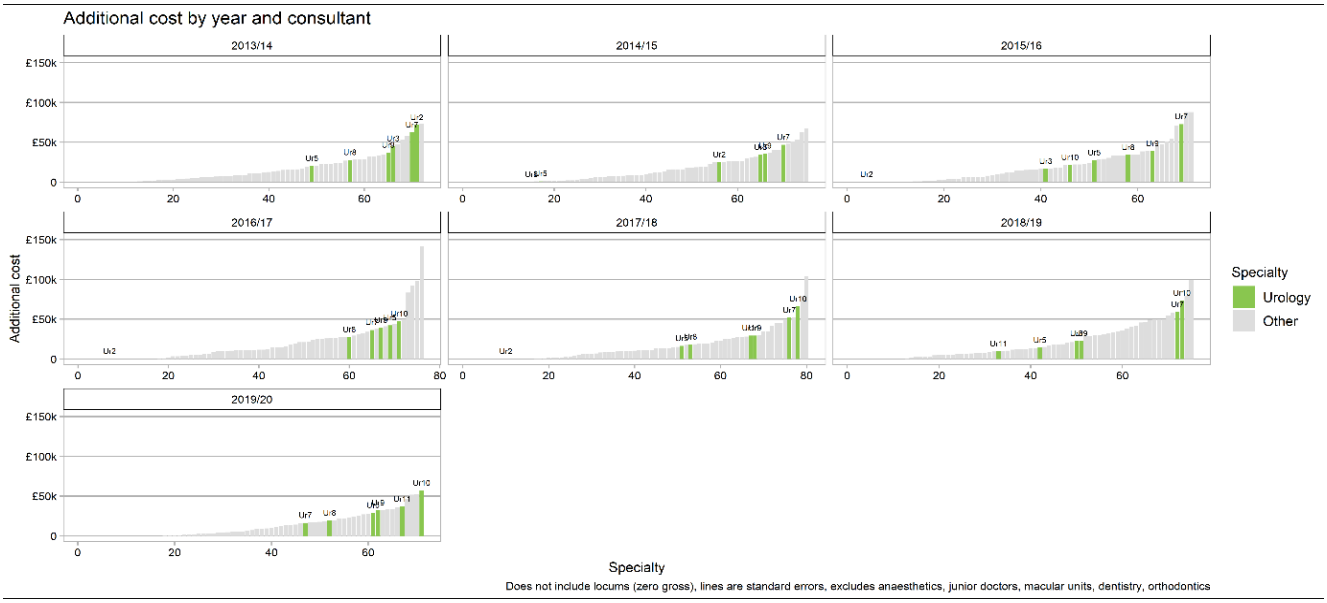
Graph 20 - Additional cost as a percentage of gross Consultant costs in Urology



6.33 There is no reliable data to show the actual numbers of AASs by Consultants. However, based on the current budget for AASs of £293,000 in 2019/20 this means approximately 580 additional sessions. This equates to at least ten additional clinic or

operation sessions per week. This is over and above core job plans and additional PAs already approved.

Graph 21 - Additional cost by year



6.34 Patients are not nursed by Urology specific nurses and the Getting It Right First Time (GIRFT) Review in 2018 identified there has been a failure to develop a nursing workforce with a commitment to this sub-specialty.

7. Chronology of key events

Key events timeline 2000–2020

7.1 The table below shows the key events taking place over the last two decades that impacted the Trust and the Urology team.

Year	Event in Urology	Event in the Trust
2000–2005	• January 2000 appointment of Consultant Urologist 2 (from a Consultant post in Scotland) • October 2000 appointment of Consultant Urologist 3 as a Locum Consultant (from a Registrar post in London) • 2001–2 concerns initially raised by Consultant Urologist 3 regarding Consultant Urologist 2 • 2002 Consultant Urologist 2 alludes to discriminatory practice and dictatorial management style • 2002 National Clinical Assessment Authority (NCAA)/Royal College of Surgeons (RCS)/legal advice sought about Consultant Urologist 2 (referred August 2004) • 2002 External Consultant Urologist 1's Report highlights communication difficulties in the department and offers support - not taken up • January 2003 breakdown in relationships documented • 2003–4 further concerns regarding Consultant Urologist 2 • Consultant Urologist 3 appointed as Assistant Clinical Lead July 2004	• Two Medical Directors covered this period – Medical Director 1 to 2001; Medical Director 2 from 2001 to March 2006 • Introduction of the NHS Consultant Contract in 2003 • Cancer waiting times introduced 2005

	• July 2004 appointment of Consultant Urologist 4 as Consultant (from a Registrar post in London) to Royal Lancaster Infirmary (RLI) • 2004–5 further concerns regarding Consultant Urologist 2. Recall of patients relating to prostate biopsies in February 2005. Approx. 90 patients reviewed • 2005 Consultant Urologist 2 raised concerns about discrimination • July 2005 Consultant Urologist 2 excluded temporarily following a NCAA Serious Concerns Report. Had practice restricted and a leak about this was reported in the media • November 2005 concerns about the impact on workload of the suspension of Consultant Urologist 2	
2006–2010	• January 2006 Consultant Urologist 2 agreed performance improvement plan (PIP) (started January 2008) • February 2006 the Medical Director recognised need to rebuild relationships due to a hostile and acrimonious department • March 2006 work related stress affected a Consultant • September 2006 appointment of Consultant Urologist 5 as Consultant (from a Registrar post in London) as a job share with Consultant Urologist 5a • February 2007 Consultant Urologist 2 finds placement in Aberdeen for retraining and signed off in August 2007 • July 2007 retirement of Consultant Urologist 1 Consultant	• The maternity incidents at Furness General Hospital (FGH) which occurred over the period 2004–2008 as well as from 2009-2013 were the subject of the Kirkup investigation • April 2006 appointment of Medical Director 3 • Chief Executive 1 (former Chief Executive of the Trust 1999 - October 2006) became Chief Officer of North Lancashire Primary Care Trust (NLPCT) (2006–2009). The former Chief Operating Officer of the Trust became Director of Commissioning at NLPCT (2006–2011) • March 2007 appointment Chief Executive 2 • July 2007 appointment of new Director of Human Resources (HR) and Organisational Development (OD)

	• June 2008 appointment of Consultant Urologist 7 as Locum Consultant (first post as a Consultant from a post in Devon). He was made substantive in September 2009 • Consultant Urologist 2 returned from placement in June 2008 for a phase 2 PIP • May 2010 Consultant Urologist 5 appointed to Clinical Lead • 2010 concerns about capacity and wellbeing raised by Consultants	• In 2009/10, there was a major IT system problem at the Trust which resulted in a failure to recall outpatients. This was discovered as the Trust was implementing the new electronic patient management system, Lorenzo • A 2010 Royal College of Physicians Report found elderly care and other acute pathways failing at the Trust • The Trust was awarded Foundation status in October 2010 despite Care Quality Commission (CQC) and commissioners' concerns over quality and financial viability
2011-2013	• Appointment of Consultant Urologist 9 in January 2011 (first substantive Consultant post from London) • In September 2011, the impact of organisational issues and changes to operating timetables impact on the wellbeing of key Urology staff • October 2011, a Urology case highlighted a significant outpatient backlog of patients and problems with Lorenzo • September 2012 concerns raised about communications within the department, the impact of absences on the team and the workload, and risks to patient safety	• October 2011, the Strategic Health Authority (SHA) declared a major incident and Gold Command to manage a situation with the Trust relating to maternity, outpatients' backlog of 37.000 patients and culture • January 2012, Cumbria Health and Wellbeing Scrutiny Committee Report on the Trust's Maternity services and other governance issues • February 2012, Monitor[38] appointed a new interim Chair of the Trust following the resignation of Chief Executive 2. He found serious governance weaknesses

[38] Monitor - Part of the Department of Health from 2004-2016 responsible for ensuring healthcare provision in England was financially effective. It merged with the NHS Trust Development Authority in April 2016 to form NHS Improvement.

	• October 2012 appointment of Consultant Urologist 8 on transfer from General Surgery as Specialty Doctor (November 2016 became a Locum Consultant)
	• November 2012 Urology team SWOT[37] analysis identifies concerns and describes significant team delivery issues
	• 2013 documented references to a poorly functioning multidisciplinary team (MDT) and fractured relationships within the department
	• November 2013 the Urology Service Manager presented a report to Finance and Performance Committee (FPC) highlighting capacity concerns and poor continuity of care
		• Monitor released three separate reports on the Trust at this time:
		  ○ An external report into the outpatient's backlog found serious governance concerns which had been clouded by the implementation of Lorenzo (Bellairs)
		  ○ A diagnostic review by University Hospitals of Central Manchester in relation to maternity services
		  ○ A PricewaterhouseCoopers' (PwC) Report on Governance
		• April 2012, appointment of Medical Director 4
		• August 2012 appointment of Chief Executive 3
		• A report by Grant Thornton, The Care Quality Commission re: Project Ambrose in June 2013 following whistleblowing concerns highlighted problems with the CQC's oversight and registration of the Trust without conditions
		• July 2013 appointment of new Director of HR, and OD
		• December 2013 appointment of new Chief Nurse

2014	• Consultant Urologist 9 raised concerns about the department with the Medical Director including lack of	• January 2014, appointment of new Chief Finance Officer

[37] Strengths, Weaknesses, Opportunities, Threats analysis

	continuity of care, waiting list problems, favouritism and targeting of Black, Asian and Minority Ethnic (BAME) doctors • A Urology business case proposed that non-elective services for Urology would be provided from RLI only with clinics and elective activity to be maintained at FGH and Westmorland General Hospital (WGH) • An incident on New Year's Day demonstrated the impact of poor communication and stress on the team with three individuals subject to Maintaining High Professional Standards (MHPS) processes including a formal racism allegation. Group mediation was offered but was resisted by some of the Urologists • June 2014 Impact Consulting were appointed to work with the Urology team with interviews held in November/December 2014 and workshops through January to March 2015 • August 2014 business case for transferring emergency cases from FGH to RLI (not pursued) • September 2014 Occupational Health raised concerns about the Consultants in the team due to service pressures • September 2014 External Consultant Urologist 2 provided a report on complaints relating to Consultant Urologist 2 • November 2014 Consultant Urologist 4 Consultant served notice and left the Trust February 2015 • December 2014 an anonymous allegation of racism was sent to the police	• June 2014, the Trust was placed in 'special measures' by Monitor after a 'requires improvement' rating for safety and leadership • 2014 concerns were raised by staff about Breast Screening and Radiology. This triggered a whistleblowing episode relating to the unit and prompted an external investigation • September 2014, appointment of new Chairman

2015	• March 2015 Consultant Urologist 5 escalated concerns about racism and a dysfunctional Urology team to the S&CC division • April 2015 Consultant Urologist 3 moved to FGH following the business case for on call cover for emergencies as well as team relationship breakdown • April 2015 NCAS decide a full performance assessment on Consultant Urologist 2 should not be undertaken • May 2015 index case inquest and major disagreements relating to care provision between Consultants • August 2015 Consultant Urologist 3 contacted the CQC to raise concerns about incidents by other Consultants • September 2015 Consultant Urologist 5 stepped down as Clinical Lead and was replaced by Consultant Urologist 3 and Urologist 6 (interim) • November 2015 grievances and incidents were submitted between Consultants • December 2015 the MHPS process relating to two Consultants about racism claims from New Year's Day 2014, was finalised and included reference to the unhappy professional relationships in the department	• January 2015, appointment of Medical Director 5 • March 2015, the Kirkup Maternity investigation report was published • July 2015 CQC inspection report rated the Trust as 'requires improvement' • Lancashire & South Cumbria Urology Network Site Specific Group established. The network produced patient pathways for kidney, bladder, prostate, testicular and penile cancers. • The Health Service Journal reported in July 2015 that the Trust was the first one to get an increase in the NHS tariff agreed by Monitor because of its rural challenges • December 2015, the Trust was taken out of 'special measures' • Grant Thornton undertook a Well-led Governance Review of the Trust
2016	• January 2016, an Invited Service Review of Urology services at the Trust was undertaken by the RCS. It highlighted interpersonal problems, behaviour and team dysfunction alongside a need for emergency services to reduce from three sites to two • In March 2016 Consultant Urologist 9 was appointed as Clinical Lead	• The CQC undertook an inspection in October 2016, the Trust was rated as 'good' overall and 'requires improvement' for the safe domain • Baxter Report 2017

	• March 2016 a thematic review from four incidents presented to Serious Incident Requiring Investigation (SIRI) panel highlighted safety concerns in covering WGH and FGH • April 2016 work to respond to the RCS Invited Service Review recommendations commenced • Consultant Urologist 3 left the Trust in September 2016 • September 2016 RCS Clinical Records Review for Consultant Urologist 2 completed • In October 2016 Consultant Urologist 2 reported a series of concerns in relation to laparoscopic nephrectomy complications • Consultant Urologist 3 applied to an employment tribunal in October 2016 for unfair dismissal • December 2016 NCAS decide a full performance assessment on Consultant Urologist 2 was not necessary • December 2016 Consultant Urologist 3 contacted the Chair of the Trust to request a conversation of detriment relating to whistleblowing • December 2016 former Chair of the GMC Diversity and Inclusion Committee[39] asked to support the Urology team in relation to poor relationships.	
2017	• January 2017 Consultant Urologist 3 provided a list of incidents to Medical Director 5	

[39] Also Chair of the Centre for Remediation and Support.

	• April/May 2017 Consultant Urologist 2 subject to internal capability hearing, demoted and referred to GMC • May 2017 External Consultant Urologist 3's Review resulted in the cessation of laparoscopic nephrectomies in the department • June 2017 Consultant Urologist 2 appealed (appeal not upheld January 2018) • October 2017 Consultant Urologist 2 was restricted in his practice by the General Medical Council (GMC) • November 2017 Consultant Urologist 3 issued further employment tribunal proceedings against the Trust	
2018	• April 2018 the Trust is contacted by the media in relation to issues being raised in Consultant Urologist 3's employment tribunal • May 2018, the employment tribunal relating to Consultant Urologist 3 set out its judgement • July 2018, the NHS national improvement programme, Getting It Right First Time (GIRFT), published its specialty report on Urology services • Consultant Urologist 2 left the Trust in September 2018	• South Cumbria Community Services transferred to the Trust - it became an integrated acute and community Trust in April 2018 • Appointment of Chief Executive 4 (previously Chief Finance Officer) April 2018 • Appointment of new Chairman
2019	• January 2019 the Quality Committee heard that concerns raised by Consultant Urologist 3 had been known to the Trust and actions had been taken to investigate them historically • In July 2019, *Whistle in the Wind* by Consultant Urologist 3 was published	• September 2019, appointment of Medical Director 6 • In September 2019, Deloitte LLP undertook a Well-led Review at the Trust • Urology improvement groups were set up

	• In August 2019 the Trust requested that NHS England and NHS Improvement support an independent investigation into Urology services • In October 2019, the Trust commissioned York Teaching Hospital NHS Foundation Trust to undertake a review of how the Trust had addressed the findings and recommendations from the 2016 RCS Invited Service Review report in Urology • In November 2019 the Trust appointed InterBe to support a cultural transformation programme across the Urology team	
2020/21	• Consultant Urologist 7 left the Trust in March 2021	• The InterBe programme ended in April 2021

7.2 Appendix 2 and Appendix 2a shows the detailed employment dates of all senior medical staff and key Executive Directors and Chairs employed in the Trust from 2000 to the present time.

Chronology of a dysfunctional Urology team

7.3 This is a summary chronology of the development of problems in the Urology team over the last 20 years. A more detailed chronology has been provided separately to NHS England and NHS Improvement including specific and overt references to discrimination.

2000–2008

7.4 The Trust was formed on 1 April 1998, following a merger of Lancaster Acute Hospitals NHS Trust, Furness Hospitals NHS Trust and Westmorland Hospital NHS Trust, with services provided from these sites alongside Queen Victoria Hospital in Morecambe Bay and Ulverston Hospital.

7.5 During 2000 and subsequent years, a major government modernisation agenda was implemented including the NHS Plan, new Consultant Contracts[40], the NHS Cancer Plan[41], introduction of the National Clinical Assessment Authority[42] and the National Patient Safety Agency[43] as well as improved incident reporting. Changes to the role of the GMC[44] and the introduction of Maintaining High Professional Standards guidance[45] also impacted on the management of clinical care. This was a significant agenda for the NHS to implement.

7.6 It included national changes to the way cancer pathways were managed as part of the NHS Cancer Plan. This meant that more complex surgery and treatment for a wide range of cancer types would be centralised in major hospitals. For the Urology service at RLI and FGH this meant a reduction in complex work and an increase in routine and diagnostic aspects of the cancer pathway. From a career perspective this meant that there would be less complex surgery and a role for core Urology work with networked arrangements in place for more specialist provision.

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[40] https://www.nhsemployers.org/articles/consultant-contract-2003

[41] https://www.thh.nhs.uk/documents/_Departments/Cancer/NHSCancerPlan.pdf

[42] The National Clinical Assessment Authority (NCAA/NCAS) was established in April 2001 as a commitment set out in the NHS Plan 2000. Its initial purpose was to help Trusts identify issues with doctors including providing advice, carrying out assessments and providing advisory recommendations on how issues can be practically resolved. It was renamed the National Clinical Assessment Service in April 2012 and was hosted by the National Institute for Health and Clinical Excellence (NICE) before becoming an operating division of the NHS Litigation Authority.

[43] The National Patient Safety Agency was established in 2001 as a special health authority of the NHS in England to monitor patient safety incidents. From 2005 it had developed the National Reporting and Learning System to collect and analyse information and it was then possible for staff to submit information through web-based forms although the roll-out took two years longer than anticipated. In 2012 its key functions were transferred to the NHS Commissioning Board later known as NHS England. In April 2016 the patient safety function was transferred to NHS Improvement. From April 2019 NHS England and NHS Improvement began working closer together to form a single organisation.

[44] The General Medical Council has been established since 1858. Its functions derive from a statutory requirement for the establishment and maintenance of a register of medical practitioners in the UK. Its responsibility is to protect, promote and maintain the health and safety of the public by controlling entry to the register and suspending or removing members when necessary. It is also responsible for the licensing (introduced in November 2009) and revalidation system for all practising doctors in the UK (the revalidation of doctors every five years was introduced in December 2012). It sets standards and provides the guidance for Good Medical Practice. This guidance outlines the standard of professional conduct expected and underpins fitness-to-practise decisions. The guidance was originally written in 1995, updated in 2006 and revised in April 2013. There are four domains to the guidance but the most significant change in 2013 was from '*Act without delay if you have good reason to believe that you or a colleague may be putting patients at risk'* to '*Take prompt action if you think that patient safety, dignity or comfort is being compromised*'. In July 2011, the GMC further changed to separate the presentation of fitness-to-practice cases and these became the responsibility of a new body, the Medical Practitioners Tribunal Service (MPTS). The GMC had previously been criticised for combining the presentation of fitness-to-practice cases with the adjudication of them. The GMC's data shows that certain doctors from specific ethnic groups or overseas qualifications are overly represented in GMC and MPTS processes. Recent research suggests that this is due to disproportionality in referrals from employers. The GMC is conscious of the stress and impact that some doctor's experience going through GMC fitness to practise procedures, which can be significant.

[45] HCS2003/012 - Maintaining High Professional Standards in the Modern NHS.

7.7 Prior to 2000, the Urology department was well respected with three Urologists in post who also had a private practice through Abbey Park Hospital (APH) at an attached 12-bed unit in Barrow-in-Furness. Consultant Urologist 1 was the Clinical Lead for Urology, Consultant Urologist 1a was based at the RLI, and was due to retire in 2002. Consultant Urologist 1b was also in the team and was due to retire imminently. This well-established position meant Consultants were attracted to work in the area.

7.8 As part of the succession, Consultant Urologist 2 was appointed in January 2000. Consultant Urologist 2's curriculum vitae (CV) stated he had worked for nine years in the United Kingdom before applying in 1999 for the job in FGH. He was keen to work at the RLI site as well as at FGH. He had not completed the formal UK process of surgical training through registrar rotation but had gained experience through surgical appointments and experience.

7.9 Consultant Urologist 3 had visited the Trust in 1999 but had not met Consultant Urologist 2 until he too was appointed in October 2000 as a locum Consultant, initially to cover Consultant Urologist 2's leave. Consultant Urologist 3 was appointed substantively in April 2001 to the RLI. Consultant Urologist 2 was on the appointment panel for Consultant Urologist 3.

7.10 Within a week of Consultant Urologist 2 starting, the relationship with Consultant Urologist 1 became problematic as Consultant Urologist 2 started to make demands (aligned to pre-appointment promises) to work at RLI despite the job being based at FGH. This was the point that Consultant Urologist 2 also started to appear to be unwilling to be flexible in his approach to teamwork. The Human Resources (HR) Director sought legal advice on whether he could be disciplined for not following his agreed work plan; this was only seven days into his new role.

7.11 It was only after Consultant Urologist 3 became substantive that Consultant Urologist 1 was prepared to consider necessary workload changes at RLI in advance of Consultant Urologist 1a's pending retirement in 2002. It also became clear that allocation of work at RLI would be a point of ongoing contention. Consultant Urologist 2 was not welcomed as part of the RLI Urology team despite written promises from Chief Executive 1 that he would be able to have sessions there. This was compounded by a suspicion amongst the two bodies of Consultants at RLI and FGH generally and a fear of a loss of local services. It is understood this antagonism persisted for several years.

7.12 Two clinical complaints in 2001 involving Consultant Urologist 2 underpinned initial concerns about his clinical practice. These cases involved work being done privately, based on alleged long NHS waiting lists. Alongside clinical issues there were probity concerns about financial donations into a 'Prostate Fund bank account' for Consultant Urologist 2. Holding this bank account was contrary to the Trust's standing financial instructions. The purpose of this fund was unclear and concerns in relation to this were still being pursued by the Trust as late as August 2007.

7.13 Throughout 2001 Consultant Urologist 2 raised concerns about the management style in the department directly with Chief Executive 1, rather than (also) through his department lead due to emerging dysfunction. In January 2002, a Urology secretary wrote to her team leader detailing the difficulties she was having because of constant disputes between Consultant Urologist 2 and Consultant Urologist 1 or Consultant Urologist 2 and '*management*'. She raised concerns about the delays for cancer patients because of some of these disputes.

7.14 In January 2002, Consultant Urologist 3 wrote to Consultant Urologist 1 setting out his plans for taking over Consultant Urologist 1a's commitments and his thoughts for short, medium and long-term plans in Urology. He excluded Consultant Urologist 2 from the correspondence, but his thoughts were accepted by Chief Executive 1 and formed the basis for developing the service further.

7.15 In turn, Consultant Urologist 2 continued to direct correspondence to Chief Executive 1 and also excluded the department from these communications but appears to have had little response to his assertions that the department was being run '*dictatorially'* other than to be redirected to his colleagues. His correspondence included reference to discriminatory behaviour and his view that Consultant Urologist 1 was autocratic.

7.16 Consultant Urologist 3 first highlighted his own concerns about Consultant Urologist 2's clinical practice in writing to Medical Director 2 in February 2002. He raised issues in relation to patients who he believed had received inadequate care; the promotion of private surgery and exaggeration of NHS waiting lists; staff unable to contact Consultant Urologist 2 when on call; and Consultant Urologist 2 not consulting with colleagues when taking annual or study leave resulting in FGH being left on occasion without Urology cover. However, we can see no evidence of incident forms being completed to reflect the (particular) clinical and concerning aspects of these cases or further action being taken.

7.17 The palpable tensions between Consultant Urologist 2 and Consultant Urologist 1 were articulated in correspondence at the time and Medical Director 2 noted '*unfortunately Urology is dysfunctional at the present time and needs to move forward'*. Notably, a letter also concluded that there was a '*lack of continuity of care at FGH, a need to look at the delegation of responsibilities for particular conditions and the need for common policies for treatment'*. These remained issues for years to come. Letters from the British Medical Association (BMA) to the Trust at this time, raised on Consultant Urologist 2's behalf, stated his frustration at being excluded from using the ultrasound equipment in the department.

7.18 In April 2002, the deaths of two Urology patients were reported by a 'hospital doctor' directly to the Coroner. This was despite a post-mortem report for one patient stating the nephrectomy had been carried out competently, that the bleed was of unknown cause and the patient had died of multi-organ failure. The other patient had died of a cardiac arrest. The Coroner did not make any further enquiries.

7.19 Disagreements between Consultant Urologist 1 and Consultant Urologist 3 with Consultant Urologist 2 increased throughout 2002, and can be evidenced through emails, memorandums and discussions within the MDT meetings. This included the exclusion of Consultant Urologist 2 by the Surgical Directorate from performing biopsies using the newly acquired equipment. Consultant Urologist 2 was also alleged to have withdrawn Consultant Urologist 3's Thursday afternoon lists without prior discussion and was reminded that it was his responsibility to carry out a ward round after operating on patients at RLI following a complaint from wards 30 and 33 that he did not visit, as well as a failure to routinely attend MDT meetings.

7.20 In May 2002, Consultant Urologist 2 directly accused the department of '*intentional inequality, injustice and discrimination*' due to the department refusing to allocate him a theatre session at the RLI and allowing Consultant Urologist 3 to take these sessions up instead. He had quoted Chief Executive 1's correspondence from 2000 on his appointment that this could be revisited on the retirement of Consultant Urologist 1a. A meeting to resolve Consultant Urologist 2's concerns raised the fact that he did not have access to the ultrasound biopsy equipment and that he was

being marginalised. The resolution to the concerns meant he would now be allocated theatre sessions at the RLI and given access to the ultrasound machine (although there is no evidence that training was arranged which was a concern given Consultant Urologist 2 had not undertaken biopsies using this equipment since he was appointed).

7.21 In October 2002, Medical Director 1 (now Associate Medical Director (AMD)) wrote to the Head of Professional Standards at the Royal College of Surgeons (RCS) asking for a rapid review of Consultant Urologist 2's performance in relation to biopsy specimens. This was after an inquest where the independent expert raised concerns about Consultant Urologist 2's practice of two stage cystectomies. The AMD had discussed the issue with the National Clinical Assessment Authority (NCAA) and, on their instruction, told Consultant Urologist 2 to stop performing both radical prostatectomy operations and two stage cystectomies, and to refer these cases to other Urologists. He stated that the Trust would also commission an audit of the prostatectomies that had been referenced although this did not occur for another two years.

7.22 In response to the AMD's letter and the inquest, a Consultant Urologist from the RCS's Rapid Response and External Visit Review Group was asked to conduct a review of Consultant Urologist 2's performance in relation to a letter from the Trust's pathologist about the quality of specimens. His response noted the lack of dialogue between pathology and the operating surgeon and that this '*might be reconciled by a mandate for cancer surgery to be discussed at the MDT'*. He concluded that invoking an RCS Rapid Response visit would probably be unproductive and possibly counterproductive although he would be happy to facilitate a meeting of the Urologists and other specialists to discuss these issues to try to come to a consensus view.

7.23 In December 2002, the HR Director documented that a meeting with all three Urologists would be helpful to discuss how effective working relationships could be established as well as full participation in MDT meetings being achieved. This was not pursued. Failure to act on the recommendation meant that the MDT meeting remained dysfunctional from this time onwards.

7.24 Consultant Urologist 3 formalised his concerns about Consultant Urologist 2 again to Medical Director 2 in December 2002. A subsequent letter from Consultant Urologist 1 to Medical Director 2 identified similar concerns about the Urology department and he asked if the Trust could resolve '*some or all of the issues before litigation ensued'*. The issues included patient care, failure to communicate and the complete breakdown in relationships between Consultant Urologist 2 and both Consultant Urologist 3 and himself. There is no evidence that any patient harms were recorded or investigated because of the issues being raised and this would also have provided a more robust opportunity to understand precise failings (if any).

7.25 In February 2003, it came to the attention of Chief Executive 1 that relationships remained a significant issue in Urology. He stated that there was a need to fully investigate the clinical, financial and managerial issues relating to Consultant Urologist 2. We can see no evidence of this request being progressed despite these concerns being put into writing by Consultant Urologist 3 and Consultant Urologist 1 as required by the Trust's 'Procedures for dealing with allegations about the conduct and competency of medical staff'.

7.26 A letter in April 2003 from Medical Director 2 to Consultant Urologist 2 clearly set out the concerns in the department - poor relationships, attitude to secretaries, poor

communications with patients, probity concerns, nursing staff having concerns about patient communications, absence without leave, problems with on call cover arrangements and numerous clinical concerns and complaints. He indicated that a referral to the NCAA was the next step.

7.27 Over the next few months, further emails became accusatory with allegations and counter-allegations about clinical practice, inaccuracies in information and discrimination being cited. Aside from the documented evidence we have been told that there was an extensive amount of time expended on trying to resolve the relationship issues with a significant volume of ad hoc one on one sessions, phone calls, and corridor conversations that went largely unrecorded. These were considered to be "*very personal, vituperative, and unprofessional"*.

7.28 This culminated in a letter from Medical Director 2 to Consultant Urologist 2 and Consultant Urologist 3 in August 2003 which confirmed that their correspondence was getting '*a bit heated and personal'.* A letter under advisement from the Trust solicitors (Hill Dickinson) to Medical Director 2 indicated that the major problem was one of communication but that if an examination of clinical outcomes was undertaken, they advised it should be carried out as a comparative examination to avoid any perception [of discrimination]. We note that further audits and assessments of Consultant Urologist 2's clinical practice were undertaken over the following years, but these did not (in the main) include the practice or outcomes of other Consultants for comparison.

7.29 We can see no evidence of further attempts being made to resolve the departmental issues described and issues steadily worsened. In March 2004, the complaints manager pulled together a list of complaints in relation to Consultant Urologist 2 - there were 12 complaints from patients between May 2003 and March 2004. Further cases of concern were collated.

7.30 In April 2004 there was an internal assessment of Consultant Urologist 2's performance with TRUS guided prostate biopsies following further concerns raised by his colleagues and by one of the specialist nurses. The outcome of this was that an external assessment would be arranged, Consultant Urologist 2's biopsies would be reviewed with Consultant Urologist 3 as a comparator, and an NCAA referral would progress. However, in our view, an independent expert opinion should have been gained at the start of this process as this would have deflected any further allegations of discrimination by Consultant Urologist 2. The process of this assessment further pitched one Consultant against the other and would have been very undermining for Consultant Urologist 2 who had been appointed prior to Consultant Urologist 3 and who already had an adversarial relationship with him.

7.31 A letter from Consultant Urologist 2 following the joint session stated that Consultant Urologist 3 should be asked not to undertake TRUS biopsies as in his view Consultant Urologist 3's knowledge of this ultra-sound technique was substandard. He alleged discriminatory (active or passive) practice as he did not expect the Trust to act on his request. Medical Director 2 responded to state there was no evidence to concede to such a request. He stated there were no discriminatory motives and he would ask an external assessor to review both techniques. We have seen no evidence of an external assessment being undertaken.

7.32 Later that month, a letter from Medical Director 2 to Consultant Urologist 2 summarised several discussions and meetings that had been held with him. It confirmed that there had been '*grumbles'* from colleagues since May 2002 about three main issues - relationships with colleagues, clinical standards and probity with

reference to private practice; however, these had been '*unsubstantiated rumours and his complaint and incident file was not unduly large therefore he was taking it with a pinch of salt and intended to take some time to make his own observations - nevertheless it was a lot of noise and not all from Consultant Urologist 1 and he was not hearing similar complaints about other colleagues'*. He acknowledged that at times the responses from Consultant Urologist 1 and Consultant Urologist 3 may have been inappropriate ('*and I have taken this up with them'*) but it '*stems from exasperation'*. The narrative included that Consultant Urologist 2 had received 20 complaints (one going to external review), six incidents and one legal case and this number now suggested genuine concerns.

7.33 Further concerns were raised through letters and emails by all parties in the following months, and as before, there were allegations and counter-allegations about behaviours and clinical practice from Consultant Urologist 1 and Consultant Urologist 3 about Consultant Urologist 2. Many emails were sent or copied to Medical Director 2 who confirmed (to Consultant Urologist 2) that issues should be recognised and '*addressed at a departmental level in an atmosphere of mutual confidence and respect but that this was difficult if the problem was not recognised, or if Consultant Urologist 2 was on the offensive*' when concerns were raised. Despite this, mediation with other colleagues was not commenced.

7.34 The central themes were deemed to be attitude and conduct, and the next step required the involvement of the NCAA, who were eventually formally written to (two years after initial concerns) on 30 April 2004. An NCAA assessment was commenced in October 2004 in line with HCS2003/02.[46] This was new guidance issued to the NHS alongside the changes to incident reporting, Consultant contracts and other changes in relation to the NHS Plan. All the documentation in relation to Consultant Urologist 2 including concerns which pre-dated this guidance was brought together at this point.

7.35 In July 2004, Consultant Urologist 4 was appointed to the Urology department. A reference was made to Consultant Urologist 3 having come from the same registrar '*stable'* in paperwork at the time. Consultant Urologist 1 was noted to be the Clinical Lead.

7.36 Consultant Urologist 3 was then appointed as Assistant Clinical Director (in the surgical division) for Urology. Consultant Urologist 2 expressed his concern to Clinical Director 1, that there was already a plan for Consultant Urologist 3 to be appointed on Consultant Urologist 1's retirement, that both had fabricated complaints against him, spread false information and rumours to discredit him and that he had previously been informed Consultant Urologist 3 would get the job and not to apply. Consultant Urologist 2 was informed, having also applied for the position, that he had performed excellently at interview, but Consultant Urologist 3 had '*a greater vision for Urology'* and so was appointed.

7.37 As Assistant Clinical Director, Consultant Urologist 3 continued to collate cases of concern relating to Consultant Urologist 2 and by November 2004, a letter was sent from Consultant Urologist 3 to Medical Director 2 regarding his position on Consultant Urologist 2's clinical performance and being '*astonished*' that there may not yet be enough evidence of poor practice to merit action. Medical Director 2

[46] HSC2003/02 - Maintaining High Professional Standards in the Modern NHS

replied saying these issues had tended to be pursued informally. He concluded that '*a breakdown of mutual trust has serious implications, so a lot of evidence was needed and why this issue had occupied a lot of time over the last couple of years*'. He also confirmed that he had perhaps underestimated the strain on individuals and the corrosive effect on the department; however, '*this was a fundamental human rights issue and if legal processes were not respected then management actions would be compromised. I will not be stampeded'*.

7.38 That said, the delay in addressing the compounding issues over the previous two years was significant and, in our view, set the tone for future behaviours in the department with little evidence of decisive action, mediation or conversion of the complaints and concerns into clinical incident reports or patient safety investigations. The reference to issues being pursued '*informally'* reflects the lack of process that was applied despite inappropriate behaviours, probity concerns, serious allegations of safety being compromised and direct patient harms.

7.39 Following the concerns in relation to the quality of prostate biopsies, a recall of patients ensued in February 2005. At least 90 patients were written to and recalled. We reviewed all available documentation but could not be convinced that the recall process provided assurance that all patients were recalled, outcomes documented, and harm reviews completed, and no assurance report was completed at the end of the recall.

7.40 We also identified additional cases from this time period in relation to concerns about Consultant Urologist 2 with 149 patients identified in correspondence from the Medical Directors' archives from this time.

7.41 At this point, Consultant Urologist 2 alleged discrimination in workload distribution of extra waiting list clinics. He was still disgruntled about not having a management position and wrote directly to Chief Executive 1 regarding these concerns.

7.42 The NCAA provided a draft Serious Concerns Report about Consultant Urologist 2 in July 2005 and this resulted in his restricted practice. From this date Consultant Urologist 2 undertook no significant clinical duties for at least the following three years whilst assessments and retraining were arranged.

7.43 Adversarial email communications also continued between Consultant Urologist 3 and Consultant Urologist 2 through 2005. Additionally, the NCAA Serious Concerns Report for Consultant Urologist 2 that was issued in July 2005 (finalised in September 2005), flagged up the strained relationships within the Urology department such that it would be preferrable for Consultant Urologist 2 to have his required supervision/retraining elsewhere. Their report also recommended that the Trust refer Consultant Urologist 2 to the GMC because concerns had been identified that could seriously compromise patient safety with indications that his practice did not comply with requirements of good medical practice. Consultant Urologist 2's clinical practice had been restricted pending a programme for remediation but a referral to the GMC was not made until January 2006, over four months later.

7.44 As a result of Consultant Urologist 2's restricted practice, the workload for the other Consultants increased. In November 2005, Consultant Urologist 4 wrote to Clinical Director 1 and copied in Consultant Urologist 3 (now Associate Clinical Director), Medical Director 2, Chief Executive 1 and the Chair. This followed a meeting with Clinical Director 1 to express his concerns that the increase and redistribution of workload had led to a deterioration in the quality of care offered to Urology patients at the RLI to an unacceptable level. Furthermore, he felt that this was in danger of

compromising the quality of his clinical decisions and was affecting him personally. It is not clear what action was taken because of this communication.

7.45 Consultant Urologist 5 was appointed in September 2006 (alongside another Consultant as a job share). In April 2007, Consultant Urologist 3 took up the post of Clinical Lead (Consultant Urologist 2 had also applied for the post).

7.46 In May 2007, the GMC decided not to take any action in relation to a complaint about Consultant Urologist 2 from a patient in 2006. They concluded following expert opinion that the operation for this patient was carried out correctly, that an opinion from Consultant Urologist 4 was incorrect and due to an error in interpretation of the scan by the sonographer.

7.47 Consultant Urologist 2 went for retraining following agreement of a performance improvement plan (PIP) from January to June 2008 (this was two years after the recommendation had been made by the NCAA and was after more than two years of non-clinical practice). In February 2008, the GMC confirmed to the Trust that all information regarding Consultant Urologist 2 had been reviewed, his conditions revoked and their investigation was closed.

7.48 A phase 2 PIP was put in place at the outset of his retraining programme for Consultant Urologist 2's return period to monitor his reintegration into the Trust and his place in the department. Consultant Urologist 3 and Consultant Urologist 5 were appointed to clinically supervise Consultant Urologist 2 on his return and the Deputy Medical Director was not prepared to consider alternative options. It is therefore of some concern that Consultant Urologist 3 had written, in advance of Consultant Urologist 2's return, to the GMC fearful of his return. He was told by the GMC that these issues would need to be dealt with by his employer if they arose.

7.49 It took nearly four years to action decisions to retrain and manage Consultant Urologist 2's clinical challenges. Whilst it was appropriate for clinical concerns to be raised and responded to, the way these were managed, and the ensuing delays, were detrimental to all concerned. This left Consultant Urologist 2 restricted in his clinical practice for a long period of time and consumed a significant part of management and clinical staff time. This also covered a period where more complex surgery was not going to continue at Morecambe Bay and so Consultant Urologist 2 remained limited to core urological procedures during his retraining and on his return to the Trust. This impacted on the tensions in the team and on the workload distribution. It also set the scene for continued poor relationships for the next ten years.

2008–2011

7.50 In June 2008, Consultant Urologist 7 was appointed as a Locum Consultant Urologist, after interview by Consultant Urologist 5. Consultant Urologist 7 was appointed from a position where he had worked for ten years, but his reference advised a period of supervision. He also had not undertaken formal United Kingdom surgical training but had gained experience through his previous positions.

7.51 Following the appointment of Consultant Urologist 7, Consultant Urologist 3 sent a series of emails regarding annual leave and cover for the 2009 school holidays. These and subsequent requests continued to be a significant area of irritation for some of his colleagues who believed that some of the leave allocations were unfairly distributed but felt they could not challenge the senior Consultant's requests. This is important as it continued to be a problem for the next seven years alongside increasing stress levels.

7.52 In April 2009, issues resurfaced regarding poor (approximately 50%) attendance by the Consultants at the Urology Cancer MDT (a critical forum) because of delayed changes to job plans and alternating MDTs. It is not clear what action was taken or what mandates were given for attendance. However, attendance at this core meeting continued to be sporadic by some of the Urologists in post.

7.53 In May 2010, Consultant Urologist 5 took up the role of Clinical Lead although he had been doing the role for some time (from January 2009) before this was formalised.

7.54 In June 2010, the Trust was the first to deploy the Lorenzo electronic patient record (EPR) system in the NHS. During, and subsequent, to this implementation there was a significant interruption of IT services which resulted in a failure to recall outpatients for a period and contributed to a backlog of patients and a loss of data.

7.55 In mid-2010, Consultant Urologist 3 escalated concerns to Deputy Medical Director and divisional managers. His concerns were that clinical standards were slipping because of staffing difficulties on Ward 34 at RLI; that urgent cancer treatments were being delayed or missed due to the lack of capacity; that [operating] lists were being cancelled and there was a shortage of theatre staff and anaesthetists. Again, it is unclear what action was taken in response to this. This is significant as these concerns continued as material patient safety issues for the next ten years.

7.56 At around this time, concerns started to be raised through emails (primarily by Consultant Urologist 3) about travelling times between sites; journey times being unrealistic with this impacting both his personal and professional life. Some emails also suggested that other (newer) Consultants were repeatedly being asked by Consultant Urologist 3 to cover his on call and that, on occasion, they did not feel they could decline given his seniority in the department. A buddy system for cross cover was established but this appears to have taken some time to embed. It is clear that at this point stress and wellbeing issues were beginning to significantly impact the team as a result of workload, travel, coordination, emergency access and on call whilst also having to deal with the relationship difficulties.

7.57 There also started to be some concern around Consultant Urologist 3 not attending all the departmental audit meetings due to his long-standing private commitment with BMI Healthcare. He apologised that his private clinics (on Thursday mornings) clashed with the mandatory meeting, but we can see no other efforts to effectively resolve this issue by him or others. Attendance at the audit meetings continued to be inconsistent by him and some of his other colleagues for the coming years.

7.58 There is also evidence of an increasing workload and stress levels impacting on individuals in Urology. This, combined with a lack of decisive intervention or observation of Trust processes (such as investigatory or disciplinary action with timely referral to HR), allowed uncertainties about clinical practice and patient safety to be prolonged and set in train some inappropriate behaviours and responses. Emails became more emotive and accusatory and Consultant Urologist 3, in particular, felt compelled in some cases to try and take matters into his own hands but equally without regard to policy (for example, incident reporting).

2011–2012

7.59 Consultant Urologist 9 was appointed in January 2011 from an Associate Specialist role in another Trust. He was noted to have significant experience in over 200 cystectomies and 200 radical prostatectomies, with little laparoscopic work independently. He had gained his experience through his previous appointments. He

was known to be quiet but dependable, and punctual with a high standard of timekeeping and attendance.

7.60 In February 2011, a case involving the death of a patient in FGH resulted in an inquest which was attended by Consultant Urologist 3. This case was not reported as an incident at the time and therefore never investigated by the Trust. The case has been reported widely in the media in recent years but there are inaccurate aspects to the version of events being narrated.

7.61 In October 2011, the Trust became heavily involved in a serious incident in relation to a major backlog of delayed follow up outpatient appointments across the Trust. A Serious Untoward Incident was raised by the Strategic Health Authority in September 2011 following the recognition that 37,000 patients in the Trust had delays to their follow up appointments and a Gold Command operation was put in place to rectify this. (This ran alongside concerns being raised more widely about the Trust in relation to Maternity services and the CQC issuing a warning notice to the Trust for breach of regulations). The report noted that '*The early indications pointed towards significant numbers of Urology patients in the priority cohort, including the [index][47] case*.' This case was a Urology patient (also a doctor) who was subject to an RCA which '*proved difficult'* and became a complaint. This incident and the subsequent actions were key events which should have resulted in significant improvements in both investigation quality and a focus on follow up and administrative processes in relation to Lorenzo. However, these issues continued to challenge the Urology service over the coming years.

7.62 In December 2011 and early 2012, it was apparent that there were continuing problems with covering Consultant Urologist 3's requests for leave, with many being requested at short notice, and reports that Consultant Urologist 7 and Consultant Urologist 9 were rostered to cover a disproportionate number of bank holidays. There were also questions in relation to mandatory training including advanced communication skills which some other Consultants had undertaken but which Consultant Urologist 3 had not. It was clear from email correspondence that tensions were increasing between Consultant Urologist 3 and both Consultant Urologist 7 and Consultant Urologist 9.

7.63 In July 2012, Consultant Urologist 3 again raised concerns about clinical safety within the department through a five-page letter sent to the Clinical Service Manager and HR (the Clinical Lead was unaware of this communication). He wished for discussions leading up to his letter to remain confidential with respect to colleagues but indicated the issues should be circulated amongst senior managers. Consultant Urologist 3 took a long period of absence at this time. He was supported to return to work with no on call for a short period.

7.64 In September 2012, Consultant Urologist 4 agreed with the views expressed by Consultant Urologist 7, Consultant Urologist 9 and Urologist 6 following a series of emails about patient backlogs, leave, workload and appraisals which were copied to both the divisional manager and Consultant Urologist 5. Consultant Urologist 4 stated that he had voiced his concerns (and those of others) on several occasions without eliciting any effective response.

[47] Referred to as index case in the incident report

7.65 In November 2012, and in response to concerns raised, a SWOT analysis was recorded at the Urology business meeting where all Urologists were present. These were:

- Loss of elective continuity - it was very difficult for the same Consultant to always see a certain patient with a complex case.
- For clinics, named lists were reviewed first and then the pooled lists. It was noted that although there was a comments section on Lorenzo this was not always adhered to.
- Referrals were pooled even when a GP referred to a specific Consultant.
- New admissions were not always seen if there were a lot of emergencies. This sometimes led to a delay of up to 36 hours.
- The weekend ward round was not always done at RLI, sometimes this was done by telephone.
- FGH cover was a problem at weekends.
- On call Consultants travelled a lot during the week between RLI and FGH which was wasted time (Consultant Urologist 5 indicated that 5.8 direct clinical PAs/week were spent travelling, 3.1 of which was for emergencies). Also, there was unequal travel time for different Consultants.
- A lack of continuity following operations as the Consultant did the operation, but the patient's post-operative care was done by the on call Consultant.
- Despite equal timetables there were different work levels for each Consultant. The level of responsibility for patients when a Consultant was on call was questioned, as was the standard of commitment to the patients. Lack of ownership was seen to be a fundamental problem.

7.66 We can see no evidence of actions taken in response to this SWOT analysis or how it was escalated to the Surgical and Critical Care (S&CC) directorate or Executive team. This is significant as many of the issues raised continued to be areas of concern through to 2021.

7.67 In December 2012 Consultant Urologist 5 wrote to Consultant Urologist 7 after it had come to the Trust's attention that Consultant Urologist 7 was doing on call from home (contrary to the distances required in his contract) and was told that, effective 1 January 2013, he must comply with being within the distances required when on call.

7.68 It was clear that by the end of 2012 the team were having considerable problems delivering a service across all sites, but their concerns were not being heard.

2012–2016

7.69 Concerns about Consultant Urologist 2 surfaced again during this period. Delays in responding through various systems were a repeat of the 2000–2008 events. It was also clear that the dysfunction in the team materially impacted the identification of error, apportionment of blame and system issues that were inherent over this time. These were all clearly highlighted by the RCS when they were invited to review the department in 2016 based on the evidence provided to them.

7.70 Disciplinary action against Consultant Urologist 7 commenced at the end of November 2012 for allegedly undertaking private work and delegating his lithotripsy clinic to a junior doctor. A preliminary investigation was undertaken in March 2013

which resulted in a decision to take his case to a disciplinary hearing in August 2013. He was cleared of both these incidents because of clear mitigating factors, but it took eight months for this evidence to be presented which calls into question the quality of the initial investigation. This painted a picture of Consultants not talking to each other and of changes being made to timetables without consultation.

7.71 During these and future months there is evidence that Consultant Urologist 3 emailed colleagues identifying that he was very stressed, unable to stay awake after dealing with emergencies and wanting a more family-friendly annual leave strategy. There is no written evidence that these issues were addressed directly with Consultant Urologist 3 in terms of his wellbeing, or that any action was taken to establish if patient safety was at risk because of these assertions.

7.72 Issues with agreeing annual leave continued throughout 2013 and 2014, and Consultant Urologist 3 made multiple requests for cover from his 'leave buddy' Consultant Urologist 9, with instances when the management team were called in to help. Consultant Urologist 3 required an absence from work in early 2013. He had returned to normal commitments by January 2014.

7.73 There were also frequent occasions when Consultant Urologist 3 asked to swap on call commitments often at relatively short notice for personal reasons, including leisure activities. These requests sometimes included missing MDT meetings and tensions became apparent as this was seen to be permitted by the Clinical Lead whereas some other colleagues (including Consultant Urologist 7) were held more to account for their absence. This perceived differential treatment did not help the continuing relationships between Consultants; this was compounded by Consultant Urologist 3 being absent from mandatory MDT and audit meetings but available for weekend paid waiting list additional activity sessions (AASs). Consultant Urologist 3 and other Consultants swapping on call caused additional difficulties through administration errors and resulted in some confusion about who was on duty at what time.

7.74 Consultant Urologist 7 was the Urology Audit Lead at this time and was charged with producing the department's cancer operational policy and annual report alongside Consultant Uro-Oncologist 1. There are several email communications between this clinician and Consultant Urologist 7 which were indicative of the hostility in the department with Consultant Urologist 7 referencing that he had been shouted at and '*subject to insult and humiliation from [Consultant Uro-Oncologist 1] and the CNS* [Clinical Nurse Specialist]*'*; as a result, he stepped down from his audit lead position. These fractured relationships added to the fragility of the department and were an insight into the increasingly bipartisan behaviour of individuals within the wider service.

7.75 In August 2013, Consultant Urologist 7 was cleared of wilful neglect from the incident relating to the lithotripsy clinic in November 2012. In this same month, Consultant Urologist 9 raised a grievance regarding the behaviour of others towards him - this included the behaviour of the Clinical Lead. Consultant Urologist 9 received no response to the range of issues he claimed, which included being bullied, undermined and having no follow-up clinics. The concerns he raised about the care of a patient were dismissed.

7.76 Also in September 2013, and following an incident involving a patient who had undergone a nephrectomy where there was no handover between Consultant Urologist 3 and Consultant Urologist 9 (Consultant Urologist 9 was not aware of the patient and an email exchange between the two indicated that Consultant Urologist 3

had intended to retain responsibility even though Consultant Urologist 9 was on call and should have been informed), Consultant Urologist 5 circulated the new handover sheet for FGH and RLI with a reminder to keep using them and to also use them when undertaking ward rounds - '*this will be important if we have to deal with any emergencies in the night and we don't know the patients'*.

7.77 Difficulties arose in December 2013 with an increasing backlog of patients with some being lost to follow-up, which appears to have been exacerbated by a move to a central booking office at FGH and non-clinical staff booking patients. An incident occurred which highlighted that Consultants were not using the booking system correctly i.e. to 'outcome' a patient (log the relevant follow up actions from the appointment) so that they were on the right 'access plan'. A poor quality investigation of the incident meant that lessons were not learned which could prevent recurrence.

7.78 2013 ended with further incidents which caused in-fighting between Consultants. These included an alleged failure by Consultant Urologist 7 to attend an emergency at BMI Healthcare whilst on call. This resulted in Consultant Urologist 3 attending to insert a catheter '*although he suspected that his alcohol consumption that evening meant that he might be over the legal limit to drive'*. Consultant Urologist 7 was reported as allegedly being 90 miles away (this appears to refer to a round trip and Consultant Urologist 7 is clear he was at FGH which is 45 miles from the BMI). It was clear that there was no protocol in place for covering private patients (even though this was an NHS Choice patient) from NHS on call Consultants. This was also not a Urology patient. This was not reported as an incident by either of the Consultants or other staff and there was no clear action taken in relation to Consultant Urologist 3 driving and attending to a patient whilst he claimed he was under the influence of alcohol.

7.79 In another example, the early hours of New Year's Day 2014 presented a disagreement between Consultant Urologist 7 and Consultant Urologist 4 over the urgency of a case. Consultant Urologist 4 had attended at the start of on call at 8.30am and found that the patient was listed for surgery. He became distressed and went 'off sick' as he was angry that the operation had been listed for him and that Consultant Urologist 7 had not done it earlier (the patient had attended at 5:45am and Consultant Urologist 7 considered he should be nil by mouth for six hours hence not operating before). Consultant Urologist 4 returned a few hours later and operated with Consultant Urologist 5. This was never reported as an incident but Consultant Urologist 7 was formally investigated under MHPS by the Deputy Divisional Manager and HR alongside another case. The conclusion a year later was that Consultant Urologist 7 was correct to wait six hours to operate to allow for the patient being nil by mouth. However, this case became one of those reported by Consultant Urologist 3 in 2017 inaccurately in a disclosure letter to the Trust which did not include the full facts of the case or the conclusion reached.

7.80 This case also raised concerns about Consultant Urologist 4's behaviour (he was investigated for his role in this event but this took nine months to conclude) and communication about who was on call as Consultant Urologist 5 and Consultant Urologist 4 appear to have swapped without informing anyone. Without a full investigation at the time the facts were not properly laid out and this was another example of the issues being focussed on Consultant Urologist 7 and aspects of his failings rather than the system issues and potential shortfalls of other Consultants.

7.81 Consultant Urologist 3 in his referral of Consultant Urologist 7 to the GMC in 2017, in the tribunal papers and in his book referenced this incident despite it having been

investigated fully under the MHPS process; he reflected versions of events which did not include the conclusions of the case and in our view were not balanced.

7.82 This event in 2013 should be considered a failure to learn in the context of a further case in 2019 in relation to a patient where the arrangements for on call cover remained unclear in respect of availability of surgeons after private operations and cross-cover. Following this incident Consultant Urologist 7 made an allegation in an email of racial discrimination against Consultant Urologist 5. Consultant Urologist 5 decided to inform HR of the contents of the email. In April 2014, NCAS wrote to Medical Director 4 confirming the allegation and setting out the process the Trust should follow under a formal MHPS process to investigate this.

7.83 The beginning of 2014 also saw Consultant Urologist 9 raising concerns with Medical Director 4. He was concerned about the process for appointing Clinical Leads, the lack of transparency for clinical excellence awards and other departmental issues. He described being treated as a '*second rate Consultant*', issues not being taken seriously when raised, no consultation in the department when changes occurred, no consultation relating to issues with Consultant Urologist 2 or on staff appointments. He raised clinical concerns of serious problems with waiting lists and outpatients, the secretaries and Consultants being undermined, a lack of continuity of care and no control of waiting lists. He felt that Black, Asian and Minority Ethnic (BAME) doctors were targeted, there was favouritism in terms of the extent of travel and days off, there were too many locum and agency doctors on long-term contracts and an inadequate distribution of operations and skilled work. He concluded that there was a misuse of position by the Clinical Lead. In relation to Consultant Urologist 2, Consultant Urologist 9 felt that he had given little help when he asked to support Consultant Urologist 2's rehabilitation/back to work programme and had never been asked to write a report on this.

7.84 Around this time, the Clinical Lead (Consultant Urologist 5) sent an email to the department to confirm that the Executive Directors had approved a business case 'Building a sustainable Urology service - Phase 1' for the Urology department for another Consultant on a two-year fixed-term contract. The intention was to reduce the additional activity sessions by 300 per year. This was declined internally, and Consultant Urologist 3 claimed that capacity was less the problem and the difficulties in the department related to inefficiency, patients not being discharged and operations being carried out on patients who did not require it. Consultant Urologist 2 and Consultant Urologist 9 disagreed with Consultant Urologist 3's observations, and this resulted in another divide with Consultant Urologist 4 supporting Consultant Urologist 3 based on clinical validation work that had been done as part of Consultant Urologist 3's return to work programme. Consultant Urologist 3 pointed out that they were already top-heavy with Consultants and exceeded the British Association of Urological Surgeons (BAUS) recommendation of one Consultant to 80,000 population - they now had eight senior full-time equivalents including an Associate Specialist.

7.85 Following some further tensions in the department in relation to the revalidation exercise undertaken by Consultant Urologist 3 who discharged over 400 cases (from all Consultants), Consultant Urologist 9 emailed Consultant Urologist 5 expressing concern that the waiting list was totally dysfunctional with lists changing daily.

7.86 Subsequent reporting on this subject in *Whistle in the Wind* draws a direct link between a deliberate failure to discharge patients and the allocation of them to AASs. There is no evidence of such a link other than increased demand which resulted in

additional clinics. The issue was largely a continuing legacy of the delay in follow ups highlighted in 2011/12 by the serious incident case which involved Lorenzo and administrative problems. The concern was never properly addressed.

7.87 In mid-March 2014 Consultant Urologist 4 required time off. A stress risk assessment was recommended for the whole department and that a clinical and non-clinical meeting be held to plan long term strategies for managing the problems that existed in Urology. Also that organisational matters needed to be addressed collectively. We can see no evidence of these actions being enacted at this point.

7.88 At the end of March 2014 Consultant Urologist 3 emailed Consultant Urologist 5 to report that Consultant Uro-Oncologist 1 wanted feedback giving to Consultant Urologist 9 that three cases of malignant spinal cord compression seen by him had not had action taken. Consultant Urologist 3 did not want to raise these cases directly due to '*recent attacks on him by email'*. We have no evidence of any outcomes from this but there are no clinical incidents reported in relation to these cases. Consultant Urologist 9 was not informed of this feedback.

7.89 The Urology audit meeting in March again highlighted a lack of ownership of patients and concerns that junior doctors were not being supported by Consultants whilst on call. This was discussed, but no clear actions or changes ensued. Also, despite this conversation, the following day Consultant Urologist 9 raised concerns that Consultant Urologist 3 had not handed over a nephrectomy patient to him. No action was taken in response to this and whilst Consultant Urologist 7 shared this (and other) problems with the Deputy Medical Director and Clinical Director the response was that '*they should work together'*. The Deputy Medical Director did offer external facilitation to help them but this was not taken up by the team despite follow-up by the HR Business Partner. Consultant Urologist 7 also sent further emails which included that he felt conspired against by Consultant Urologist 3, Consultant Urologist 5 and Consultant Urologist 4 with an unfair distribution of work and that actions were only taken against people of Asian origin whilst other colleagues had no action taken against them. (Consultant Urologist 7 had requested his email remain anonymous, but this request was not honoured).

7.90 By this point in April 2014, there was an increase in feelings of mistrust and there are at least three specific cases that evidence a culture of blame towards individuals in the department in preference to learning from system issues. These three cases were later reported inaccurately in the media - one from May 2014, one in August 2014 and a further case in December 2014 - and we are concerned that individual blame has been unfairly attributed over the following seven years, particularly in the media and book publications. The difficulty with inaccurate reporting followed by inadequate investigation is that it becomes difficult to disentangle genuine clinical errors from process and system learning.

7.91 In May 2014, Consultant Urologist 5 made a complaint to the HR department in relation to racism allegations made against him in the emails from Consultant Urologist 7 two months earlier; however, he was still chasing a response to the concerns that had been raised 18 months later.

7.92 In June 2014, several record-keeping issues, incidents and patient complaints in relation to Consultant Urologist 2 resulted in a MHPS investigation, he was placed on restricted practice and subsequently suspended. A hearing in August 2014 was chaired by the Associate Medical Director. A report by a Consultant Anaesthetist presented at the hearing identified failings in his practice in three cases (for one case it took some time to secure the full picture). Consultant Urologist 2 was largely

exonerated in one case where Consultant Urologist 3 had reported a near miss and an external investigation of two patient complaints was undertaken by an External Consultant Urologist on 8 September 2014. This report concluded there were failings in the surgical procedures and documentation but also highlighted the lack of continuity of care in line with 'Good Surgical Practice' between clinic, operation and follow-up by Consultants. This recommended requesting an RCS Invited Clinical Record Review into Consultant Urologist 2.

7.93 NCAS was invited to assess Consultant Urologist 2's practice again but, as he was suspended for the incidents pending investigation, they were unable to assess him. The Trust was also unable to secure a back-on-track programme and it fell on the department again to supervise his practice. Considerable efforts were made at the time by Medical Director 4 to help Consultant Urologist 2 to recognise concerns about his clinical practice and to engage with the processes suggested to support his improvement. However, a lack of recognition of concerns from Consultant Urologist 2 contributed significantly to delays in facilitating improvements in his clinical practice and assessments of it.

7.94 Around this time feedback about Consultant Urologist 3 indicated that he was slow to relinquish patients, stayed late and was overworked in emergency cases. He reported that he did not get involved in management decisions as his views were not taken into consideration, he did not attend meetings on this basis, he shunned interaction with some colleagues and admitted that he avoided some people and the buddy system of annual leave. We can see no evidence of these issues being addressed with Consultant Urologist 3.

7.95 The EDG became aware of the difficulties in the department around this time and Impact Consulting Psychologists were commissioned in June 2014 by the Chief Operating Officer (COO) and the (Consultant Oncologist/Lead Clinician for Cancer). They were asked to carry out a pilot programme for the MDT in the Urology department to increase effective working; the focus was on the meetings but also covered working practices. Their draft report that was issued subsequently described:

- A lack of respect between specialties, Surgery, Oncology and Radiology, with differences of opinion on clinical decisions.
- Ineffective audit meetings, with some cases missed and heated debates which 'sometimes get out of hand'.
- Problems with personal resilience with reports of 'a negative downward spiral'.
- Communication mainly by email, which can be misinterpreted, and attributions of meaning made which may not be true, and the copying-in of people to support the case being made.
- Complaints made against each other by several Consultants rather than trying to understand why decisions have been made and discussing the issues in a positive non-confrontational manner.
- Insufficient theatre capacity and follow-up appointments.
- Perception by some that there was prejudice in the area by some patients against non-white Doctors, in line with there being very little diversity in the local population.
- Not feeling like a team, with a clash of personalities between the Consultants.

- Some staff feeling undervalued or that their hard work was unappreciated by their colleagues.
- An unequal workload with some Consultants seeing more patients than others.
- 'The team feels as if it has disintegrated, people don't listen or respect each other, and people work as individuals and don't learn from each other.'

7.96 Despite this intervention, we can see little evidence of the various issues being addressed and there is evidence of hostile relationships continuing between Consultant Urologist 3 and both Consultant Urologist 9 and Consultant Urologist 7 throughout 2015 with occasions when the handover of patients was compromised due to the inability of clinicians to communicate with each other.

7.97 The service continued to be under significant pressure and in August 2014 a service pressures options appraisal went to the Trust Management Board (TMB). The risks identified included insufficient Consultant cover for the on call rota due to constraints of restricted practice and that for one in six weeks there would be no cover as well as an additional week at FGH having no cover (two weeks in six), concluding '*patient safety would be heavily compromised'*.

7.98 In November 2014, Consultant Urologist 4 and a CNS resigned for roles in other Trusts. This prompted Consultant Urologist 3 to email the Deputy Medical Director and Clinical Director giving his significant concerns about the state of the department and its standards. He again did not go to MDT as he said he was '*absolutely exhausted, had further operations to do that morning and was too tired to do any preparation for it'*. The Urology department was at this time still clearly dysfunctional with patient safety cases not being properly reported or investigated. A further case reported by Consultant Urologist 9 summed up the lack of teamwork, poor processes and the effect on patients. The stress in the department was clear but engagement with Impact Consulting was weak and some individuals refused to engage in the process.

7.99 In response to an email from Consultant Urologist 3 on 21 December 2014, outlining a '*dangerous weekend*' at RLI and FGH with travel and on call where he was so tired that he drove on the wrong side of the road, Consultant Urologist 5 drafted a provisional emergency plan to centralise non-elective Urology at RLI but he received no confirmation from senior management or external stakeholders as to how to proceed and we can see no evidence that this was progressed. No action was taken in respect of Consultant Urologist 3's assertion of dangerous driving and the inherent risks.

7.100 Also that month, a Consultant Urologist (there were assumptions as to who but we can see no corroborating evidence for this) felt compelled to write to the police asking them to investigate Consultant Urologist 3 for racism because he felt that the Trust was taking no notice of the concerns raised. The Deputy Director of Workforce advised that Consultant Urologist 3 be informed about this. However, Medical Director 4 did not want to show the letter to Consultant Urologist 3 as it contained allegations that he '*doubted Consultant Urologist x could substantiate'*, and which may provoke Consultant Urologist 3 going to the law himself. He was concerned that raising these issues this way would make things worse and would resolve nothing. Consultant Urologist 3 appears not to have been informed. Face-to-face discussions to resolve issues had become very difficult for the Urologists given the fractured relationships that were progressively more evident and there was a clear lack of desire to engage directly.

7.101 There were an increasing number of incidents being reported by Consultants about care and treatment given to patients by other Consultants. There were also several claims made by Consultant Urologist 3 about inadequate care and management plans by Consultant Urologist 9 and Consultant Urologist 7 who were so concerned about the allegations that they convened a meeting in early December 2014 with Consultant Urologist 5, the Service Manager, and a representative for one of the Consultants from the British Medical Association.

7.102 The meeting covered a range of issues that had been highlighted in the department many times previously relating to handover, sickness, working in private practice, bullying, the role of the MDT, on call tensions, Asian doctors being treated differentially by white members of the team, incident use and 'a gang of four who blindly supported each other' (Consultant Urologist 4, Consultant Urologist 3, a CNS, and Consultant Uro-Oncologist). Four actions were agreed at this meeting including:

- development of a departmental process for managing disagreements;
- a review of the Clinical Lead appointment process;
- allocation of an additional supporting professional activity (SPA) for the Audit Lead; and
- input from a psychology consultancy (with a potential for mediation if that failed).

7.103 Consultant Urologist 3 moved to FGH to cover Monday to Friday emergency cover. A job plan was constructed that offered a revised 12 PA plan and offered Consultant Urologist 3 additional work through AASs. The Clinical Director would not sign off a job plan (that the Clinical Lead proposed) that permitted excessive PAs. The management team wanted an option appraisal and business case, but Consultant Urologist 3 and Consultant Urologist 5 along with the Clinical Service Manager agreed and went ahead with the proposed job plan without formal approval. Contractual arrangements for additional PAs were put in writing by HR the following month.

7.104 In May 2015, Consultant Urologist 3 emailed the department regarding an inquest (the index case) that he provided a witness statement for and attended. This led to a further breakdown in relationships as Consultant Urologist 3, Consultant Urologist 7 and Consultant Urologist 9, who had all been involved in the care of the patient, disagreed with each other's versions of events and so followed six years of unravelling and distress to all concerned. Our subsequent investigation into that case demonstrated the impact of the dysfunction in the department including the lack of handover, continuity of care, use of emails as the primary form of communication, blame, failure to report incidents, failure to investigate adequately, interspecialty failures, clinical failures, blame and counter-allegations, which all contributed to the extremely poor experience leading up to the death of the patient.

7.105 In August 2015 Consultant Urologist 3 contacted the CQC regarding his concerns about the Urology department. He contacted them again in September claiming the Trust incident system was 'dodgy' and that incidents he had recorded had disappeared (there is no evidence to support this assertion), no one was doing anything about repeat incidents, there had been high-profile resignations, patient care was jeopardised, Consultants were '*untouchable'*, there were '*stitch up reports*', and the Trust were not engaging with the Coroner. He said he '*remained terrified of anyone finding out that he had contacted them'.*

7.106 In August 2015 questions also began to be raised about claims for AASs by Consultant Urologist 3 on the ePay claim system by the Clinical Service Manager. She had to authorise these but could not reconcile the sessions with actual clinical activity conducted.

7.107 In September 2015 the Royal College of Surgeons (RCS) was asked to undertake an Invited Service Review in addition to the invited clinical record review relating to Consultant Urologist 2's practice.

7.108 Consultant Urologist 5 stepped down from his Clinical Lead role effective 1 October 2015 in the run up to the RCS Invited Service Review and was succeeded by Consultant Urologist 3 and Urologist 6 who chose to share this as an interim position. Consultant Urologist 7 subsequently submitted a grievance about Consultant Urologist 3 as he had called for advice on an emergency case and had been told by Consultant Urologist 3 not to call him again about emergencies. Consultant Urologist 7 was upset by this response having asked for assistance from the Clinical Lead. He noted that Consultant Urologist 3 had also arrived late to his first business meeting as Clinical Lead due to his private practice and he raised that Consultant Urologist 3 had not attended the MDT for the same reason. Consultant Urologist 3 had told the department that '*certain Consultants were performing badly, and the department might be shut down'*. Consultant Urologist 7 again raised concerns about Consultant Urologist 3's attitude to BAME doctors and wanted to look for a job elsewhere. The Clinical Service Manager asked HR for a meeting with Consultant Urologist 7. This was at the same time as Consultant Urologist 5 requested a response from HR on the allegation of racism that had been ongoing for 18 months without conclusion. HR responded to say the report for Consultant Urologist 5 would be ready by Christmas.

7.109 In November 2015, Consultant Urologist 7 submitted an incident form against Consultant Urologist 3 for not recording the need for a stent change. The stent had been left for 14 months and there was no operation note available from the previous emergency stent change. Urologist 6 peer reviewed the case and put it down to '*operational capacity issues'* and this resulted in actions to develop a policy, register and audit for stent changes. This was a year after the index case which resulted in death and there was still no standard operating procedure (SOP) in place for ensuring stents were registered and monitored. It took a further two years for an audit to be carried out (in 2017) which identified that only 48% of stents were being registered. From 2015 to the start of this current investigation, there was no process for monitoring action implementation from investigations, compounded by the lack of formal RCA being undertaken by someone independent to the department.

7.110 Later that month, Consultant Urologist 9 submitted a grievance about Consultant Urologist 3 regarding bullying and harassment when Consultant Urologist 9 had been challenged by him as he was late to a clinic. The grievance cited a history of intimidation and of Consultant Urologist 3 '*trying to frame him'* for holidays not being covered. The response indicated concern from the Clinical Service Manager that Consultant Urologist 9 wanted to take this further as *'she did not want strained relationships in the department'.*

7.111 The investigation report in relation to the allegations of racism against Consultant Urologist 5 from Consultant Urologist 7 was produced (after two years) on 18 December 2015. The investigation concluded that there was sufficient evidence to suggest that improvements relating to behaviours and communication in the Consultant team would be beneficial in building trust, respect, improved team dynamics and to prevent the possibility of similar concerns being raised in the future.

It did not uphold the allegations of racism. It recommended that the Deputy Medical Director accept the report and note the points of concern relating to behaviours, communication and team dynamics within the Urology team. No obvious actions followed.

7.112 Also in December 2015, Consultant Urologist 3 raised four cases which he believed had been mismanaged by other Consultants to Consultant Urologist 5. However, he had not logged these as incidents and was asked by him to register them as, '*until the cases had been investigated, he was just expressing defamatory views'*.

7.113 In this same month, the Medical Director wrote to Consultant Urologist 3 to inform him that the Clinical Lead role would cease on 31 March 2016 and that a new Trust Clinical Lead structure would be established to which anyone could apply. Consultant Urologist 3 indicated he and Urologist 6 would reapply but that he would also wish to take down and readvertise the Urology MDT and Audit Lead roles.

7.114 The HR grievances against Consultant Urologist 3 from Consultant Urologist 9 were not heard until early January 2016. Consultant Urologist 9 raised clear concerns about Consultant Urologist 3 ignoring him, refusing to talk to him and being confrontational. He raised concerns about the culture in the department, bullying towards BAME doctors and the difficulties with team working. Consultant Urologist 9 said '*he did not have a problem working with Consultant Urologist 3, but he wanted him to be professional'*. The refusal to agree leave as a buddy had reached a head two years earlier and was still not resolved. Following the meeting the Clinical Director emailed the Director of People and OD, and Medical Director 5, and explained that '*as a very private man it had taken a lot for Consultant Urologist 9 to come forward'*. He also reported that another Urologist was equally upset at the differential treatment.

7.115 The RCS Invited Service Review took place on 11/12 January 2016. The initial feedback letter on 14 January to the Trust highlighted:

- An unsustainable three site service - it recommended two sites at FGH and RLI.
- Lack of continuity of care and poor lines of Consultant responsibility.
- Poor handover between Consultants.
- Lack of bed capacity at RLI and difficulty accessing emergency theatres.
- Stent management in single kidney patients.
- Clearer pathways needed for kidney obstruction, stents, and management of testicular torsion.
- Reliance on the level of responsibility of waiting list coordinators.
- Management of Mortality and Morbidity meetings was poor.
- MDT meetings were not minuted and that some cases discussed were not appropriate for this forum.
- Interpersonal problems between Consultants.
- Some concerns about one Consultant relating to robotic practice and behaviour.

7.116 The RCS also highlighted their concerns about negative working in the department to Medical Director 5. An action plan following the formal RCS report received in February 2016 was agreed; however, this was not progressed until over three years

later even though a Urology Action Group had been set up to monitor the actions. We have no evidence that this formally met.

7.117 In February 2016, Urologist 6 and Consultant Urologist 3 withdrew their applications for the Clinical Lead role. The Clinical Service Manager explained to Medical Director 5 that she thought Consultant Urologist 3 felt a lot of hostility to him and Urologist 6 had not got the salary he wanted when promoted to Associate Specialist. A few individuals (Consultant Uro-Oncologist 1, the Clinical Director and Medical Director 5) appeared disappointed and asked them to retract their withdrawals. Consultant Urologist 3 responded to Medical Director 5 to say he was apprehensive of a backlash from Consultant Urologist 7 and Consultant Urologist 9 if appointed and that he was mindful of the clinical incidents submitted '*targeting'* him.

7.118 The interviews for Clinical Lead were held in February 2016 and Urologist 6 and Consultant Urologist 9 were offered a joint role but Urologist 6 turned this down and Consultant Urologist 9 was offered the role on his own. Consultant Urologist 3 was told that Consultant Urologist 9 was a better role model, and the Trust had more confidence in his leadership abilities; Consultant Urologist 3 wrote to the Clinical Director and Medical Director 5 to express his 'anxiety, distress and disbelief' over this appointment and reiterated a wide range of allegations made over the past years about Consultant Urologist 9 and colleagues. The decision was clarified by Medical Director 5 in a conversation with Consultant Urologist 3 when he explained that during the interview Consultant Urologist 3 had refused to work with Consultant Urologist 9 which made appointing him impossible given the need to bring both sides of the team together.

7.119 After Consultant Urologist 9's interview Consultant Urologist 3 asserted that this was due to CQC putting pressure on quotas for BAME doctors in management positions. There was no basis for this claim.

7.120 Later that month, Consultant Urologist 3 was spoken to by Medical Director 5 for approaching two patients by telephone (six months earlier) following two incidents being reported and before an investigation was undertaken into two stent cases. These had resulted in complaints and possible litigation by the patients involved. He apologised for contacting the patients, but this inappropriate conduct was not formally investigated further. He reiterated health concerns that he had been having and that he could not see how he could have a good relationship with people in the department.

7.121 In March 2016, a Urology thematic review from four clinical incidents reported by Consultant Urologist 7 was completed. This highlighted safety aspects of the current arrangements for providing inpatient care at WGH and cover for urological patients at FGH over the weekend.

7.122 Consultant Urologist 2 worked under supervision until April 2016 and undertook no clinical activity until July as he wanted to work independently. NCAS confirmed they would undertake no further assessment by which time the Trust were managing a testicular implant recall process. This recall was instigated due to a legal claim.

7.123 In May 2016, Consultant Urologist 7 received the outcome letter of the grievance that he had raised in relation to Consultant Urologist 3 in November 2015. It stated that the main issues of his grievance were unprofessional behaviour and conduct making him feel demeaned and bullied. Also, there were several issues with Consultant Urologist 3's behaviour towards BAME doctors including Consultant Urologist 7 feeling he was constantly being questioned, judged, and criticised without being able

to discuss any issues as everything was escalated to senior management and clinical incidents were submitted. The letter included that there had been a meeting to discuss the incident and that Consultant Urologist 3 did not feel his behaviour was inappropriate and that in relation to his alleged behaviour towards BAME doctors, Consultant Urologist 3 felt that it was his role and responsibility to report and challenge issues that were not meeting the required expectations of the department. Consultant Urologist 3 had given reassurance that he would always be professional, and they considered this grievance closed; however, there is no evidence that witnesses had been called or that a formal investigation of Consultant Urologist 7 (or Consultant Urologist 9's) concerns took place.

7.124 Consultant Urologist 9, as new Clinical Lead, announced that he intended to undertake a review and revision of the job plans in the department in line with a Trust-wide exercise. This was met with resistance from Consultant Urologist 3 who considered it '*a waste of time in the face of clear divisional intention to force his resignation'*. However, this was a Trust-wide initiative led by the Medical Director and was required given that some job plans had not been reviewed for over five years. Job planning was also a recommendation of the RCS Invited Service Review and has been a requirement as part of the Consultant Contract since 2003.

7.125 Consultant Urologist 3 submitted a resignation letter on 6 July 2016, with his last working day being 26 September 2016.

7.126 During the years of 2012–2016, allegations and counter-allegations used up significant management time and distracted attention from improving services. As before some concerns were not reported as incidents and were not investigated, others were reported but not investigated adequately and inaccurate assertions of events have become 'believed fact' as a result. It is of concern that despite the evidence that events between 2011 and 2016 are not accurately described, Consultant Urologist 3 decided to report his colleagues to the GMC in November 2017 for historical cases relating to 2011–2014. The seven cases in relation to Consultant Urologist 7 highlight the ongoing dysfunction, mitigating circumstances and lack of named Consultant. In our view, the referral was unwarranted at this time based on our knowledge of these cases.

September 2016 onwards

7.127 The RCS invited clinical record review into 33 of Consultant Urologist 2's cases was reported in September 2016. It raised issues in 20 cases with six patient safety concerns.

7.128 At the end of October 2016, Consultant Urologist 7 emailed MPs and the Medical Director, NHS England and NHS Improvement (Northern Region) having received death threats following media coverage involving a Urology case published with his photograph. He also sent an image of a newspaper cutting with the words '*I am going to get you (Consultant Urologist 7)*' to Medical Director 5. He claimed that this was due to '*one-sided media articles, that this was not whistleblowing by Consultant Urologist 3 but a personal vendetta and not the professional way to manage clinical issues'*. He indicated that the Trust had been supportive in reporting the incident and advising on personal security but wanted the MPs to take action to stop him and his family being caused further harm.

7.129 In October 2016, a list of clinical incidents was submitted by Consultant Urologist 2 into cases involving Consultant Urologist 5 in operations involving laparoscopic nephrectomies. These included '*failure to diagnose an acute abdomen which*

resulted in death; sending home a patient with bleeding abdominal aneurysm; sending home a patient with bladder perforation; causing massive bleed while performing operation due to surgical incompetence; not removing all of ureter when needed; clipping inferior vena cava; and clipping coeliac artery'.

7.130 These were serious complications which related to patients seen between April and October 2016 and resulted in a referral to the GMC. Consultant Urologist 3 supported Consultant Urologist 5 saying the complaint was '*vexatious'* and raised concerns again about the culture in the department. It was difficult for the GMC to determine Consultant Urologist 5's exact role as other clinicians were also involved. In April 2017, the GMC stated there was no case to answer in relation to the fitness to practice for Consultant Urologist 5. A review by External Consultant Urologist 3, Consultant Urologist at Leeds Teaching Hospital, followed on three cases after a request by Medical Director 5 in May 2017. He advised further training but Consultant Urologist 5 decided to stop doing these procedures in agreement with the Trust.

7.131 In December 2016, after he left the Trust, Consultant Urologist 3 wrote to the Chair of the Trust claiming that false allegations had been made against him, and that discrimination had been used as an '*offensive retaliatory weapon and smokescreen from very serious and easily avoided errors raised as part of "protected disclosures"* and a '*colossal mess of whistleblowing/protected disclosures/avoidable deaths/bullying and abuse/retribution/and a series of detriments directed at him by colleagues and management'*. He copied this to a Non-Executive Director and the FTSUG. The Chair asked for more detail and offered a meeting but the focus related to the incidents contained in the correspondence and not the allegations of discrimination. In his correspondence Consultant Urologist 3 detailed information about nine cases involving ten patients. Consultant Urologist 3 also contacted NHS Improvement with the same information. Medical Director 5 provided a report on these cases on 27 March 2017 to both Consultant Urologist 3 and NHS Improvement following their enquiries. The report was also shared with the CQC by the Director of Governance on the same day. Consultant Urologist 3 made further comments disagreeing with the conclusions of this report in April and May 2017 (as the report had gone to the wrong email address).

7.132 On 20 December 2016, the Trust Chair responded to say they had done everything possible to support Consultant Urologist 3 following his whistleblowing allegations and he had been reassured that the Trust had taken the issues seriously and handled them in line with policy.

7.133 In late 2016, the Trust asked the former Chair of the GMC Diversity and Inclusion Committee to support the Consultants within the department and continuing relationship problems. He had been previously involved, at the request of Chief Executive 3, in supporting staff in relation to concerns in the Radiology service. His role was to meet with Consultant Urologists and identify key issues and problems. However, his view was that the biggest focus was on the need for professionalism of the doctors involved and working together as measured by expectations in GMC Good Medical Practice Guidelines. Regular feedback was provided to Chief Executive 3. There is no clear output from this intervention.

7.134 However, his opinion over this time and subsequently was that the department was divided on ethnic lines, it reflected the culture of the wider organisation and that this culture was filtering down to Urology. He commented on the patient safety implications of poor culture and team working. He used an example of the culture of

the organisation - *'the rudeness of people in front of others in meetings and need to show respect'.*

7.135 On 12 May 2017 Consultant Urologist 3 contacted the GMC regarding his view that the report about the cases raised with Medical Director 5 and the Chair in December 2016/January 2017 was '*completely inadequate'* and that there were 27 other cases that had not been investigated.

7.136 In May 2017, Consultant Urologist 2 was sent the outcome letter from the Trust's MHPS hearing. It stated there were significant concerns to result in dismissal but sufficient mitigation to warrant consideration of an alternative, '*demotion to specialty doctor and a final written warning valid for two years; a referral to the GMC would be updated and a back-on-track programme would be offered to ensure practice appropriate for a specialty doctor'.* He was referred to the GMC on 24 May 2017. In June, Consultant Urologist 2 appealed his demotion and the GMC responded in August to confirm their decision to investigate him. In October 2017, the GMC imposed an interim order for 18 months restricting his practice, amended in September 2018 to closely supervise him. It took a further two and a half years for the Medical Practitioners Tribunal Service (MPTS) process to conclude that he would remain on the register with conditions to practice.

7.137 Whilst we do not challenge the decisions made by the MHPS process, MPTS and GMC, we are concerned by some aspects that highlight the poor governance in place that impact individuals and the team to a significant degree. For example, there were no RCAs for two of the three cases in 2014 on which Consultant Urologist 2's June suspension was based, and the sequence of events relied upon in relation to wrong site surgery allegations (that still persist in public reporting today) were later found to be inaccurate. Not having the full details of cases used for disciplinary purposes is a risk to individuals and the organisation. Another example is the time taken to commission a clinical record review from the RCS which reported in 2016 on practice from 2013-14 (this was partly due to processes requiring consent from a Consultant for a review of their records, which was withheld). The invited clinical record review was based only on patient records as requested and in line with normal procedure; however, as this was a stand-alone clinical record review it was not designed to inform the invited service review and therefore did not consider wider team dysfunction or involve a comparative review of practice. Part of the difficulty related to delays in identifying an appropriate cohort of patients that were a fair reflection of Consultant Urologist 2's individual performance as distinct from the performance of the pooled team. It was also too late for the Trust to respond to any concerns identified by reviewers in clinical care for some patients given the elapsed time between care given and the record review.

7.138 Consultant Urologist 3 spoke with Medical Director 5 on 17 May 2017. He covertly recorded this (and other meetings) and used these recordings in the tribunal without consent. The transcription of this call, predominantly arranged to discuss the incidents Consultant Urologist 3 had written to the Chair about in December 2016, records a conversation about racism in the NHS but also in the Urology department. Consultant Urologist 3 said that '*Consultant Urologist 2 had got away with so much that there was a sense from Consultant Urologist 7 and to a lesser extent Consultant Urologist 9 that they could also get away with some really bad personal and professional behaviours; there's a real sense that the three musketeers, as they're known, are very much in control of the department now'*. He also referenced a '*three-way tactical allegation of racism'* against him and that he and Medical Director 5

'*should not be held hostage'*. Several cases that had been highlighted by Consultant Urologist 3 were discussed and Consultant Urologist 3, on each occasion, said that incidents were due to poor clinical practice by Consultant Urologist 2, Consultant Urologist 7 and/or Consultant Urologist 9; this is despite Consultant Urologist 3 also being involved in some of the cases raised.

7.139 On 25 May 2017 Medical Director 5 met with NHS Improvement following the report on eight cases raised by Consultant Urologist 3. No further action followed as NHS Improvement were assured by the meeting. We have reviewed all these cases as part of our analysis.

7.140 In November 2017, the GMC received complaint letters regarding Consultant Urologist 7, Consultant Urologist 9 and Consultant Urologist 2 and they notified the Trust. These were referrals made by Consultant Urologist 3.

7.141 Consultant Urologist 3 issued further employment tribunal proceedings against the Trust in November 2017.

7.142 An appeal hearing in January 2018 did not uphold Consultant Urologist 2's capability hearing appeal.

7.143 The employment tribunal for Consultant Urologist 3 was held in April 2018 and a judgement was issued in June 2018. Due to contractual breaches the Trust was determined to have constructively unfairly dismissed Consultant Urologist 3, but there was no evidence that the pay issues were linked to the protected disclosures made by him. Key factors material in the judgement were:

- the lack of job planning; and
- the delays in processes by divisional management and the HR department, which led to up to eight months being taken to investigate Consultant Urologist 3's pay issues.

7.144 In April 2018, the Daily Mail contacted the Trust following Consultant Urologist 3's employment tribunal hearing and named Consultant Urologist 7, Consultant Urologist 2 and Consultant Urologist 9, referencing claims of racism towards Consultant Urologist 3 from Asian colleagues. A response was requested but the Trust advised the named Consultants not to comment. The Chief Executive, Medical Director 5 and Director of HR and OD 2 were all informed. The Telegraph also picked up the story. The Times picked it up the following day and it began to spread across European publications by 24 April. The European headline was 'Top Surgeon in Racism Purge'. This had a significant personal and professional impact on the named Consultants and the department.

7.145 Consultant Urologist 2 resigned (by mutual agreement) and then left the Trust on 28 September 2018. This resulted in the withdrawal of an employment tribunal claim.

7.146 In December 2018, an email from Consultant Uro-Oncologist 1 to Medical Director 6 (then Deputy Medical Director) and the Lead Clinician for Cancer confirmed the discussions from a meeting held the previous week regarding the treatment of members of the MDT, particularly by Consultant Urologist 7, and decisions regarding some care pathways. Consultant Uro-Oncologist 1 stated that MDT members were worried that raising concerns would leave them open to accusations of racism. Medical Director 6 and the Oncology Clinical Lead apparently suggested not raising a formal complaint given *'ongoing circumstances that can't be discussed'* and that they would speak to Consultant Urologist 7 about his conduct.

7.147 On 25 July 2019, Consultant Urologist 3 published *Whistle in the Wind* after notifying the Trust the day before of the publication.

Current

7.148 Recognising that there were historic relationship issues within the Urology department, a cultural support and development programme was commissioned with the team through external provider InterBe, at the end of 2019. The first phase of their cultural transformation project investigated the culture of the Urology department with key findings from the Phase One report (published in January 2020) including:

'a lack of trust and teamwork; a culture of conflict, fear, blame, retaliation, and recriminations; and long-held divisive 'us' and 'them' narratives'.

7.149 We understand that staff at all levels were involved in co-designing the next phases of the programme which sought to address some of the ongoing concerns associated with relationships. Individual coaching sessions as well as team sessions were used to address themes such as conduct and behaviour, building trust and navigating difficult conversations.

7.150 In our Current Controls Assessment Report in October 2020, we considered that dynamics between a small number of senior clinicians remained fragmented thereby presenting risks to a safe and effective clinical working environment, particularly given that Urology patients continue to be pooled.

7.151 Documentation in relation to a Consultant Urologist in 2021 summarised the impact of the difficulties in the department as follows:

'You highlighted the continuous pressure and stress that emanated from working in Urology at [the Trust] for many years, particularly those that followed from the actions of a former Consultant colleague. [During 2020] … you were in a state of despondency, helplessness and hopelessness'.

7.152 We understand that working relationships are now improving assisted by the InterBe programme.

8. Outcomes and harms

8.1 Our investigation commenced with collating information relating to the 29 cases identified in the book Whistle in the Wind published in July 2019. We then extended our request for information relating to any patient safety investigation undertaken by the Trust as a root cause analysis (RCA) or reported as a serious incident (SI). We then examined incident records, complaints information, legal claims, procedures of interest (major procedures undertaken in small numbers or unusual coding), cases examined by the Royal College of Surgeons (RCS) and included any case brought to our attention through interviews, directly by patients or staff or identified through documentation provided to us.

8.2 Our review resulted in 574 notifications of possible harm which we identified as patient cases of interest. The master list of cases of interest reduced to 523 cases once duplicated notifications were taken into account. The cases are predominantly male, which reflects the gender mix of the Urology service. 77% of cases were male; 21% female and for the remaining cases (2%), gender could not be identified.

8.3 The list was not exhaustive and does not include all complaints/concerns or every incident notified. It does however provide a detailed list to form a basis for the analysis of clinical and governance issues.

8.4 The cases were identified through a range of sources including:

- Cases identified in the published book (29)
- Cases identified in the submission from Consultant Urologist 3 to the Trust in 2017
- Cases known to be SI (34)
- Cases known to be considered RCA (30) and 104 day breach analyses (37)
- Cases identified by the Trust as none of the above, but complaints made at the time of book publication (15)
- Cases identified by Niche through a review of incidents where harm was moderate or above
- Procedure review by Niche of unusual and low number complex procedures of special interest
- Inpatient deaths and mortality reviews from 2013
- Cases reported directly to Niche through stakeholder interviews including with NHS staff
- Cases identified as Niche undertook the document review including Quality Committee and Serious Incident Requiring Investigation (SIRI) panel minutes
- RCS 2016 invited clinical record review (33)
- Prostate biopsy recall information relating to 2004–5
- A review of archived documentation relating to 2000–2005
- All Urology claims logged by Legal Services (68)
- A list of complaints during 2020

- Complaints drawn to the attention of Niche by patients or their families or via the Trust at patient or family request
- Media cases in the public domain
- Clinical Commissioning Group (CCG) SI information

8.5 There are lessons to be learned about drawing a list of this type together on a specialty basis. The Trust could not provide a comprehensive list of all Urology related Serious Incidents or RCAs in the first instance from its systems. The Trust also found difficulty in robustly identifying all Urology related incidents without further guidance, to provide a comprehensive data set and further difficulty in drawing together a list of Urology related inpatient deaths from 2013 onwards. This was on occasion due to patients not being admitted or discharged under the specialty of Urology.

8.6 A summary of our review of the individual cases of interest will be provided to the Trust. These are our confidential comments based on the information available to us for each case. In some cases, we requested full patient records and in others we required only minimal intelligence to form a view. From this a range of themes were drawn to inform this report. Each of the cases were assigned a score to indicate to the Trust our views on which needed to be prioritised for further action e.g. in relation to investigation quality or Duty of Candour. An anonymous version of the analysis will be provided to NHS England and NHS Improvement as commissioners of the investigation.

8.7 We identified 131 cases where we provided an impact/priority rating above 1 for the Trust to consider further action. 54 of the 131 patients are now deceased but the evidence indicates that investigations were not adequate or there remain outstanding enquiries.

8.8 However, the index case in December 2014 (as summarised in section 4) is a culmination of the failures of this team to work together and to learn together and reflects the inadequacy of the systems in place in the Trust to protect patients.

8.9 We consider that each of these events was an opportunity for intervention to improve the way the team ran as well as the systems and processes that supported safe, efficient, and effective care. The table below provides a tabular picture of 511 of these patient specific events over the last 20 years from which we have drawn our findings.

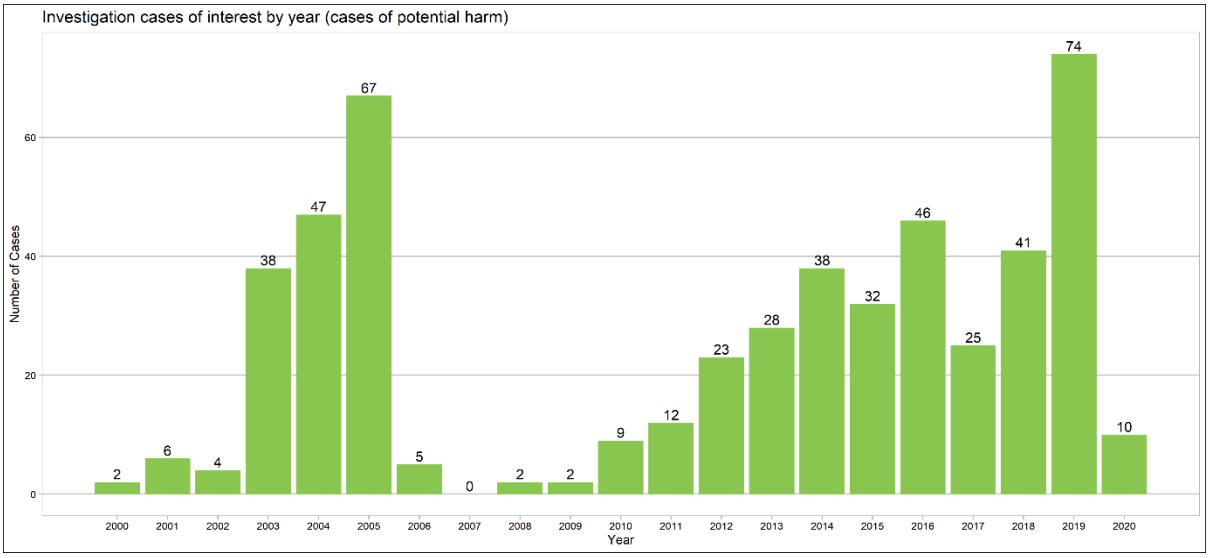
Table 3 - Cases of interest 2000-2020

Year	Incident only	Incidents - breach 104 days	Incidents RCA	Incidents StEIS	Claims	PHSO	Never Events	Complaints	External Reviews	Coroner/ Inquests	Mortality Cases	Clinical Concerns	Other	Total
2000	0	0	0	0	0	0	0	0	1	1	0	0	0	2
2001	0	0	0	0	0	0	0	2	0	1	0	1	2	6
2002	0	0	0	0	0	0	0	2	0	0	0	1	1	4
2003	0	0	0	0	2	0	0	15	0	0	0	21	0	38
2004	0	0	0	1	5	0	0	3	0	0	0	38	0	47
2005	0	0	0	0	3	0	0	1	0	0	0	63	0	67
2006	0	0	0	0	2	0	0	1	0	0	0	2	0	5
2007	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2008	1	0	0	0	1	0	0	0	0	0	0	0	0	2
2009	0	0	0	0	2	0	0	0	0	0	0	0	0	2
2010	5	0	0	0	1	1	0	1	1	0	0	0	0	9
2011	1	0	1	1	1	1	0	0	1	1	0	0	5	12
2012	7	0	1	0	6	0	0	1	5	0	0	0	3	23
2013	11	0	1	1	3	0	1	1	8	1	0	0	1	28
2014	8	0	5	3	6	1	1	2	6	0	2	1	3	38
2015	12	0	6	1	5	0	0	1	0	1	3	0	3	32
2016	22	0	10	2	3	0	1	0	1	0	4	0	3	46
2017	14	0	1	5	1	1	1	0	0	0	1	0	1	25
2018	10	10	2	7	6	0	0	1	0	0	0	0	5	41
2019	21	15	8	10	6	0	1	10	0	0	0	0	3	74
2020	2	1	0	1	4	0	0	1	0	0	1	0	0	10
All	114	26	35	32	57	4	5	42	23	5	11	127	30	511

8.10 Of the 523 cases of interest, three procedures were reviewed for which no concerns were identified, and nine cases could not be identified to an individual patient.

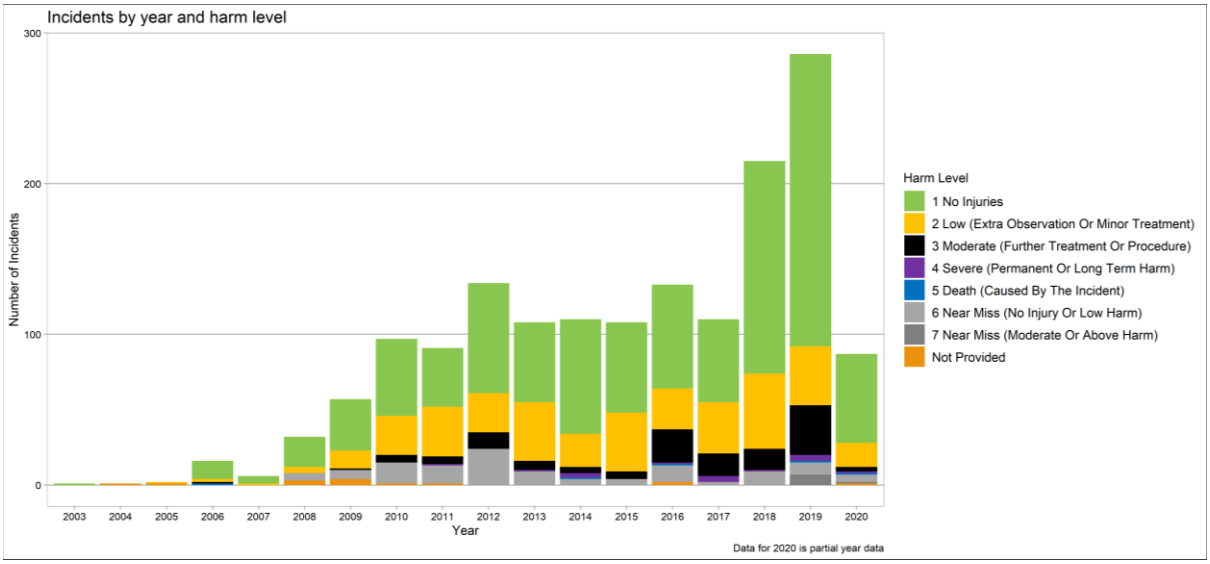
8.11 The absence of data from 2006 to 2010 is stark. We cannot be assured, however, that this equates to an absence of harm. There were two 'waves' of cases of interest.

Graph 22 - Cases of interest by year 2000-2020



8.12 The chart below shows the total incidents reported in relation to Urology to the Ulysses[48] system. There were 1,700 incidents reported. A subset of the moderate and above harm cases were included in the cases of interest data set above. The incident reporting system developed and became further embedded from 2003 with the introduction of a national reporting and learning system (NRLS). The number of incidents reported increased significantly from 2018 from a previously steady level partly following media publicity and partly due to efforts to improve incident reporting across the Trust. We cannot verify the harm ratings assigned and from our review we cannot be confident that all relevant incidents were reported during this period.

Graph 23 - Incidents reported in Urology 2000-2020



[48] Incident reporting software

Themes and detailed findings - clinical care for patients

8.13 The following section provides our thematic analysis of the cases represented in the above tables. It includes a qualitative review of the documentation relating to each case in the form of patient notes, investigation reports, incidents, claims and other review material.

Procedural complications

Failure to stent/delays in stenting

8.14 Stenting[49] of patients is a key function of Urology provision. This is undertaken either as a routine planned event as part of managing a patient's condition, as an emergency where the stent may have become infected or blocked or because of a newly diagnosed condition. As a foreign body a stent needs replacing regularly (usually every 6–9 months, although may be more frequent) and is a common feature of treatment for cancer or kidney disease to maintain the drainage of urine from the kidney and prevent hydronephrosis. When replacing a stent this is often an opportunity to examine the bladder with a cystoscopy to assess the health of the bladder and stage of a cancer.

8.15 The cases we reviewed identified that there have not been adequate arrangements for monitoring and replacing stents for patients.

8.16 Stenting was one of the issues identified within the 2016 RCS Invited Service Review Urology Report. The RCS Invited Service Review reported on a lack of interventional radiology support (for nephrostomy insertion) (new arrangements have been put in place but delays in transferring emergency cases remain), the need for a clearer protocol for the management of stents, a function to track all ureteric stents electronically so that forgotten or lost stents should be prevented, the introduction of a protocol for the management of ureteroscopies especially in the case for a solitary functioning kidney, and a clear protocol for the management of obstructed and infected kidneys.

8.17 A SOP was not written until 2016, a stent register was not put in place until 2017, and compliance with the SOP and stent register was not sustained after improvement in 2019. The table below shows our analysis of stent register compliance from 2017–2020.

Table 4 - Stent register compliance 2017-2020

Period of Audit	Audit Number	Sample Size	On stent register?	Compliance
Sep 2017 – Aug 2018	*1353*	266	127 – 129 (*)	48%
Jan 2019 – Aug 2019	*1691*	315	293	93%
Aug 2019 – Mar 2020	*2080*	300	182	61%

8.18 (*) Note: only the sample size (266) and the compliance rate (48%) were issued in the data source - therefore the 'On stent register?' number could feasibly lie within the range of 127–129.

8.19 In relation to stenting, over the period of 2012–2019 we found:

[49] Stenting - insertion of a tube to keep the ureter patent. An antegrade stent is placed in through the kidney and down into the ureter (as opposed to placing a stent through the bladder and up the ureter which is a retrograde stent; A retrograde stent is placed up into the ureter via the bladder. It needs the ureteric orifice to be visible to do this initially hence once the antegrade stent was in it was then possible to undertake a retrograde stent as the orifice could be located.

- the use of the stent register was not consistently evidenced;
- evidence of delays in the removal/change of stents, with some patients developing urosepsis as a result of the delay/failure to remove a stent in the prescribed clinical timeframe;
- a lack of protocols and procedures for stenting;
- a lack of protocols for stenting in a single obstructed kidney; and
- a lack of clarity on the appropriateness of stenting over nephrostomy.

8.20 The table below summarises the known cases from the cases of interest list demonstrating repeated stenting concerns and how many involved emergency stenting or urosepsis.

Table 5 - Cases of interest relating to stenting

Year reported	No of cases relating to stent concerns	Emergency stenting issue	Urosepsis
2012	2	0	0
2013	0	0	0
2014	3	2	2
2015	3	1	0
2016	2	0	0
2017	4	0	1
2018	4	1	2
2019	7	4	3

8.21 Emergency stenting also caused a great deal of dysfunction in the team. There are examples where more prompt attention was required although access to emergency theatres appears to have been an additional challenge for the Urology team. Rather than discuss concerns as a team, the behaviours exhibited between some individuals meant that this became a no-go area for discussion or review. The inability to discuss and agree parameters for appropriate management or assessment of blocked or infected stents was a fundamental risk to patient safety. Different Consultants were pitted against each other for different clinical decisions which on occasion resulted in inadequate emergency attention.

8.22 Recurrent pattern of issues with stenting combined with very poor investigations and RCA has meant that there is no evidence of effective actions taken or identified to prevent further occurrence.

8.23 In 2020, as part of our case review, all enquiries relating to stent insertion received positive affirmation from the Trust that stents for the individual patients had been registered; however, it has taken years to implement an adequate arrangement with no single Consultant or Clinical Lead taking full control of ensuring this core essential need was enacted sooner.

Adequacy of cystoscopy procedures

8.24 There were issues identified from the patient case reviews (in six specific cases and one in our Current Case Review) including where cystoscopies reported no abnormal findings. Subsequently patients were found to have developed malignancy a short time afterwards. Whilst there may be mitigating circumstances due to the difficulty of visualising the bladder wall, there was no evidence that in these cases a review process was undertaken to ensure that the individual professionals were subject to peer review or that the reasons for the failure to identify the progression of disease was explored to learn from these cases. None of the investigations undertaken referenced the quality of cystoscopy procedures, peer review or audit of this core function.

8.25 It has also recently been brought to our attention that at RLI the Urology service is using Sheath Flexible Cystoscopies in the One Stop Clinic, which is considered sub-optimal for diagnostic purposes. We understand there is also no suction facility. Requests for updated equipment have been discussed in Urology business meetings but not resolved. Business cases now being prepared for some new equipment following a further serious in December 2020.

Bladder perforation

8.26 Bladder procedures are one of the most common procedures in Urology. Bladder perforation is a known serious complication and can result in significant harm.

8.27 The table below shows eight cases involving bladder perforation between 2013–2020.

Table 6 - Cases relating to bladder perforation

Year reported	Reported bladder perforation incidents/claims
2013	1 (x3 same patient)
2014	1
2015	0
2016	1
2017	1
2018	2
2019	1
2020	1

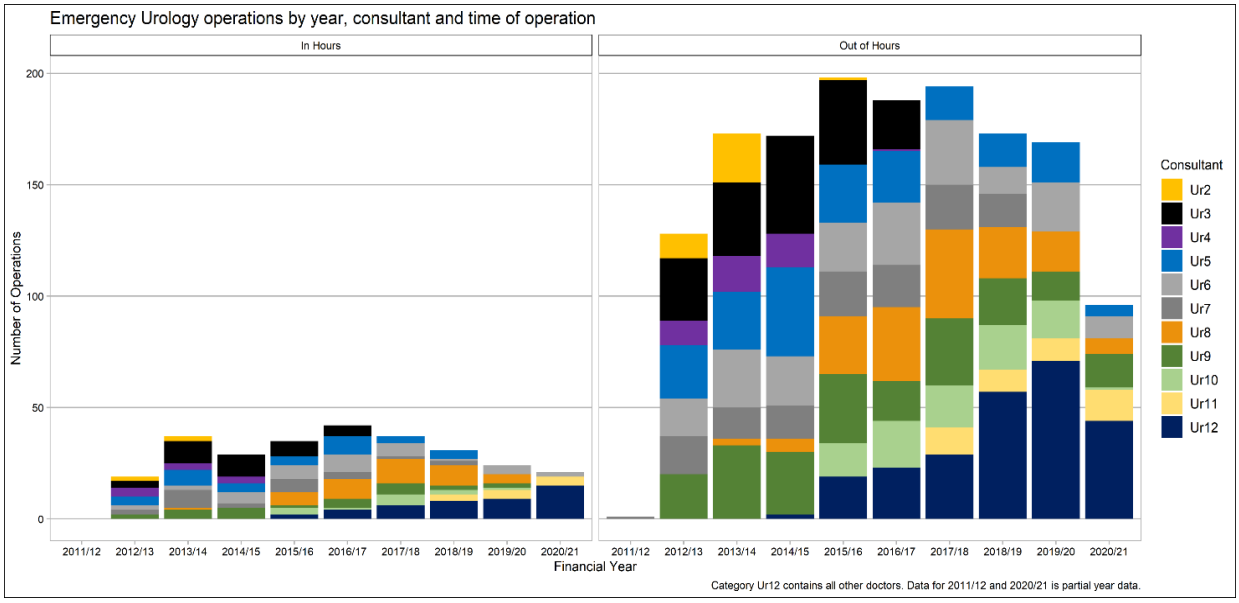
8.28 We cannot confirm whether all bladder perforations were reported as incidents, but the learning from those that were has not resulted in change or thematic review. Equipment is key to supporting the clinician in reducing the risk of perforation. The learning from cases of perforation was limited and has not resulted in the provision of new equipment in a timely manner. For example, the business case for the diathermy equipment was first noted in review in 2017 and was a repeated action noted across reviews up to, and including, those undertaken in 2020. There was no clinical audit to establish if all cases have been reported for learning purposes.

8.29 The actions noted following the investigation of a patient in 2017 included strict fluid balance to be recorded in theatre and a business case for diathermy and drain/suction equipment, these were the same as those noted for a patient in 2019.

Emergency surgery out of hours

8.30 The charts below show the split of emergency procedures being undertaken in hours and out of hours since 2012/13. The proportion of emergency work being undertaken by non-core Consultants has increased with the majority of emergency in hours work being undertaken by non-core Consultants (Ur12) and accounting for 50% of out-of-hours work. The distribution of emergency cases between core Consultant Urologists over this period appears relatively even. Since July 2018 Consultant Urologist 7 was not undertaking on call duties and over the pandemic two others were also not on call due to Covid-19 BAME risk assessments. Locum cover was in place as a result.

Graph 24 - Emergency Urology operations 2011-2020 in and out of hours



8.31 Emergency surgery over the last ten years has been largely undertaken outside of normal working hours. This is sometimes unavoidable but for Urology patients this seems to be the norm. Concerns about the time of day the patient is being operated on are compounded by the increasing number of emergency operations being conducted by locum surgeons. This raises several concerns in terms of why the permanent Urologists appear to be undertaking so little emergency surgery and increases the risks to the patient of ongoing lack of continuity of care and team communications.

8.32 There is currently no dedicated 24/7 CEPOD[50] theatre at either RLI or FGH available to Urology. We understand this continues to impact the Urology service when trying to access theatres for emergency cases in the context of demand from other specialties. There is an emergency theatres operating procedure but we have been told and our analysis confirms that the Urology service, in the main, can only access emergency theatres after 18:00hrs. Alternative arrangements to reduce the need for emergency theatres (e.g. for catheterisation and stenting) are not yet sufficient.

[50] A CEPOD theatre is a permanently staffed operating theatre that can be run on a 24 hour basis.

8.33 Whilst Consultant Urologist 3 argued in his book that the emergency surgery was disproportionately undertaken by him, this data would suggest otherwise.

8.34 There is no evidence that any one surgeon undertook more emergency surgery than another based on this analysis. Emergency surgery, where possible, is safer to deliver during normal working hours. The above analysis indicates that more than 80% of emergency work has been undertaken outside of normal working weekday hours. This meant that access to alternatives e.g. nephrostomy options instead of stenting for obstructed kidneys, was not a viable option even though this might have been a safer alternative for some sick patients There are examples in our patient case review of surgeons booking urgent cases in for their own lists a few days in advance so we consider this may have become a normal practice within the team, possibly so that surgeons controlled their own workload or did not have to hand cases over to other Consultants. The emergency theatre was and is still controlled by other specialties and so accessing it could be difficult at times. This was identified in the RCS Invited Service Review in 2016 which recommended that the Trust should review the process by which smaller specialties accessed emergency theatre lists to ensure emergency surgery was appropriately clinically prioritised with sufficient capacity to meet demand. Since 2016 less 'in hours' emergency work has been conducted by core Urologists and there has been no discernible change in the proportions of in hours and out of hours surgery since then. This up-to-date distribution of emergency work (Graph 24) was brought to the attention of the Trust in our interim report in December and needs to be monitored and addressed.

Lack of pathway management resulting in delayed diagnosis and treatment

8.35 Our analysis showed that there were repeated failures to review, follow-up or diagnose patients. The following table shows 47 cases where there was a failure to review the patient or their test results or where they were lost to follow-up:

Table 7 - Cases of interest relating to failure to review

Year reported	Failure to review test	Failure to review patient	Failure to review - spinal cord compression	Lost to follow-up	Failure to diagnose	Failure to counsel
2000	-	-	-	-	-	1
2001	-	-	-	-	-	1
2002	-	-	-	-	-	-
2003	-	-	-	-	-	1
2004	-	-	-	-	-	3
2005	-	-	-	1	-	-
2006	-	-	-	-	-	1
2007	-	-	-	-	-	-
2008	-	-	-	1	-	-
2009	-	-	-	-	-	-
2010	-	1	-	-	-	-
2011	-	2	1	-	1	1
2012	1	-	-	1	-	2
2013	1	1	-	3	-	1
2014	4	3	2	1	-	2
2015	1	1	-	2	1	1
2016	4	1	-	2	1	-
2017	3	2	1	1	-	1
2018	2	-	-	1	-	1
2019	2	4	-	4	6	-
2020	1	1	-	1	2	-
	19	16	4	18	11	16

8.36 Of the cases identified in Table 7, 19 cases involved a failure to review test results, 16 related to a failure to review the patient clinically and 18 were lost to follow-up.

8.37 The analysis showed tests and clinical investigations were either not carried out or carried out and results not reviewed in 16 cases. There was no clear process identified for the recording and reviewing of tests, especially the review of abnormal results.

8.38 The October 2019 SIRI panel recorded the following (this was an incidental finding as the case being referred to was not Urology):

'*A discussion took place regarding the Trust not currently have an electronic automatic flagging system for clinicians to access regarding patient's results. [Clinical Quality Manager] asked for it to be detailed within the RCA that this is included on the Trust's Risk register. This is likely to be queried when the signed off report is reviewed by the CCG.'*

8.39 During our Current Case Review in October/November 2020 this theme continued to be apparent. A results acknowledgement system was still not in place throughout 2020. The systematic review and acknowledgement of results in Lorenzo has been an ongoing issue which has only just been addressed by the Trust[51]. Evidence indicates that the Trust had been working on results acknowledgement since 2016. At that time the system 'auto-acknowledged' results after seven days if not reviewed.

8.40 The development of Lorenzo has continued since its introduction in 2010 with changes and updates being added over time. The use and impact on staff of having to keep up to date with how to use Lorenzo does not appear to be a consideration in investigations and incidents. In our view, the ability to find the right information requires confident use of Lorenzo and may be a contributory factor in establishing a patient's history in a clinical setting, in particular when acknowledging results and recording information.

8.41 There were 16 cases identified where a patient was not reviewed when they should have been. Four cases involved metastatic spinal cord compression not being reviewed.

8.42 For some patients who required follow-up appointments/active surveillance, there were missed, delayed or incorrectly sequenced dates which identified an issue with the underlying process. There were at least 18 occasions identified in the cases of interest where patients were not on the correct access plans in Lorenzo or who were identified as having missed appointments, some by several months or years, These were due to a lack of capacity within the department, however, the underlying investigations did not identify the system issues involved.

8.43 There are two key issues in relation to patients who were lost to follow-up:

- the lack of individual accountability and the shared care model meaning that an individual clinician was not responsible for the patient's care pathway; and
- organisational failures relating to booking in 2011 and the introduction of Lorenzo in 2010.

8.44 Several cases highlight the issues relating to system problems affecting patients being lost to follow-up. The following case study is the Urology case which triggered

[51] The Trust state that a system of results acknowledgement for CT, MRI and abdominal X-rays went live on 17 May 2021.

the originating serious incident in October 2011. This involved a Urology patient and drew attention to a Trust wide backlog of 37,000 outpatients (as detailed previously) and patients not being followed up.

Case study

> *'[A complaint in 2011] alerted the Trust to the fact that delays in outpatient follow-up appointments had occurred affecting a number of patients. On making enquiries into why this should be the case, it has been identified that the booking system process is not fit for purpose. For patients who are not given an appointment when they leave the Urology department, the booking system did not identify these patients as a priority and therefore when a shortfall in capacity occurred and appointments could not be sent out, the system did not "flag" these patients as a priority, nor did it identify those patients at risk. Our enquiries identified that over several months, a backlog of patient appointments had developed. Furthermore, enquiries identified that patients at risk were not prioritised, appointments were not being made chronologically and there was no formal process in place to resolve problems at periods of limited capacity'.*
>
> This case identified that a failure to follow up from July 2010 for 12 months resulted in extensive metastatic disease from which the patient died.

8.45 However, after the issues in 2011/12, there are references to cases in 2013, 2016 and 2018 that state there were ongoing issues with dual Oncology appointments and waits for Urology. In May 2019 the case of a patient identified a continuing and growing problem of 2,600 patients not being seen in a timely manner. This incident identified an Indicative Review Date (IRD) backlog of cancer patients which was stated to be due to ongoing demand and capacity issues with Urology follow-ups. The Urology service was said to be developing a protocol to urgently validate patients within the backlog; the plan was to contact patients to enable up-to-date investigations and follow-up after clinical validation of their results. The action identified at the time of this RCA was that all patients past their IRD were to be administratively validated before being clinically validated.

8.46 The issue of a (Guaranteed Activity Date) GAD/IRD backlog was known to the Trust from 2011 and had also been on the risk register since 2018.

8.47 In November 2020, we held a meeting with Trust staff regarding the backlog of 2,600 patients for Urology who had breached the IRD and which was being validated as part of an action plan identified in October 2019. However, there were a number of issues that were raised as part of this discussion, including:

- No identified validation methodology/SOP to govern the process of ensuring all patients who had breached their IRD were accounted for and were being systematically reviewed.
- No data extraction at the point the issue was identified, therefore the 2,600 patients could not be individually identified.
- No record of whether patients were formally notified of their missed/late appointments and, where appropriate, that the Duty of Candour was followed.
- No record of how many of the patients were urgent/cancer/routine as a result of the initial administrative validation and no assurance could be provided that these patients were being reviewed in clinical as opposed to chronological order.

- No clear process for assessing if a patient was harmed because of a delayed appointment.
- No systematic change from a given date whereby no new patients would breach their IRD due to an identified change in practice.

8.48 Following this exercise, our review found that no assurance could be given for the following:

- What the validation process is for those who have breached their IRD.
- How many patients have currently breached their IRD and by what time period (i.e. within one month, two months etc.)?
- How those patients who are deemed to be clinically urgent or a suspected/known cancer are being triaged as a matter of urgency.
- What process is being used to determine harm.
- How the patients are being made aware of possible delays to their care and that Duty of Candour is being adhered to.
- What the monitoring and governance arrangements are for the ongoing breaches of IRD.
- How the risk register and risk mitigation is being implemented and deployed.
- What the process is, going forward, to ensure consistent validation and prioritisation.

8.49 As at May 2021 the Safe Today Report showed 2,800 cases past IRD in April 2021 although this is not consistent throughout the report.

8.50 Table 7 also shows that there were 11 cases of failure to diagnose the patient's condition. Eight of these cases occurred in 2019/20.

8.51 There were also 16 cases where there was a failure to counsel patients on treatment options. It is of note that the General Medical Council (GMC) had been involved with Consultant Urologist 2 in relation to this subject. The GMC had written to the Trust in 2008 and included in their communication the issue of the failure to counsel patients in terms of options for treatment - particularly chemotherapy/radiotherapy options and surgical treatment.

Continuity of care

8.52 Urology services were largely delivered by separate teams based in FGH and RLI. Over time, however, patients were increasingly seen across the sites and a pooled model developed so that referred patients would be seen and managed by whichever Consultant or Associate Specialist was available in clinic appointments or for surgical review or treatment.

8.53 The shared care (pooled) model in Urology whereby patients did not have a named lead Consultant required strong communication. As a direct result of poor team communication continuity of care was likely to fail and continue to fail in this team. A shared care model whereby a Consultant lists and consents a patient who is likely to be operated on by a different Consultant who is unfamiliar with the patient, requires exemplary communication, note keeping and case review. There are multiple incident reports, RCAs and investigations that have demonstrated that this has been an ongoing issue in this department that remains unaddressed. This resulted in numerous cases of poor patient experiences, with patients being unclear who was

responsible for their care and instances of a Consultant turning up to undertake a surgical procedure when the patient had been given the expectation that the consenting Consultant would be the one operating.

8.54 Ward rounds/clinical reviews undertaken by different Consultants who did not know the patient or had been involved in only one part of their care contributed to a lack of accountability for individual patients. This created a situation where multiple Consultants 'dabbled in the care' and no one Consultant appeared responsible for ensuring that an adequate management plan was initiated and implemented. Different Consultants disagreed with each other's management plans, in particular when they were called to see patients whilst on call.

8.55 This has resulted in many cases (the index case describes the impact in detail) where multiple Consultants all had input to individual patients. This precipitated cases of harm where decision-making was delayed, or management plans changed and patient safety was compromised.

8.56 This has also directly resulted in the inability to hold any individual Consultant clearly to account for any potential or reported failings in a patient's care. This lack of accountability due to there being no continuity of care directly resulted in risks to patient safety exemplified by changed management plans, poor management plans, uninformed decision-making, lack of continuity at MDT, late involvement in cases and a failure to follow-up key cases/results.

8.57 This led to the inability of the department to report clinical incidents as it was unclear who the responsible Consultant was at times; a lack of independence when investigating incidents that were reported because all Consultants were invariably involved in a patient's pathway at some point; and an inability to investigate system failures as a result. There are specific cases of concern, where the reported incident focuses on individual errors but there were system and team-wide failings. Failing to identify root causes in a robust manner has contributed to an inability to develop and agree protocols for managing patients, work together and change practice.

8.58 The transfer of care of a patient from one Consultant to another was critical in the pooled model of care in place on a day-to-day basis and as a need resulting from on call cover arrangements across two or more sites. The inability to directly communicate between some individual Consultants meant patient safety was compromised. The failure of handover in the index case over three separate days is the exemplification of the failure of individuals to rise above their personal grievances. A further 20 cases in our review, dating back to 2010, highlight concerns about handover problems.

8.59 A specific example is a disagreement between two Consultants (Consultant Urologist 9 and Consultant Urologist 3) in March 2014 where the debate about clinical ownership/patient safety is clearly articulated in an email exchange which occurred in relation to Consultant Urologist 3's failure to inform a colleague about a post-nephrectomy patient. The communication between them, and after the Clinical Lead had attempted to introduce a system, was terse:

'I saw her that evening and again on the Wednesday morning as well as keeping in touch with ICU [intensive care unit] overnight so didn't see any need for a handover as she was fine and the staff knew to call me first. Patient ownership'.

The response came back: 'The on call person still needs to know about the patient, as we are called!! Patient safety!'

8.60 The issue of handover has been repeatedly referenced from this case in 2014 even after a new handover sheet and protocol were introduced in 2013. This remained an issue in the index case in December 2014 and the RCS Invited Service Review raised concerns again in 2016 stating that the quality of handovers between Consultants was a cause for concern, had the potential to undermine the benefits of the on call system and potentially was a factor in errors and harm relating to patients. In November 2020, an electronic system was eventually rolled out at FGH.

Failure of multi-disciplinary team processes

8.61 Decision-making is a vital part of keeping the patient on track on their care pathway. The MDT meeting is a key discussion and decision-making forum, and an opportunity for Urologists to work together to decide the best course of action for patients with cancer and complex conditions. However, attendance at the MDT meetings has been very poor for more than ten years. Decisions were often taken when the Consultant who was supposed to present the patient was not present and there were delays in enacting decisions such as making referrals (exemplified in the index case). These meetings were also described as being unprofessional at times, with poor behaviour and arguments ensuing. There were attempts by Impact Consulting in 2014 to agree a code of conduct for MDT meetings, but the long-term impact of this was limited and many of the identified problems persisted.

8.62 Some of the cases we reviewed show the problems which resulted from the lack of MDT continuity and decision-making. For a patient in 2014 the MDT notes were incorrectly recorded for a left-sided nephrectomy when a right-sided operation was required - this was a system issue that went unrecognised for some time even though this was a case which formed part of an Maintaining High Professional Standards (MHPS) process. The system issue was not noted until 2016 in the RCS Invited Service Review report. Another patient (2018) is a case where the wrong diagnosis was made and there was insufficient discussion in the MDT - this forms the basis of an ongoing and unresolved complaint. A further patient is a case where a wrong diagnosis was also made at the MDT.

8.63 We have found the method of recording MDT notes confusing, insufficient in some cases and difficult to follow in terms of understanding the chain of decision-making and who was responsible for implementing agreed actions. MDT notes were not always shared with the patient as part of the medical records when requested.

8.64 We are particularly concerned that the MDT was repeatedly arranged on days when individuals determined that they could not attend. The MDT was a mandatory function for core members who then did not attend either due to private practice or due to a need to attend to emergencies at other sites. This repeated pattern of behaviour, whilst challenged by individual Consultants, was not adequately addressed. The non-attendance of one Consultant for reasons related to private practice became an underlying difficulty in relationships. Emails sent at the time clearly state a refusal to attend due to private practice even when dates were agreed well in advance. The expected standard for attendance by a core member of a Cancer MDT was not clearly set out in guidance but varied nationally from 75% to a locally set target of 65%. However, only one core member Consultant Urologist achieved this standard as measured by local or network MDT meetings from 2011-2021. Tables 8a, 8b, 9a and 9b show attendance at MDT by all Consultants in local or network MDTs across 2011-2021 and in the last two years. Table 9c shows the average attendance between 2008-2011. Consultant Uro-Oncologists 1 and 2 had significantly higher attendance at both local and network MDTs. There is a marked

reduction in attendance of Consultant Urologists at MDT meetings in the last two years. This may be due to nationally revised streamlining guidance for MDTs[52] (August 2019) which suggests that these can now move to having at least two Urologists in attendance, with one Urologist as a core member and that meetings should be quorate on 95% of occasions. (Although formal introduction of this guidance and the steps advised were not evidenced during our investigation).

8.65 Clinical sessions have now been allocated in Urology job plans during the time of MDT meetings and attendance by all Consultant Urologists is therefore not seen as mandatory. However, at times this leaves the MDT Urology Cancer Lead with little support from other substantive Consultant Urologists. With the introduction of the named Consultant, however, it is important to audit the new processes (as required by the guidance) to ensure Consultants are attending to present their own patients in line with new Standards of Care (SoC), if set, or that others are able to cover appropriately. We have seen no audit prior to the introduction of new Standards of Care and as we have identified concerns about effective MDT meeting management in this report (see below) an audit of improvements will be a priority. This should be re-examined in Autumn 2022 as per recommendation 67.

Table 8a - Local MDT attendance 2011-2021

Consultant	Number of meetings between 2011-2021	Present	Absent	Attendance %
Ur2	394	128	266	32.5%
Ur3	290	163	127	56.2%
Ur4	206	125	81	60.7%
Ur5	548	271	277	49.5%
Ur6	548	237	311	43.2%
Ur7	520	302	218	58.1%
Ur8	548	202	346	36.9%
Ur9	546	293	253	53.7%
Ur10	330	238	92	**72.1%**
Ur11	230	94	136	40.9%
UroOnc1	548	407	141	**74.3%**
UroOnc2	289	235	54	**81.3%**

Table 8b - Local MDT attendance 2019-2021

Consultant	Number of meetings between Sept 19 – Sept 21	Present	Absent	Attendance %
Ur5	104	28	76	26.9%
Ur6	104	32	72	30.8%
Ur7	78	48	30	61.5%
Ur8	104	45	59	43.3%
Ur9	104	33	71	31.7%
Ur10	104	78	26	**75.0%**
Ur11	104	27	77	26.0%
UroOnc1	104	84	20	**80.8%**
UroOnc2	104	84	20	**80.8%**

[52] https://www.england.nhs.uk/wp-content/uploads/2020/01/multi-disciplinary-team-streamlining-guidance.pdf

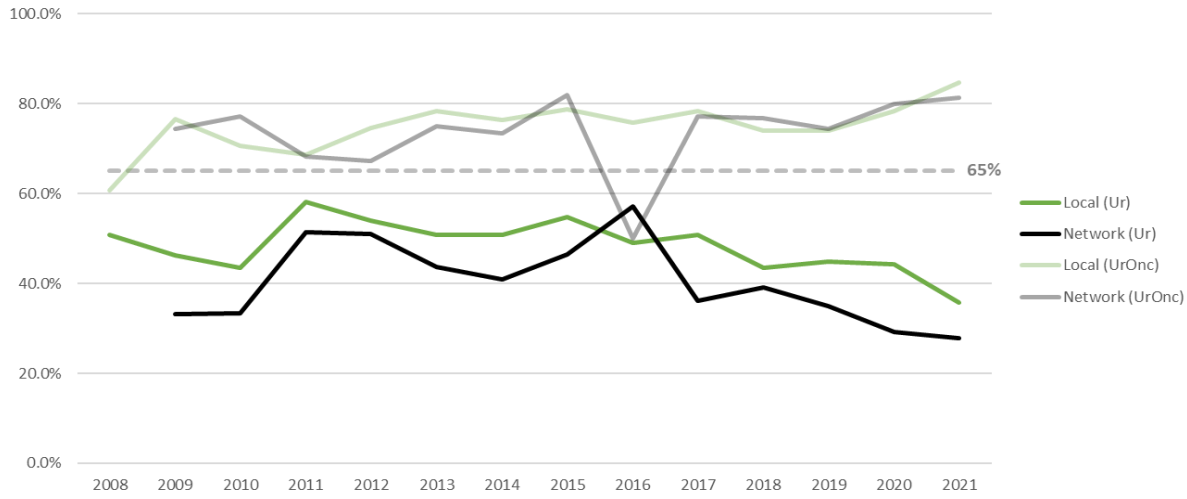
Table 9a - Network MDT attendance 2011-2021

Consultant	Number of meetings between 2011-2021	Present	Absent	Attendance %
Ur2	324	100	224	30.9%
Ur3	217	121	96	55.8%
Ur4	197	81	116	41.1%
Ur5	404	156	248	38.6%
Ur6	95	10	85	10.5%
Ur7	377	179	198	47.5%
Ur8	308	59	249	19.2%
Ur9	403	199	204	49.4%
Ur10	199	140	59	**70.4%**
Ur11	178	64	114	36.0%
UroOnc1	404	299	105	**74.0%**
UroOnc2	201	161	40	**80.1%**

Table 9b - Network MDT attendance 2019-2021

Consultant	Number of meetings between Sept 19 – Sept 21	Present	Absent	Attendance %
Ur5	91	10	81	11.0%
Ur6	0	0	0	-
Ur7	66	16	50	24.2%
Ur8	91	17	74	18.7%
Ur9	91	26	65	28.6%
Ur10	91	65	26	**71.4%**
Ur11	91	23	68	25.3%
UroOnc1	91	73	18	**80.2%**
UroOnc2	91	71	20	**78.0%**

Table 9c - Average MDT attendance at local and network MDTs 2008-2021



8.66 The MDT should act as a fail-safe in the process for patients identified with cancer. However:

- MDT meeting records are insufficient to provide a detailed decision record for the clinical treatment planned, proposed and undertaken. The recording of decisions is minimal and written in a manner that makes it difficult to understand which day various decisions have been made and who was in attendance to make those decisions.
- Abnormal tests were not clearly flagged, there have been missed reviews of scans and test results at the MDT. Some of this was due to poor sequencing and some was a result of the poor flagging of results.

- There was insufficient evidence of the CNS and cancer coordinators actively contributing to the management pathway of patients.
- The process link between the MDT and the patient tracking list (PTL) was unclear. This process should prioritise patient cases and expedite actions.

8.67 The RCS Invited Service Review report in 2016 identified that management plans were not always followed by Consultants in the team and that in some instances those cases were not brought back to the meeting for further discussion and learning. Outcomes were recorded by the MDT coordinator, however, when they were reviewed later the actions were not always clear. They also noted that the rushed nature of some meetings led to inaccuracies. It was recognised that there was no dedicated Urology MDT coordinator and a high turnover in this role.

8.68 Delayed decision-making in the MDT and a tendency, in complex cases, to over investigate and not expedite referrals to the tertiary centre in a timely manner is a theme arising from 104 day breach cases report which we discuss below.

Long cancer waits (and tertiary referrals)

8.69 Cancer waiting time standards monitor the length of time that patients with cancer or suspected cancer wait to be seen and treated in England. These were first introduced through the NHS Cancer Plan (September 2000) and were extended in the Cancer Reform Strategy (2007). A 2010 review of the standards (Improving Outcomes: A Strategy for Cancer, 2011) confirmed they would be retained.

8.70 The NHS Constitution set out principles and values for the NHS, which includes the right for patients to access certain services within maximum waiting times. The list of services made under this pledge included three high-profile standards: for Emergency Department waits, referral for elective treatment and cancer services.

8.71 There are several standards for accessing cancer treatment. The most prominent of these is the standard that at least 85% cent of patients should begin treatment for cancer within 62 days of an urgent referral from their GP. There is also a requirement that any cases of cancer patients waiting 104 days or more from referral to the first definitive treatment should be reviewed to identify any avoidable non-clinical delays.

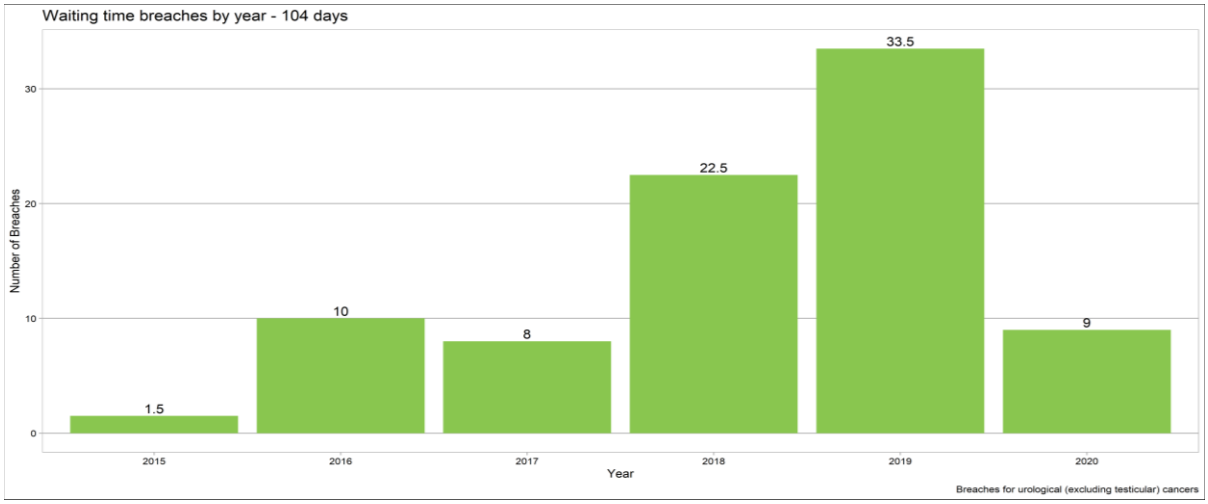
8.72 The Urology service at the Trust is a core service responsible for non-complex cancer management and diagnostics. It works in association with Lancashire Teaching Hospitals NHS Trust (Preston and Chorley) and East Lancashire Hospitals NHS Trust (Blackburn and Burnley) for specialist treatment. Prompt referral to these centres is critical for complex and high-risk cases.

8.73 The Getting It Right First Time (GIRFT) Review in 2018 highlighted long delays in making tertiary referrals: the average time from referral for cystectomy was 204 days compared with a national average of 144 days at that time. This is important as the chance of curative treatment in muscle invasive bladder cancer increases with the speed with which definitive treatment can be provided. This was an element of the index case in 2013–2014 where we identified a significant delay in referral for cystectomy.

8.74 Potential harms are also highlighted by our analysis of 104 day breaches on the cancer pathway. The chart below shows the increase in 104 day breaches from 2015 to 2020. This shows 86.5 breaches by the Trust which affected 111 patients and required specialist intervention. Urology tumour sites made up the majority of all Trust 104 day breaches, in particular the prostate pathway.

8.75 Some cases were lost to follow-up for extended periods of time including two for over three years.

Graph 25 - Cancer waiting time breaches 2015-2020



8.76 An analysis of all RCAs undertaken by the Trust should have included investigations in relation to breaching the 104 day cancer waiting time backstop position as defined by Gateway reference: 04237 Managing long waiting cancer patients - policy on backstop measures, from October 2015 onwards.

8.77 There should have been a clear and defined patient group, as reported via national cancer waiting time reporting procedure, linked to all reported breaches made by the Trust in the reporting period June 2015 to March 2020 inclusive. This was not evidenced in the initial data extraction to Niche or in further updates but did subsequently identify 111 patients pertaining to 86.5 breaches. 85 patients were reported that did not have a corresponding RCA despite being declared as a breach of the 104 day cancer wait backstop position. In addition, there have been 14 cases where it was identified that a patient had breached the 104 day cancer backstop and had not been reported via the statutory reporting requirement.

8.78 Key concerns are:

- Lack of appropriate identification of patients who had breached the long cancer wait target.
- Insufficient rigour on the timeliness of investigations and a lack of clarity on when an RCA should be instigated.
- Lack of correct reporting of patients, including to the Board.
- The Trust maintains that the CCG/Cancer Alliance had overridden the national requirement of Gateway reference: 04237 (2015) to provide an individual RCA for every patient. However, even if this were the case, the primary purpose of reporting 104 day breaches, RCA and harm analysis is to ensure that patient care is improved, and this remains unacknowledged by the Trust.
- There is no evidence of how the clinical harm review was being undertaken and how it was sufficiently robust to allow for only patients with identified harms to be reviewed.
- There was a fundamental lack of understanding of the primary purpose of undertaking RCAs and a lack of rigour in the governance process which failed to identify the thematic issues arising from the exercise.

8.79 In June 2019, an Intensive Support Team review of the prostate pathway was undertaken. This identified:

- Delays in biopsies being undertaken
- Staff shortages and capacity issues as a result of sickness and vacancies
- Delays in Oncology counselling
- Difficulties with triaging referrals and access to bone scanning and MRI scans
- Delays in cases waiting to be discussed at MDT
- Delays between appointments
- Delays in repeat prostate-specific antigen (PSA) tests
- Referral pathway concerns by GPs
- The management of the Patient Tracking List (PTL)

8.80 We identified some of the issues above throughout our patient review and many of these factors were a feature of the index case from 2014.

Furness General Hospital on call

8.81 Out-of-hours emergency care is currently provided at Royal Lancaster Infirmary (RLI) and Furness General Hospital (FGH). There is cover for seven days a week at RLI; however, FGH carried vacancies and relied on locums throughout this period. This often resulted in two out of four weekends not having emergency out-of-hours cover.

8.82 The risks posed by the on call model were long-standing; they were highlighted by the RCS in 2016 and more recently by the York Report in January 2020. A review of past iterations of the Surgical and Critical Care Group (S&CCG) risk registers shows that a risk relating to on call arrangements in Urology was identified as far back as 2014 (risk 1812). A near-identical risk was also raised on the care group risk register in 2017 (risk 2191). The rationale for removal of these risks from the risk register is not clear; whilst plans are developing to strengthen the out-of-hours emergency service, these plans are recent and have not been fully implemented, therefore the potential risk to patient safety remains. This raises concerns not only about the length of time this risk has been known about within the department, but also about the identification and management of risks more broadly.

8.83 On 16 June 2020, a proposal to implement a new model for out-of-hours care in Urology with effect from June 2020 was approved by the EDG. Staff who we spoke with were broadly supportive of the new on call model and shared the view that it will be safer for patients and more sustainable for Urology staff. The key features of the model (originally proposed in part by the Clinical Lead in 2014) include:

- out-of-hours emergency care to be based at the RLI;
- non-elective patients presenting at FGH to be assessed and, where necessary, transferred to RLI;
- patients presenting at FGH and assessed as too ill to be transferred will be visited by a second on call Urologist who will travel to FGH; and
- Urologists to be supported by middle grades on call to ensure that there is the capacity to go to FGH if necessary.

8.84 The Trust has engaged with North West Ambulance Service NHS Foundation Trust and Morecambe Bay CCG on the new model. We were told that a full consultation exercise will be undertaken if the Trust feels that a permanent change of service is required.

8.85 Interviewees attributed the delayed implementation to the need to undertake thorough job planning, and the impact of Covid-19. Some interviewees shared the view that the delay is also partially due to the need to reassure junior doctors that they will receive the appropriate level of out-of-hours Consultant support.

8.86 A number of cases identified the impact of the difficulty in covering emergency situations and requiring transfer to RLI from FGH between 2013 and 2018.

8.87 We understand that the new model was implemented in October 2020 and the impact on patient numbers was expected to be monitored through the Safe Today Report. A review of recent Safe Today Reports indicates that the numbers involved are not being reported on a monthly basis as stated.

The deteriorating patient

8.88 We have noted in a number of RCA reports that some patients deteriorated significantly over a period of time but there is little reference to the involvement of nursing staff in relation to the identification of deteriorating kidney function and urosepsis in these cases. The role of nursing staff in early escalation is key where medical staff are dependent on nurses to escalate cases. There are also cases where nurses have tried to escalate their concerns but have been unable to elicit a response and resorted to calling medical staff who were not on call. The index case, in particular, identified the underscoring of Early Warning Scores and inadequacy of the POTTS[53] chart being used during this period. There has been recent implementation of an electronic NEWS2[54] scoring system put in place which is linked to Lorenzo which has a central monitoring function so that any patient who shows signs of deterioration is clearly identified to senior nurses.

Prostate biopsy recall

8.89 There were multiple concerns being raised during 2004 of a potential risk to patients with regards to the adequacy of prostate biopsies undertaken by Consultant Urologist 2.

8.90 The potential risk to patients was identified by the Urology Nurse Specialist, who highlighted an issue with the adequacy of prostate biopsies undertaken by at least one of the Trust's Consultant Urologists. There is reference to an audit, which is not evidenced, that suggests that inadequate biopsies were carried out. There was no indication of whether this audit gave assurance that biopsies carried out by other Consultants were adequate, but the recall appeared limited to those carried out by Consultant Urologist 2 and the process of clinical review was carried out by the other Urologists.

8.91 Patients identified for biopsy recall in December 2004 were seen from January 2005 onwards.

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[53] Physiological Observations Track and Trigger System
[54] NEWS 2 - National Early Warning Score 2 - a calculation based on points to establish if a patient is deteriorating and inform escalation decisions. NEWS2 is the latest version.

8.92 There was no agreed plan for the recall and no defined processes to be followed and completed. There are gaps where the following elements were not demonstrated:

- Definition of the total patient group who may be affected and must be accounted for. This should state the timeframe under review and the inclusion/exclusion criteria with supporting rationale.
- How the control total would be agreed and how patients would be tracked to ensure that all were accounted for throughout the process.
- The communications strategy outlining how the organisation would deal with the press and the reporting to other organisations and regulatory bodies.
- How the patient group would be reviewed and categorised with an agreed protocol for contacting and managing the care of each group.
- What resource would be available and how this would be managed.
- Who was responsible for 'holding the ring' i.e. managing the master list throughout the process, to ensure that the appropriate steps are taken and progressed to completion for every individual?
- The target timeframe for completion of the recall and any remedial action required.
- How the mortality reviews and review of harm would be undertaken and reported.
- The governance and reporting framework for the outcomes of the recall and final report to the Trust Board.

8.93 The recall process was flawed by design and not adequate to give assurance that the identified risk to patients was mitigated.

Never Events

8.94 Reporting Serious Incidents is a requirement under the Serious Incident Framework 2015 and through CQC Regulation 16. Never Events are defined in guidance as Grade 2 serious incidents requiring investigation and should be reported to the CQC via the NRLS (even where there may be no harm). They should also be recorded on the Strategic Executive Information System (StEIS).

8.95 The process for reporting Never Events is clearly set out in policy frameworks. Never Events may, on occasion, be discovered some time, even years, after the incident itself occurred. The delay between the incident and its discovery is not in itself a factor in determining whether an incident is a Never Event, but neither should it stop an incident being reported. The guidance goes on to state.

'Failure to report a Never Event which subsequently comes to light through a third-party route, for example a Coroner's Inquest, media report, patient complaint or other soft intelligence, is an extremely serious failing on the part of the staff involved as well as the organisation. It is likely to constitute a breach of CQC regulation requirements (Regulation 16 and 18 of the Care Quality Commission (Registration) Regulations 2009). It also breaches NHS Standard Contract Section E Clause 25, which requires the appropriate reporting of serious incidents and patient safety incidents to the Commissioner and CQC'.

8.96 A detailed review of the Never Events that we identified was undertaken during the investigation to inform our key findings. We also summarise several Never Events that were identified during our work that do not appear to have been reported by the

Trust over the period 2010 to 2020. These cases were notified to NHS England and NHS Improvement on completion of our review. We note that the CQC inspection in June 2014 commented that the Trust had a higher number of Never Events than similar Trusts. We identified eight Never Events that had not been reported as such which, in our view, should have been; four were before this inspection finding and four subsequently.

8.97 We applied the national criteria for the categorisation of Never Events to each of the incidents (criteria in place at the time of the incident); eight patients who attended the Trust to have their health care needs addressed experienced unintended Never Events which were not classified as such by the Trust and were not reported by the Trust even though they meet the conditions to be classified in such a way.

8.98 Five of the Never Events concerned an item of medical equipment being inadvertently left in the patient's body after the completion of a medical procedure. Three events related to wrong site surgery.

8.99 There were three events that have not been included as Never Events after our review because one incident was averted just prior to surgery, one where the guidewire retention was known, and one was an incidental finding of a pressure ulcer.

8.100 The identification of these Never Events came from the review of the patients' case notes and information supplied by the Trust as part of the overarching Niche review of patient cases. Each case was reviewed by external reviewers and where necessary additional information was sought from the Trust and then reviewed against the national published criteria in place at the time.

8.101 The reviewers of the cases were explicitly cognisant of the National Patient Safety Agency (NPSA) guidance regarding bias and that *'Care should be taken to avoid the following: "Hindsight bias is when actions that should have been taken in the time leading up to an incident seem obvious because all the facts become clear after the event"'.*

8.102 Only one of the identified Never Events was subject to an RCA investigation. Two resulted in legal claims. The level of investigation for all these cases was unacceptable and resulted in very limited learning for patient safety purposes or in transparent reporting to commissioners.

8.103 There is also very little in the way of evidence provided in the text to support assertions made in the investigation reports. It would appear that a check to ascertain the current criteria governing the classification of a serious untoward incident as a Never Event did not always happen. In our view, several dysfunctional human factors and patterns of behaviour had an influence on some of the incidents concerned.

8.104 These events were not classified as Never Events but should almost certainly have been. The Trust needed to take a more forensic approach to understanding national guidance and reporting requirements. Without this, important lessons were missed, and regulatory and contractual frameworks breached.

8.105 One of the Never Events (Testicular Implant Recall) identified above is described in the next paragraphs.

Testicular implant recall (Never Event)

8.106 In December 2015, the Trust received notice of a litigation claim from a patient. In November 2012 he had undergone a radical orchidectomy with insertion of a testicular prosthesis following a diagnosis of testicular cancer. Post-operatively he appeared to be healing well and he was put under the care of Oncology for ongoing surveillance. His follow-up care was transferred to another provider when he left the area and he presented there with pain around the implant. He underwent surgery in March 2015 and the Urologist identified that the plastic needle guard had been incorrectly left attached to the implant and this was removed.

8.107 On receipt of the claim notice, the Trust contacted the company Coloplast who manufactured the implant. Initially it was incorrectly thought that the retained foreign body was a pastille which can be left in situ. This understanding was subsequently corrected and it was identified as the plastic needle guard which must be removed and cannot be left attached.

8.108 The Urology Consultant who had performed the original surgery confirmed to the Trust that he had left needle guards in situ during other procedures. The Trust therefore identified the need to initiate a recall of patients who were at risk of having a needle guard left in place with a testicular implant. A recall process was commenced.

8.109 However, the recall process[55] was flawed by design and could not give the Trust assurance that all patients who were at risk of having a retained needle guard were identified, contacted, managed appropriately and would have a definitive conclusion to their process. Areas of concerns include:

- The decision by Medical Director 5 not to classify this case as a Never Event as the Consultant stated he intended to leave the objects in despite the manufacturer clearly stating that it should be removed.
- The timeframe for the recall was not defined and was unacceptably protracted.
- There was no control total to which all the various outcome groups were to be reconciled. This resulted in a confusing variation in the number of patients in various tables and documents which are inconsistent with each other and did not add up.
- There is insufficient evidence that the process, even as designed, was followed and completed for the identified cohort and several patients remain unaccounted for in terms of a completed outcome.
- There was no governance response demonstrated to identify the root causes of the issue that occurred and to ensure adequate steps and actions have been taken to prevent recurrence.

8.110 In our view, the evidence presented does not give assurance that the identified risk to patients who had this procedure has been fully mitigated.

[55] A further recall process was instigated in August 2021 following Niche reporting of this concern at draft report stage.

Record-keeping

8.111 During our review we identified some failures to record key clinical findings and general poor record-keeping. This was noted in both the contemporaneous patient notes and the subsequent information provided for review.

8.112 In some patient notes key clinical details were missing including clinic notes, clinic letters, discharge summaries, operation notes, ward round details and reviews. They were also not sequential, with, in some cases, whole years missing from the record. Records were markedly poor in many cases.

8.113 There were also many cases where record entries were illegible, not clearly dated, not timed, not signed in accordance with expected practice (e.g. grade/GMC number), nursing documentation had missing fields or remained blank and assessments were not completed. We have referred to the specifics of this in the index case and our Current Case Review from October and November 2020, where we commented on the standard of record-keeping from a sample of 123 cases; 77% of records were rated as adequate or good and 23% as poor.

Poor consenting practice

8.114 A surgery consent form is used to indicate that a patient receiving surgery or special procedures has been made aware of the nature of the operation, the risks involved, the required medication/anaesthesia, and any other pertinent information that may affect their decision to consent. The patient must sign off that they have had ample opportunity to field any questions they need answering and to address any concerns they might have going into the operation. For consent to be valid, it must be voluntary and informed, and the person consenting must have the capacity to make the decision.

8.115 Most case notes that we reviewed have evidence of appropriate consent for the procedures that were undertaken; however, we have identified inadequate or invalid consent for at least 24 patients. Errors and omissions included a failure to explain the risks associated with the surgical procedure, consenting for a different procedure to the one carried out, verbal rather than written consent and illegible documentation.

8.116 We also noted some consenting issues in the Current Case Review that we undertook in October to November 2020 and cases where consent forms were not dated by the patient and where the confirmation of consent had not been completed because the consent had been signed by a different surgeon on a previous occasion.

Private practice

8.117 There are three cases involving the transfer of patients from private to NHS care. These cases demonstrate that on occasions there is some reliance on NHS care when complications arise in private practice. However, there is evidence that the learning has not been implemented between cases from 2013 and 2019 in relation to clear protocols for cover. The job plans/private session arrangements for Consultants implicitly rely on the Consultant not needing to be readily available post-operatively. For example, an operation in Lancaster in the morning may be followed by an NHS clinic in the afternoon in Barrow. This means there is a built in risk of difficulty in the event of the need for post-operative review and an inbuilt reliance on the on call Consultant in the NHS. We have seen no written protocol between the BMI Healthcare provider in Lancaster and the Trust, despite asking, to cover the various eventualities that may arise and have been referred back to the protocol for practising privileges which places the onus on the Consultant to make cover

arrangements. We have seen no formal process for communicating between the private and NHS providers on performance issues of individual Consultants other than the presumed reliance on the appraisal process in place conducted by the NHS.

Impact on Primary Care

8.118 During phase one of our review, we issued an online survey to the GPs in the Trust's catchment area and received 22 responses. Nine GPs referenced 'good care' by the Urology service with reference to the One Stop Clinic being very effective and stated that some of the Urologists were very responsive and helpful.

8.119 Three of the 22 GPs also recorded no specific concerns about the care provided in the Urology service at the Trust. However, others reported historic and current concerns in relation to:

- Inadequate monitoring and communication of conditions and test results to patients and GPs, leading to additional appointments in General Practice to explain clinic letters and 'pick up the pieces'.
- Unclear advice about monitoring (e.g. PSA levels) and no clear plans for some patients (e.g. with urine retention 'they simply get catheterised to relieve the retention and discharged').
- Delayed or missed follow-up appointments including for patients with prostate cancer.
- GPs having to chase Urology referrals through secretaries to get patients into the system; on occasions this has been felt to be challenging and time consuming.
- A perceived reluctance for some Urologists to accept 'reasonable' referrals by some Consultants leaving the GPs feeling that they have to send their patient to the Emergency Department.
- A lack of continuity of care.
- Five GPs had been involved in Trust investigation processes for their Urology patients. Three of these GPs said they had not been informed of findings or action taken in response to these.

8.120 We have been unable to validate all the cases referred to by the GPs; however, the issues raised reflect many of the themes which we have identified throughout this review including through the individual patient case studies (where we have noted 30 patients who have had their referrals/follow-up appointments/monitoring expedited by their GPs because of the failures described), the index patient and the Current Controls Assessment Report.

9. Departmental and divisional governance

9.1 The Urology department has always been a sub-department within the surgical division of the Trust - currently named the Surgical and Critical Care Group (S&CCG). Urology has historically had an inadequate office base and facilities as well as having no dedicated Urology beds within the surgical division. This remains the case with practical implications of the lack of dedicated ward facilities for simple procedures which can result in bookings for emergency theatres which could otherwise be avoided.

9.2 There has always been a Clinical Lead for Urology and at times an Assistant Clinical Lead. Historically, the Clinical Lead has been supported through various changes in structure by a Business Manager at Care Group level. In more recent years this has become a triumvirate of the Clinical Lead, Clinical Service Manager and Matron.

9.3 Currently, the main forum for the Urology leadership team to formally meet is the Clinical Business Unit (CBU) meeting. This is replicated across every specialty in the Trust.

9.4 Urology Business Meetings (UBMs), held until July 2020, were described throughout the review as a key opportunity for information sharing across the service, particularly with clinicians. Chaired by the Clinical Lead, the agenda for these meetings was structured around workforce, experience (including complaints and compliments), safety, effectiveness, and efficiency. The UBMs were discontinued during the pandemic, but it is our understanding that these have now reconvened.

9.5 The department holds a monthly Urology audit meeting, the main focus of which is to review mortality, reportable concerns including incidents, and progress against the clinical audit programme. This is a key meeting which should focus on safety related issues. However, to date the outputs of the Urology audit meetings have not been formally aligned or shared with any other meetings at the Trust which significantly undermines the consistency, effectiveness and oversight of its function, particularly in relation to mortality reviews.

9.6 The Urology audit meetings are chaired by the Clinical Audit and Governance Lead, who is also a Consultant Urologist. This postholder is now the lead for mortality and they are also responsible for ensuring appropriate completion of 72 hour reviews and root cause analyses (RCAs).

Clinical leadership and the role of the Clinical Lead

9.7 The overall clinical leadership of Urology has historically, in our view, been suboptimal, particularly in relation to driving quality and safety improvements at pace in relation to incidents, complaints, claims and identified errors.

9.8 The Clinical Lead's role is described as:

'… *responsible for the overall management, delivery and strategic direction of his/her speciality. This includes the delivery of all performance and cost improvement targets, service modernisation and development and clinical governance within the speciality. The Lead Clinician will have a key medical leadership role, with professional and managerial responsibility, supported by the Matron(s) and Service Manager(s). The Lead Clinician will work closely in a triumvirate leadership team with Matrons and Service Managers to manage the business of the Clinical Service Unit (CSU)'.*

9.9 The role of the Clinical Lead is a significant one, described by the extensive job description as covering a wide range of responsibilities, however, in reality the role in Urology sat alongside a full time clinical responsibility and set unrealistic expectations even in normal circumstances. Managing the medical aspects of the Urology service has been time consuming for Clinical Leads and different leads have been unable to bring the team together.

9.10 Interviewees and survey respondents were critical of the extent to which poor behaviour and underperformance was challenged by clinical leaders. There has been a disconnect between the senior leaders of the Trust and the clinical leadership of the department, with no consistent attendance from the Clinical Lead for Urology, or other members of the leadership triumvirate, at corporate meetings at which Urology is reviewed. We also note that, until recently, Clinical Leads did not consistently attend the Surgical Governance and Assurance Group (SGAG), despite this being the key forum at which incidents, risks and complaints for each specialty in the care group were discussed.

9.11 Clinical Leads have been expected to manage highly complex tensions in a poorly functioning department without a dedicated and consistent Urology CSM until 2018. A maximum of one day per week was an inadequate time allocation for Clinical Leads to address, with any degree of rigour, the lack of systems and processes within the department and to manage senior clinicians. We can see no evidence of a structured induction or development programme for the Clinical Leads on appointment until the introduction of a clinical leadership development programme in 2018. There is also no evidence that key skills required to manage peers were developed including issues, such as conflict resolution, that would have helped in the department.

9.12 Clinical Leads did not receive sufficient support and guidance in handling extremely difficult personnel issues. They were themselves the subjects of investigations, grievances, or accusations at times. This was complicated by the personal relationships that sat (and continue to exist) behind the professional ones potentially compromising or complicating their actions or decisions. These relationships were also seen to interfere with fair process and gave rise to perceptions of bias. This is illustrated by the Clinical Leads who were in post from 2003–2016. These Clinical Leads had stronger personal and professional alliances and relationships with some members of the team than others. This left them compromised at times in how they were seen to equitably deal with individual members concerns and in holding them to account, especially when this involved difficult subjects relating to differential treatment, listening to all sides of events and to accusations of discrimination or racism. The role of the Clinical Lead includes working with the Audit Lead in the department. Good clinical audit processes may have helped to validate clinical concerns amongst the team. There is no evidence of a planned approach to clinical audit linked into any triangulation of complaints or concerns outside the national audit programme to which data was also not submitted.

9.13 In our view, Clinical Leads partly failed to respond to the growing difficulties in the team due to the closer relationship of the two incumbents over 13 years than with others and the perceived conflict of interest this created. This is particularly the case as the line management function could not be reasonably and objectively delivered. It was a clear responsibility to harness effective team working and whilst the Clinical Lead in post between 2009 and 2015 tried to act in a fair and proportionate manner, the perceptions of bias undermined his balanced intentions.

9.14 The current Clinical Lead job description requires this postholder to '*foster a culture that values respect, teamwork and excellence in all aspects of the delivery of patient care'*. Also, to develop a working environment where all staff are empowered to meet the requirements for team working and raising concerns. Throughout 2000-2019 the Clinical Leads for Urology failed to ensure that a good working environment was achieved through their personal leadership approaches. Senior managers and the Executive Team also failed to support these postholders to achieve their objectives, to respond to the concerns raised or to emerging signs of team distress. In particular, the Responsible Officer and Medical Directors, who were aware of the team dynamics, failed to decisively intervene in relation to the behavioural problems through internal processes and through external support at regional NHS level or through, ultimately, referral of individuals to the GMC.

9.15 There are processes by which Consultant Urologists are personally held to account for the delivery of their contract and their professional development. These are managed through line management, job planning and appraisal. We describe below some of the failings in these processes as ways to improve the delivery of the service, the functioning of the team and for holding clinicians to account.

9.16 Operational management of the department is regarded internally as stronger than it has been previously. Whilst historically the department has shared a Clinical Services Manager (CSM) with other specialties, Urology has benefitted from a dedicated CSM since August 2018 when the current postholder took up office. The departmental leadership triumvirate is now generally perceived, by the staff we interviewed, to work well together, and there was a high-level of positivity about the support now being provided to the leadership team.

9.17 Interviewees were optimistic about the leadership that is being provided via the Enhanced Support Programme (ESP). Several interviewees welcomed this appointment and the strength of leadership that it has brought to the department. However, the resource provided by the ESP is currently limited and the scope of the ESP has been extended to support four services within the Trust with potential to expand further if there is an identified need.

Line management

9.18 One of the key roles of the Clinical Lead is to provide line management of medical staff within the specialty. There is no evidence of regular, structured line management meetings held with each Consultant Urologist. There are numerous communications from some of the Consultants directly with members of the Executive team that bypassed the Clinical Lead (and also the Surgical and Critical Care Director) prior to 2009. The Surgical Clinical Director subsequently became increasingly involved in dealing with disputes and line management issues.

9.19 In dealing with some of the difficult issues in more recent years, (e.g. incident investigation and claims of discrimination) the role was undermined by confused governance and investigation processes, a lack of independence (i.e. Consultants investigating each other when they provided part of the care themselves) and bipartisan relationships within the department.

9.20 Part of the line management function is to ensure Consultants are delivering to their agreed contract but processes for keeping job plans up-to-date and in line with capacity demands were inadequate.

Job planning, capacity and demand management and AASs

9.21 Job plans form part of the contract through which line managers should manage senior clinicians. Job planning has historically been weak in Urology (and across the Trust) and attempts to agree job plans have been resisted by some members of the team or have failed to be approved. There has also been no effective capacity and demand planning or systematic utilisation analysis to address perceived capacity shortfalls, inequitable workloads and travel concerns; as a result, job plans have not accurately reflected the work undertaken.

9.22 Furthermore, the recognised geographical challenges of having three main sites in the Trust have not been openly acknowledged and addressed when it comes to the expectations of clinical staff and the fair recognition of time required to travel to direct clinical care sessions. This has directly impacted on time available, has led to genuine difficulties of punctuality and has placed additional pressures on Consultants between sessions and whilst on call (including some allegations of lack of availability during on call sessions, as well as patient safety risks arising from travel for the provision of emergency care at Furness General Hospital (FGH)). These issues have been an underlying theme of clinical incident reporting and grievances between team members that have not been supported through the job planning process.

9.23 The absence of these structured processes and the lack of transparency across the team has led to unclear availability and capacity constraints and occasions when resources were underutilised. This has fuelled discontent between Consultants when they perceived their peers to have inequitable workloads. The lack of capacity and demand analysis until 2020 with the introduction of Patient Level Information and Costing System (PLICS), means there has been limited clarity for planning purposes and this has resulted in haphazard and unplanned initiatives to manage backlogs. Alongside this, the evident stress and subsequent long periods of absence (in 2005–2009, 2012, 2014 and 2016) through anxiety, sickness and restricted practice resulted in cancelled sessions and led to a cycle of unbalanced and excessive workloads. Job planning has not been revisited for many years at a time.

9.24 This has directly driven the demand for additional activity sessions (AASs) which in turn has driven up the cost of the service and has been a driving incentive for additional pay for all concerned. The service is loss-making as a result, yet patients remained subject to backlogs and delays.

9.25 We address the proportion of cost to the Trust of the Consultants undertaking AASs in section 6. In 2015, AASs were also used inappropriately to increase the reward of Consultant Urologist 3 without appropriate transparency and formal agreement. We believe the use of AASs has become endemic in the department creating an expectation which drives additional pay and reward, but which did not have the intended impact on reducing patient backlogs and delays in follow-up care. There is reference by individual Consultants of clinics being overbooked but also examples where clinic sessions were often not full (including AASs), but this was not monitored formally. A lack of attention to these areas of capacity management again drove further demand for AASs.

9.26 Our Current Controls Assessment Report identified that each S&CCG specialty is allocated a budget for AASs and ‘any requests for sessions over this limit must be approved at the discretionary spend meetings and approved by the Assistant Director of Operations (ADoP) or deputy’. Urology was allocated £293k for AASs in 2019/20 (this equates to approximately 580 additional sessions, i.e. ten per week, with some clinicians undertaking two to three additional sessions per week). Interviewees could

not recall any instance of an AAS being challenged or refused. This was not sustainable.

9.27 Urology did not have a robust control environment to support the management and risks associated with AASs. Inherent risks relating to these include:

- an over-reliance from clinicians on AAS income;
- the legitimacy of AAS need;
- the impact of AASs on an individual's job plan; and
- the impact on an individual's wellbeing as a consequence of doing an excessive number of extra sessions

9.28 We found the department's oversight of AASs to be lacking in two aspects:

- Oversight of income - On average, 16% of gross salary costs for those undertaking additional activity (six staff) could be attributed to AASs which equates to an average supplementation to base salaries of £27,346 (based on 2019/20 salary costs). One individual earned £56,875 by undertaking AASs in 2019/20 (31% of their gross salary cost). This shows poor line of sight by senior management to the true extent by which some clinicians enhanced their income through AASs and this has been a long-standing issue.
- Impact on job plan - Interview feedback suggested that there is a tacit agreement that AASs can be undertaken at the same time as scheduled supporting professional activity (SPA) and administration time if required and that this arrangement is '*based on trust*'. Several interviewees explained that this approach is undertaken throughout the Trust and is not unique to the Urology department.

9.29 The spend in the last four quarters (as reflected in the May 2021 Safe Today Report) demonstrates a significant reduction in annual AAS spend in Urology. However, at this stage, it is not possible to draw comparisons with previous years spends, due to the impact of the pandemic on workloads. It will need to be investigated if this level of AASs stabilises or increases again. It will also be affected in large part by the need to manage patient backlogs (as is the case nationally).

9.30 The relationship between an increasing workforce and a relatively stable demand for care did not form part of capacity and demand planning. Data shows that medical staffing in Urology increased over time whilst the demand appears to stabilise from 2011. Capacity and demand have been significant reasons, cited in the investigations and RCA reports undertaken by the department, for error and delays but this has not resulted in quantitative assessment of these suggested factors. The perceived workload pressures set against the establishment of increased medical staffing potentially indicates the considerable impact of absence, restricted practice and dysfunctional team working as major contributory factors to perceived heavy workloads.

9.31 In response to this perception, a process of validation of patients was undertaken by one of the Consultants as part of a phased return to work during 2014. This validation activity was undertaken without a clear structure, process or protocol and without reference to peers. It was also not a regularly repeated exercise forming part of the departments planning. There was no evaluation of whether such an exercise resulted in the right decisions for patients given that the discharging Consultant was not familiar with individual cases.

Appraisal processes

9.32 The structure for annual NHS Consultant appraisals was established nationally in 2002. Since 2012 all practicing doctors have been regulated through a continuous five-year cycle for revalidation with the General Medical Council (GMC), the process for which is overseen by the UK Revalidation Board.

9.33 We do not have detailed information prior to 2012 in relation to appraisals at the Trust[56], however, it was stated within the Trust Assurance Framework in 2004 that the process for medical and professional appraisals could be more robust. This is supported by some email communications between Consultants and other senior managers during that time, indicating that appraisals had not always been signed off appropriately or undertaken each year.

9.34 Appraisal is a professional process to ensure that medical staff remain competent in their roles and that they are fit to conduct those roles. Line management feeds into the appraisal by virtue of informing the process of any concerns in relation to practice. We can see no such link being used in Urology.

9.35 In line with national requirements, a Trust Appraisal and Revalidation of Medical Staff Policy was introduced in 2012 which confirmed that it is the responsibility of each individual doctor to ensure that they undergo annual appraisals and that they can present adequate evidence from all areas of practice to ensure revalidation at the end of each five-year cycle. This was supported by the procurement of a bespoke software package for the recording of appraisals which allowed full capture of the documentation completed and submitted for each Consultant Urologist. The documentation is centred around the key domains of good medical practice and includes 'safety and quality' (complaints and incidents), 'communication, partnership and teamwork' and 'maintaining trust (of patients and colleagues)'. Each of these domains requires documentation input from the individuals being appraised.

9.36 From the evidence provided we can see that appraisals have been undertaken broadly in line with the policy since 2012–13 and that the 16 appraisers listed for the Consultants had undergone approved training with reassessment in the role at least once in every two years, other than for:

- Urologist 6 who appears to have completed an appraisal for Consultant Urologist 5 before completing his initial training;
- Urologist 6 and Consultant Urologist 9 who are not recorded as having attended refresher training since their initial training in 2015, but who were still appraisers three years later; and
- four other appraisers who on one occasion had refresher training after the required two-year period.

9.37 We have been told that appraisers meet at group events throughout the year and also for an annual update (although we do not have attendance lists to validate this). However, it is not clear how the following aspects have been achieved:

- the requirement for an annual review of job plans prior to appraisals given that there has been significant reference in Urology to insufficient and ineffective job planning until a new proposed Consultant Job Plan was agreed in October 2019

[56] A different appraisal system (MAG) was in use prior to this time.

(this was designed for the Urologists to have equal share of work in all the sites); and

- whether there were appraisers in every case (we have seen six appraisals which state 'not assigned').

9.38 In relation to other key requirements of appraisals, we have seen reference within the documentation to incidents and complaints being discussed (from the perspective of the appraisee), and to interpersonal problems in the department causing considerable distress and anxiety to the team over the years; although there are no collective outputs to address these issues as a team. We can also see some occasions where Continuing Professional Development (CPD) (including reflection and learning) was more limited than expected due to time constraints and other commitments.

9.39 The appraisals clearly reference the stress and impact on the wellbeing of several individuals in the team. Whilst this is a professional process there is no evidence that, despite the knowledge of the Responsible Officer and the Medical Directors that there was significant dysfunction in the team, the information held within this process facilitated an alert or initiated intervention to respond to the clearly articulated problems.

9.40 Appraisals in Urology were largely conducted on bipartisan lines which did little to provide robust challenge or reflection in line with the intentions of the process. One group of Consultant Urologists appraised each other and the other group looked outside the department for their appraisals.

9.41 We also note that the latest version of the Trust's Appraisal and Revalidation of Medical Staff Policy (dated February 2019) states that '*data relating to activity*' should be presented at an individual's annual appraisal. We were told that there is little focus on AASs as part of individual's appraisals. There is no formal monitoring of whether SPA and administration time is undertaken at a different time, nor to whether the total number of hours worked by clinicians is safe.

Inability of the department to hold individuals to account for poor behaviour

9.42 The strain in the professional relationships between Consultant Urologists was well known within the department for many years. As a department there was a failure to hold individuals to account for comments and performance. Despite definitively acknowledging difficulties as a team in November 2012 and again with Impact Consulting in 2014 and 2015, no change in behaviour occurred and professional relationships remained sour. Some individuals also refused to engage in group activities when these were offered, including mediation, and were not held to account for those refusals.

9.43 We have seen numerous examples of poor behaviours within the team that remained unchallenged including:

- inappropriate levels of detail and accusations in some email communications
- unprofessional behaviour in MDT meetings
- inconsistent recall of events for investigation processes
- failure to support colleagues asking for advice and assistance
- inappropriate letters to GPs which undermined peers
- turning up late to clinics and theatre sessions

9.44 However, throughout our investigation we have seen numerous email communications and reports particularly from one Consultant Urologist which, in our view, are indicative of a pattern of behaviour that has been a fundamental contributing factor to the inability of the team to come together. This included:

- A failure to use processes afforded to him including annual leave policy, on call protocols, claim forms and incident reporting procedures.
- Sending emails to the whole department including nursing staff at an inappropriate time, in an inappropriate manner and to an inappropriate audience.

9.45 Other conduct concerns raised in these emails were not addressed, the underlying wellbeing messages being conveyed were not taken seriously and the nature of the communications were likely to contribute to relationship difficulties and frustration amongst other members of the team.

9.46 Even when the concerns raised in the emails did get discussed, there was an apparent failure to explore to any significant degree the factors underlying the emails, or to investigate and establish whether the behaviour and judgement was a patient or staff safety concern, and to ascertain whether action needed to be taken.

Incident reporting

9.47 Clinical incident reporting is now a well-established system in the NHS to ensure that there is learning arising from errors and to help prevent harm to patients. The Trust is no exception in that incident reporting has also been established and all staff made aware of requirements to report incidents and near misses as they occur via the electronic system.

9.48 In our survey of Urology related staff in 2020, 88.5% of respondents agreed that they were encouraged to report incidents.

9.49 We were told in interviews that there are historical examples of incidents being reported to undermine colleagues, rather than in the spirit of learning and improvement. This finding was also echoed in the January 2020 InterBe report. Some interviewees expressed concerns that there remains a reluctance to report incidents and a sense that incident reporting is punitive rather than an opportunity for learning.

9.50 There is little substantive evidence to support suggestions that clinical incidents that were submitted did not need to be. Whilst it is possible that the motivation to report was a punitive one, there is substance to the vast majority of the incidents raised. What is of greater concern is of serious concerns being raised without being reported as incidents. Alongside this, some key incidents have been reported inaccurately with narrative detailing unsubstantiated allegations and blame.

9.51 It is of particular note that from 2007 to 2009 there was a marked absence of incident reporting which in our view reflects a change in reporting culture in the context of a better team environment after Consultant Urologist 2 was restricted and before other appointments were made.

9.52 Several interviewees also reported that, some years ago, potential incidents had to be reported to and approved by the then Medical Director for validation that they were a ‘true’ incident before submission. There is no documented evidence to back this up as being a formal directive or systematic process but the specific recall of individuals would confirm there was some basis to this. Some recent attempts have been made to reinstil a positive reporting culture and to stress that individuals should

report incidents without moderation from others; for example, the Governance Business Partner attended a Urology Audit Meeting in summer 2019 to clarify the incident reporting process and to encourage individuals to report concerns proactively and independently.

9.53 Throughout this review, we have asked for a comprehensive overview of recent incidents affecting Urology services. We were provided with three iterations of this information which is indicative of the Trust's inability to draw down accurate, reliable and timely data at a specialty level.

9.54 Consultant Urologist 3 raised significant patient safety concerns throughout 2001–2016 via email and other routes. However, he only reported a total of six incidents in his own name. The nature of the incident reports that were submitted by Consultant Urologist 3 were at times emotive and overdramatised. Other reports were submitted via nursing staff who were asked to report on his behalf, with these reports containing the detail he wished to submit. We did not see this from other Consultants.

9.55 Different Consultants reported incidents at different rates following the implementation of the electronic reporting system. The table below shows those incidents where the Consultant is named as the reporter.

9.56 Despite the large number of patient safety related concerns raised in email communications and referenced in the published book, there is little evidence of these being formally reported by the Consultant concerned. This was also the case before the incident system became an embedded electronic process. The variability of formalising incident reporting by some Consultants (and potentially continuing reluctance) compromised the Trust's ability to investigate concerns in a timely manner.

Table 10 - Incident reports by Consultant 2010-2019

Consultant	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total
Urologist 2	-	1	-	-	-	2	6	3	-		**12**
Urologist 3	1	-	1	-	4	-	-				**6**
Urologist 4	1	1	2	2	1						**7**
Urologist 5	8	1	5	3	7	7	2	1	8	5	**47**
Urologist 7	-	-	1	1	1	8	9	14	3	3	**40**
Urologist 8	-	-	-	-	-	-	-	2	-	-	**2**
Urologist 9		2	1	5	9	3	9	9	4	7	**49**
Urologist 10						-	-	-	-		**0**
Urologist 11								-	-	-	**0**
Total reported by Consultants	**10**	**5**	**10**	**11**	**22**	**20**	**26**	**29**	**15**	**15**	**163**
Total incidents reported	**100**	**99**	**154**	**124**	**146**	**128**	**158**	**117**	**211**	**299**	**1536**

Incident investigation

9.57 The Reporting and Investigation of Incidents Policy clearly sets out the investigation process for incidents of no or low harm, moderate harm, severe harm, or death. It states that incidents graded moderate or at a score of three should be subject to a 72 hour review (historically referred to as a 'rapid review') by an appropriate clinician to determine whether a serious incident (SI) has taken place. A score of four or five (severe harm or death) follows the same process but then a root cause analysis (RCA) should be undertaken within 20 days. The policy does not define what an appropriate clinician is and does not refer to the importance of investigator independence[57].

9.58 Historically, there has been insufficient clarity on the process of how harm was assigned to incidents and there are clear instances of the harm being set at a level that was inconsistent with the details of the investigation.

9.59 The approach to incident investigation in Urology lacked rigour and independence. The effectiveness of incident investigation was also undermined by a reluctance from some senior clinicians to participate in the process and we were told that a lack of trust between individuals caused some people to refuse to undertake investigations. This resulted in incidents being reallocated by the CSM to another clinician. We have been told that, if appropriate, the Clinical Lead would pick up the investigation if there was no one else able or available to do it. The continued assumption that the Clinical Lead and others would investigate incidents in the climate that prevailed at the time was not appropriate. This is because, in the pooled nature of the service model, there were few cases that all Consultants had not, in some way, been part of the patient's care and this has meant a clear conflict of interest has arisen in several cases.

9.60 We also understand that some Consultants and other staff in the department had not undertaken investigation training. Some interviewees stated that they had received training several years ago whilst others said they had never received any. It is essential that those undertaking investigations are trained to do so and a register held so that all staff are aware of who can be approached when an investigation is required.

9.61 Investigation reports have not detailed a comprehensive investigative process, nor an adequate level of analysis or inquiry. The lack of investigator independence is of concern especially given the poor quality of the reports. The reports consistently failed to identify the underpinning reasons for care and service delivery problems, the 'why', or set out active recommendations designed to improve practice and prevent reoccurrence. Consequently, opportunities and actions to make improvements for patients in practice have been limited. Our review has also highlighted significant concerns about the quality of assurance processes in the Clinical Commissioning Group (CCG). We are of the view that these factors presented a continuing risk to patient safety for incident investigation to remain a departmental responsibility, particularly in the context of continuing fractured relationships and mistrust in the department.

9.62 There was a passive as opposed to active governance process - on numerous occasions it was noted that an investigation had been instigated as a result of a patient's complaint which prompted the start of governance process. There was no

[57] We understand the Serious Incident Policy has been updated to reflect this point.

clear process for the sub-identification of investigations and additional reporting requirements necessary, for instance:

- Never Events
- 104 day cancer breach
- 62 day cancer breach
- Serious Incident Requiring Investigation (SIRI)

9.63 Furthermore, the SIRI panel was ineffective in ensuring investigations were sufficiently robust, stood up to scrutiny, identified the correct actions, followed Being Open and Duty of Candour Policies, or that actions were implemented. There was no clear process for the sign off or challenge of investigation findings, review and accountability.

9.64 Thematic reviews were limited in relation to incidents raised. When thematic reviews did occur, they related largely to the early stages of Maintaining High Professional Standards (MHPS) processes and were conducted externally. This meant that they tended not to follow a structured approach through governance systems. There was no triangulation of complaints, concerns, claims and incidents which informed the need for other thematic reviews.

9.65 In our review of investigations undertaken (38 RCAs, 34 SIs and 30, 104 day breach analyses) we have seen no single example of a high quality investigation. Because of our findings, early in our interim reporting we highlighted the need for a radical shift to an external investigations process for a period of at least 12 months.

Divisional oversight

Governance issues at care group level

9.66 As identified in the Current Controls Assessment Report, the S&CCG has a Senior Management Board (SMB) which is responsible for monitoring the performance of the care group, including quality. Oversight of quality and safety is then delegated to a subgroup of the SMB, the Surgery Governance and Assurance Group (SGAG); however, Urology does not have a high profile at either meeting despite the historic challenges it has faced.

9.67 Scrutiny of the Urology department at SMB has tended to be limited to the status of the action plan following the Royal College of Surgeons (RCS) Invited Service Review rather than a rounded review of Urology performance through, for example, a dashboard of quality, safety, finance, workforce and operational key performance indicators (KPIs). The Safe Today Report, which has been developed to triangulate Urology performance data, was not initially presented at either SMB or SGAG, and interviewees could either not articulate how performance was monitored or gave vague and contradictory responses when asked about this.

9.68 We also found several significant weaknesses in the way that SGAG operated, namely:

- full agendas, with the Urology department typically allocated between 5–10 minutes, although several interviewees told us that the time dedicated to Urology was often less;
- agendas which differed significantly in terms of their content from the role and remit of SGAG;

- the delineation between SMB and SGAG meetings was not well defined with, for example, oversight of strategy included in the SGAG terms of reference, whereas we would typically expect to see this role undertaken by SMB;
- SMB and SGAG meetings were often run immediately after each other with combined agendas and minutes produced, and there was no formal reporting mechanism from SGAG to SMB; and
- minutes and actions lacked clarity and did not sufficiently evidence that effective discussion had taken place.

9.69 Our review determined that there was no well-defined nor well-understood process by which Urology was held to account for its performance at care group level. Also, governance enacted at care group level has not effectively monitored the safety and quality of this service. Without effective monitoring forums at care group level, the line of sight of the performance, quality and safety of services for the Board and its committees was fractured.

9.70 Many of the clinical and behavioural issues raised in this report do not appear to have been escalated or systematically addressed at the care group level. There were several mechanisms available to the care group but fundamentally a review of the appropriate use of clinical incidents was not undertaken, Human Resources (HR) input was weak in supporting the Clinical Lead to address the behaviours of some of the Consultants and the elapsed time to resolve relevant issues was considerable, the time spent discussing Urology issues was very limited within the governance structures in place, and key requests for restructuring (in relation to on call and emergency cover at FGH) were essentially ignored.

Complaint handling

9.71 Complaint processes are handled at a Trust level through the Patient Relations department or Patient Advice and Liaison Service (PALS) team. There are clear response times expected to support the resolution of complaints. However, we have seen numerous complaints which raised patient safety concerns, but which were not converted to incident reports and therefore followed a separate investigation process. The step from one process to the other remained unclear throughout the full timeline of our review. This is despite the Parliamentary Health Service Ombudsman (PHSO) sanctioning the Trust in 2012 for the poor quality and responsiveness of its complaint process regarding four upheld complaints. They required the Trust to '*prepare an action plan to remedy the poor complaint handling identified and detailing the steps the Trust will take to help prevent a recurrence of the maladministration experienced by these complainants*'. However, we can see no evidence of this being enacted**.**

9.72 One patient (2011) is a key example of where complaints processes are not aligned with incident investigations. A complaint response to this health care professional written for Chief Executive 2 by a legal firm was never sent as the patient died before it was sent. Another patient was also a health care professional for whom a complaint response was not sent for a year in 2019.

10. Corporate oversight of Urology

Board governance at the Trust

10.1 The Board exercises its core function through a set of standing committees. Pre-May 2014, this was comprised of:

- Finance and Performance Committee
- Clinical Governance and Quality Committee
- Risk Committee
- Audit Committee
- Remuneration and Nomination Committee

10.2 In May 2014, a Workforce Assurance Committee (WAC) was established, and the Clinical Governance & Quality Committee became the Quality Committee following critical feedback from a Care Quality Commission (CQC) inspection and the 2012 PricewaterhouseCoopers (PwC) Review about the inadequacy of governance systems and the 'Board's grip' on these processes.

10.3 Board members at the Trust have changed for various reasons over the years; however, in 2013 the whole Board, including the Executive team, was replaced. This followed intervention by Monitor (the then-regulator) in late 2012 acting on the concerns that had arisen in the Maternity service. Many new Board appointments were made on the basis of candidates having past experiences of working with troubled organisations. Staff we spoke with were united in their view that the pressure on the new leadership team, led by Chief Executive 3, to recover the reputation of the Trust and the quality of the services it provided was significant. Organisational memory (including in relation to Urology) was largely lost at this point.

10.4 We noted throughout our investigation that engagement by Non-Executive Directors, including the Chair, with Consultants as a whole was limited. This has restricted their ongoing understanding of service pressures. There were few formal occasions in place to facilitate stronger engagement between Consultants and members of the Board (outside the Medical Directorate).

The knowledge and awareness of the Trust Board in relation to issues in Urology

10.5 Weaknesses in Board effectiveness have been repeatedly highlighted by a number of external reviews over the past ten years, dating back to 2012 (PwC Governance Review). Issues such as ineffective Board level scrutiny and challenge, weak risk management processes and inadequate ward-to-Board reporting have been identified. This has resulted in a Board that was, for many years, disconnected from front-line services and blind to signs of Trust-wide systemic issues; the Board has not consistently tried to seek robust assurance on the safety of the patients being cared for or of the workforce who delivered that care.

10.6 When asked when they were first alerted to Urology as a service of concern, recollections amongst past and current Board members varied. While it is not unrealistic to expect some degree of variation amongst Board members given their different exposures to the Trust and depending on their portfolio or area of expertise, there was significant disparity in relation to this. Interviewees tended to fall into three groups:

- those who believed Urology had been a service of concern since 2015, following the index case in 2014;

- those who believed that Consultant Urologist 3's 2018 employment tribunal and associated press coverage raised the profile of the Urology service to the Board; and
- those who felt they were not sighted on issues in Urology until the publication of *Whistle in the Wind* in 2019.

10.7 The inconsistency of opinion about when the Board first became aware of issues in relation to Urology is, in itself, an indication of failures associated with corporate governance at the Trust. It points to an inequity of knowledge about the organisation's risks, as well as the effectiveness of the Board members themselves, their acceptance of signs of dysfunction, and the extent to which they sought assurance that issues had been resolved and that resolutions were sustained.

10.8 Also, there is evidence that there was individual and Executive team awareness of Urology being a potentially fragile service before being captured within the corporate governance framework at the Trust. This can be evidenced through the 2014 EDG meetings described above. Also, by previous Medical Directors, Human Resources (HR) Directors and Chief Executives who were directly involved in correspondence which referenced a breakdown in relationships as far back as 2002–3 but, as described throughout this report, limited action was taken in response to this.

10.9 A review of Board minutes shows that whilst concerns had previously been noted, Urology was only explicitly described as an area of concern for the first time in November 2018; the catalyst for this was Consultant Urologist 3's employment tribunal and the associated national press coverage. However, we have found several occasions prior to this when risks associated with Urology were reported to the Board (or one of its committees). Had these issues been more robustly reported and scrutinised, it is possible that Urology would have been identified as a service requiring support and possible intervention at an earlier date. Some examples of information that reached the Board (or a committee) that would indicate Urology was a service requiring further scrutiny and support are outlined in the table below.

Table 11 - Urology concerns reaching the Board/committee

Date	Indications of a service in distress
April 2014 (onwards)	Urology repeatedly fails to meet the referral to treatment target and has a significant outpatient backlog which is reported to the Board via the Integrated Quality and Performance Report (IQPR).
January 2016	The Board was told that '*a number of concerns were raised last year about the functioning of the Urology department*'.
May 2016	Following a thematic review of incidents in Urology, the Quality Committee was informed that there was a need to improve team working and address breaches of the Trust's Behavioural Standards Policy.
September 2016	The Quality Committee was alerted to '*very poor results*' following an inpatient record-keeping audit in Urology.
November 2016	The Quality Committee was informed that clinical audits had been suspended in Urology due to capacity issues.
January 2017	Risk 2181 on the Board Assurance Framework (BAF) was increased from 16 to a score of 20. The risk related to the clinical capacity available to undertake incident reviews in Urology.

10.10 Factors which prevented the Board from being aware of issues in Urology and the severity of the issues prior to the publication of *Whistle in the Wind* include:

- Committee effectiveness, for example, the Quality Committee and WAC had no mechanisms for sharing information which presented a missed opportunity to identify that both committees were receiving concerning reports in relation to Urology. Also, the terms of reference for WAC stated that one of its roles was to develop a staff engagement culture through receipt of reports on staff engagement and involvement activity in care groups (including Staff Survey Action Plans) and Staff Friends & Family Test results/actions. However, we found insufficient divisional focus at this meeting which, in turn, diluted the committee's understanding of service-level issues. When service-level issues were raised (often repeatedly), the impact of the committee was low when it came to identifying the need for action and ensuring that implementation occurred (for example, in 2014/15, the meeting is repeatedly informed of capacity and workforce issues in Urology but there is no evidence of challenge or action identification). Also, in June 2015 the Leadership Development Strategy was approved by the Board but its subsequent implementation received very little scrutiny by WAC. Interview feedback suggests that the committee's focus until approximately 2018 was more on recruitment and workforce numbers, rather than on culture and behaviour. The cycle of business indicated that Maintaining High Professional Standards (MHPS) would be a standing agenda item; however, we did not find this to be the case.
- Known issues relating to Urology being reviewed at too low a level in the Trust's governance structure. For example, the Quality Committee's awareness of the findings of the 2016 Royal College of Surgeons (RCS) Invited Service Review of Urology was limited to what was contained in SIRI panel minutes.
- Insufficient lines of sight from the Board and its committees to care groups (formerly called divisions) and services, resulting in the Board being reliant on upwards escalation to identify services at risk.
- A tendency from 2014 onwards towards summaries of assurance (from committees and sub-committees) which often emphasised positive findings whilst also making unsubstantiated and over generalised assertions of improvement (confirmation bias). By 2017, the Trust was also developing a strong narrative of improvement (which was validated by the CQC rating of 'good' from 'requires improvement' in 2015). Several interviewees during our investigation shared the view that the effect of this was to create a bias towards positive news amongst Trust leadership; there was little appetite to hear any bad news about services in the wake of the Kirkup investigation.

10.11 Executive interviewees also reflected that there was often a disproportionate amount of focus on high-profile issues, such as maternity and breast radiology, but insufficient attention afforded to services that were not subject to regulatory or media scrutiny. One interviewee noted '*looking back, we were all a bit too ready to accept that things were getting rosier*'. The reluctance to acknowledge areas of weakness or concern by senior leaders is also demonstrated in the Trust's response to the 2019 CQC report. The formal response reviewed by the Board noted that '*there has been significant external recognition of the leadership approach at [the Trust] since the previous inspections from informal (such as Roy Lilley's promotion of Magic Morecambe Bay in 2017 and 2018), formal (such as the Personnel Today awards for Overall Winner and Employee Engagement in November 2018) and regulatory (such*

as buddying with Aintree and Isle of Wight to share learning) routes.' The response did not acknowledge the material issues raised by the CQC, such as:

- The lack of Non-Executive Director (NED) challenge, focus on actions and governor accountability.
- A disconnect between the awareness of individual Board members and the content of Board/committee meetings. We found examples of formal business being conducted in informal settings.
- Low levels of engagement by some Board members in service areas. For example, we found that many Board members in late 2020 had not yet visited the Urology team despite the high-level of external scrutiny and internal turbulence caused by the publication of Whistle in the Wind.
- Limited triangulation of key information, including with feedback from external parties.

10.12 We were also told there have been specific Board champion roles; however, there has been a lack of clarity about what these roles[58] have meant in practice and their overall impact has been limited. For example, there is a nominated NED for MHPS, but, as one interviewee put it, '*this mechanism has not alerted us to a broader issue*'.

Board challenge

10.13 As mentioned previously, the issues associated with the impact and efficacy of Board (and committee) challenge have been highlighted as far back as 2012 when an independent review of governance was highly critical of the level of scrutiny from the Board and its seemingly low appetite for robust assurance. Throughout the intervening years, we note that there was significant churn in Board membership, coupled with immense pressure for the post-Kirkup Report leadership of the Trust to achieve improvement, particularly in relation to Maternity services. We found, however, that Board members were too ready to accept reassurances that services were safe, and that action taken had generated the desired outcome. For example, the Quality Committee was told in February 2017 that the '*behaviours standards framework has been adopted and embraced by the Urology team*'. No questions were asked at the Quality Committee about the basis of this assertion and, given the findings elsewhere in this report, it is apparent that this was not the case.

10.14 Interview feedback also suggests a lack of Board level scrutiny, even in relation to actions that are regularly referred to as successful examples of Board led improvement; one interviewee noted '*the Board never looked at the impact of the work that the Trust had done on bullying*' and another stated that '*there was no check and challenge on [the anti-bullying work]*'.

10.15 Furthermore, our review has found that there tended to be a low level of challenge and action orientation afforded to issues; even repeatedly reoccurring issues. Throughout 2014, the Workforce Assurance Committee (WAC) was continually informed via the Medical Staffing Establishment and Recruitment paper that there

[58] The role of a designated Board member for MHPS cases is set out within the MHPS framework, with a role to ensure that momentum is maintained and provides a route for escalation of concerns for the practitioner. Practically, their role is to:

- Ensure that the investigation is being carried out promptly an in accordance with the Trust's policy.
- Acts as a point of contact for the practitioner, making him/herself available after due notice if the practitioner has significant concerns about the progress of the investigation or any exclusion from work.
- Reviews the progress of the case with the Case Manager (as required).

The designated NED receives a briefing on the role and expectations when they are appointed.

were capacity and demand issues in Urology which were exacerbated by on call issues and a Consultant with restrictions to practice. Despite the same issue being reported over several months, we cannot find any suggestion that the matter was discussed, or assurance sought that steps were being taken to resolve it.

10.16 We also found examples of the Board transacting formal business in an informal setting which not only sets an inappropriate context for any ensuing challenge but undermines the evidence trail of robust challenge. For example, the Grant Thornton Well-led Review in 2016 was received in an 'informal Board meeting' and we can see no evidence of it being reported and reviewed in a formal Board meeting. Minutes were not maintained for the informal Board meeting so it is not possible to gain a picture of the level of discussion applied to the report, and no actions were generated which would indicate a low level of scrutiny and discussion.

10.17 The Board's response to being informed in November 2018 that there were issues in Urology that extended beyond individual clinical competency was insufficient and reflects the low level of challenge and scrutiny applied. At the November 2018 Board meeting itself, a NED '*noted his disappointment at the content of the media coverage in relation to clinical incidents in Urology and was pleased [the Medical Director 5] had addressed these*'. Importantly, the Board had at this point only been verbally informed that the RCS had been invited in and that '*an action plan was developed to address the issues identified in the review*'. The Board did not see the RCS Invited Service Review report, the associated action plan, nor any other evidence to support the assertion that issues had been addressed other than verbal reassurance from Medical Director 5. The RCS President had, however, been informed in a letter from Chief Executive 3 on 9 October 2017 that the actions were in hand. The letter stated:

"*In response to the service review a number of relationship concerns and service management issues were identified. We developed an action plan in response, the implementation of which has been overseen by our Deputy Medical Director with the support of an external consultant […], a former chair of the GMC [Diversity and Inclusion] Committee. We have monthly meetings with the Care Quality Commission with Urology as a standing item to provide assurance on our progress from a regulatory viewpoint. We have also reported our progress in response to the invited review back to your college through your Invited Review Manager, most recently in April this year."*

10.18 There was more attention afforded to Urology at the January 2019 Quality Committee; this was the first Quality Committee meeting following the Board discussion about the Urology service in November 2018. The Quality Committee was assured that '*an action plan has been completed*' and the quality and safety of urological services was being closely monitored '*through departmental audit*'. However, there is no evidence that members of the Quality Committee sought verification of the impact of the completed action plan, nor was the escalation route from departmental audit to the Quality Committee clarified should concerns be identified. This was a key missed opportunity for the Quality Committee and Board to scrutinize the nature of the original issues, the extent to which they impacted the department, and the effectiveness of intervention. It was also a missed opportunity to identify the fractured line of sight from the service to the Board.

Knowledge and awareness of the Executive team in relation to issues in Urology

10.19 It is very clear that between 2000–2008 members of the Executive team were fully aware of the tensions in the Urology team. The management of the concerns raised about Consultant Urologist 2 by his colleagues are well documented and consumed

considerable amounts of time. The Medical Directors over this period, the Deputy Medical Director and Chief Executive 1 and Chief Executive 2 were directly engaged in dealing with the difficulties at that time and with the management of Consultant Urologist 2's retraining plan. There are frequent references to the impact and tensions apparent between the Consultant Urologists over this period.

10.20 During 2008-2013, there was very limited activity involving Urology services outside of the October 2011 major incident which was declared in relation to a significant outpatient backlog. We are of the view that the maternity issues became the focus for Executive members and the Board at this time.

10.21 In the year ending March 2013, the whole Board, including Executive team, was replaced. This followed Monitor intervention in late 2012. Many Executives were appointed based on their track record of having either operated at a high performing Trust or having previously been involved in a turnaround agenda.

10.22 In 2013, new Executive team appointments were being made. We have seen no evidence that there was a handover that included any concerns about Urology.

10.23 A Trust Management Board ('TMB') has also taken place on a quarterly basis to which the Executive team, deputy directors, and clinical leads were invited. Terms of reference describe this as '*a forum to consider strategic challenges and issues, development of the operational plan and financial plan, significant service change, performance, and to address cross-care group issues'*.

10.24 In 2013, a weekly Executive Director's Group (EDG), chaired by the Chief Executive, was also established. This is in line with good practice, although we note that the meeting did not have a forward plan until August 2017 and there has been a limited service or care group focus during these meetings. Instead, the meeting has typically concentrated on material areas of underperformance, regulatory action and strategic developments thus limiting the potential for oversight of emerging risks or early indicators of underperformance within services.

10.25 We have been told by some of the Executive Directors that communications in relation to Urology often occurred outside of formal EDG meetings (reducing the opportunity for rounded views). We have also been told that some Executives (for example, the Executive Chief Nurse who had corporate responsible for quality governance from 2019), were consciously held back from discussions about escalating concerns in Urology in order to ensure that there were senior leaders at the Trust who were independent from the operational response to concerns; although we have not received a clear explanation for why this would be necessary or how they have been involved since issues have been more clearly defined. It is also concerning that the Executive Chief Nurse was not involved in the scrutiny of quality governance concerns at a much earlier stage and that the Executive Director of Governance is reported as not involving colleagues.

10.26 A review of EDG notes shows that it was unusual for a service to receive specific and sustained focus at this meeting. It is therefore particularly notable that:

- In May 2014, the EDG held a discussion under an agenda item titled 'Urology team'. The rationale for this agenda item is not clear, although three incidents were raised at this time, but the notes refer to the need for 'potential mediation/team development with [Occupational Psychologist].
- In June 2014, the EDG was briefed on the exclusion of a Consultant Urologist and informed that an investigation was underway.

- In July 2014, the EDG discussed an agenda item titled 'Urology MDT Team Development'; the notes from this session are brief but refer to the '*current issues being experienced in this department'* and the fact that '*Chief Operating Officer, will keep the team updated*'.

10.27 The brevity of the EDG notes mean that is it not possible to identify exactly what the Executives were told, however, the three agenda items outlined above relate to the commissioning of Impact Consulting Psychologists who were asked to pilot a development programme for the Urology MDT. The aim of this was to focus on the effective working of the MDT with agreed values to create a culture of collaboration and enthusiasm to provide excellent patient focused services. The pilot, if successful, was to be considered for use in other MDTs in the Trust.

10.28 These discussions indicate that the Executive team were aware of issues associated with the behaviours and team dynamics in Urology at this point. The EDG was also in receipt of the results of a recent pulse survey which suggested that '*bullying and harassment stands out as a problem area … work must be done to analyse where in the organisation these issues are*'. What is not evident is whether EDG identified Urology as a potential area of the Trust that had a bullying and harassment problem at that time.

10.29 In August 2014, Urology featured on the TMB agenda as an 'operational hotspot'. The associated paper refers to:

- pressures within the clinical team being exacerbated by working restrictions for two out of six Consultant Urologists;
- Occupational Health concerns about the impact on the remaining Consultants in the team;
- the fragility of the out-of-hours service which 'is having an impact on the timely review of patients'.

10.30 There is then no further evidence of Urology being discussed at either the following TMB meeting or the next EDG meeting which points to a weakness in the communication between TMB and EDG. Except for brief references to referral to treatment (RTT) performance, Urology is not directly referred to at EDG or TMB after this point until June 2016. There is no evidence to suggest that EDG considered how the concerns brought to its attention between May and August 2014 had been resolved, or whether the pilot that was undertaken with the Urology MDT was successful, with any effective changes made being sustained going forwards.

10.31 The next reference to Urology at EDG is in June 2016 when the Trust's Improvement Director describes the service as being on their '*worry list*'. Despite this, there is then no further discussion about the quality, safety, performance or sustainability of Urology at EDG or TMB for over three years when, on 30 July 2019, EDG agreed that Urology would be a standing agenda item for forthcoming meetings. It became clear in the notes of EDG meetings held in August 2019 that the trigger for this enhanced focus was the publication of a book. Of concern is that notes of the meeting suggest that the EDG was focused on reputation management rather than on the substance of the claims in the book relating to the safety of the service.

10.32 As outlined earlier, the Trust has displayed a tendency to consider service-level issues in isolation, rather than as potential indicators of organisation-wide risk. The publication of the book and subsequent scrutiny of Urology in the latter part of 2019 and into 2020 was no different. Chief Executive 4 summarised this perspective at an

EDG meeting in September 2019, '*this is not a reflection of the whole organisation - it is one specialty*'. This is despite issues in Maternity in 2011-2013, Breast Services in 2012-2014 and more recently in Orthopaedics in 2021.

10.33 Many members of the current Executive team were employed in the immediate aftermath of Maternity concerns in 2012.

10.34 There were mixed views about the cohesion of the Executive team over the last decade; however, most interviewees agreed that the Executive team has operated at its most effective in the last 18 months to two years. Several NEDs described a team that is '*constantly fire firefighting*' and '*doesn't have time to stand back*', which is likely to be a contributory factor in the failure to identify and sustain focus on quality and safety risks in Urology. Some NEDs voiced their concern about the action orientation of the Executive team, citing that '*there can be a spirit of satisfaction just because people appear to be busy*', and questioned the extent to which Executives robustly test the effectiveness of action taken.

10.35 The Executive team has struggled to ensure visibility and connectivity to services for many years. Much attention was given to the concept of Executive team visibility throughout 2014 following the CQC inspection. A paper titled 'Improving Ward Visibility' was considered by EDG in August 2014 - this suggested a number of mechanisms from patient safety walkarounds to informal Executive and senior management visits. However, EDG notes during the latter months of 2014 suggest that the implementation of service-level Executive visibility remained unresolved and became a recurring issue from 2014-2017. We would suggest that this remains an area of weakness for the Executive team, but also the Board. When we interviewed serving Board members in late 2020, we found that with the exception of Chief Executive 4 and Medical Director 6, Board member visits to Urology had not taken place, despite the publication of *Whistle in the Wind,* intense media scrutiny and the inevitable pressure that this placed staff in the service under. Between October 2020 and June 2021 some Executive Directors including the Executive Chief Nurse attended monthly meetings with members of the Urology management team as part of the Enhanced Support Programme (ESP). The Urology service is in the process of leaving the ESP and this focus is changing to service review within the Care Group only.

Role of the Council of Governors and Trust response to concerns raised

10.36 Urology is not directly referenced at the Council of Governors (CoG) meeting until August 2018 when the governors were informed of Consultant Urologist 3's employment tribunal. There is no evidence that wider concerns associated with the service were discussed at this point. The governors were next alerted about Urology in August 2019, shortly prior to the publication of *Whistle in the Wind*.

10.37 However, prior to August 2018, a number of concerns were raised by governors which have links to the issues in Urology, such as bullying and harassment, and the Trust's incident reporting culture. These concerns tended to be dismissed by the Trust or responded to with an over emphasis on signs of improvement.

10.38 That said, there was also failure on the part of the governors to seek a robust response to their concerns; causal factors include poor understanding of their role, as well as a tendency for key issues to be discussed outside of formal governance frameworks, resulting in disparity of understanding amongst governors and the informal management of issues.

10.39 The CoG and Board have had a suboptimal relationship for many years. This is rooted in distrust following the Kirkup Report but was exacerbated by governance failures relating to the way in which the CoG is reported to and engaged with.

Key findings

10.40 Between December 2016 and August 2018, governors raised several concerns associated with bullying and harassment. These concerns failed to illicit a meaningful response from the Trust, or any actions designed to understand the extent of the potential problem. CoG minutes indicate that governor concerns were not taken seriously and were typically met with verbal reassurance suggesting that significant improvement has been made in these areas. For example:

- In December 2016, the CoG's Quality and Patient Experience subgroup reported that 'an issue had been raised recently regarding Freedom to Speak Up and bullying … it has been arranged for a meeting to be held with several governors, Chief Executive 3, the Chairman, Medical Director 5 and Director of People and OD. Following the meeting it will be agreed whether the discussion will be reported back to governors via the Quality and Patient Experience Group or the Council of Governors meeting'. The minutes of the January 2017 CoG show that such a meeting did take place, however, the report back to the CoG indicates that governors were simply reassured that progress has been made to encourage staff to come forward. The next meeting of the Quality and Patient Experience subgroup received an update from the FTSUG which did not include any tangible actions to understand the extent of bullying at the Trust. The subgroup was also informed 'it does feel like culture is changing' but it is not clear on what basis this assertion was made.
- In October 2017, the CoG agenda included an item titled Raising Concerns, presented by Medical Director 5. The minutes suggest that this report was heavily skewed towards the positive. For example, minutes state '*Since the introduction of FTSUG there had been a 52% increase in the number of issues raised. The staff survey results showed that 90% of respondents felt the organisation encouraged them to report errors, incidents or near misses, 70% felt the organisation took action following concerns/complaints to ensure that they do not happen again, 62% felt they were given feedback and 95% knew how to report a concern of unsafe clinical practice. The Trust has made very good progress and has a high profile nationally and is viewed externally as an exemplar site*.' The minutes capture one of the governors noting that '56% of concerns raised were around bullying, harassment and dysfunctional teamwork' but the response to this concern was dismissive; '[*Medical Director 5] confirmed that improvements have been seen over the years and the staff survey supports this, however, there is still work to be done'.*

10.41 We also found indications of a dismissive attitude to CoG concerns associated with Urology. A group of governors wrote a paper to the Trust in May 2019 which highlighted issues that had been raised to them by staff; however, this was not discussed until a private meeting was requested by governors which was held in September 2019. We understand that the Chair, Medical Director 6 and two governors (including the Head Governor) were present and discussed the governors' concerns linked to behaviours and relationships in three services; Trauma & Orthopaedics, Obstetrics & Gynaecology, and Urology. We were told that '*nothing happened after the meeting … we were assured that it was being dealt with*'.

10.42 Like the example above, we found there to be a predilection for governor concerns and issues to be raised with Board members outside of formal governance routes which represents a material failure of corporate governance at the Trust and created an environment in which concerns about Urology were diminished and mismanaged. Some governors had direct concerns about the safety and efficiency of Urology some two years prior to formal discussion at a CoG meeting. This became apparent when we found inconsistencies between the evidential trail of information and assurance provided to governors in relation to Urology in formal forums (namely CoG and Quality and Safety subgroup), and the recall of governors in interviews and focus groups on the subject of when they first became concerned about the safety of the Urology service. For example, we were told that '*the governors became fully aware of the scale of issues in 2017*' and that at this time '*it was clear there was an issue with AASs … and high referral rates*'. A review of governor meeting minutes between January 2017 and August 2018 reveals no evidence of a discussion that directly references the Urology service.

10.43 The first direct reference in a CoG meeting to issues linked to the urological service is in August 2018 when the governors were briefed on Consultant Urologist 3's employment tribunal. There is no indication that broader concerns associated with the safety and function of the service were raised to or by governors at this time. There is then no further reference to Urology or the legacy of the employment tribunal for a further 12 months when *Whistle in the Wind* was published.

10.44 There were efforts to involve governors in the introduction of Respect Champions[59] and in the Bullying and Harassment Working Party. However, to this day, the Trust displays a reactive and sluggish response to acting on the concerns of governors whose worries associated with bullying and harassment started to increase with staff survey results and the breast radiology case. Repeated concerns were raised at CoG meetings, but the Trust told us that '*despite plenty of encouragement to do so, there was very little evidence offered that the Board could investigate*.' This response is indicative of the reluctance on the part of the Trust to proactively and forensically assure itself that there is no substance behind the repeated claims of an organisational bullying and harassment problem. It also adds weight to the criticism levelled at the Trust by some governors that '*the response to concerns raised focus on the person and not the system*'.

10.45 The relationship between the governors and the Board has been suboptimal for a large part of the chronology. In part, this stemmed from a lack of trust fostered by the conclusions of the Kirkup Report, however, we also found that the mechanics of Board–governor engagement to be flawed. The Health and Social Care Act 2012 (HSCA 2012) clarified the statutory role of the governors '*to hold the NEDs, individually and collectively, to account for the performance of the Board'*. In practice, the most effective CoG–Board relationships tend to be built on early engagement and transparency on emerging issues, strong Board member visibility with the governors both at formal CoG meetings and via more informal mechanisms, and a positive response to governor concerns. We found strong indications that the role of the governors was not taken seriously by the Board which, in turn, led to missed

[59] The Trust has 'Respect Champions' who voluntarily carry out their role alongside their contracted post. Coming from all disciplines and sites within the Trust, their primary role is to provide confidential support for colleagues who feel they are victims of bullying, harassment or incivility.

opportunities for the Board to triangulate governor concerns with other indications about the quality and safety of the Urology service. These include:

- Low Board member presence at CoG meetings - typically CoG meetings until 2018 were only attended by the Chair, one other NED, and one to two Executives. This significantly reduced the opportunity for governors to directly seek assurance from the Board.
- Poor Chief Executive visibility - CoG meetings have a Chief Executive update as a standing agenda item, but it is more common for the Chief Executive to be absent and for this to be presented by another Executive Director. The low level of engagement between the Chief Executive and governors serves as a signal in relation to the importance placed on the role of governors.
- Papers not presented by NEDs or subject matter experts - we found several examples of agenda items being presented by someone other than a NED or a subject matter expert. For example, the Company Secretary presented the Performance Update to the CoG in January 2015 and a Patient Safety Unit update to the CoG's Quality and Safety subgroup in November 2016. This limited the extent to which governors could ask questions regarding NED scrutiny of a topic (in line with the governors' statutory role) or seek further information and clarify matters with an individual with expertise or accountability in a topic. A further and more recent example is the presentation of the Urology action plan to the CoG's Quality and Safety subgroup in November 2019 by the Company Secretary. This was not appropriate given the profile of the topic and the severity of concerns.
- Poor governance practices in relation to the recruitment and appraisal of NEDs - those present at the governor focus group held in October 2020, reported that governors were not appropriately involved in the recruitment process; for example, they were presented with a short list of candidates and were not involved prior to this point. Governor input into and knowledge of NED appraisals is also weaker than we would expect for an established foundation trust. A NED appraisal report was presented to the governors in August 2017 and the level of detail was insufficient to assure the governors that a robust process had been followed and that NEDs were objectively assessed against criteria linked to the needs of the organisation. The report stated that several NEDs did not need a Personal Development Plan because no development needs have been identified; this is concerning and reflective of a governance culture that lacks rigour, scrutiny and ambition.

10.46 There are also a number of references to the relationship between CoG and Board between 2014 and 2017 and efforts to strengthen it. In 2014/15, the Chair set a specific objective to improve the way in which the CoG and Board worked together. By June 2016, there were indications that this had been addressed from the perspective of the governors, however, we found there to be a number of deficiencies in the interaction between the Board and CoG that extend to the present day, including:

- Insufficient sharing of performance, quality and safety information to the CoG.
- A continual tendency to emphasise the positive, improvements and even unsubstantiated, subjective assessments that 'things are better' when briefing the governors. Another example of this is the introduction of Chair's reports from

Board committees, the structure of which begins with 'successes' which tends to have significantly more detail that the section on concerns and action required.

- No evidence that NEDs were challenged by governors on how they held the Trust management to account, which reveals a fundamental lack of understanding about their statutory role.

10.47 Governor role clarity has also been identified as an area requiring improvement in several external reviews. There are a number of ways in which this links to Urology:

- Governors were being used by staff as a route to raise concerns about the quality and safety of services and we have been told this included Urology; however, there is no evidence that the governors received training or a clear protocol about what to do in response to concerns being raised.
- The Lead Governor role has tended to be a more substantial role than is typically found in other Trusts. In the case of Urology, this led to the Lead Governor along with a small group of other governors having dialogue with the Trust about concerns in relation to services that the rest of the CoG was not aware of. This led to an inequity of knowledge about Urology; had concerns been more widely shared at formal CoG meetings, it is possible that greater assurance regarding the validity of concerns would have been sought.

10.48 The quality of reporting to the CoG is poor in general. There is insufficient information in relation to performance, quality and safety. We would expect governors to receive at least quarterly summaries of the Trust's position against metrics such as Single Oversight Framework (SOF) targets, sickness levels, incidents and Never Events. Instead, agendas tend to be focused on stand-alone items, a failure that is also captured in Deloitte's Well-led Report in 2019. Specifically for Urology, the weaknesses in reporting to the CoG undermined the extent to which concerns associated with bullying and harassment were put into a wider context. For example, the WAC Chair's Report to the CoG in January 2017 simply states, '*staff survey - initial draft is encouraging*'.

10.49 Whilst the staff survey results did show some signs of year on year improvement, the percentage of staff who experienced harassment, bullying and abuse in the previous 12 months was still 27% compared to a national average of 24%; this was not included in the report or referenced in the meeting. The lack of detail in the report coupled with the overarching positive statement perpetuates a narrative of improvement at the Trust which is not supported by analysis. It is worthy of note that the January 2017 CoG meeting was also the meeting that received feedback following a governor/director meeting about bullying allegations raised by the FTSUG. If the quality of reporting to the CoG had been more robust, it is possible that the governors may have sought further assurance about the actions the Trust was taking to both understand and address organisational bullying.

Broader matters relating to governance

Strategy, vision and values and proliferation into services

10.50 External strategic initiatives have demanded a significant amount of time and energy from the Executive team. EDG meeting agendas often included a bias towards the stewardship function of the Executive team, rather than the day to day management, forward planning and performance management of the organisation. The quality, safety and performance of individual services and even Business/care groups were rarely discussed in detail at EDG, whereas topics such as Better Care Together

(BCT) were afforded a lot of focus. That said, the connectivity of plans such as BCT with individual services appears to have been very low with little evidence to suggest that the Executive team (or the Board) oversaw the development of localised strategic implementation plans.

10.51 The Trust was criticised for its lack of oversight of operational plans at care group and service level in the 2019 CQC inspection. The Trust's contextual response focused on how the Board, NEDs and governors contribute to the development of strategic plans which was not the basis of the CQC criticism.

10.52 Appendix 4 illustrates the key strategic initiatives that the Trust has been involved in since 2013. The Trust Board has been focused on strategic initiatives that are largely externally focused.

10.53 The desire to have a single-site approach to emergency care has been explored since 2013. In August 2013, EDG considered a paper called 'Medical Workforce Drivers for Change', which set out the safety, efficiency and workforce advantages of a single-site approach. In October 2019, the Clinical Services Strategy was presented to the Quality Committee and noted Urology as one of the services that would require consolidation onto one of the acute sites. The Trust was still exploring this as a possibility during our fieldwork in late 2020.

Impact of legacy, reputation and profile

10.54 The last ten years have been turbulent for the Trust, with the achievement of Foundation Trust status in 2010 and significant regulatory intervention from 2012 onwards; addressing the regulatory issues was time consuming for the Executive team and staff have told us in interview that this was a distraction from other aspects of their work. A timeline of regulatory intervention and external reviews is outlined in Appendix 3.

10.55 There were regular Board membership changes including Chairs and Non-Executive Directors throughout 2013 to the present time. There was little evidence of formal handover between the Chairs in particular, including Non-Executives who chaired key Board committees. This risked loss of institutional memory and contributed to a lack of momentum on monitoring the implementation of some action plans.

10.56 The impact of the Report of the Morecambe Bay Investigation (Dr Bill Kirkup, CBE: referred to here as the Kirkup Report) is important context for the investigation into Urology services. Not only do many of our findings outlined here and in the Niche Draft Current Controls Assessment Report (issued in October 2020) bear similarities with those from Kirkup, but the attention placed on Maternity services at the time of the Kirkup Report impacted the focus afforded to other services, including Urology. Comments made in interviews included: '*Kirkup took up a huge amount of time*', *'a lot of Board and Executive time was spent on servicing the regulators*' and '*the Executive team always seem to be fighting fires*.'

10.57 Interviewees were also in broad agreement that the impact of failings in Maternity and the subsequent Kirkup Report, did not result in the Board considering whether issues in Maternity were also present in other services. Several interviewees reflected that '*there is too much consideration of issues in an isolated manner*'. The Kirkup Report itself was critical of the '*inadequate flow of information through professional and managerial reporting lines*' and pointed out that '*inappropriate reliance was placed on poor quality internal investigations*' with incidents treated as individual unconnected events, and no link made with previous incidents; these are

issues that we have found to exist in Urology in the years prior to and since the Kirkup Report was published.

Escalation

10.58 Weaknesses in the Trust's escalation framework contributed to the poor oversight of Urology at a corporate level:

- Chair's reports were used to communicate key issues from Board committees to the Board and the CoG, however, there was significant variation in the style in which these were completed. There was a standard template, but the level of detail varied significantly. The template also started with a section titled strengths which resulted in a tendency for this section to contain more detail that the 'issues' section. This contributed to the culture of positive bias in assurance reporting at the Trust.
- We found misleading summaries in reports to assurance-seeking forum, as well as some direct contradictions between assurance reports and detailed minutes of meetings. For example, in October 2015 when the Quality Committee received a direct contradiction between the Clinical Audit and Steering Group minutes (that there is a delay in Urology audits) and the Clinical Audit Update provided to the committee in the Clinical Quality and Governance Summary (that everything is on track). A further example is in the May 2016 SIRI Panel when the quarterly report omitted key findings from a Urology thematic review. Indeed, the findings from the review that are captured in the SIRI Panel minutes but that are summarised to the point of obscurity in the quarterly report are still relevant today and included concerns associated with 'continuity of care, out-of-hours cover, M&M meetings and interpersonal issues'.
- External reviews have too low a profile. The capacity to manage and implement recommendations from repeated external scrutiny is also a challenge.

10.59 The escalation of issues from services and care groups/divisions also appears to be ad hoc, subjective and arbitrary rather than through a consistent focus on risk. We found that references to services and even care groups tended to focus on isolated issues, rather than there being a systemic and consistent flow of assurance through the Trust's governance structure. Some attempts have been made to address this; for example, the WAC introduced a cyclical focus on care groups in early 2014. The effectiveness of this was, however, limited by its implementation; we found that the focus on the surgical division was repeatedly postponed during this period, resulting in a period of over 12 months between committee presentations.

10.60 The Board's committees tended to operate in isolation, rather than as component parts of a holistic governance framework. Had there been stronger communication between the committees, it is possible that isolated issues raised to a single committee in relation to Urology could have identified the wider issues associated with the function, performance, safety and quality of the service. For example, in late 2014, issues associated with capacity, demand and out-of-hours cover are raised to the attention of the WAC. At the same time, the Quality Committee was alerted to capacity issues in Urology having an adverse impact on the completion of clinical audits, and the Board continued to be informed of Urology's poor RTT performance and outpatient backlog via the Integrated Quality and Performance Report (IQPR).

Action orientation

10.61 The Board and its committees did not promptly identify actions in order to resolve issues, even long-standing issues, and did not resolutely ensure that actions were delivered on time and with the intended impact.

10.62 From early 2014, Urology was referred to at Board meetings as one of a handful of services that repeatedly failed to meet its RTT target; this was an issue that extended over several years and yet there was little evidence that the Board sought robust assurance about the remedial action being taken. More concerningly, there is no evidence that the Board or Quality Committee explored the impact on patient harm as a consequence of a backlog of patients waiting for treatment.

10.63 We also found examples of actions relating to Urology not being monitored, resulting in service issues remaining unresolved. Throughout 2014–2016, there were occasions when urological engagement with the Clinical Audit and Effectiveness Steering Group (CAESG) was flagged to the Quality Committee as a problem. This resulted in an action being identified in the CAESG minutes for October 2014 for representation from Urology to attend the November 2014 Quality Committee to account for the department's performance against the audit programme. This was an appropriate action, however, it failed to be implemented. We can see no evidence of a Urology representative attending the November 2014 Quality Committee and concerns about the service's engagement with clinical audit appear to cease.

10.64 One area in which there is more monitoring of actions from the Board and its committees is in response to CQC findings although the rigour of this scrutiny is weak. For example, the July 2014 WAC received the CQC special measures action plan which included material actions such as '*Improve incident reporting. All staff must be aware of their responsibilities to both report incidents and implement remedial action and learning as a result*'. The action plan presented to the committee simply states, 'on track to deliver' and rates the action as green; however, it is not clear what action has been taken and how the impact of this is being monitored. The specific role of the WAC, as opposed to the Quality Committee, in monitoring this action is also not clear and points to an arbitrary allocation of action monitoring which raises the risk that the importance of the action and the effectiveness of improvements were not being scrutinised in the correct forum. Interview feedback also suggested that the Trust has tended to respond to actions in a '*autocratic manner*'; there was often limited involvement from those staff responsible for an area in which action was required and once an action had been determined to have been complete by the corporate team, no further assurance or testing would be sought.

10.65 The Quality Committee was repeatedly alerted to issues associated with clinical capacity in Urology throughout 2014, 2015 and 2016, culminating in the pause to the service's clinical audit programme in late 2016. The CEASG minutes are submitted to the Quality Committee and capture:

- multiple instances of the Urology Clinical Audit Lead not attending CEASG meetings or responding to requests for information;
- an instance of a new Urology Audit Lead not receiving a handover from the incumbent Audit Lead;
- clinical audit progress for Urology being incomplete, whereas data was available for all other services; and

- a number of examples of urological clinical audit action plans being incomplete, or in some cases, audits not having action plans at all.

Use of risk registers and decisions taken in response to the escalation of risk

10.66 The Trust's risk management culture has been consistently criticised over the past ten years:

- In 2012, PwC found that 'whilst risk management policies, systems and tools exist, these are not consistently applied and understood by a wide enough base of staff'.
- In 2016, Grant Thornton found that divisional risk registers were not well maintained and did not include sufficient emphasis on and oversight of target dates for risks.
- In 2019, Deloitte found weaknesses in the escalation of risks from care groups upwards, and insufficient attention on risk actions and mitigations.

10.67 Other contextual findings in relation to risk management include:

- The Trust implemented Ulysses in 2011. Prior to this, risk registers were paper-based and there was no central repository.
- Post-2011, risks were coded to a urodynamics Royal Lancaster Infirmary (RLI) risk register as well as a Urology risk register.
- The internal auditors, Mersey Internal Audit Agency (MIAA), gave the BAF a positive assessment in 2018/19, 'The organisation's Assurance Framework is structured to meet the NHS requirements, is visibly used by the Board and clearly reflects the risks discussed by the Board.' It is possible that this gave the Board false confidence about its oversight of risk.

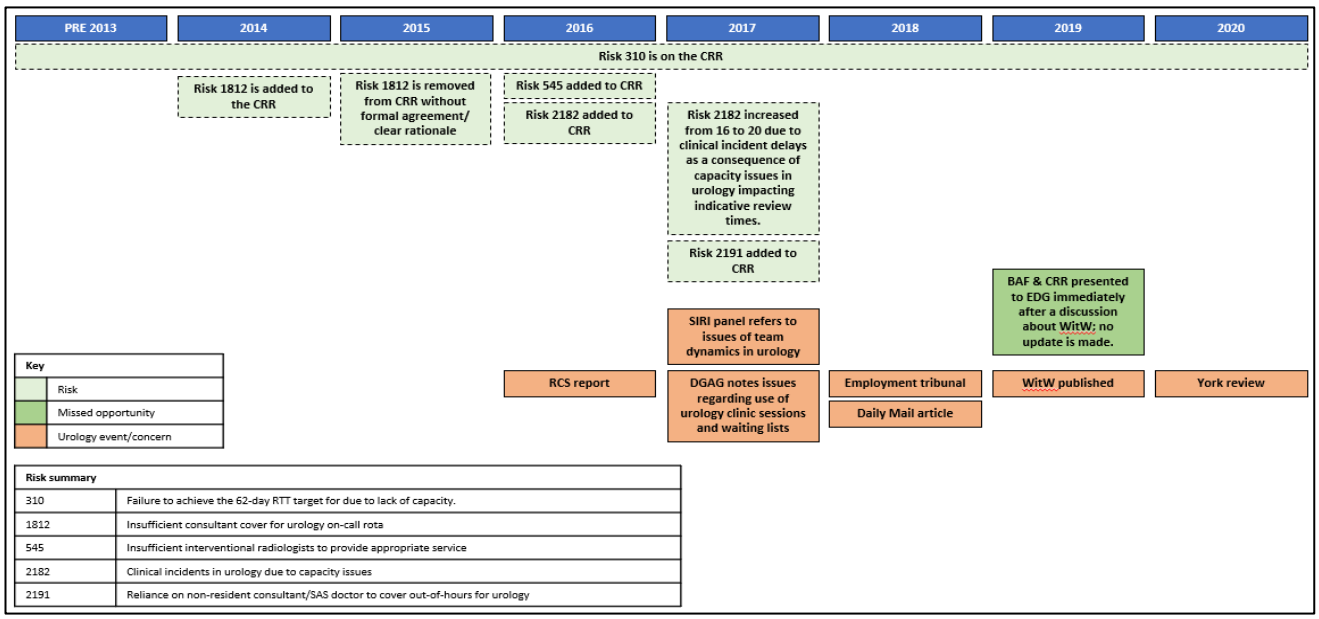
10.68 A summary of key findings in relation to risk management includes:

- There has been insufficient scrutiny of key risks at Board and committee level. Corporate Risk Register (CRR) risks are allocated to Board committees, but we found that the review of these risks in the respective committee was not sufficiently detailed or frequent enough. Agendas regularly include the risk register at the end of the agenda and minutes rarely capture meaningful debate about the nature of risks or new risks.
- The process for a risk being closed is not robust. Risks are removed from the CRR without agreement, challenge or evidence of awareness from the owning committee.
- Risk review at a care group level is ad hoc. Sometimes risk is a consistent agenda item as a verbal update, sometimes the care group risk register is reviewed, but there is little evidence in the notes of detailed scrutiny, challenge, or escalation of high scoring risks.
- Risk management is not an embedded aspect of service-level management meetings - risk registers, or even a verbal update on risks, is still not a standing agenda item at the Trust in late 2020.
- Risk registers are static, with risks relating to Urology remaining unchanged and unchallenged. This is despite several Urology risks at points in the chronology being highly scored and the same mitigating actions being included for several months and sometimes years.

- The identification of risks relating to Urology is poor and retrospective. In reviewing papers from key meetings, at no point have we located a risk register which includes all Urology risks. This was requested during our review but there is no evidence that Urology risks are routinely and holistically reviewed, even following the commission of this review.
- There is insufficient link between potential risks to patient safety (identified at Urology Audit Meetings) and risk management more generally.

10.69 The diagram below provides a summary of the Urology risks on the CRR aligned with some of the risks apparent.

Diagram 2 - Urology on the risk register 2013-2020



Oversight of external reviews, monitoring, implementation and testing of changes made

10.70 Since 2011, the Trust has been subject to numerous external reviews, often instigated by the regulator (Monitor and the CQC). The profile of many of these reviews, coupled with the extent of adverse findings and associated recommendations has resulted in the Trust being under significant scrutiny and pressure to deliver for a significant part of the last decade. Several interviewees referenced the impact on Executive time of high-profile reviews, notably the Kirkup investigation as well as CQC inspections, and its effect on the attention that was then afforded to other reviews.

10.71 We do not believe that the Trust has shown the ability to apply learning from an external review of one service to the rest of the organisation. Several interviewees noted that post-Kirkup, there was a sense that the same issues could not arise again in the same organisation. We also found that the oversight of learning from Kirkup was disjointed and inconsistent. For example, the WAC received reports relating to Kirkup which outlined the Trust's actions in relation to education and development, but there was no equivalent report which summarised the action taken in relation to the other themes in the Kirkup Report which would fall under the remit of the committee, such as engagement and culture.

10.72 The Trust invited the RCS to review the quality and safety of Urology in late 2015 with initial feedback in January 2016. A number of factors combined to result in the

Board's weak oversight of the RCS Invited Service Review report and associated actions:

- The Board did not receive a copy of the RCS Invited Service Review report or a summary report outlining its findings. Instead, it was reported on, via the Medical Director's report in January 2016, to the Board but contained insufficient detail to constitute meaningful assurance to the Board about the Urology service and overemphasised the positive findings in the report.
- Despite the Board being told via the Medical Director's report that the full RCS Invited Service Review report would be available in February 2016, we can find no evidence that it was presented to the Board in full at this point and can only conclude that neither the Board nor the Quality Committee received the report. Subsequent Board agendas and minutes throughout 2016 are also silent on this topic.
- Oversight of the agreed RCS Invited Service Review action plan was predominantly left to the SIRI Panel (via the Medical Director), with escalation to the Quality Committee via SIRI panel minutes. Minutes were often too brief and/or included a positive bias so that the Quality Committee was left with little insight into the status of RCS actions and their impact. For example, the February 2017 Quality Committee received but did not discuss minutes that stated '*The Panel noted the hard work which has gone into addressing concerns raised by the Royal College report. It was also suggested that an away day might help to reinforce team working and spirit*.'
- The January 2016 Board meeting was therefore the only opportunity for Board members to understand more about the RCS findings. Minutes of the meeting do not capture any discussion about Urology. We also note that the same meeting received an update on the Kirkup Report and progress against findings which consumed a significant part of the meeting's agenda.
- Review of the RCS Invited Service Review report and monitoring of associated actions took place too low in the Trust's governance structure. For example, the SIRI panel minutes presented to the May 2016 Quality Committee presented the link between the findings of an internal Urology thematic review and the Invited Service Review report. There is no evidence that the Quality Committee explored this in any detail.

10.73 The failure to exert robust oversight of the RCS Invited Service Review report and the resulting action implementation was one of many missed opportunities by the Trust to identify Urology as a service that fits neatly into an unmistakable pattern drawn by findings in various external reviews throughout the last ten or so years. External reviews, including CQC inspections, contain many findings which we concluded existed as live issues in the Urology service when we issued our Draft Current Controls Assessment Report in October 2020. This pattern of common findings, illustrated in Table 12, is indicative of the Trust's failure to critically assess the possible implications of a single-service report on the rest of the Trust, to implement Trust-wide improvement, and to assess the impact and sustainability of changes made.

10.74 Most worrying is that the Trust was informed of its failure to respond effectively to external reviews as far back as 2012. For example, the CQC inspection report from 2012 observes the Trust's apparent inability to take an external report, implement

recommendations, and assure itself that the risks identified in one service were not reflective of an organisation-wide issue.

10.75 We found significant weaknesses in the Trust's governance of external reviews at the Trust:

- Delays between the publication of a report and its consideration at the appropriate forum. For example, the Board received the 2016 Grant Thornton Well-led Report four months after it was issued to the Trust.
- Failures to formally review external reports by an appropriate assurance function, resulting in an absence of oversight of action.
- A tendency to review external reviews in isolation, rather than considering their findings in a wider organisational context.
- A lack of corporate coordination of external reviews.

10.76 The Board has also displayed an inconsistent approach to the monitoring of actions and their outcomes. Action plans arising from CQC inspections tend to be monitored frequently; individual action plans for each care group (formerly, division) are produced and monitored at care group/divisional meetings, Quality Committee and at Board. However, other external reviews do not generate a sustained focus on action plans. The PwC Follow-Up Governance Review in 2013, coupled with the Trust's internal Divisional Governance Review in 2013, both found material weaknesses continuing to exist at the Trust, such as the Board's poor line of sight to services and significant inconsistencies in divisional governance. Despite the nature of these findings, there is no evidence that the Board sought assurance that these areas were being addressed throughout 2013 and into 2014. Indeed, a number of these findings were echoed again by the CQC during their 2014 inspection.

10.77 We observed a tendency for the Trust to respond defensively and to overestimate its strengths and improvements made in response to external findings, and to be overly accepting of indications that action it has taken has had the desired outcome. Key examples include:

- In the 2015 Independent Well-led Governance Review, Grant Thornton gave the Trust lower ratings in six out of ten areas against their self-assessment which points to over-optimism and a lack of self-awareness on the part of the Board in relation to existing governance deficiencies.
- The Trust's response to the 2019 CQC inspection.

10.78 The table below provides a summary of the common themes in external reviews:

Table 12 - Themes in external reviews 2012-2020

(Key: Theme not included ✗ Theme included ✓)

	CQC inspection 2012	PwC Governance review 2012	PwC Follow-up review 2013*	CQC follow-up inspection 2013	CQC inspection 2014	PHE Breast screening 2014	Kirkup 2015	GT Governance Review 2015	CQC inspection 2015	RCS Invited Service review (Urology) 2016	GT Follow-up Governance Review 2016*	Internal Well-led review 2018	CQC inspection 2019	Deloitte 2019	York 2020
Inadequate Board scrutiny	✗	✓			✓	✗	✓	✗	✗	✗			✓	✓	✗
Poor Board line of sight on risks, issues and performance	✗	✓	✓		✓	✗	✓	✓	✗	✗		✓	✓	✓	✗
Concerns about Executive team capacity or capability	✓	✗			✗	✗	✓	✓	✗	✗		✓	✗	✗	✗
Weaknesses in clinical leadership	✓	✓			✗	✓	✓	✓	✗	✓			✗	✗	✗
Weaknesses in divisional/ CG governance	✗	✓	✓		✗	✗	✓	✓	✗	✗	✓	✓	✓	✗	✓
Ineffective incident reporting and management	✓	✗			✓	✗	✓	✓	✗	✗	✓		✓	✗	✗
Poor oversight and action implementation	✓	✗			✗	✓	✓	✓	✓	✗			✓	✗	✗
Concerns regarding culture, engagement and team working	✓	✗		✓	✓	✓	✓	✗	✗	✓			✓	✗	✓
Unclear and incoherent service-level strategy and risk	✗	✓		✗	✓	✗	✓	✗	✗	✓			✗	✓	✓
Concerns about service configuration (inc. on call)	✗	✗		✗	✗	✓	✓	✗	✗	✓			✗	✗	✓

*These reviews were follow-ups and emphasised areas in which the Trust had made little or no progress; they did not give complete assurance that the other issues identified in previous reports were completed and improvement was embedded.

10.79 Appendix 3 provides a summary timeline of external reviews and regulatory interventions.

Quality of Board reporting

(Including clinical incident reporting and Trust approaches to identifying patients who have been harmed, being open, and Duty of Candour)

10.80 Weaknesses in integrated performance reporting have been independently reported to the Trust throughout the last decade. The PwC Governance Review in 2012 noted that '*The Trust has not adopted a coordinated or comprehensive approach to performance reporting that brings together all of the key performance information relating to quality and safety*'.

10.81 An Integrated Quality and Performance Report (IQPR) was developed in 2014 following further criticism about the oversight of performance from the CQC. The structure of this, however, failed to give an overarching view of performance to the Board, a weakness which has been reported to the Board as recently as September 2019 in the Deloitte Well-led review, as well as in Niche's Current Controls Assessment Report.

10.82 A review of Board papers from 2014 onwards also shows that the IQPR has included little external benchmarking with low levels of information pertaining to actions being taken to address an area of sustained underperformance or concern, such as RTT performance. Urology's RTT performance, for example, was reported to the Board as an area of underperformance for several years. The Board, however, is not provided with, nor does it request, benchmarking analysis that would set this performance in a regional or national context.

10.83 The content of Board/committee reporting more generally does not give Board members a clear line of sight to service-level issues, rendering it almost impossible for the Board to identify performance hotspots, trends and areas of deterioration without proactive escalation from the Executive team. For example, the WAC received a workforce dashboard from July 2014 which included information on the numbers of disciplinaries, disputes, and grievances but this information was at Trust level only. After February 2015, the workforce dashboard no longer included metrics relating to employee relations; however, the rationale for this omission is not clear.

10.84 A more positive example is the Operational Performance Report received by the Quality Committee. There is evidence that this report was used by Quality Committee members to gain insight into the performance of individual service areas. In July 2019, this included two deep dives into breast cancer and Urology pathways. The deep dive highlighted the forthcoming publication of *Whistle in the Wind* and clinical restrictions as contributing factors to the failure to meet the 62 day cancer target. However, the impact of this analysis is less clear and there are no clear actions relating to Urology arising from this meeting.

10.85 There is also lack of service-level analysis in relation to other areas of known weakness at the Trust. For example, in May 2015 the WAC received a paper showing that the proportion of BAME staff saying that they had personally experienced discrimination at work from managers and colleagues was three and

a half times greater than that of white staff. The paper included some analysis by staff groups but did not report which areas of the Trust were performing worse than others in this area. This limited the extent to which WAC could understand the contributory factors to this metric and, importantly, seek assurance that targeted actions would be effective.

10.86 Reporting in relation to Urology at Board/committee level increased significantly following the publication of *Whistle in the Wind.* The Quality Committee also began to receive a Urology Service Report in October 2019 which included benchmarking data at both an Integrated Care System (ICS) level and a national level. The report outlined the reasons for poor performance against regulatory standards, including insufficient theatre capacity, even when theatres were fully operational. It refers to AASs and the impact of the pension tax change on the appetite to carry these out. The report emphasises that there are pathway delays for all patients, but particularly routine patients. It notes '*increased capacity enabled through internal efficiencies*', however, what these internal efficiencies are is not made clear in the report or in the associated committee discussion.

10.87 Most interviewees gave either unclear or negative responses when asked how the Board had oversight of job planning. A review of WAC meetings shows that there was not a consistent approach to providing the committee with oversight of the job planning process, nor the escalation of any areas of the Trust in which job planning was a particular challenge.

HR directorate

10.88 The corporate oversight of complex employee relations cases, including MHPS cases, has been recognised by the Trust to be a weakness. We have been told that steps have been taken to improve case management over the past two years and the Director of People and OD, Medical Director 6 and Responsible Officer now meet monthly to discuss live cases.

10.89 Board reporting on employee relations issues remained a significant area of weakness until 2019 when a stand-alone Employee Relations Report was introduced to the Private Board. This report included analysis on the number and type of grievances and disciplinaries by care group, alongside performance improvement plans. It also included narrative about the impact on staff and the Trust's reputation. A review of 2020 Board packs shows that one further Employee Relations Report was received in June 2020; however, the style of this report changed considerably and no longer provided insight into employee relations cases across the Trust, but instead provided a narrative overview of known hotspots. We note that in late 2020, requests were made by WAC members that more information be provided on employee relations '*which had not been reported to the committee for some time*'. A new style Employee Relations Report was received by the committee in November 2020; it includes hotspot areas at the Trust but is heavily narrative in focus and does not include rolling data on the numbers of employee relations cases by care group or service, this inhibits the extent to which Board members, and particularly NEDs, can independently identify areas of increasing concern.

10.90 In relation to employee relations, we found that:

- Workforce Advisors (junior roles in the HR directorate who report to the HR Business Partner) were heavily involved in the management of Urology cases we reviewed, despite their complexity and sensitivity.

- Oversight of the work of the Workforce Advisors was delegated to too low a level in the HR directorate.
- There was no case management system until 2014.
- Complex HR cases were intermittently on the EDG agenda from 2014; however, EDG's scrutiny in this area was not consistent and it was often not clear from these discussions how these cases were triangulated with quality and safety information in order to identify potential areas of escalating concern at the Trust.
- Identification of potential cases of bullying and harassment lacked objectivity and a structured escalation process. We were told that the Trust emphasised the importance of early intervention, however, the opportunity for this was restricted by the way in which bullying cases were identified and escalated.
- Despite the nature of the concerns about the Urology service, and particularly in relation to the competency of some Consultants, the HR directorate (in conjunction with the Fitness to Practice team) has not undertaken any assessments of the quality of appraisals in the department.
- A workforce operational meeting existed between June 2016 and April 2018. This meeting was chaired by the HR director and its purpose was to review workforce performance and risks. A review of agendas and papers shows that little focus was given to culture, engagement and employee relations at this meeting.
- A bullying and harassment working party has been established, which reports to the People and Organisational Development Divisional Governance and Assurance Group.
- A Staff Engagement Task and Finish Group was established in February 2015. This reports to WAC but reporting from this group is very limited.

10.91 Between 2000–2008 the department's Clinical Leads were heavily involved in MHPS processes in relation to Consultant Urologist 2, with the direct involvement of Medical Director 1, Medical Director 2 and Chief Executive 1. The Medical Directors, Director of HR, Chief Executive 1, Clinical Director 1, Clinical Lead and Assistant Clinical Lead were well aware of the processes in train at the time and responded to the concerns being raised. In this regard, HR was supportive and responsive to the needs presented.

10.92 However, these processes were extremely protracted at times and continued to be so for subsequent MHPS events. We can see little evidence of formal engagement since 2013, when departmental concerns began to increase, between the following groups and their respective responsibilities:

- the Medical Directors, the Responsible Officer and the management of the fitness to practice arrangements;
- the Director of People and Organisational Development or HR managers; and
- the care group and department.

10.93 The quality of HR support to the care group and the department has been limited amidst the complex issues presenting from 2013. These issues were devolved to junior staff with no evidence of senior or executive oversight provided to support advice given or subsequent investigations in the cases we reviewed.

10.94 Support to the Responsible Officer from HR in respect of appointment processes and delivering key requirements under the RO regulations, e.g. checking the GMC register especially in the context of increased use of locum staff, is an ongoing area of potential weakness.

10.95 Internal grievance processes were unacceptably delayed in several key scenarios; two years for a claim of racism between Consultant Urologists to be reported on by the Trust (handled through MHPS) (Consultant 5 was the subject of this accusation and was subsequently cleared); several months to investigate grievances relating to behaviours and to provide inadequate responses which were referred to as 'just being process'; eight months to produce a draft report in response to queries about claims for AASs; some concerns not responded to (e.g. police racism allegation) or dropped without investigation. None of these were caused by any form of appeal or delay from the individuals concerned. These delays contributed to underlying tensions and unresolved complaints within an already dysfunctional team.

The role of the Responsible Officer, Medical Director and Medical Directorate

10.96 There remains a concern about medical leadership and accountability at the Trust. Interviewees suggested that '*there is still a risk regarding accountability'* and '*if you ask Consultants who line manages you, you'd get a variety of responses, even now'*

10.97 Clinical leadership and accountability have been areas of focus for the Executive team since 2014. A Consultant Leadership Investment Framework was developed in 2014 with a view to strengthening the quality and effectiveness of this throughout the Trust; however, corporate oversight of this (for example, through WAC or EDG) was minimal and there is no evidence to suggest how actions taken to strengthen clinical leadership were meaningfully evaluated. This was replaced by a Clinical Leadership Programme, and we have been told that this programme is relied upon to ensure that clinical line management works throughout the Trust.

10.98 Job planning has been a work in progress for Medical Directors since 2014. In June 2014 Medical Director 4 informed EDG that he was working on the Pay for Consultants/Job Planning Policy, but there were no further updates to EDG regarding changes to the policy, how it would be implemented or when it was approved. Job planning has been an area of concern for Urology over the last 20 years and has remained so until very recently.

10.99 The role of the Responsible Officer (RO) is to be accountable for the local clinical governance processes in a Trust focusing on the conduct and performance of doctors. Duties include evaluating a doctor's fitness to practice and liaising with the GMC over relevant procedures[60]. Medical Director 3 became the Responsible Officer when the 2011 regulations became into effect. On the appointment of Medical Director 4 in 2012, the RO role was retained by Medical Director 3 who remained as RO until 31 August 2019. However, we can see no evidence that this decision was formally approved, recorded or revisited by the Board after the initial decision to appoint to the RO role was made in 2011.

[60] https://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/06/ro-guidance-draft.pdf and https://www.england.nhs.uk/medical-revalidation/ro/ro-faqs/

10.100 This was an important role but from 2012 the responsibilities were internally and informally divided between the RO and the Medical Directors from 2012 onwards. This meant that there was restricted oversight of Consultants' conduct and performance as information was not all held in one place. Between them, the RO and Medical Directors were aware of the extent of dysfunction in the Urology team but failed to objectively assess the need for decisive intervention. This was partly due to the informal separation of duties, in that the RO took responsibility for Appraisal and Revalidation processes and Fitness to Practice/GMC referrals, with the Medical Directors leading MHPS (internal investigation) processes. This resulted in some aspects of the regulations not being effectively delivered. In particular, the RO guidance[61] specifies that the RO has a duty to investigate the causes of concerns about a doctor's performance, and where necessary, to initiate action to address wider systems or team issues that result in poor performance. Without any formality of the separation of duties, the role of RO could not effectively be delivered and the Board did not pay appropriate attention to the importance of this function.

10.101 We also understand that access to the Board was limited to the Medical Director only (despite recommendation 6 of the Pearson Review published in January 2017[62] which highlighted the need for Board level reporting and challenge). The RO was, instead, asked to report via the Board Committees. In addition, Medical Director 4 (in post between 2012 and 2015) had not undertaken RO training[63] and despite the updated regulations in April 2013 the value of this training was missed individually and corporately. Ultimately, there was a failure by both roles to jointly reinforce GMC guidance in relation to the conduct required of doctors despite liaison with the GMC Employer Liaison Advisers. The tri-partite combined impact was ineffective in Urology.

10.102 It should be noted that our review has identified that the NHS RO guidance in place has not been revised since publication on 26 July 2010. There are draft (2013) and consultation (2015) papers in place but it is of note that nationally this guidance has not been updated.

10.103 Confidence in the current Medical Director (Medical Director 6) and his predecessors has been mixed, with several interviewees feeling that little leadership has been offered in relation to clinical governance. Some also questioned whether the Medical Director has the support and capacity to contribute effectively to some key areas of the governance agenda, such as mortality.

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[61] The Role of Responsible Officer, Closing the gap in Medical Regulation – Responsible Officer Guidance. Paragraph 4.21 (26 July 2010) RO guidance states in reference to Regulation 16(4)(h)(iv):
If an investigation confirms a valid concern, the root cause should also be traced. Many cases of apparent poor performance of an individual may in fact be due to a dysfunctional team or a wider organisational system. The Responsible Officer has a duty to investigate the causes of concerns about a doctor's performance, and where necessary, to initiate action to address wider systems or team issues that result in poor performance.

[62] https://www.gmc-uk.org/-/media/documents/Report_of_Sir_Keith_Pearsons_review_of_revalidation.pdf_69136669.pdf
Recommendation 6 ROs should report regularly to their board on the learning coming from revalidation and how local processes are developing. Boards should challenge their ROs as to how they are learning from best practice and how revalidation is helping to improve safety and quality.

[63] Medical Director 5 had undertaken this training in the Department of Health prior to appointment between 1 April 2013 and 31 August 2014 but evidence cannot be provided. The RO at the time had not been required to attend update courses. After the regulations were updated, the ROs were not required to attend any refresher courses and we are informed there were not any specific courses available to attend.

10.104 Medical Director 6 became the Responsible Officer for the Trust in September 2021 in recognition of the need to combine the roles again. This was before the appointment of a new interim Medical Director (with Responsible Officer status) in November 2021.

Opportunities for intervention - Trust oversight

External reviews including RCS Invited Service Review Report 2016

10.105 The commissioning of the RCS Invited Service Review (distinct from the RCS Clinical Record Review involving Consultant Urologist 2) was undertaken because of concerns regarding performance, clinical incidents, the functioning of the team, and the delivery of the Urology service.

10.106 The findings are clear, and recommendations addressed many of the key concerns raised in this report. However, the internal preparation between the Deputy Medical Director and the department prior to the review focused on which incidents to share with the RCS team. The selection appears to have been partly based on specific incidents raised by the Clinical Lead and a small number of other Consultants, without accurately reflecting the difficulties across the team. This was not an inclusive selection. Individual Consultants had an unbalanced opportunity to identify their concerns, and the motivation behind some of the accusations contained in some incident reports appeared to be personal and based on individual performance. This placed the focus, to some extent, on individual concerns and not on wider team functioning. In this respect, it was a missed opportunity to require all Consultants to work professionally, communicate better and address the bipartisan culture.

10.107 The monitoring of the actions and implementation of the recommendations arising from the review by the Trust was inadequate. The SIRI panel was not the appropriate forum for monitoring the action plan which became a thematic review and was not followed up post October 2016. We were told that Medical Director 5, the Deputy Medical Director and the Clinical Director for Surgery met with the S&CC Group triumvirate on request on 12 June 2019 after it became apparent that an action plan existed but that the Care Group were not aware of it. This meeting discussed the actions from the RCS Invited Service Review report, but nothing was reported or escalated outside of this meeting (e.g. to EDG, TMB, Quality Committee or to the Board). The action plan had originally been developed in 2016 by the Deputy Medical Director and Medical Director 5 as well as the Clinical Director but had not been shared further. It was expected to be monitored through this ‘Urology Action Group’, however, there is no evidence this group met or undertook the anticipated monitoring. This meant that the action plan was not properly operationalised and explains some of why the actions did not get fully implemented. The S&CC triumvirate then sought to update the action plan in 2019 ready for the York review that was expected to take place.

10.108 The original ownership of the action plan and its ‘retention’ within the medical jurisdiction of the Trust was a key factor in lack of implementation. Assurance was provided to Chief Executive 3 from this Group but without the operational support needed this was over optimistic assurance of the implementation of actions. This in turn meant the RCS President was provided with assurance by Chief Executive 3 in 2017 that was not sufficiently robust.

10.109 Essentially, recommendations from the RCS Invited Service Review report were not implemented promptly in 2016. As indicated in the report from the York team in

January 2020 some changes had been made, but in our view given the length of time elapsed from the RCS Invited Service Review these were insufficient and minimal sustained improvements had been made. There were no clear action implementation forums to ensure that an already dysfunctional team was supported to make significant changes as indicated by the RCS.

Mortality review

10.110 A mortality review process was introduced in late 2014. This was a discrete activity undertaken by a small number of individuals. Whilst those that instigated the review process should be commended, it was not sufficiently supported by the Trust to provide enough authority for the reviewers to report any concerns and to ensure that all care groups and departments followed up the initial case review undertaken by a more thorough investigation. By June 2015 mortality reviews were taking place on a site basis. Greater proportions were being reviewed in FGH due to the smaller number. The Deputy Medical Director asked for a mortality dashboard to be developed at this point. In August 2015 Mortality Review Group minutes noted the challenges with mortality reviews at RLI and difficulties in establishing a mortality dashboard.

10.111 Cases were scored against National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and HOGAN scales, with any score above a two on either scale identifying either or both a clinical/organisational opportunity for improvement. However, these were not reported as incidents for investigation.

10.112 From September 2017, all inpatient deaths should have been reported and subjected to a case review. This mandatory requirement was set out under the Learning from Deaths guidance published by the National Quality Board in March 2017[64]. The guidance is designed to ensure that learning to improve services is identified when someone dies - it is not solely about whether a death was avoidable or preventable. It presents an opportunity to talk to families, answer questions and ensure that the experience and services provided in these circumstances is subject to approach scrutiny. The Trust's revised Learning from Deaths Policy September 2021 (which is due for review in March 2022) clarifies the important link with mortality reviews and the need to report any incidents identified in these.

10.113 The Health and Social Care Act[65] requires that Trusts set out their policy for Learning from Deaths, report the number of deaths occurring within the parameters of the policy, and report how many have been reviewed and investigated. Trusts are required to report on this in their published Quality Accounts since 2017/18. Whilst the Trust can identify inpatient deaths at the Trust level, this is proving difficult to do accurately and in a timely fashion at specialty level.

10.114 The Trust has found considerable difficulty in reporting deaths associated with Urology services - this was reported as part of our Draft Current Controls Assessment Report. Our case review in October/November 2020 also identified that there remain deficiencies in the approach of the Trust to assure itself that

[64] https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf

[65] https://www.england.nhs.uk/wp-content/uploads/2020/08/Detailed_requirements_for_quality_report_-update.pdf

there is robust mortality review and learning. A Trust mortality dashboard does not currently exist.

10.115 There were largely poorly documented mortality reviews. The current policy/SOP is not sufficiently clear in line with other NHS organisations following the March 2017 'Learning from Deaths guidance' which have a comprehensive suite of procedures and review processes. (This policy was updated in September 2021).

10.116 We have also observed the lack of protocol for managing patient records post-death which gives rise to the potential for amendments to be made retrospectively. This is a national issue but one that we have identified as being a potential risk to proper governance.

10.117 We examined 11 mortality reviews relating to cases between 2014-2017 and the relevant patient notes. (This was prior to the issuing of Learning from Deaths guidance but we have seen little improvement since then). There were significant learning opportunities highlighted in these cases consistent with other findings in this report which would support service improvements. We made the following observations:

- The mortality review process did not document specific actions or learning from the review and there was no evidence of how and where this process occurred at a Trust level.
- Some cases showed poor palliative and End of Life care documentation and associated decision making.
- 10/11 cases were noted as expected deaths. There was no policy or methodology for defining this category and determining at what point the death was expected.
- There were gaps in the clinical notes. For several of the patients it is noticeable that there was a lack of review or failure to act on tests/results.
- There was very little evidence of either good or excellent end of life care.

Claims processes and legal services

10.118 New and settled claims are currently reviewed at a departmental level in Clinical Business Unit (CBU) meetings and at care group level in Surgical Governance and Assurance Group (SGAG) meetings; litigation activity in Urology is generally low.

10.119 68 legal enquiries were made between 2003 and 2020 relating to care in the Urology department. Some have not been pursued following an initial enquiry. Only 18 cases were subsequently logged as incidents with the remaining 50 being investigated instead through legal processes with limited opportunity for learning purposes. Of the 68 logged claims five were investigated, of which three were reported as serious incidents (SIs) amounting to only 7% of claims being investigated through the incident policy.

10.120 33 of the claims (48%) had complaints logged.

10.121 In our view, all claims should have been logged as incidents in order to better understand the basis of the concern for learning purposes, regardless of an ultimate successful claim. We understand the care group were informed about claims but there was no protocol in place to ensure these were subsequently logged as incidents.

10.122 Niche reviewed the 68 claims (notably, we were only initially notified of 17 by the Trust).

10.123 The claims were grouped into five categories; logged with no further correspondence, cases that were closed, cases settled with and without quantum, and those cases still pending.

10.124 The key areas where claims were made fell into three broad categories. The largest area related to surgical complications at 60% (including alleged negligent surgery, consent, bladder perforation and circumcision), followed by 32% relating to alleged delay in diagnosis and treatment (for cancer and patient's requiring a ureteric stent). The remaining cases involved retained items during surgery and a miscellaneous category that was difficult to analyse due to limited data.

10.125 A sample of 20 cases (34%) from across the years, claim topics and Consultants were selected for a more in-depth review of the supporting documentation including the expert witness reports where available.

10.126 The claims reviewed found the following themes. These triangulate with other themes found throughout this investigation although we note that the Trust considered there was no learning in some cases:

- Delays in diagnosis/diagnostics/follow-up/lost to follow-up.
- Poor cancer pathway management and reporting.
- Surgical stent management process and complications.
- Poor consent processes.
- Poor documentation and retrospective entries.
- Interprofessional issues between Consultants/Consultant attitude.
- Surgery undertaken which should have been carried out in a tertiary centre.
- Inadequate Duty of Candour.

10.127 The quarterly report to the Quality Committee includes broad numbers and categories of claims for each division, but provides no further triangulation, trend or thematic analysis.

10.128 Also, whilst one of the reports from March 2019 states that, 'A clinical review is carried out of claims that are settled with payment of damages to assist care groups to learn any necessary lessons. A pre-claim analysis report is prepared for SIs and complaints for the Patient Safety Summit', we have found no evidence to support this statement. Equally it is difficult to evidence any improvements made as a result of claims to the legal department or the Quality Committee.

10.129 In interviews and through the survey, staff reported limited oversight of thematic reporting, including same causal factor analysis from complaints, claims, Patient Advice and Liaison Service (PALS) information, and incidents. We were told that themes will sometimes become apparent when complaints or incidents are being discussed (this is evident, for example, in the minutes for the June 2020 Urology Audit Meeting in which two complaints are discussed and both are linked to continuity of care) rather than through deliberate analysis of themes and trends over time.

10.130 We requested information relating to thematic reviews undertaken over the last ten years; the information provided shows a disjointed and incomplete approach to

thematic reviews, with some incidents incorrectly assumed to have been subject to a thematic review.

10.131 The lack of proactive, consistent and frequent thematic analysis results in the Urology department being unable to articulate and evidence the common causes underpinning complaints, claims, PALS concerns and incidents.

10.132 We would expect a formal, retrospective analysis of themes arising from incidents and concerns, either on a quarterly or six-monthly basis; this is not currently undertaken at departmental or care group level. Without this understanding, complaints are responded to on an individual basis, and the department is missing the opportunity to identify opportunities for systemic improvement.

10.133 The need to strengthen this area of clinical governance was highlighted in the Kirkup Report which stated that ‘the quality of information being shared was poor, focusing on numbers and rates of completion, … rather than identifying issues and learning’.

10.134 There is also a need to strengthen the communication of findings, actions and lessons learned arising from reportable concerns. A number of interviewees felt that the outcomes of SIRI panels, for example, were not always well communicated to staff which undermines their opportunities to learn from incident reporting. Without strong communication of learning, action and outcomes arising from concerns, there cannot be a culture of positive and open reporting and continuous improvement

11. External interventions and oversight

Commissioners

11.1 This part of our report considers the role of commissioners[66] in the planning, purchasing, contracting and monitoring of Urology services provided by the Trust. In line with the terms of reference, we focus on the following aspects of the commissioning role:

- oversight and interventions across the timeline of events;
- engagement in relation to pathway design;
- awareness of issues within Urology, including serious incidents (SIs), complaints and adverse outcomes; and
- oversight of Urology and enhanced monitoring mechanisms (including the sharing of external reports with commissioners).

11.2 We set out in Appendix 5 a timeline of key developments of relevance to the relationship between the Trust and its commissioners over the period 2000–2021, and to the commissioning of Urology services. We have concentrated on the period from 2009 onwards, as commissioners were unable to easily source documentation before this point. Contract related records were only available from 2013/14.

11.3 From 2017 the main commissioner of the Trust's Urology services has been Morecambe Bay Clinical Commissioning Group (MBCCG) and, to a lesser extent, North Cumbria CCG (NCCCG). The total contract values for all commissioned services in 2019/20 were £228m and £4.3m respectively. Urology income to the Trust is approximately £7m per annum and has been relatively constant over the last 12 years.

11.4 The focus of our review is on MBCCG (in place since 2017), and the predecessor commissioning organisations covering Morecambe Bay and South Cumbria, i.e. North Lancashire CCG/Primary Care Trust (PCT) and Cumbria CCG/PCT who were also responsible for commissioning services prior to 2017 (See Appendix 6). Securing complete quality assurance documentation prior to 2013 from Cumbria PCT/CCGs has not been possible but joint meetings covering the Trust's contractual performance were held from this period onwards. (See Appendix 7).

Commissioning structures

11.5 The main commissioner of the Trust's Urology Services is MBCCG which covers North Lancashire, South Cumbria and Barrow-in-Furness following boundary changes in April 2017 when NCCCG was established. The service locally mainly focuses on diagnostics and non-complex procedures; tertiary services are commissioned through Lancashire Teaching Hospitals NHS Foundation Trust and East Lancashire Hospitals NHS Foundation Trust.

11.6 There have been a multitude of changes in structures and geographic responsibilities in the region over the last 20 years. These include mergers of Primary Care Trusts (PCTs), Practice Based Commissioning (PBC), the establishment of CCGs in 2013 and subsequent boundary changes. Since 2006,

[66] Clinical Commissioning Groups and former Primary Care Trusts

North Lancashire PCT (NLPCT) and then Lancashire North CCG (LNCCG) was the main commissioner for Royal Lancaster Infirmary (RLI), and Cumbria PCT/CCG was the main commissioner for Furness General Hospital (FGH) services. Commissioning structure changes over time are summarised in Appendix 6.

11.7 Joint commissioning arrangements with the Trust were not in place until 2017 with the emergence of the Lancashire and South Cumbria Sustainability and Transformation Partnership (STP). MBCCG became lead commissioner on a co-commissioned contract with NCCCG. Before this, there were periods when commissioners came together on quality and performance oversight, but this was inconsistent (see Appendix 7). The Kirkup[67] Report in 2015, noted that the former PCTs were unwilling to *'cede "lead commissioner" status to the other'.* We were told that a key factor was the different financial challenges facing commissioners and the need to retain control over contracts to manage financial sustainability. This created a fragmented approach to the commissioning oversight of the Trust.

11.8 Commissioning teams have had to deal with an increasingly complex agenda with limited resources and experience. Commissioning, contracting and performance management also required new skills in GP led commissioning groups. CCGs took on additional statutory responsibilities and heightened scrutiny over quality and safety has had to be managed within the constraints of a financially challenged system. There were many changes in senior commissioning teams as a result. The Kirkup Report referred to the impact of these challenges for both commissioners and providers, *'the organisational changes led to confusion of roles and responsibilities, loss of organisational memory as personnel changed and, in some cases, staff of new organisations struggling with responsibilities for which their previous experience had not equipped them.'*

11.9 Since 2017, the focus on system working presented new problems in terms of the additional layers of governance across the stakeholders involved. This continued fluidity and uncertainty does not give confidence that governance processes at a local level will be effective.

Commissioning priorities and relationships

11.10 As for many health systems, financial sustainability has been the main driver of commissioning priorities. From 2006 the strategy focused on reducing reliance on acute care which became the national direction of travel under Transforming Community Services[68] (TCS). The priorities for 2009 were Acute configuration and Mental Health services. Consultant cover was the key challenge locally and FGH had a heavy reliance on locums.

11.11 Following the maternity incidents at FGH (2004–2008), commissioners' attention turned to Maternity services. The Kirkup Report found serious failings in clinical governance, culture and behaviours at the Trust which in fact had wider implications for other Trust services.

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[67] https://www.gov.uk/government/news/morecambe-bay-investigation-report-published

[68] https://webarchive.nationalarchives.gov.uk/20120503091528/http://www.dh.gov.uk/en/Healthcare/TCS/Abouttheprogramme/DH_121964

11.12 Issues were surfacing in Urology before 2009. There were concerns about the clinical competency of a Urologist and cultural problems were also emerging, with reports of disquiet between Consultants and some other team members. We were told that these issues were contained within the Trust and not raised with commissioners at the time.

11.13 We were told that there were also tensions in relationships at more senior levels in the Trust and with commissioners; for example, the former Chief Executive 1 and Chief Operating Officer (COO) of the Trust became Chief Officer of NLPCT (2006-2009) and Director of Commissioning at NLPCT (June 2007-April 2010). Therefore, senior commissioners were tasked with holding the Trust to account on issues for which they had previously been responsible. Despite commissioners' and CQC concerns over quality and financial viability, the Trust was awarded Foundation status in October 2010.

11.14 In 2010, a failure to recall significant numbers of outpatients was identified; this was during the time when the Trust were implementing the new electronic patient management system (Lorenzo). The relevant patient case was from Urology and the majority of the first cohort of overdue patients who were addressed were in Urology; however, the issue affected several specialties so there was no particular attention placed on this one service.

11.15 In view of the compounding problems facing the Trust and as a result of a serious incident, in October 2011, the Strategic Health Authority (SHA) declared a major incident in relation to outpatient follow ups and maternity issues. Cumbria PCT led the 'Gold Command' response which consisted of twice weekly and sometimes daily updates. A subsequent external report by Helen Bellairs, previous Chief Executive NHS North West into this issue in 2012 found serious governance failings and a '*culture of passing the buck to others and clinical disengagement*'. This built upon the failings identified by the major incident report which included failings in the quality of RCA reporting.

11.16 Kirkup reported that the benefits of this process were debatable and that it was a significant distraction to all concerned, causing further strain in relationships with the Trust. Much of commissioners' attention continued to be absorbed by maternity services together with heightened external scrutiny, for example by the Cumbria Health and Wellbeing Board, Monitor and a PricewaterhouseCoopers (PwC) Report which found fundamental governance failings at the Trust. In 2012 the Care Quality Commission (CQC) issued a warning notice with concerns about A&E.

11.17 In February 2012, Monitor appointed an interim Chair for the Trust who found serious governance weaknesses. His interview with Kirkup noted that upon his appointment, *'commissioners were very disengaged'.* At this time, the PCTs were also busy with the transfer of community services to the Trust.

11.18 The Better Care Together (BCT) programme was initiated in 2013/14 as a joint commissioning strategy for North Lancashire and South Cumbria. There had been significant changes in the Trust's leadership team, and we were told that relationships improved. BCT shifted the focus away from the micromanagement of the Trust and presented an opportunity to look to the future. Commissioners were dependent on the cooperation of the Trust to deliver financial sustainability. Further intense scrutiny of the Trust would have been counterproductive; however, from 2015 to 2019, progress was slow and clinical engagement, culture and behaviours were recognised as barriers. During 2019/2020, there was a focus on

developing an accountability framework to better reflect emerging system level requirements. The operational imperatives following the Kirkup recommendations, A&E challenges and the Trust's CQC improvement plan also remained prominent.

11.19 The BCT strategy refresh in December 2019 was a clear change in direction towards quality improvement. Urology improvement plans also became visible in response to the issues which had emerged following the whistleblowing publication in July 2019.

Commissioning of Urology services

11.20 Core Urology services are not commissioned to a service specification. This is common practice in the commissioning of acute services which, in the main, are commissioned using a pathway approach from referral to treatment and discharge. Activity planning is therefore based on points of delivery (inpatient spells, outpatients (first/follow-ups), day cases etc.). In our opinion, this approach limits the ability of commissioners to understand the drivers of service performance and ask the right questions about quality. The Trust's Operational Policy for Urology 2018/19 does, however, set out the services, care pathways and multidisciplinary team (MDT) requirements and would be a useful reference for commissioners going forward.

11.21 Following the publication of the NHS Cancer Plan[69] in 2000, there have been various national initiatives for the local commissioning of Urology services. Guidance has been routinely updated for urological conditions by the National Institute for Clinical Excellence (NICE). Of note are:

- 'Improving Outcomes in Urological Cancers'[70], published by NICE in 2002. This set out how Urology services should be delivered including a specification for MDTs.
- The National Cancer Intelligence Network set up in 2008 (now the National Cancer Registration and Analysis Service) advocated service specifications for Urology cancers with data and tools to support their development.
- Cancer Commissioning Guidance[71] published in 2009 set out the key considerations for the commissioning of prostate, bladder, renal, penile and testicular cancers.

11.22 Cancer Networks and Cancer Alliances were set up to support the delivery of the Cancer Plan. Their role was to oversee the commissioning and provision of cancer services, compliance with NICE guidelines, peer review and MDT monitoring[72]. There was funding for a lead GP for cancer in each PCT.

11.23 This led to a shift in service provision between the Trust and other tertiary centres as the implementation of the Cancer Plan took place. More specialist provision was provided away from the Trust.

11.24 The Scheduled Care Group/Elective Care Board was established in 2011. This has continued as a joint forum between MBCCG and the Trust for the oversight of

[69] https://www.thh.nhs.uk/documents/_Departments/Cancer/NHSCancerPlan.pdf
[70] https://www.nice.org.uk/guidance/csg2
[71] https://webarchive.nationalarchives.gov.uk/+/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_092051
[72] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216205/dh_131669.pdf

the commissioning of elective care services and the implementation of service developments and improvements. We have reviewed the meeting papers provided for the period from 2011 to 2017. The group has managed an extensive work programme including care pathway development, service improvement and performance monitoring of cancer waiting times and referral to treatment times (RTT).

11.25 However, the work programme set out in 2013 was unmanageable as it covered over 40 projects. The group has tended to focus on projects relating to outpatients, referral management, 18 week targets and cancer access targets. Since 2017/18, the workplan has concentrated on a smaller basket of priorities to support delivery of BCT (which made no specific reference to Urology, other specialties or to cancer plans). There has been some important work at specialty level on pathway redesign, but there was an absence of any specific programme for Urology. Instead, the Trust developed plans for the reconfiguration of Urology services due to the pressures on the six Urology Consultants covering all sites. The proposal was for non-elective services to be provided from RLI only, with clinics and elective activity to be maintained at FGH and Westmorland General Hospital (WGH) but this was not progressed.

11.26 The Lancashire & South Cumbria Urology Network Site Specific Group (NSSG) was established in 2015. The network produced care pathways for kidney, bladder, prostate, testicular and penile cancers. Commissioners are not members of this group, and it was unclear from documentation reviewed whether or how their work routinely came to the attention of commissioners. The Trust's Cancer Strategy Action Plan (2013-16) indicated that Trust teams work with the NSSG

11.27 In July 2018, the NHS Getting It Right First Time (GIRFT) programme, published a report[73] on Urology services which made recommendations to improve care pathways. There is no evidence that MBCCG considered the work by GIRFT in Urology for commissioning or oversight purposes until after concerns were raised in 2019.

11.28 The BCT Strategy refresh in 2019 does reference Urology as a '*fragile service*' due to concerns over staffing levels and site cover. It states that consolidation was likely based on a 'centre of excellence' model but does not commit to any firm plans. The Strategy refers to new care pathways for prostate cancer, working across the system to increase capacity to eliminate 52 week waits, and the better management of outpatients. There is no reference in the plan to how CCGs will maintain oversight of Urology performance improvement plans.

11.29 In June 2020, the Trust approved a proposal to implement a new model for out-of-hours emergency care in Urology. The Trust has engaged with the commissioners on these plans, but implementation has been delayed due to the need for further work on cover arrangements and the impact of Covid-19.

11.30 The GIRFT work continues in Urology; its most recent report and self-assessment toolkit for Trusts (A Framework for Re-establishing and Developing Urology

[73] https://gettingitrightfirsttime.co.uk/wp-content/uploads/2018/07/GIRFT-Urology.pdf

Services in the Covid-19 Era[74]) was published in September 2020. This provides another good reference point for commissioners.

Awareness of Urology issues

11.31 Commissioners have struggled to embed a robust governance framework for the quality oversight of the Trust's services. Arrangements have not been effective in identifying 'red flags' or potential systemic issues in this Trust. Upon refreshing the framework in 2020, MBCCG referred to these challenges:

'The CCG's collective capacity has often been steered to respond to external motivations such as, inspection, regulation, targets and performance with little resource left to bring about improvement "from within" and "across" the system.'

11.32 There have been many changes in the arrangements for contract performance and quality governance (see Appendix 7), made even more complex by the joint working between the PCTs/CCGs. Over the period 2013 to 2019, we found much duplication of discussion and content relating to quality and performance between the various contract meetings, the Elective Care Board and the Quality Improvement Committee. There was no clear, documented mechanism in place for the sharing and escalation of issues from and between these groups.

11.33 The main forums for the quality oversight of the Trust's services by commissioners were the Contract Quality and Performance/Assuring Quality[75] Meetings (meetings between the Trust and the PCTs/CCGs). Other key elements of quality assurance described in MBCCG's framework are assurance visits to wards/departments, the CCG Serious Incident Review Group, the NHS England and NHS Improvement led Quality Surveillance Group and other soft intelligence. Reliance was also placed on CCG attendance at key Trust meetings including their Quality Committee and Serious Incident (SI) Review Group[76].

11.34 We have reviewed the papers of the Quality Improvement Committee (QIC) for NLPCT and subsequently MBCCG from April 2013 to May 2020. We did not receive any Quality Committee papers for North Cumbria PCT/CCG prior to 2017.

11.35 In Appendix 9, we list the references to Urology found in meeting papers to provide a flavour of the extent of discussion. We have listed references between 2013 to May 2019 before the CCG became aware of the whistleblowing concerns as after this there was a more reactive focus placed on Urology. We found 19 references in the Contract Quality and Performance meetings and three references in the QIC across six years.

11.36 Our observations based on records in minutes and action logs are as follows:

- There is no evidence of any awareness of the emerging issues in Urology. From 2012 to 2019, there are various Urology references including, peer review feedback, follow-up appointment waits, RTT performance, the outpatients backlog, the testicular implants recall and the failed implementation of the prostate pathway. No links were made between these issues to trigger any scrutiny on the service as a whole. However, we can see attendance by the Midlands and Lancashire Commissioning Support Unit (MLCSU) on behalf

[74] https://www.gettingitrightfirsttime.co.uk/wp-content/uploads/2017/07/A-framework-for-reestablishing-and-developing-urology-services-v1.0-4-Sept-2020.pdf
[75] The name of this forum changed to Commissioner Assuring Quality Meeting in August 2020
[76] Serious Incident Group (SIG) from 2017

of the CCG at SIRI panel in September 2016 where the interpersonal difficulties are clearly referenced.

- A service and clinical records review in Urology, commissioned by the Trust and undertaken by the Royal College of Surgeons (RCS), was first referred to in the October 2015 Assuring Quality Meeting: this was not followed up by commissioners. Its findings were reported in January 2016. This report referred to serious failings including cultural and relationship problems. There is no record of the report being shared with commissioners and we found no evidence of commissioner oversight of the resulting actions until the further scrutiny of Urology in 2019.
- There was no mechanism to draw together the pockets of intelligence on issues in Urology into a cohesive picture of the specialty. There was also no triangulation of intelligence: for example, clusters of incidents in a specialty which might lead to questions about waiting times and capacity.
- Performance reporting focused on numbers rather than trends and commentary to provide insight. There was a distinct absence of specialty level information. On the rare occasion when more detailed analysis was requested, Urology tended to be subsumed within General Surgery.
- The focus was on issues which cut across specialties, and which mainly affected the Primary Care interface: for example, the outpatients backlog, and the quality and timeliness of discharge summaries. There was no 'deep dive' into the specialties involved in these long-standing issues.
- In our opinion there was a lack of professional curiosity and probing about the potential clinical hotspots for persistent cross-cutting problems, for example 'unsafe discharges' were referred to in November 2009 and February 2018; a GP complaint in September 2010 described a system '*in chaos'* with a '*couldn't give a damn attitude to clinical governance'*; in October 2011, GPs referred to the outpatients backlog as a regular occurrence but this had not been raised previously.
- We found no evidence of an assurance visit by commissioners to the Urology department/wards other than by MBCCG in December 2019. Assurance visits had not been systematically undertaken and this was recognised in the QIC in 2018.
- There was no reference to the higher rate of surgical complications in nephrectomy surgery at RLI in 2016 (these were identified in 2019 as part of the 'deep dive' process and this specialist surgery ceased to be undertaken by the Trust).
- There was duplication on elements of performance oversight within the Elective Care Board, the minutes of which were not routinely received by contract monitoring or quality assurance forums.
- Risk registers did not refer to concerns in Urology. There was no consistent mechanism for escalation of concerns and sharing of information between the various meetings. Action logs were typically about process. Reliance was placed on verbal reassurance from the Trust and CCG staff rather than evidenced assurance on completion of actions.

11.37 The Trust's Integrated Quality and Performance Report (IQPR) was provided to some contract meetings although not consistently. Over the period from August 2016 to February 2019, there were some hotspot references to Urology including in relation to:

- the reconfiguration of clinics to increase capacity;
- 62 day and 104 day breaches;
- Clinical Nurse Specialist (CNS) vacancies and Consultant sickness affecting performance; and
- capacity issues affecting the prostate pathway and the subsequent failed implementation of the pathway due to staffing problems in 2018/19.

11.38 However, there is no evidence in the minutes of any discussion on these points.

Serious Incidents

11.39 Prior to 2009, oversight of SIs was the responsibility of the SHA. The Kirkup Report referred to the developmental and '*hands-off*' approach by the North West SHA. Responsibility for SIs transferred to PCTs in 2009.

11.40 Information on incidents has been presented to the QIC, Contract Quality and Performance Group (CQPG)/Assuring Quality Meeting and the local Quality Surveillance Group through a combination of Trust information and CCG reported information.

11.41 The Trust's reporting to commissioners on serious incidents has been weak. It has been sporadic and high-level with a focus on the analysis of numbers with a distinct lack of analysis of trends, themes, learning and actions for monitoring. We found no routine analysis by specialties, which could only be identified in the individual descriptions of the incidents. On occasions where there was analysis by care group, Urology was subsumed under General Surgery.

11.42 Similarly, summaries of Strategic Executive Information System (StEIS) incidents from commissioners do not provide a level of insight that enables identification of problem areas. This is exacerbated by the lack of inquisitiveness into the areas where incidents relating to cross-cutting themes may be occurring: for example, delayed diagnosis and treatment. The quarter 2 Serious Incident report 2017/18 highlighted two Never Events in surgery, but the minutes of the QIC do not reference any discussion of these incidents.

11.43 Before 2013/14 when Datix was introduced for incident reporting for Primary Care, GP practices were required to submit a 'significant event analysis'. There was no system to routinely collate and evaluate these. This is concerning as there are Urology specific incidents which have not been followed up. For example, in 2009, a survey by Lancashire County Council highlighted some incidents of particular concern:

'An older gentleman with learning disabilities underwent a hernia operation. On examination by his GP, it was discovered that one of the patient's testicles had been removed without his prior knowledge or consent.'

'An older person, who was awaiting an outpatient appointment for a prostate condition, had been left with a catheter in place for 28 weeks despite being told that this should only be in place for up to 13 weeks.'

11.44 More recent examples of poor oversight of incidents includes in the December 2017 QIC when a Never Event in Urology at RLI is referred to. This involves a patient attending an outpatient follow-up appointment where it was identified that a procedure had been undertaken on the wrong patient. The minutes state '*This instance is being reviewed and the catalogue of errors being investigated'.* However, no further discussion or follow-up is evident.

11.45 Also, at the Assuring Quality Meeting in August 2019, reference was made to 18 Urology incidents in 2014 with a cluster relating to stents. These were only picked up following the Urology deep dive in 2019.

11.46 Discussion in these key meetings has tended to focus on processes and the challenges in obtaining reliable information rather than the incidents themselves. There has also been a reliance on members of CCG's quality teams attending the Trust's internal SI review meetings with no structured feedback to CCG's quality governance forums.

11.47 In October 2015, NHS England introduced a policy managing long wait cancer patients with specific requirements for 104 day cancer breaches. This was discussed at the Assuring Quality Meeting (AQM) in July 2016 and following a request by NHS England for assurance that no patient had come to any harm because of 104 day waits, the Trust provided verbal reassurance at the AQM in March 2017 which was also reported at QIC in April 2017.

11.48 To support compliance with the policy, a checklist was developed by the Cancer Alliance for completion by the Trust which set out the CCG and Trust's responsibilities regarding 104 day cancer breaches. The Cancer Commissioning Clinical Lead is recorded as confirming that the Trust were compliant with the policy through the Cancer Alliance backstop policy checklist in May 2018 (See Appendix 4)[77].

11.49 There has been some limited commentary on 104 day breaches in the AQMs and at the QIC since 2017/18, however, the focus is again on process compliance rather than understanding why these breaches occurred and on actions to address them. For example, breaches for Urology were reported in January 2018 and the commentary stated *'Rapid reviews and RCAs are underway. Once those are finalised, they will be forwarded to MBCCG'.*

11.50 In July 2018, a Checklist for Backstop Policy Template was completed by the Trust and the Lancashire and South Cumbria Cancer Alliance which signed off the 104 day cancer breach process. The meeting was not formal but the Trust state that all representatives at the meeting agreed the process. They also maintain that it was verbally agreed with MBCCG and the Cancer Alliance that they were not required to complete a root cause analysis (RCA) for all 104 day cancer breaches. The Trust, in line with this agreement, introduced a new 104 day incident pathway in December 2018 defining the process for review of patients who had breached the 104 day backstop position, but that only patients whose harm was assessed as moderate, severe or resulting in death would require an RCA. This agreement was not formalised with the alliance and was in breach of the national policy which requires all long waiting patients to be the subject of an individual RCA.

[77] Backstop policy checklist question May 2018 position statement: The Commissioning Clinical Lead would be expected to confirm with the provider the actions taken as a result of the SI, as part of its overall existing process?

11.51 We noted an additional requirement in the Trust contract quality schedule for 2019/20 to provide an annual report to the CCG which provides a review of SIs where there is a repeated theme in three or more instances, for example, failure to escalate or delayed diagnosis. This was a helpful addition, but this has not been fully implemented in either the serious incident annual report in 2019/20 or in 2020/21. There is no thematic review in the annual report in 2020/21. Increased frequency of this type of reporting would be helpful to the Trust and also the commissioners, although we note that the Urology Assurance Report to the QIC in February 2020 refers to the continuing difficulties experienced in reporting incidents and identifying serious incident themes in a systematic way.

Complaints

11.52 Oversight and monitoring of the Trust complaints by the commissioners has historically been weak largely due to the quality of reporting provided by the Trust. This has been highlighted by the CQC and referred to in the Kirkup Report.

11.53 Complaints monitoring became part of commissioners' responsibilities as part of the NHS contract from 2009. Accordingly, in July 2009, minutes of the NLPCT Quality and Performance Meeting indicate that developmental work was being undertaken with the Trust to establish complaints monitoring. A quarterly report on incidents, complaints and claims was provided by the Trust in December 2009. The complaints information analysed numbers and complaint types but did not include departmental or speciality analysis. Complaints reporting from the Trust then became sporadic despite the PCT periodically requesting more information and trend analysis. This unsatisfactory situation continued with commissioner oversight covered by attendance at Trust meetings where complaints were reported.

11.54 A revised complaints report was provided in December 2012; complaint numbers were broken down by division and specialty, but Urology was subsumed within General Surgery and Outpatients.

11.55 During 2013, it was noted in the February CQPG that the outpatient backlog issue had not been identified through complaints. In our view, the inability to pick up the backlog by commissioners was partly due to the absence of a robust system for reporting GP complaints relating to the Trust; these tended to come through various routes with many being verbal reports. This was subsequently addressed through Datix reporting for General Practices during 2013/14. However, commissioners did not analyse this information at the time; instead, it was provided to the Scheduled Care Group to be fed back to the Trust's operational and quality groups.

11.56 In March 2014, reports were received from the Trust for December 2013 and January 2014 which listed all complaints by division and type. The analysis was poor, and recommendations were sparsely populated. Urology was included in General Surgery, so it was not possible to identify which specialty most complaints related to. However, it was possible to identify three complaints for Urology through the descriptions given:

- July 2013 - a diagnosis issue due to a Pathology testing error and lack of MDT Pathologist cover.
- November 2013 - maladministration of treatment; a Urology Consultant was to be supervised by specialist clinicians on template biopsy.

- November 2013 - regarding attitude and clinical treatment, a patient had been discharged without being given a full explanation of their treatment.

11.57 The frequency of complaints reporting decreased further with the Trust's annual standard complaints reports provided. These were not at a granular enough level to identify any themes relating to Urology. Verbal updates on complaints were provided by the Trust but we found no evidence of questions from commissioners about specific complaints, clusters or actions being taken. This is perhaps understandable given the poor standard of information provided by the Trust, although in our view there should have been further efforts by commissioners to improve this. In June 2018, the QIC minutes record continuing concerns on assurance about complaints.

11.58 Urology complaints were only examined in detail from October 2019 onwards when commissioners started to look at links between complaints, incidents and claims as part of the deep dive work. Complaint information has also been provided to the Urology Task and Finish Group which MBCCG attend and through the Trust's Safe Today Report.

11.59 We also note that the 2019/20 contract requires from the Trust '[a] Complaints monitoring report, setting out numbers of complaints received and including analysis of key themes in content of complaints.'

Current arrangements for Urology oversight

11.60 Issues in Urology surfaced in July 2019 and then became the main topic of discussion at MBCCG quality oversight forums. There have clearly been efforts to re-establish effective quality governance arrangements and the framework was refreshed in November 2019 with the latest version[78] set out in a paper which went to the QIC in August 2020. This gives a specific example of how the structure would work for oversight of Urology. The governance structures are provided in Appendix 8.

11.61 The structures described are comprehensive but complex as they incorporate arrangements for system level and regulatory oversight. They show confusing two-way lines of reporting between committees and groups so the escalation routes through to the QIC and Governing Body are unclear. We would expect the governance relationships for escalation in a structure chart to feed upwards as distinct from information which would flow both ways.

11.62 The Elective Care Board (which provides one of the few sources of intelligence at specialty level) is shown as a system level forum rather than a way of providing intelligence to CCG governance.

11.63 For additional context, the Assurance and Accountability Framework for the MBCCG (version 0.10) which was presented to the Quality Committee in August 2020 recognises this complexity and also acknowledges the value of system level forums as a way of providing additional insight on safety and quality. The framework states:

"The CCG exists within a complex structure of organisations and partnerships which can at times of heightened monitoring confuse responsibilities and lines of accountability. The CCG is currently working with Bay Health and Care Partners

[78] Quality Improvement, Assurance and Accountability Framework for the CCG v0.10, June 2020

(BHCPs) to implement governance structures that are coherent, unified and enable the CCG to collectively oversee and manage the quality and performance of commissioned services. We also recognise through the evolving Integrated Care System (ICS) approach to partnerships there will be improved assurance and accountability structures being developed in the coming months. We look forward to utilising the BHCPs and ICS lens to help to generate a system-wide perspective to issues and when necessary, a refreshed approach to resolve."

11.64 The paper itself is helpful on setting out the multiple information sources, assurance processes and soft intelligence to be used to inform commissioning oversight. However, there is not enough definition in the accompanying paper on the roles of the different groups, reporting required, how issues are escalated, and which group is responsible for action when issues arise. Also, we note that the approach and content is very similar to the framework presented in 2016[79] when the area of focus was Maternity services, with incidents and complaints not specifically referenced as intelligence sources. It is therefore difficult to envisage how the revised framework will fundamentally change the way commissioners scrutinise performance at a specialty level and obtain an understanding of the challenges facing specific services.

11.65 While there is a clear reliance on MBCCG attendance at Trust quality forums for assurance, this requires discipline in terms of documented feedback to internal CCG governance arrangements. The CCG attends:

- The Urology Task and Finish Group which considers regulatory, safety, quality, finance and workforce information on the service through the Safe Today Report which was introduced in October 2019. We noted some weaknesses regarding this report in our Draft Current Controls Assessment Report.
- The Urology Service Improvement Group which looks at operational and service configuration challenges such as the out-of-hours emergency cover business case.

11.66 An assurance visit was made by MBCCG to the Urology service in December 2019. This identified several areas of concern including delayed diagnosis and inappropriate discharges. The paper did not describe the formal mechanism for escalation of such issues into the governance structure and some of the proposed actions are weakly articulated and internalised, for example *'work with matron'.*

11.67 Since January 2020, additional external governance support has been established through the NHS England and NHS Improvement led Urology Oversight Group (UOG). The CCG provides a detailed progress report to the UOG which includes an update on the CCG's approach and its areas of focus for Urology assurance. It provides an action plan with an assurance score in each area alongside commentary as evidence for the scoring. Appendix 10 shows the summary heat map (for July 2020) the CCG uses to RAG[80] rate its view of the level of assurance they have in each area. The heat map is also shared with the QIC and provides an effective way of summarising the work underway with the Trust for UOG oversight.

11.68 We make the following observations on this progress report for July 2020:

[79] Framework for University Hospitals of Morecambe Bay, June 2016
[80] Red, Amber, Green scoring

- The clarity, logic and impact of this report could be strengthened by removing repeated contextual and descriptive information from actions which tends to distract from the core messages on progress made.
- There are several areas where assurance scores have not improved over the period from January to July 2020, including the RCS action plan, RTT, medical vacancies, plans for out-of-hours cover, stent-related incidents, follow-up of results and SIs. We note that the latest report refers to Covid-19 pressures impacting on delivery plans. The rationale for changes in scores is not always sufficiently articulated: for example, regarding the RCS action plan, the report states:

'The Trust have reviewed their approach to action improvement plans across the Trust including Peer Reviews. The level of assurance remains at 2, over the next three months the CCG will monitor assurance of sustainability of actions'.

- The report provides reassurance in the main rather than evidenced assurance. It does not clearly explain the additional actions being taken by the Trust or the enhanced assurance mechanisms employed by the CCG. For example, for SIs, the report refers to assurance processes which are already established and which have not previously been effective in identifying issues in Urology:

'All StEIS reportable incidents are discussed at the SIRI […] panel. All moderate or above harms and moderate near misses are discussed at the Weekly Patient Safety Summit. The level of assurance will remain at 2, the CCG will continue to engage in the SIRI panel to gain assurance.'

11.69 The Trust had raised its concerns on the pace of progress in some areas with NHS England and NHS Improvement who subsequently undertook a Quality Risk Profile Exercise with the Trust. A multi-agency single item Quality Surveillance Group was held on 10 September 2019 including attendance by the CCG. A regional oversight group was then established. This stalled with the Covid-19 outbreak but was picked up again in summer 2020 and closed in September 2020. The CCG was then tasked with monitoring risks through normal assurance processes.

Regulators and external agencies

11.70 The Royal College of Surgeons (RCS) has an advisory remit to be invited to review the clinical performance of a surgical team. It did this in the Urology invited review in January 2016. However, as the organisation has an advisory status it has no powers to enforce actions i.e. there is no formal process by which the Trust is held to account for implementation of advised resultant actions.

11.71 The GMC has powers to review individual Consultants but not the whole team, and there is little evidence of a connection with the RCS on tackling team performance issues that arise from fitness to practice processes.

11.72 The CQC does not intervene on individual performance issues or on individual patient cases either.

11.73 A lot of external activity has occurred between the various regulatory bodies in respect of clinical quality, but this has not been effective in successfully supporting the Trust to effectively tackle the Urology team and its dysfunction.

11.74 Also, delays have led to difficulties in concluding cases. For example:

- It took from November 2014 when it was initially decided a clinical case review was required by the Medical Director for it to be commissioned in October 2015; then until March/April 2016 for the Trust to identify and provide the records to the RCS; and for a report to be completed in September 2016 to support the MHPS process. This delay was largely due to the difficulty in identifying a fair and balanced cohort of cases for review. During this time, the individual was restricted in practice which fundamentally affected his performance and meant that reporting in September 2016 on cases relating to practice three years previously lacked contemporaneous evidence.
- In the case of one patient it took four years for the Trust to commission an independent review and a further three years before the GMC determined no further action would be taken (January 2008). This was from a referral relating to a concern in 2000/2001.
- Following formal referral, it took a year for the NCAS assessment to take place for Consultant Urologist 2 and a further two years to arrange retraining at a host site.

11.75 The failure to address concerns in both internal and external processes in a timely fashion had a mitigating impact on the cases presented by individuals as they were unable to demonstrate competence or develop their skills. Consultants refused to work with other Consultants in some procedures and the combination of these factors increased the difficulty for regulators to take decisive and reparatory action in supporting medical staff back to competent and effective practice.

11.76 Dysfunctional relationships and issues being linked to the wider department also made it difficult to determine whether clinical practice was deficient for individual Consultants or due to systems and governance failings.

11.77 In our view, there was an element of ‘it is another agency’s responsibility’ and ‘we have done our bit’. As a result there was no clear picture of the Urology department difficulties across the CQC and other regulatory bodies to support their interventions and improve patient safety. The only actions that were focused on the specialty were not enforceable as they were advisory in nature. We are also of the view that the failure by the Trust to provide validated, properly investigated incidents including to regulators contributed significantly to the lack of a rounded view which would support clear and targeted improvement. This was complicated by the lack of escalation and decisive intervention through the combined responsibilities of the Responsible Officer and Medical Directors.

General Medical Council (GMC)

11.78 Between 2001 and 2006 there were five referrals to the GMC from patients and/or members of the public about four Consultant Urologists. All cases were closed with no action. From 2010 additional anonymous complaints began to be made to the GMC.

11.79 The GMC were informed of concerns relating to Consultant Urologist 2 in 2006. Prior to this, the Trust had largely managed these issues internally before working with the National Clinical Assessment Authority (NCAA) to assess his performance and arrange retraining. However, there were significant delays in arranging this retraining and at one point the NCAA assessors determined that they could not reassess him given his restricted practice.

11.80 The role of GMC Employer Liaison Advisor (ELA) was introduced in 2013. 25 meetings have occurred between the ELA and the Trust (the Responsible Officer, the Revalidation Lead and the Medical Director) between 2013 and 2020. Since 2015 three formal meetings have been held annually in line with normal processes but despite the significant levels of concerns apparent. The ELA was available to give advice outside these formal meetings and there was additional communication predominantly between the ELA and the RO to discuss matters arising. The meeting has included HR representation only since April 2017.

11.81 The Trust did not refer any other Consultants to the GMC until a referral of Consultant Urologist 2 in 2017, despite the myriad of safety concerns arising. The information we have been provided with indicates that referrals were made either by peers or through complaints from patients or members of the public.

11.82 During this review, we have been struck by the (at times significant) delays in internal Maintaining High Professional Standards (MHPS), National Clinical Assessment Service (NCAS), GMC and Medical Practitioner Tribunal Service (MPTS) processes. We are particularly struck by the lack of referral by the Trust to report individual Consultants to the GMC, to liaise with the GMC when repeat issues occurred and to leave peer Consultants to repeatedly refer each other to this statutory body. We recognise, however, that the lack of timely referrals to the GMC by the Trust was complicated by an absence of incident reporting, inaccurate incident reporting which lacked wider context, in combination with inadequate investigations to determine specific facts which would support reasons for referrals. A number of internal MHPS processes also found mitigating circumstances for some of the incidents on completion e.g. Consultant Urologist 7 in November 2012, December 2013, January 2014 and Consultant Urologist 2 in relation to a patient.

11.83 Whilst we do not directly challenge the final decisions made through MHPS processes, the MPTS and by the GMC, we are concerned by some aspects that highlight the poor governance in place at the Trust that impacted individuals and the team to a significant degree. For example, there were no RCAs for two of the three cases in 2014 on which Consultant Urologist 2's June suspension by the Trust was based, and the sequence of events relied upon in relation to one case (wrong site surgery allegations that still persist in public reporting today) were later found to be inaccurate. Not having the full information around individual events when used for disciplinary purposes is a risk to individuals and the organisation.

11.84 GMC investigations focused on individual performance aligned to Good Medical Practice (GMP). In our view, there has been limited attention paid to the aspects of GMP that examine the requirement to work professionally with colleagues. It may be that these issues have been mitigating factors in decisions to close cases but this has not been explicit in the documentation we have seen. This investigation has shown that whilst there were individual errors and poor clinical judgements, the safety issues were fundamentally down to the failures in team working and wider system issues. It appears to us that the GMC had limited powers to be able to adequately review the wider context in which individuals are working and whilst we do not directly challenge their decisions, the performance of Consultants is significantly impacted by the environment in which they work. Whilst we understand that systems have been developed to consider a wider variety of information sources and frameworks (such as a Patient Safety Intelligence Forum, the Emerging Concerns Protocol arrangements and regional meetings hosted by

NHS England and NHS improvement) there remains no GMC power to examine a team's performance.

Care Quality Commission (CQC)

11.85 The CQC was unable to provide this investigation with detailed written information on their work and we have had to rely on information provided through other sources to assess the timeline of intervention. However, key points arising from our engagement with the CQC are as follows:

- The RCS Invited Service Review report was not shared with the CQC by the Trust at the time it was finalised. It was, however, shared with them by Consultant Urologist 3 on 21 April 2016. As part of pre-inspection information sharing requests sent in July 2016 from the CQC, they were informed by the RCS on 4 August 2016 that an Invited Service Review and Clinical Record Review had been conducted into Urology and a report was available. The notes of the August 2016 CQC engagement meeting with the Trust refer to the CQC having received the report.
- The RCS action plan was not kept up to date by the Trust.
- There was difficulty securing assurance from the Trust to the CQC on actions being completed generally.
- There was a view that there was a clear divide in the Urology team on race lines.
- Kirkup remained a legacy and was still blamed for issues in the Trust.
- The CQC had concerns about Duty of Candour, the complaints process and the quality of RCA's and involvement of families in investigations.

11.86 A report by Grant Thornton[81], commissioned in June 2013, following whistleblowing concerns relating to Maternity services, highlighted problems with the CQC's oversight of the Trust.

11.87 There is evidence of engagement meetings held regularly with the CQC from October 2015 where the Trust shared updates about Urology and discussion on the key issues occurred but records typically focus on workforce changes. The CQC state that Urology was very time consuming for about three years from the point concerns were raised by Consultant Urologist 3. But the assurances from the Trust and the scope of the CQC inspections informed by other intelligence did not result in specific inspection of the department and its problems. It is also clear that whilst there were numerous concerns being raised by Consultant Urologist 3, some of these were not always appropriate to raise with the CQC and at times were untrue. It is clear the CQC knew by 2016 that there was considerable tension between Consultant Urologists. The sequence of events and relevant references in inspection reports to subjects in this investigation are outlined below:

- June 2014 CQC inspection (on site February 2014) - reference is made to a higher number of Never Events than other similar Trusts. Notably, in our analysis there were also eight Urology incidents (four before this time and four

[81] The Care Quality Commission re: Project Ambrose, 14 June 2013

after) that, in our view, should have been Never Events in Urology but were not reported as such by the Trust.

- An initial approach was made by Consultant Urologist 3 to the CQC in August 2015. As he wished to remain anonymous, the CQC stated they would make discrete enquiries. In September 2015 further issues were raised by Consultant Urologist 3 to CQC. These were discussed at the next engagement meeting. On the same day, a Clinical Nurse Specialist also spoke to the CQC about concerns in the department.
- December 2015 CQC inspection (on site July 2015) - the inspection report noted difficulties with the quality and timeliness of the response to complaints in the Trust. CQC noted good progress with the management of Serious Incidents and stated staff had received training. This cannot be evidenced in Urology in this investigation.
- The RCS undertook an Invited Review in January 2016.
- 23 May 2016 - an anonymous letter was sent to the CQC regarding dysfunction in the Urology team.
- By June 2016 CQC were informed by the Trust that an action was being put in place following the RCS Invited Service Review.
- The CQC met with Consultant Urologist 3 during this inspection on site in October 2016 after he had left the Trust. The CQC explained to him that there were regular meetings and Urology was discussed with the Trust. Action plans that they reviewed were considered concise and effective but there is no reference to whether these related to Urology services.
- November 2016 - CQC were informed of a referral to the GMC of a Urologist.
- November 2016 - CQC inform the Trust of whistleblowing concerns raised to them of discrimination from ‘white’ colleagues. The Trust reported back that there was new leadership, more stability and quality improvements being made in the Urology service.
- December 2016 - correspondence with Consultant Urologist 3 including alleged fraud, breach of contract and other concerns. He was assured that the CQC would be monitoring the Urology department. The Trust had already reported concerns relating to laparoscopic nephrectomies and temporary stoppage of these. The CQC was also informed that the former Chair of the GMC Diversity and Inclusion Committee had been asked by the Trust to support the continuing relationship problems.
- December 2016 meeting with the Trust - CQC (Deputy Chief Inspector, Hospitals, referenced in a letter of 23 January 2017) assured that risks had been acknowledged and were mitigated through further information from the Trust.
- 23 January 2017 - the CQC stated in a letter to Consultant Urologist 3 that his need for anonymity had caused delays to processes.
- February 2017 inspection - the inspection report stated Duty of Candour was addressed and CQC considered families were communicated with and apologies given in 10 serious incidents reviewed. There was no reference which services these involved.

- In December 2018, the onsite visit for the inspection report of May 2019 occurred. The only reference to Urology is the difficulty in recruiting specialist Radiologists.

11.88 Inspection reports from 2014 make no specific mention of the Urology specialty other than an acknowledgement in May 2019 that there were difficulties in supporting MDT meetings from Radiology due to recruiting problems. Patient outcome data in relation to Urology demonstrated that Urology was not an outlier in respect of readmission rates and length of stay. It was below England average for referral to treatment times (RTT) but was still the best performer of the five specialties showing poorer performance

12. Press and media

Media handling and reporting

12.1 Concerns regarding the Urology service began to surface in the public domain in 2011 when a patient complained about the care that was given by Consultant Urologist 3 the previous year. This resulted in a referral to the General Medical Council (GMC) although the case was closed six months later without action required. Consultant Urologist 3 referred to the Trust as unsupportive over the allegations made in the press. He said that once the GMC had reported their findings to him (and the Trust) it was left to him to pursue the redaction or removal of media articles related to the complaint so he could defend his reputation.

12.2 When Consultant Urologist 3's employment tribunal started in April 2018, some media articles were published with details of cases and allegations about three 'Asian' Urology Consultants who worked in the department. Other Consultants were concerned about the patient details that had been released and stated:

'[Consultant Urologist 3] … released patients details and confidential information of their conditions and care which was reported in the media without the consent of many of the patients. This was very upsetting to the Urologists, many of the patients and their families who contacted the Trust after this publication'.

12.3 These press allegations continued in the local media, in print as well as online, and were also picked up by the national newspapers.

12.4 Although asked by the newspaper if they wanted to respond to the allegations, the affected Urologists were advised by the Trust not to respond, however, there was no organisational response to support their reputation either internally or externally. Also, no further investigations were undertaken to validate the published stories despite the other Urology Consultants believing that the articles were defamatory and against good medical practice. One Consultant stated: '*We were told that their hands were tied as a public body facing a doctor who was allegedly claiming to be a whistleblower*'.

12.5 In October 2018 another media campaign was launched by Consultant Urologist 3 with further allegations against the Trust and some of his former colleagues. This included that he had whistleblown against three medical colleagues, whom he believed were '*guilty of grave medical negligence'*, but that in response he was labelled a racist. This article contained a number of inaccuracies about the patient cases and events described (including in relation to the index case). Consultant Urologist 3 also participated on some national platforms about whistleblowing where he made direct and indirect comments about the Trust and his colleagues.

12.6 Another news item (titled '*Consultant NHS Surgeon Voted Doctor of The Year Was Forced to Quit His Job After Three Asian Colleagues Branded Him a Racist When He Raised Concerns About Their Work'*) appeared in the Mail Online and other media channels in April 2018, highlighting issues with the difficult relationships in the department. Consultant Urologist 3's book was launched in July 2019, with further articles published in local newspapers and through other media. Again a Consultant Urologist stated his concerns about the undertones of the reporting: '*Consultant Urologist 3 has only raised concerns about Asian colleagues which suggest that all his allegations are racially motivated and not about patient care. There is not a single incident or issue raised about the care*

provided by his white colleagues who were in the majority when he was working in Urology'.

12.7 On 31 July 2019, an internal email from Chief Executive 4 was published in the media stating that all patient cases in the book would be identified and reviewed.

12.8 At the same time, the Director of HR and OD asked Consultant Urologist 9 and Consultant Urologist 7 to let him know if there were specific elements of the book that they would like specialist advice on and provided them with a link to an online resource about defamation remedies and defences. We have no other evidence of further direct support to the Consultants being provided. It fell upon the Consultants themselves to inform the Trust's lawyers about which aspects they believed were defamatory. A legal note was provided via the Trust in October 2019. The final decision was to take no further action due to the inability to prove defamation and the prohibitive costs involved.

12.9 In August 2019, the North West Evening Mail wrote an article about failings within the Urology department. It named and included pictures of Consultant Urologist 9, Consultant Urologist 7 and Consultant Urologist 2 and confirmed that '*their investigation*' had uncovered '*countless errors'* made by the Consultants, with two of the most serious contributing to two deaths. Purported investigations were not based on the full versions of events as the reported facts do not concur with those identified in our investigation. Stories were selective as they omitted to include naming other non-Asian Consultants who had also been directly involved in the care and treatment of the two avoidable death cases cited.

12.10 In August 2019, Consultant Urologist 7 spoke to the local journalist in response to an incident involving a lady who was treated by him at the BMI Lancaster Hospital. The article alleged that she had not been reviewed by Consultant Urologist 7 post-operatively and that this meant that she now had to have a permanent suprapubic catheter. Consultant Urologist 7 asserted that he worked very hard and could not comment to the press on individual cases. Our review demonstrates that the article is not wholly accurate and draws links to other unrelated and inaccurate cases.

12.11 In September 2019, a newspaper article confirmed that a patient had complained to the Trust. The Trust RCA explored all the patient's questions and the GMC closed the complaint in April 2020 with no case to answer. The details of the case as reported in the media are also not fully representative of the case or that ten Urologists were involved in their care.

12.12 Also in September, there was an article in the local newspaper that described an extraordinary meeting of the Council of Governors (CoG) where governors had expressed '*very serious concerns about the shocking revelations'* in Consultant Urologist 3's book *Whistle in the Wind*. The article stated that the CoG were concerned by incidents involving Consultant Urologist 9, Consultant Urologist 7 and Consultant Urologist 2, and that the governors were also concerned about the '*cover-up relating to the inquest into (index case's) death, which we believe are criminal'*. The article also claimed that a Coroner had ruled that mistakes made by Consultant Urologist 7 and Consultant Urologist 9 contributed to the index case's death and that similar mistakes, involving Consultant Urologist 7 and Consultant Urologist 2, contributed to the death of a patient in 2011. We are concerned at the continuing inaccuracy and focus on individual aspects of the care and individuals involved.

12.13 In October 2019, Consultant Urologist 7 became the victim of death threats following extensive media coverage about the Urology department and individual Consultants. After contacting the Trust, Consultant Urologist 7 emailed NHS England and NHS Improvement stating that one-sided and continuously negative articles had been published about him by Consultant Urologist 3 and '*his [journalist] friend'* and that the threats were also due to them contacting some patients and their relatives. He believed this to be a personal vendetta but that '*racism as well as communal hatred could not be ruled out'*. He confirmed that the Trust was being very supportive by referring the case to the Kendal police and they had also briefed him about personal security measures. These threats and adverse media publicity resulted in Consultant Urologist 7 referring Consultant Urologist 3 to the GMC.

12.14 In early December 2019, it was again covered by the local press that Consultant Urologist 3 had attended an extraordinary meeting of the CoG which was also attended by Board members and the index case patient's daughters. The local press reported that an apology had been made by the Acting Chair of the Trust to Consultant Urologist 3 for what he, his family and his patients had been through. The article included that Consultant Urologist 9, Consultant Urologist 7 and Consultant Urologist 2 had been implicated for mistakes which had contributed to patient deaths as well as other incidents causing harm. This again perpetuated that it was only actions in relation to these three Consultants that were of concern; our review has shown many of the reported references were not accurate and were unfairly attributed.

12.15 In mid-December 2019, a local newspaper published another article about the Urologists and their alleged involvement in a range of clinical incidents. It named Consultant Urologist 9, Consultant Urologist 7 and Consultant Urologist 2 and referred to other cases involving some of these Consultants. The article included that Consultant Urologist 7 had made a complaint about Consultant Urologist 3 to the GMC which the Trust was cooperating with. The complaint was in relation to claims that Consultant Urologist 3 did not allow Asian colleagues to take annual leave and also to his being accused of taking drugs.

12.16 In conclusion, the media campaigns, which were often inaccurate, and which resulted from some of the issues in the Urology service have caused personal distress to many people and have led to:

- patients and their families losing confidence in the Urology service, with many current and new patients becoming worried and concerned about their own or family member's management.
- patients who have previously been treated by the Urology department becoming concerned about the care they had received and wondering whether they are one of the many cases that have been referenced in the press.
- reputational damage for individual Consultants who have not had a right of reply to the allegations that have been made against them.
- reputational damage to the department and Trust leading to increasing challenges in the recruitment of Urology staff to the department.

12.17 It is not clear how the information was known to journalists in all cases. While some elements of the publications were based on facts (some of which were only known to a small number of people), there were also many occasions where there

were inaccurate or unsubstantiated allegations made about the care delivered particularly by other (Asian) Consultants. They were not, in the main, supported by robust counter communications based on thorough investigations of the facts by the Trust until very recently.

Other publications

12.18 The publication of a book by Consultant Urologist 3 in July 2019 caused a great deal of media interest and generated income for Consultant Urologist 3 through personal sales. The book is Consultant Urologist 3's version of events. We have reviewed the 29 cases identified in the book, four could not be identified. Of the 25 cases that could be identified we consider sixteen cases to be wholly or partially inaccurate. In particular, the events involving a patient in Chapter 10 have been forensically examined as part of this investigation (the index case); our examination sheds a more impartial light on this case and the involvement of the author himself in the chain of catastrophic events. To accuse colleagues of gross negligence and medical manslaughter on inaccurate grounds is not, in our view, consistent with Good Medical Practice.

12.19 We would also bring attention to three other cases:

- One patient is a case where Consultant Urologist 3 alleges that a listing error by Consultant Urologist 2 caused a near miss. The cause of this near miss has been unfairly attributed to Consultant Urologist 2 who was exonerated after an investigation identified an error in multidisciplinary team (MDT) documentation which was not of Consultant Urologist 2's making. This case was referred to in a section of another book, NHS Dirty Secrets, with the claim that it was Consultant Urologist 2's 'intention' to remove the wrong kidney. These inaccuracies undermine the facts and complicate investigation processes.
- Another patient is a case where Consultant Urologist 3 alleges Consultant Urologist 7 and Consultant Urologist 9 planned to discharge a patient inappropriately. He alleges they had no management plan. This accusation is unwarranted and unfair. The patient did have a management plan, one which was not challenged by the Clinical Lead at the time, who also saw the patient and is not named in the book. The events leading up to this case meant that the clinical decision to delay treatment for a few weeks was, in our view, compassionate with the circumstances of the patient's condition (following major surgery under the General Surgeons) and was not likely to have resulted in a change in outcome.
- In a third patient the full version of events is not described in the media with the focus solely on Consultant Urologist 7's actions on a single day. It does not provide the details of the remainder of the care from other Urologists and a subsequent eight day delay prior to operating involving Consultant Urologist 3.

12.20 We question the motives behind the inaccurate recording of all these and other cases and consider the naming of individuals highly irregular and discriminatory.

13. Thematic and key learning points

1. Management of emerging dysfunction

13.1 Disruptive behaviours within a team impact on all staff and have been shown to cause stress, frustration and an inability to concentrate. This results in impaired communications and transfers of information between team members - in healthcare this can significantly compromise patient safety given the requirement for shared decision making and comprehensive handovers between team members to ensure continuity of care and management plans. The importance of effective team working is especially critical when employing a clinical operational model such as 'pooling' as this depends almost entirely on seamless handover.

13.2 There is significant evidence to support the negative impact that poor teamwork has on patient outcomes and that improvements in team behaviours are associated with reduced surgical mortality.

13.3 From as early as 2000, the Urology Consultant body at the Trust has displayed many features of team dysfunction including:

- Persistent complaint(s) and grievances between clinicians;
- Camps, cliques and factions;
- Undermining colleagues' professional opinion;
- Pursuit of personal agendas (including for personal gain e.g. AASs);
- Disconnection from the senior management team; and
- Failing to ensure collaborative upskilling.

13.4 This has, on many occasions, left other nursing and administrative staff compromised and they too have on occasion perpetuated the dysfunction, through allegiances to some Consultant staff, against each other and have had to adopt work-arounds rather than risking conflict.

13.5 Relationship difficulties also significantly impacted the MDT, the key forum for determining the care and treatment of complex patients; this relied on collective decision making which was not always possible given the interpersonal challenges between senior medical staff. Offers and attempts were made on several occasions to improve the dynamics of this meeting but improvements were not sufficiently targeted or sustained.

13.6 While individual members of the Executive Team were aware of the poor Consultant dynamics from as early as 2000, they did not successfully tackle the issues as they arose or understand the impact that some individual behaviours were having on the team and patients. The Trust clearly felt compromised because of the extent of the polarity of 'sides'; and not wanting to reinforce this. They were also faced with some vociferous behaviours and people who were exhibiting extreme responses to interventions potentially because of the stress they were feeling.

13.7 There were many occasions where the Trust could have intervened more decisively. As it was, the situation gathered pace and gravity and became more about the 'handling' than about the initial concerns over time.

What should have been done differently:

13.8 Organisations need to fully understand the emerging signs of team dysfunction through a range of 'hard' and 'soft' intelligence. Holistic intervention for the team came in 2019 when Interbe Consulting were commissioned to assist with their development. This was positively received but too late and interventions should have been enacted many years before, and possibly as early as 2002.

13.9 Patient concerns that were raised by individual Consultants should have been incident reported and thoroughly investigated - same causal factors (across the range of incidents, complaints and claims) could then have been recognised and addressed through more formal routes and governance channels.

13.10 Difficult relationships and their impact on individuals and the team should also have been understood and tackled, with support from the HR function, associated policies and team building exercises rather than being allowed to play out through adversarial email communications and other forms of media. Resultant action should have been timely, proportionate and consistently applied.

13.11 Consultants could then have been held to account for their poor behaviours and inaccurate reporting, to ensure that what started out as concerns for patient safety did not turn into individual blame and resultant failures to learn from events.

13.12 At the least, the pooling model should have been reconsidered at the point that it was known that relationships were becoming intractable so that any patient harms and operational issues were minimised.

Recommendations:

R1, R2, R3, R5, R7, R9, R11, R12, R13, R16, R28, R31, R38, R39, R44, R45, R46, R47, R48, R64(E), R65(E), R68(N), R70(N)

2. Whistleblowing and raising concerns

13.13 Whistleblowing remains a mechanism which is deeply problematic within the NHS. Whilst much progress has been made since Robert Francis completed his Freedom to Speak up Review in 2015 - including the introduction of national and local Freedom to Speak up Guardian(s) - there remains a significant lack of resolution in this area.

13.14 The lack of a properly accountable governance framework surrounding whistleblowing and raising concerns has left organisations trying to deal with issues locally (often utilising their own legal counsel) yet, for full probity and conflict avoidance such disclosures should, ideally, be lifted out of their immediate authority. This is not to say that NHS organisations cannot (and should not be allowed to) deal with concerns in a pragmatic and honest way, more, that it will always be challenging for organisations to demonstrate that they are not directly conflicted in dealing with such concerns, or that they have no conflicted motivations.

13.15 All too often, poor handling, the involvement of lawyers, the desire to protect reputations and the increasing involvement of social or other media leads to poor outcomes of the whistleblowing process and an increasing moral panic around whistleblowing itself. Often the act of whistleblowing becomes so much

the focus of concern that it eventually supersedes the original concern raised; it is our view that this has been the case with Urology in the Trust.

13.16 Consultant Urologist 3 believed reasonably that the disclosures in his book were made in the public interest and in 'good faith'. In publishing a book detailing these allegations Consultant Urologist 3 needed only to believe that these allegations were substantially true. In the Trust not addressing these concerns properly as they arose, they allowed an adversarial situation to develop and Consultant Urologist 3 felt the only option was to raise concerns outwardly. Whistleblowing, as an act, is precarious for all parties involved. By the time issues have been made public and start to involve the media there is little opportunity to dial back the process and to regain the opportunity to fully validate the facts when the perceived facts are already being played out in the 'court of public opinion'.

13.17 There are stories in the media of whistleblowers who have been disadvantaged and whistleblowing cases that have allegedly been so poorly handled as to become a subject of national interest. Over time the balance of public view has been distorted around whistleblowing, indeed, one rarely hears of 'successful' and well-managed cases of whistleblowing in the press.

13.18 The current framework[82] for whistleblowing neither protects the whistleblower, the organisation or the truth. Specifically, the current law does not compel organisations to properly investigate concerns, there are no legal duties of protection and no accountabilities for errant behaviours or handling. Organisations can be deeply compromised in how they act in relation to whistleblowing. It is a topic which inspires a fear of adverse media and publicity, which might open the door to a slew of other complaints and which often forces NHS leaders to go into 'self-protect' mode, especially where concerns have been raised 'on the watch' of their own leadership. For these reasons alone, cases of whistleblowing should be handled, investigated and reviewed completely independently from the outset by parties with no interests. NHS organisations are simply unable to arbitrate independently in matters of their own defence. This might also be a particularly complex matter for certain organisations, such as the Trust, which have been through significant periods of very public national criticism (Kirkup) and who have attempted to improve safety and revise their poor public image; there is a perverse incentive to protect reputations.

13.19 In his Freedom to Speak Up[83] review, Sir Robert Francis put forward the view that any obstruction of whistleblowing should be a criminal offence. Ultimately, this type of rhetoric has left organisations hide-bound in how they deal with this issue. Whistleblowers need only demonstrate that they have reasonable concerns before they make wider disclosures; this means that potentially biased, unvalidated information can be made public, with catastrophic consequences for individuals, staff and patients.

13.20 In this case, Consultant Urologist 3 initially raised a series of justifiable concerns; however, due to poor initial handling of those concerns by the

[82] NHS England External Whistleblowing Policy 2017

[83] www.freedomtospeakup.org.uk

organisation and a failure to independently validate the events, much of the narrative was able to stand as ‘the facts’. This has caused considerable harm to all parties involved, including to the whistleblower. The process of whistleblowing in this case has become deeply problematic, gathering in significant media attention, media-gaming, and even bereaved families have been drawn into matters; in this sense it has become unintentionally weaponised.

13.21 Promoting a culture where raising concerns is encouraged is not enough, it is only a small part of the process that needs to be in place to ensure there is a successful mechanism to safely surface the truth. Particularly where these truths might reflect badly upon individuals and organisations - the only protections in matters of whistleblowing and raising concerns is good governance.

What should have been done differently:

13.22 At the earliest stage when concerns were raised, these should have been thoroughly addressed in line with Trust policy. Patient safety concerns should have been consistently incident reported, fully investigated and the practice (of all clinicians) audited to ensure that standardised approaches to patient care were being followed in line with best practice guidance.

13.23 In relation to allegations regarding the conduct or competency of colleagues, at the point where these were put into writing, the Medical Director should have investigated each of these with support from the Responsible Officer and Director of People and OD.

13.24 Consultant Urologist 3 raised numerous concerns about patient safety and the competency of his colleagues (although not always using available processes) over a period of 16 years. These continued largely unchecked when he felt that he was not being listened to or that appropriate action was taken in response to the matters raised. The rationale for persistent communications from Consultant Urologist 3 should also have been established and formalised into a governance process.

Recommendations:

R8, R26, R28, R29, R31, R38, R44, R45, R48, R50, R52, R64(E), R66(E), R68(N), R70(N)

3. Having difficult conversations about race, discrimination and inequality.

13.25 Discrimination is defined as 'the unjust or prejudicial treatment of different categories of people, especially on the grounds of a ‘protected characteristic’. These includes an employee's age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

13.26 Multiple reports still show that BAME staff and staff with protected characteristics in the NHS experience being treated differently. Statistics continue to show that BAME staff in the NHS are ‘more than twice as likely to face discrimination at work’ compared to their White colleagues.

13.27 Around 1.3 million people were employed by the NHS at the end of March 2020; around 77.9% of NHS staff were White (out of staff whose ethnicity was known), and 22.1% were from all other ethnic groups combined. People from

each of the Asian, Chinese, Mixed and Other ethnic groups made up a larger percentage of medical staff than non-medical staff, and a higher percentage of junior doctors than senior doctors were from the Black, Chinese and Mixed ethnic groups. Among non-medical staff, there was a higher percentage of people from Asian, Black, Mixed and Other ethnic backgrounds in 'support' and 'middle' grades compared with 'senior' and 'very senior manager' grades (WRES data).

13.28 It is crucial that organisations are given the practical skills and equipment to reduce inequity (real and perceived) and to be able to have difficult conversations about race, discrimination and inequality. When you are not an individual who has experienced discrimination, it can be easy to (passively) say 'I am not racist' and 'I don't discriminate', without knowing fully what that means or what the impact of passivity, inaction or acceptance might be. Nationally, 2020 was a pivotal year where such passivity on discriminatory behaviour was uprooted and exposed as inadequate to combat current levels of 'systemic' or 'structural' discrimination.

13.29 Discrimination can come in many forms and is often not as overt as 'racism' or 'sexism', but perhaps as 'essentialism[84]', presenting itself in more subtle forms in the workplace; for example, in applying different principles or standards between individuals, applying differential or unequal scrutiny on their practice, or placing people last in the queue on decision making around issues such as leave allocation or work rotas. These can all be seen as 'structural' or 'systemic' issues. Unless you are an individual who has experienced these sort of 'micro-aggressions' on a daily basis it can be difficult to a) be equipped to identify this subtle but pervasive ingress and b) to be able to have competent and informed conversations about it in order for these issues to be safely surfaced.

13.30 Arguably, the Trust has done at least as much, if not more than other trusts to tackle inequality. They have had clear and positive aims in relation to this and were awarded 'most inclusive employer in the UK' in 2020. However, this Urology review shows that, over many years, in the moments where decisive action was needed to investigate and intervene around allegations of discriminatory behaviour, this was lacking and leaders seemed to develop action paralysis in the face of intractable dysfunction.

13.31 Discriminatory behaviour can be very difficult to definitively surface (particularly when structural) and often individuals are forced to state only that they 'feel' discriminated against without always having definitive evidence to support this. Allegations of discrimination are often taken very personally and are met with *profound emotional offence* by the individuals who are said to be perpetuating this behaviour. It is easy to see how quickly a polarised and emotive position can develop where individuals accused of discrimination feel a profound injustice yet are unable to see the true context and impact of actions which they perceive to have nothing at all to do with discrimination.

13.32 Individuals might have no feelings of, or any intrinsic sense that they are discriminatory ("I have Asian/Black/Chinese friends") just as the system in which they work might have no intrinsic sense of discrimination because it takes

[84] Essentialism - a belief that things have a set of characteristics which make them what they are. It is the view that certain categories (e.g. women, racial groups) have an underlying reality or true nature that one cannot observe directly.

outward ‘positive action’. However, structural discrimination is often caused by discrete forms of both *action* and (importantly) *inaction* which, taken in totality, becomes a complicit ‘behaviour’.

13.33 This is what, in our view, some Urology Consultants were trying to articulate when they raised repeated concerns about a consistent set of behaviours which had resulted in their cumulative disadvantage. This set off an emotive and polarising chain of events which ultimately lacked any psychological protections for the individuals involved (those feeling discriminated against and those accused of discrimination). This direct tension, combined with a lack of decisive intervention by the Trust allowed whistleblowing (in this case), to become weaponised and potentially some allegations of racism and discrimination.

13.34 Undoubtedly this will not be the first such occurrence in the NHS and this is precisely where the Trust must improve to promote the emotional and psychological safety of all staff (applicable to the wider NHS), whether they have protected characteristics or not. The differences between overt discrimination and structural discrimination are extensive and the latter is much more challenging to tackle. Tackling the root causes of structural discrimination must become the responsibility of every single member of staff in an organisation, whatever their background or preference. This will require significant awareness raising including individual self-reflection (tackling ignorance and passivity), improving both ‘hard’ and ‘soft’ human resources and cultural processes and vastly improving the ability for all individuals to have uncomfortable, but safe conversations, thereby getting closer to the ultimate goal of respectful inclusivity.

What should have been done differently:

13.35 Investigating and resolving allegations of discrimination is undoubtedly challenging. However, every employee has the right to be treated equally, and organisations should have the necessary procedures and policies in place to be able to deal with discrimination claims effectively and fairly.

13.36 The Trust should have taken every claim of discrimination seriously and each case should have been treated with equal attention; all allegations should have been investigated, no matter how minor they may have appeared. This would have allowed them to establish whether the claims were legitimate or more akin to defamation (i.e. a false statement intended to harm the reputation of others); appropriate, targeted action should then have been taken in line with Trust policy.

13.37 One clear way of ensuring that discrimination is not inadvertent is to ensure there is the implementation of comparable audit and equitable assessment of practice on a day to day basis and as part of investigation processes.

Recommendations:

R8, R11, R28, R29, R31, R38, R41, R45, R46, R47, R48, R52, R64(E), R68(N)

4. Decisive leadership interventions

13.38 There is evidence that an organisation’s leadership is the single biggest influence on culture. In healthcare, the quality of leadership significantly influences care provision and organisational performance. There is a proven link between good people management practices and increased staff

engagement, reduced sickness absence and improved patient satisfaction[85]; ensuring that staff are cared for, valued and supported is hugely important.

13.39 Ultimately, leadership standards are set by the Board who must themselves demonstrate the behaviours that they expect to see in their teams. The senior leadership team should have a good degree of access to the Board and senior leaders, in turn, should ensure a consistent level of holding to account.

13.40 Clinical leadership, particularly, is a challenge. Whilst medical colleges have improved training in clinical leadership and teamworking, and clinically-led models are now much more prevalent in the NHS, there are still challenges associated with this. Consultants and individuals who are very advanced in their clinical careers can operate in fiefdoms, where they offer super-specialist skills and are effectively 'managers' of their own practices. Consultants have different levels of training and experience in relation to team working and managing others and a 'fit' between individuals cannot always be assumed. Professional hierarchies will always be a factor between Consultants, who between them can apply a subtle rank and file; either hubris or subjugation can develop between parties.

13.41 Becoming a Clinical Lead does not necessarily alleviate the problems of clinical management. Indeed, in some senses this can make things worse when some Consultants perceive they are being managed by someone with lesser skills, competencies or training. Again, difficult behaviours can emerge which are difficult to manage. This is a frequent factor which sometimes makes the job of becoming a clinical leader unenviable and unattractive to many clinicians, on many levels.

13.42 The challenge of being a clinical leader should therefore not be underestimated. Particularly, as most often these appointments are often internal and one can end up managing colleagues who were once their senior or, at the least close contemporaries.

13.43 We still see significant work being required nationally to train Consultants as 'managers' too. Particularly, how to bring different working styles together to get the most from people; how to design services which are inclusive and how to manage dysfunction.

13.44 Supportive leadership and effective line management is critical for promoting health and wellbeing in the workplace. However, for long periods of time it was not clear what the role of the Urology Clinical Lead was in this regard and how this responsibility was enacted. There was also a lack of clarity around the onward escalation routes with many communications, particularly in the early 2000s, going straight to the Medical Director or Chief Executive rather than through the surgical divisional management team.

13.45 Also, when concerns were raised there was often little or no resultant action taken. This meant that poor staff relationships and team dysfunction continued unchecked.

13.46 The role of the Clinical Lead and the triangulation of line management with appraisal process and job planning was disjointed. Used well and as intended,

[85] http://whatworkswellbeing.org/product/good-work-wellbeing-and-changes-in-performance-outcomes/

these three processes are key to the balance between supporting staff to deliver their services and to manage their performance and wellbeing.

What should have been done differently:

13.47 There should have been clear line management arrangements for the medical staff. The role of the Clinical Lead should have been clearly articulated in relation to their roles and levels of authority, and staff taking up these posts should also have been supported in the workplace and developed through formal training. Particularly, that they had a clear process of escalation and access to impartial advice when these challenges started to emerge.

13.48 Strong decisive leadership was also required. Concerns raised should have resulted in decisive action and untoward behaviours should have been tackled and addressed as they arose.

13.49 The juxtaposition of line management, appraisal and job planning should have been recognised as all being key to supporting staff and Trust objectives instead of three disparate processes.

Recommendations:

R1, R2, R3, R4, R7, R8, R28, R29, R31, R39, R45, R46, R47, R48, R49, R50, R51, R52, R65(E), R69(N)

5. Demand management and specialty development

13.50 Systems have been established nationally to ensure that Consultants deliver their contracted responsibilities within set frameworks. To deliver these responsibilities, individuals must demonstrate competence and a continuous learning cycle to keep up to date with practice. This is turn ensures that Consultants are safe to lead and/or deliver clinical services.

13.51 A job plan is a prospective, professional agreement which aims to describe a doctor's duties, responsibilities, accountabilities and objectives. It also sets out the activities required of an individual over the seven day week between clinically delivered work, administrative and development activity. Job planning was introduced in 1991 and was at the heart of the Consultant Contract which was originally set out in 2003.

13.52 Medical appraisal is a process of facilitated self-review supported by information gathered from the full scope of a doctor's work. Appraisals are the professional system which helps to ensure that Consultants adhere to the requirements to demonstrate competence and reflect on their personal learning. This includes incidents and events as well as a focus on their stress and personal well-being. Job plans should inform the appraisal process to ensure that doctors are working productively and in line with the priorities and requirements of the organisation.

13.53 Despite the passage of time since its introduction, the Trust has had an inadequate approach to job planning until very recently. Attempts to undertake and implement job plans collaboratively within the Urology department failed and this meant that they were therefore not aligned to the capacity and demand required across the service. This, in conjunction with a failure to regularly undertake capacity and demand reviews, meant that requests for additional staffing were based on insufficient data and (expensive) AASs continued unchecked.

13.54 The lack of regular capacity and demand assessments, effective job planning and poor performance information in conjunction with fractured relationships and an inability to collectively discuss the service strategy contributed to their inability to develop as a specialist service. While there were some attempts for individual Urologists to take a lead on some pathways, this was resisted by some and not pursued.

13.55 Following the introduction of the Cancer Plan, some specialist work has been directed to tertiary centres and there has been an increasing sense that Consultants are being de-skilled.

What should have been done differently?

13.56 Given the focus on core Urology activity and concerns that the service is becoming deskilled but will need to attract new Consultants into the team and rebuild itself, there are areas that should be developed that are appropriate for the local community and safe to deliver as a team.

13.57 There should have been regular capacity and demand assessments based on accurate data to underpin job planning processes and supported by agreed action plans.

13.58 The Urology Team should have collectively considered whether they can provide any specialist services including, for example, female incontinence and paediatric surgery. They should also have reviewed whether any other specialist services could be developed such as Andrology or stone work as well as the management of high risk superficial bladder cancers.

Recommendations:

R13, R36, R37, R39, R40, R41, R53(C), R62(E), R63(E)

6. The importance of penetrating investigations and reviews - gaining impartial insight

13.59 The need for investigative work is required in response to incident reporting, legal processes and claims, complaints or concerns and at times for inquests. However, each of these are subject to different processes and staff are involved in a different manner depending on which process is followed. Not all these processes result in recommendations for improvement as an output (even when identified) which can result in missed opportunities for learning.

13.60 When incidents involving patients and/or staff happen, the effects can be devastating to all involved. It is therefore essential that everyone involved in the incident/complaint or legal claim is properly supported and that a just, open and transparent approach to understanding what went wrong is adopted.

13.61 It is also important for NHS organisations to use the information gained from incidents/complaints and legal processes to establish what could have been done differently or what might need to happen in the future to prevent a recurrence of the same.

13.62 The Serious Incident Framework 2015 describes the processes and procedures needed to help ensure that serious incidents are identified correctly, investigated thoroughly and, most importantly, learned from. It also confirms that the needs of those affected should be the primary concern of those involved in the response to and the investigation of serious incidents. Patients

and their families/carers must be involved and supported throughout the investigation process.

13.63 During our review, however, we found a significant number of occasions when patient safety concerns were either not recognised (e.g. 104 day cancer breaches and Never Events), or they were included in email communications, media and other publications (including the book) but not formally reported through the Trust's electronic incident system. This meant that the cases were not consistently logged or investigated.

13.64 In cases which were reported (either through the incident reporting system or via complaints), however, the investigations were mostly of a very poor quality. In both cases, this has resulted in the facts of many incidents or events not being fully understood. The importance of good quality independent investigations cannot be underestimated; the NHS has historically been poor at investigating itself.

13.65 Furthermore, recommendations resulting from investigations in the Trust were often weak, with actions not fully aligned or progressed to ensure the changes required were implemented and embedded in practice going forward. Actions have also been devised in isolation of those responsible for implementing them - which again, weakens their impact. These factors have allowed repeated events of the same, or similar causes, to occur (see Section 6).

What should have been done differently?

13.66 The Trust should have been fully aware of the guidance for reporting and investigating instances of patient harm including in relation to Never Events and 104 day cancer breaches. All actual or potential patient harms (identified through any source) should have been reported in line with statutory requirements.

13.67 All concerns regarding patient care and safety should have been logged as an incident on the electronic system and fully investigated in line with CQC Regulation 16. All patient harms regardless of source should have been recorded as an incident (including arising from inquests and legal processes).

13.68 RCA investigations should have been undertaken by experienced and trained practitioners who are impartial to the service.

13.69 Individual patient files should have been compiled for all complaints. These should have included all relevant correspondence, statements, email and letters pertaining to the process of the investigation stored in a single file held by the governance team.

13.70 Duty of Candour (from November 2014) should have been enacted, in all instances, for all patient harms.

Recommendations:

R8, R10/15/26, R27, R29, R32(E), R35, R42, R60(E), R61(E), R69(N)

7. Action planning, development, implementation and governance assurance

13.71 Effective governance is the essential conduit to good healthcare delivery; in its absence an organisation is without the necessary systems, process and controls to ensure patient and staff safety. Governance, however, is an expansive topic and incorporates multiple key elements which when working in

tandem can provide control, but when working in isolation can expose multiple gaps.

13.72 'Governance' is constituted of key domains such as Board governance, corporate governance, operational governance, clinical governance, project-based governance and strategic/partnership governance. Within all of these sits risk management, policies, training, culture, change management, reporting and audit.

13.73 At a basic level, the lack of application of good governance in this case, led to a failure to validate the facts of issues and allegations. This, in turn, allowed polarised positions to develop which led to a damaging impact upon individuals and the Trust.

13.74 There are many aspects of governance in this case which required improved approaches. These include:

- The ability of the department to collate accurate data and insights on performance;
- Lack of the ability to ascertain a position on 'harms' meant that patients and their families were not always treated with candour;
- Lack of speciality focus on reporting;
- The Trust did not recalibrate the pooling model when it was known that the operational governance model was not working;
- Clinical leadership model was insufficient and unsupported and not recalibrated when issues were known;
- Concerns did not trigger 'fact validation', the department was investigating itself - insights were not brought forward and actionable recommendations were not made;
- In turn, this meant that sustained improvement did not occur;
- Lack of decisive leadership intervention led to divisive, emotional and erratic behaviours;
- Inaction from leaders drove increased incident reporting which led to an imbalance of view on 'harms'; and
- Staff felt unsupported in raising their concerns and felt they were being targeted including requests for external, independent reviewers.

13.75 The importance of the 'chain' of governance and assurance in this case was not employed and arguably, not fully recognised. This chain is represented as:

Set standards > gain insight about performance against those standards > hold to account against those standards > take improvement action when standards are not met > check those actions have demonstrated sustained improvement.

13.76 Important to this process is how actions are devised and implemented. Meaningful recommendations and interventions can often only be derived with the benefit of an impartial view. Actions should only be developed in association with the team who will be implementing them. In this case, action planning was flawed because of the lack of availability of proper insight.

13.77 Without the availability of a clear improvement plan, an audit plan cannot be fully utilised and continued underperformance will not be triggered on an ongoing basis. There are multiple factors which contribute to 'action paralysis' and all of the above factors, when taken concurrently, will contribute to an adverse outcome such as in this case.

What should have been done differently:

13.78 Action plans should have been drawn up and monitored, by specialty, for all investigations (prioritising serious incidents, RCAs, Never Events and external report recommendations).

13.79 The role of the Quality Committee and SIRI panel in respect of monitoring the implementation of the action plans should have been enforced to ensure the Urology department could provide assurance that actions were being implemented.

13.80 Risk registers should have been regularly aligned with external reporting and regularly visited on a specialty basis involving senior department staff.

Recommendations:

R1, R2, R3, R4, R5, R6, R7, R8, R9, R40, R49, R50, R60(E), R64(E), R70(N)

8. GMC, Coronial, Tribunal and CQC processes

13.81 Concerns about doctors (and other health care professionals) can be identified in a number of ways including through performance data, Coroner's courts, serious incident reviews, claims and patient complaints. Colleagues/patients/families can also raise concerns through the Trust and other statutory and regulatory bodies such as the GMC, CQC and NHS England and NHS Improvement.

13.82 Unfounded and malicious allegations can, however, cause lasting damage to a doctor's reputation and career prospects. Therefore, all allegations, including those made by patients or their relatives, or concerns raised by colleagues, must be properly investigated to verify the facts so that these can be shown to be true or false. It must also be recognised that remedial and supportive action should be taken quickly before problems become serious or patients harmed.

13.83 Nationally, and for several years, there has been concern about the way in which complaints and disciplinary actions against doctors have been handled in the NHS; also about the use of suspension in such cases - although numbers are small, the costs of suspensions to the individual (in terms of stress) and the NHS (financially) are substantial. The National Clinical Assessment Authority (NCAA), which was established to improve arrangements for dealing with poor clinical performance, has helped to avoid or reduce suspensions but this process invariably relies on timely referrals and accurate information sharing to ensure that correct processes are enacted.

13.84 Dealing with concerns is, however, challenging. It has been evidenced through research (by the GMC), for example, that many senior staff and managers find balancing confidentiality with an open and transparent culture difficult.

13.85 Concerns regarding the care and treatment of patients, the competency of some colleagues, behaviours and conduct were raised by a range of Urology and other staff over the last 20 years. This was through a variety of mechanisms including conversations, meetings, email communications, letters,

incident reporting and referrals to regulatory and statutory bodies such as NCAS, CQC and the GMC. However, inconsistent approaches to resolution were adopted including at the point where formal interventions were required. A failure to appropriately investigate the concerns raised meant that some onward referrals (which in our view were required) were not made, others were made but not in a timely way, while yet others were made without a full understanding of the facts. It is of note that Consultant Urologist 2 was either suspended or in very restricted practice repeatedly and on one occasion for over three years.

13.86 We also note occasions when the clinical practice of individual Consultants, in particular Consultant Urologist 2, was under scrutiny. Some auditing of his practice took place but often the terms of reference for this were not stated and there were missed opportunities to also audit the practice of other Consultants. This was particularly in relation to TRUS guided prostate biopsies and travel expenses but also the RCS Invited Clinical Records review which might have been better scoped in looking at practice across the team; comparative audits of practice did not occur despite legal advice supporting this.

13.87 The development of statements for Coroners processes are not subject to any form of assurance as they are individual statements. Typically, only one Consultant is asked to provide a witness statement in relation to a patient's care. This is usually taken from the medical records. This does not however always guarantee an accurate report of all the circumstances and in this case has given rise to inaccuracy in reported facts.

What should have been done differently:

13.88 The Trust should have more consistently responded to concerns raised about the competency and conduct of all Urology Consultants. The Trust should have followed their own internal investigation and grievance policies and ensured the quality of investigations, in line with the Department of Health's Maintaining High Professional Standards in the Modern NHS (MHPS) process for dealing with serious concerns, were thorough and wide ranging as these underpinned some GMC processes.

13.89 The Trust and division should have supported working practices which emphasised the importance of doctors keeping their skills and knowledge up to date, with an open approach to reporting and tackling concerns about clinical practice. Personal and team accountabilities should have been made clear.

13.90 There should have been more comparative audits of the Urology Consultants' practice. These should have focussed on areas of concerns but also as a part of a planned approach to clinical audit to ensure that pathways and guidelines were being adhered to.

13.91 The Trust should have reopened each case shared with them in 2017 and put in place clear parameters in a transparent manner with NHS England and NHS Improvement and the CCG for these to be fully and externally reviewed. This would have indicated a willingness to listen and given all parties a fair right to reply. The detail of the events might then have been shared and agreed for learning purposes.

13.92 A review of the provision of witness statements where an individual represents the Trust or department should have been in place. Whilst we recognise that there are standard processes for the Coroner, we have made a specific recommendation in reference to this potential risk.

Recommendations:

R10/15/26, R32(E), R59(E), R61(E), R64(E), R68(N), R69(N), R70(N)

9. Triangulation of intelligence at a specialty level

13.93 In his Public Inquiry report, Sir Robert Francis concluded that 'there lurks within the system an institutional instinct which, under pressure, will prefer concealment, formulaic responses and avoidance of public criticism' and 'an institutional culture which ascribed more weight to positive information about the service than to information capable of implying cause for concern. The pressure to send 'comfort seeking' rather than 'difficult' information upwards is strong'.[86]

13.94 This supports the imperative for Trusts to triangulate and use a range of information upon which to base decisions about their service delivery options. This includes the use of hard data (i.e. information which can be measured) and soft intelligence (i.e. thoughts, feelings, observations). The latter can be challenging to collect as patients and their families do not always want to complain feeling that their care may compromised if they do so. Also, some issues are 'normalised' by staff so not readily visible, and it may be hard to distinguish the 'usual staff moans' from serious concerns.

13.95 Information at a specialty level has historically been limited at the Trust. There has been little triangulated departmental or divisional management information, with an absence of hotspot reporting to the Board. Although there was 'noise' about Urology through email communications from as early as 2000, this was not reviewed alongside any other information (such as patient outcome measures, complaints, incidents, claims, staff disciplinaries and absence) which would have allowed the Executive Team to recognise the involvement of Urology Consultants in key events or the impact that difficult relationships were having on patient care and the Urology department. There were some occasions when the performance of the Urology Department in relation to cancer targets and outpatient backlogs; however, this was associated with constraints in capacity and we can see no evidence of other team factors also being considered.

13.96 Concerns regarding the care and treatment of patients, the competency of some colleagues, behaviours and conduct were raised by a range of Urology and other staff over the last 20 years. This was through a variety of mechanisms including conversations, meetings, email communications, letters and incident reporting. However, the approach was inconsistent.

13.97 There was also very little in the way of thematic reporting. Complaints, claims, incidents and other patient feedback were not reviewed for same causal factors and learning was focused on individual events rather than systemic issues which may have affected a wider range of people and services. This impeded learning and actions required to prevent recurrence of the same. Our review of patient harms has identified a number of themes which the Trust could also have been sighted on if information had been reviewed 'in the round'.

[86] Francis R. Report of the Mid Staffordshire NHS Foundation. Executive summary. Trust Public Inquiry, 2013.

13.98 Commissioners have a responsibility to ensure that the services they commission are safe for the population. We have reported on the wholesale lack of information, specification or quality assurance at a specialty level which should have been a safety net for intervention at an earlier stage.

What should have been done differently:

13.99 The Trust should have ensured that a range of quality and performance metrics were reviewed at departmental, Care Group, Trust and CCG levels with regular thematic analysis of complaints, litigation, incidents and other patient feedback information to determine whether there were any same causal factors which could have been addressed.

13.100 The Safe Today report was introduced in October 2019 and seeks to triangulate Urology performance across regulatory performance, safety, quality, finance and workforce; however, the range of metrics and analysis in the report was initially too narrow to give a rounded picture of performance or to enable the reader to identify key emerging risks to quality and safety. This has recently been revisited and improvements noted.

13.101 The CCG should have ensured they had a sub-specialty focus as part of their commissioning outside of a Trust level/Surgical division review which sought to ensure risks at a sub-specialty level did not get lost.

Recommendations:

R1, R2, R3, R5, R9, R24, R28, R35, R39, R40, R41, R47, R53(C), R54(C), R55(C), R56(C), R57(C), R63(E), R70(N)

10. Media, messaging and conduct

13.102 Sustained inaccurate reporting in the media partly due to a lack of challenge by the Trust has brought the reputation of individuals, the Trust, and the NHS into disrepute. As a result of inaccurate and poor investigation in the Trust, events have been narrated which are now in print but contain inaccuracies. These have not been challenged - partly due to a fear of being seen to victimise a whistleblower and possibly due to an underlying belief in the narrative but certainly a lack of willingness or ability to provide an accurate version of events.

13.103 The sequence of events that became a whistleblowing story cover 16 years. It is of interest to note that the whistleblower was in fact the Clinical Lead or in a leadership role and presided over the arrangements for patient safety over a cumulative period of 10-11 years. There is a professional responsibility to be accurate and, in our view, it is not in line with Good Medical Practice to name other doctors prior to formal validation of the facts or be involved in inaccurate reporting.

13.104 This is not to say that the media can have a role in ‘accountability’ (and there have been many cases of positive media interventions in health), however, matters as complex and multi-factorial such as surgical delivery cannot ever be properly addressed in a reductive way. It is true that matters relating to poor quality healthcare can be easily scandalised and can accumulate a pace and narrative which might ultimately have only a limited basis. It is of course, not just the ‘traditional’ media, individuals can have access to multiple social media platforms to campaign and articulate their views.

13.105 Equally, it is not just the media who have a role to play in such cases, it is also MPs, the police and even healthcare regulators who can easily, without careful handling, become part of the issue of bias. In this case, for example, both the police and local MP were involved (by the whistleblower) in subsidiary allegations in relation to falsified emails. The independent investigation team subcontracted a review of these emails to two separate companies (working on a blind basis to each other) to undertake an expert review of these emails; both concluded that there was no reason to doubt the validity of the emails. However, Consultant Urologist 3 escalated his concerns to both the police and the local MP and despite the fact that the police have not taken the issue further the narrative now stands as ‘‘falsified’ emails have become a police matter”. In this sense there has been significant ‘gaming’ of the narrative and this is incredibly challenging for parties to manage.

What should have been done differently:

13.106 Any case reported in the media should have been subject to immediate and detailed scrutiny. The book cases should each have been subject to an external review and the facts validated or challenged. Whilst this investigation will go some way to achieving this the original narrative remains in the public domain.

Recommendations:

R52, R59(E), R66(E)

11. Managing the impact upon families

13.107 Individuals and families have undoubtedly been harmed as the result of some interventions of urological services at the Trust. We now know that this has been for a variety of reasons (individual, team and organisational) which have not always been reported accurately in the media. This has been deeply distressing for patients and their families and has undoubtedly caused a very public fear and loss of confidence in urology services at the Trust. This can be frightening for patients and their families who are undergoing urology treatment.

13.108 It must be noted as a form of counter-balance, that many thousands of patients have had good outcomes of care when using this service.

13.109 There are times when information in relation to cases has been made public as discussed in this report. For example, information at tribunal or at Coroner’s Court, and subsequently in the media. There are times when uses of this information has been assumed and families have not been protected by disclosures of this nature. Greater safeguards need to be in place to ensure that identifiable or near-identifiable is not used for purposes other than immediate care. Where individual cases are used patient details should always be anonymised.

13.110 There are few occasions where the organisation did undertake investigations only for this process to become protracted and mired in indecision. Certainly in the index case this led to the family waiting for over 6 years for the answers in relation to their case. Other families that we spoke to, and kindly gave us their time during this investigation, have waited patiently for answers in relation to failings, which should have been provided in a timely, transparent and reliable way.

13.111 Of particular concern, is that some families and patients have been contacted in relation to cases outside of what we feel are professional boundaries. There are

other families who have become embroiled in support of the whistleblower, who, in their bereavement required an honest and completely impartial view of the facts.

13.112 In such instances it was (again) the organisations responsibility to investigate and to apply Duty of Candour to any family who may have been harmed, we strongly recommend that this now occurs in light of the findings of this investigation.

What should have been done differently:

13.113 Timely and decisive interventions, followed by robust investigations, were needed when concerns were raised by families. Duty of Candour (where applicable) should have been triggered and families and patients given an honest, impartial appraisal of the facts. Individual professional conduct in relation to patients and families should have been upheld at all times.

Recommendations:

R8, R15, R26, R27, R35, R52, R59(E), R66(E)

12. Managing the impact on staff

13.114 The index event that set off a chain of poor relationships was the initial interaction between Consultant Urologist 1 and Consultant Urologist 2 on Consultant Urologist 2's appointment in 2000. Consultant Urologist 3, alongside Consultant Urologist 1, then became concerned about the alleged poor standards of care being provided. The protracted management of a range of concerns had a lasting impact on future relationships in the team.

13.115 The need to manage concerns relating to Consultant Urologist 2 and the relationship difficulties at play from 2000–2008 was a significant burden that impacted on the organisation's ability to respond to genuine concerns and led to protracted proceedings set in a context of perceived discrimination.

13.116 A frustration from some Consultants over the clinical actions of others and the repeated defence of those actions by the accused have not always been properly addressed through timely investigation. The department was often left to investigate itself, and the increasing importance of being independent in these investigations was lost. Individuals also investigated each other which was grossly inappropriate given the personal and professional difficulties apparent and as 'lacking due process' given the involvement of all Consultants in nearly all patient cases.

13.117 This has led to a great deal of distraction due to focus being placed on the wrong issues. The blame culture in the department has led to some incidents not being fully investigated and some events being described inaccurately. Blame has at times been unfairly attributed to individuals within a pooled model where everyone and no one was held responsible or accountable. Poor investigation and incident management processes, with undertones of discrimination and racist attitudes, have meant that errors have not been used to improve services.

13.118 The period of 2010 to 2019 has been one of distraction from examining the true root causes and failures that occurred. Systems and processes in place to hold individuals to account for clinical and professional (medical) failings were not effective. Several underlying themes affecting the team were apparent:

- A shift in specialist work to other centres due to the NHS Cancer Plan drove a degree of deskilling and some potentially territorial behaviour, so that only a small number of clinicians retained the more complex work.
- A demand for diagnostic, routine elective work which required long-term management of patients was impacted by the introduction of an electronic patient record system and structural changes that did not fulfil the needs of the department.
- An emergency workload (albeit small numbers at FGH) across two sites that are 50 miles apart, with on call challenges has led to increased stress and patient safety concerns. The elective workload spread across three main sites with long travel implications has led to punctuality difficulties, job planning disputes and numerous challenges for individuals delivering the service.
- An increasingly stressful work environment has led to disputes as individuals tried to manage work/life balance through annual leave and has driven some of the sickness absence through a lack of control of that balance.
- A focus on individual failings has distracted from the wider development of the service and the team functions required e.g. handover, MDT, workload management and practice improvement.
- An increasingly retaliatory culture led to repeated MHPS processes and GMC referrals which consumed management time, focused on individual events, failed to hear the system issues that were leading to individual difficulties and worsened team functioning.
- An unchallenged series of defamatory statements about individuals internally and externally has impacted personal reputations and enabled 'facts' to go unchecked and unvalidated. The personal impact on those against whom false allegations have been made is significant. Online trolling extending to deaths threats have been deeply distressing.

What should have been done differently:

13.119 Fundamentally, the Trust should have used all available opportunities to investigate concerns in a precise manner to validate concerns or allegations. This would have enabled fair challenge, robust defence or appropriate referrals to be made at the right time in support of staff.

13.120 External support offered throughout the last 20 years should have been enforced and individuals held to account for their engagement in these efforts.

13.121 We have been told that relationships have improved very recently with the early successes of the InterBe programme; however, these claims will need to be tested, with regular opportunities for team development, over the short to medium term.

Recommendations:

R8, R11, R28, R31, R37, R39, R45, R46, R49, R52, R62(E), R64(E), R65(E), R66(E)

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