University Hospitals of Morecambe Bay
NHS Foundation Trust

PUBLISHED INFORMATION REQUEST

Reference: 8554

Description: Urology Review undertaken by Royal College of Surgeons

Response

RCS review of urology surgery

1. Could I please have a copy of the redacted version released to the local paper The Mail in response to an FOI Act request?

   Please find attached a redacted copy of the Royal College of Surgeons Report - Invited Review Mechanism, a copy of which was supplied to the local paper The Mail.

2. Could you also send me your response to the review findings?

   A Urology Action Group was established by the Deputy Medical Director for the purpose of responding to and implementing actions to addressing the issues and recommendations contained in the report. It comprised the Service Managers for the Urology Department, the two joint Urology Clinical Leads, the Divisional Governance Lead, the Clinical Director and the Deputy Medical Director (Chair).

   The Action Group developed an action plan in response to the review. Implementation of the action plan was overseen by the Deputy Medical Director and discussed monthly with the CQC to ensure progress.

Trust Headquarters:
Westmorland General Hospital
Burton Road
Kendal
LA9 7RG
Tel: 01539 716621

CHAIR: IAN JOHNSON
CHIEF EXECUTIVE: AARON CUMMINS

PRIVATE AND CONFIDENTIAL

THE ROYAL COLLEGE OF SURGEONS OF ENGLAND

INVITED REVIEW MECHANISM

A Service Review on behalf of:

The Royal College of Surgeons of England
35 – 43 Lincoln's Inn Fields, London WC2A 3PE

British Association of Urological Surgeons
35 – 43 Lincoln's Inn Fields, London WC2A 3PE

Report on the urology surgical service

University Hospitals of Morecambe Bay NHS Foundation Trust

11-12 January 2016

REVIEWERS:

[redacted]
The Royal College of Surgeons of England

[redacted]
British Association of Urological Surgeons

[redacted] Lay reviewer

Royal College of Surgeons
ADVANCING SURGICAL CARE

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Royal College of Surgeons
ADVANCING SURGICAL CARE

1. Background to the review

1.1 On 16 October 2015 [redacted] at University Hospitals of Morecambe Bay NHS Foundation Trust, wrote to the Chair of the Invited Review Mechanism (IRM) to request an invited service review of the Trust's urology surgical service. In particular it was requested that the quality and safety of the current provision of the service be reviewed and recommendations be made for the consideration of the Chief Executive and Medical Director of the Trust as to possible courses of action to ensure that safe and high quality urological services are delivered in the future.

1.2 This request was considered by the Chair of the RCS IRM and a representative of British Association of Urological Surgeons, and it was agreed that an invited service review would take place. A review team was appointed and an invited review visit was held on 11-12 January 2016.

2. Terms of reference for the review

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

a) To evaluate the quality and safety of the current provision of urological surgical services, taking in to account:

- the service's configuration;
- the overall standard of emergency and elective care provided, including the surgical outcomes of the service;
- the effectiveness of patient care pathways including the timeliness of interventions in emergency care;
- the administrative support provided;
- the current systems of audit and governance within the Urology service and the Trust, considering whether these are effective in maintaining and improving standards of quality and safety;
- whether there is evidence of poor communication between colleagues or difficulties in team working and whether these pose a risk to quality and safety.

b) To make recommendations for the consideration of the Chief Executive and Medical Director of the Trust as to possible courses of action to ensure that safe and high

quality urological services are delivered in the future.

3. Details of surgical team beingreviewed

3.1 The department of Urology sits within the Surgery and Critical Care division of University Hospitals of Morecambe Bay NHS Foundation Trust (the Trust). Inpatient, day-case and outpatient urological services are provided at three sites; Furness General Hospital (FGH) in Barrow-in-Furness, Westmorland General Hospital (WGH) in Kendal and Royal Lancaster in Infirmary (RLI) in Lancaster.

3.2 Additional outpatient services are provided at Queen Victoria Hospital (QVH) in Morecambe and Ulverston Community Health Centre (UCHC) in Ulverston, Cumbria.

3.3 An acute urology service is provided at both RLI and FGH. These two sites are approximately 50 miles apart.

3.4 The consultant team consists of six consultant urologists:

- [redacted]

3.5 The consultant team is supported by four SAS grade doctors:

- [redacted]

3.6 There are no specialty trainees in the service. The junior doctors supporting the service are:

- [redacted]

3.7 The service is further supported by advanced nurse practitioners, cancer nurse specialists and administrative staff.

4. Royal College review team

Lead reviewer [redacted] The Royal College of Surgeons of England

[redacted]

[redacted]

Clinical reviewer [redacted] British Association of Urological

[redacted]

[redacted]

[redacted]

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ADVANCING SURGICAL CARE

[redacted]

Lay reviewer [redacted]

[redacted]

[redacted]

[redacted]

[redacted]

5. Interviews held

Monday 11 January 2016

[redacted]

Tuesday 12 January 2016

Royal College of Surgeons
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Wednesday 20 January 2016

[redacted]

6. Documents received as part of the Invited Review visit

The review team asks that the Trust keeps a copy of all the documentation listed below for their records and in order to be in a position to make it available on request to those reading a copy of this report. Once the report has been provided to the Trust the RCS will not keep a "master copy" of this information – it is for the Trust to do this should this be required for reference purposes.

Trust organisation

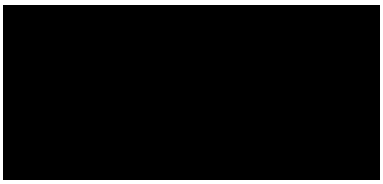
- Description of the Trust
- Trust management structure
- Surgery and Critical Care division structure
- List of Urology Department staff
- Divisional Management Board Terms of Reference

Details of the staff

- [redacted]

Appraisal and revalidation

- Description of appraisal process at the Trust
- Medical Appraisal and Revalidation Annual Report
- Sample Appraisal and Revalidation newsletters
- MyL2P (electronic appraisal provider) checklist specification
- Template email notification to staff on incidents to be included in appraisal
- [redacted]



Policies and protocols

- Urology handbook (revised March 2015)
- NICE guidance. Baseline Assessment: Bladder Cancer. Implementing the NICE guideline on bladder cancer. (NG2) (February 2015)
- Trust Antibiotic Prescribing Guidelines (November 2014)
- New Antibiotic Prescribing Guidelines- Summary of changes (December 2014)

Incidents and complaints

- List of Urology incidents, low or no harm, 2014-15
- Root cause analysis report incident number 98735
- Root cause analysis report incident number 93808
- Root cause analysis report incident number 95253
- List of Urology incidents, moderate harm and above, 2014-15
- Root cause analysis report incident number 110121
- Rapid review report incident number 112246
- Root cause analysis report incident number 104795
- Statements produced by staff in relation to incident number 104795
- Root cause analysis report incident number 98294
- Root cause analysis report incident number 95755
- Root cause analysis report incident number 95740
- List of complaints in the urology department relating to clinical care 2014-15
- Sample patient complaints and Trust responses

Activity and Outcome data

- Cross-Bay mortality data August 2013-August 2015
- Furness General Hospital Urology mortality data August 2013-August 2015
- Royal Lancaster Infirmary Urology mortality data August 2013-August 2015
- Westmorland General Hospital Urology mortality data August 2013-August 2015
- Hospital Standardised Mortality Ratio (HSMR) by procedure for Urology
- Performance targets for admitted and non-admitted incomplete pathways in Urology
- Cancer waiting times data
- Furness General Hospital Urology readmission rates
- Westmorland General Hospital Urology readmission rates
- Royal Lancaster Infirmary Urology readmission rates
- Urology performance data presented to the business meeting on 8 January 2016
- Activity dataset- April 2012- December 2015
- Lists of operations performed, by consultant, 2013-2015

Audits

- Urology forward audit plan
- Sample Urology audit meeting attendance registers and agendas
- TUVP/TURP audit 2013-14
- Prostate biopsy audit 12 March 2015
- ESWL audit (undated)
- Consultant ward round audit 2014
- Yellow form audit- urology (undated)
- Cross-Bay audit of circumcision outcomes (undated)
- Stent surgery audit (January 2015)
- Outcomes of TURBT audit (January 2015)

Morbidity and Mortality review

- Sample of six most recent M&M presentations

Unit and Divisional meetings

- Sample minutes from meetings of the Divisional Governance and Assurance Group
- Sample Urology Monthly Exception Performance Reports
- Sample minutes from Urology Specialty Business meetings
- Review of pilot MDT improvement process
- Urology team summary themes of structured interviews (conducted as part of pilot improvement process)

Documents provided by interviewees during the visit

- Letter dated 2 October 2015 from [redacted] to the urology team regarding the management of obstructed kidneys
- Undated letter from [redacted] concerning an email in relation to a dispute over the handling of an emergency out of hours
- Annual emergency turnover figures, by consultant, 2011-2014 (anonymised excepting [redacted])
- Surgical log book [redacted] May-December 2015
- Statement dated 17 October 2014 regarding an encounter between [redacted]
- Clinic letter dated 9 December 2015 from [redacted]
- Email exchange dated 10-11 July 2013 between various parties regarding the potential inclusion of a consultant's CV as an appendix to an annual report
- Undated email from [redacted] raising a clinical concern
- Email exchange dated 9 June 2014 between various parties regarding a clinical concern
- Email dated 19 October 2015 from [redacted] raising concerns over the treatment of two patients
- Summary of a meeting held on 4 December 2014 between [redacted]

- Letter of complaint dated 14 October 2014 from a patient to the [redacted]

7. Information gathered by the review team

The following information represents a summary of the information gathered by the reviewers in the interviews held during the review visit and from the documentation submitted. It is organised under the headings of the themes that emerged. The information presented will sometimes reflect the viewpoints of those individual staff members being interviewed; it will not necessarily always reflect the views of the RCS or its reviewers on these circumstances.

Service configuration

7.1.1 The review team heard from a number of interviewees that delivering the urological surgical service across a number of sites in a wide geographical area presented a significant challenge.

7.1.2 Travelling times between Royal Lancaster Infirmary (RLI) and Furness General Hospital (FGH) were said to vary significantly, but to be no less than 75 minutes by road.

Elective care

7.1.3 Inpatient care is provided at RLI, FGH and Westmorland General Hospital (WGH).

7.1.4 The review team heard that there were no urology medical staff based at WGH, but that surgeons in the team attended the site to undertake surgery on Tuesday, Wednesday and Friday mornings. The procedures undertaken on those lists were said to include Transurethral Resection of Prostate (TURP)[1] and stone removal.

7.1.5 A urology clinic takes place on Tuesday afternoons at WGH, meaning that the operating surgeon on the morning list remains on site. At all other times post-operative care for urology patients is provided by a non-urological Resident Medical Officer (RMO) and ward nurses. For this reason, interviewees reported that only the fitter patients, whose treatment was less likely to result in complications, were added to lists at WGH.

7.1.6 The review team heard that, in the event that post-operative complications arose that could not be managed at WGH, urology patients were transferred by ambulance to RLI for emergency treatment (a journey of around 20 miles by road). One interviewee reported that roughly one patient per month was transferred by ambulance to RLI from WGH to be returned to theatre after undergoing a TURP.

7.1.7 Interviewees told the review team that urology bed capacity pressures at RLI and FGH necessitated the delivery of in-patient care at WGH. A number of interviewees

[1] A surgical procedure that is used both to diagnose bladder cancer and to remove cancerous tissue from the bladder. General anaesthesia or spinal anaesthesia is often used.

expressed the view that this arrangement was safe, because only those patients likely to require the lowest level of post-operative care were listed for surgery at that site. Others reported concern over the potential risk posed to patients resulting from the absence of post-operative urological cover at WGH and were not satisfied that this risk was mitigated by the selection criteria applied when populating lists there.

7.1.8 In addition to inpatient services at RLI, FGH and WGH, outpatient services are provided at Queen Victoria Hospital (QVH) in Morecambe and Ulverston Community Health Centre (UCHC). These services were reported to be much appreciated by patients in the local area, though the review team heard that clinic slots were not always fully utilised.

7.1.9 The review team heard that, although holding clinics at these smaller sites did result in more travel for surgeons in the team, attempts were made to ensure that staff were not required to travel long distances to deliver elective care in the course of one day. For instance, a consultant might undertake a clinic at UCHC in the morning and then travel around 8 miles to work at FGH in the afternoon.

7.1.10 It was reported that clinics at the smaller sites did not always have a Cancer Nurse Specialist available to provide support and advice.

Emergency care

7.1.11 An acute urology service is provided at both RLI and FGH. Interviewees reported that around two thirds of all emergency urological admissions (around 15-20 per week) went to RLI, while the remaining third (5-7 per week) went to FGH.

7.1.12 The review team heard that there were only two ambulances available in the Barrow area, limiting the number of patients who could be transferred between the sites if only one site is providing an acute urological service.

The consultant on-call rota

7.1.13 [redacted]

7.1.14 One consultant and one associate specialist are primarily based at FGH. The rest of the team are based at RLI, though they have elective commitments at other sites.

7.1.15 The review team heard that the on-call rota is populated by four of the consultants based at RLI and the two associate specialists in the team on a 1:6 basis.

7.1.16 The surgeon on-call is responsible for providing emergency care across both RLI and FGH, as well as the daily ward round at RLI. The ward round at FGH is undertaken by the consultant based there from Monday to Friday. There is no regular ward round

led by a consultant urologist over the weekend at FGH.

7.1.17 The review team heard that, prior to that consultant moving to FGH, the consultant on call had been responsible for conducting a ward round at RLI, then driving to FGH to undertake the ward round there. This was reported to be very onerous for the consultant on call.

7.1.18 At the time of the review visit there was no dedicated consultant cover at FGH over the weekend and so foundation doctors and the RMO on duty overnight were responsible for urology patients, with the option of calling the consultant on call at RLI for the weekend for assistance as required.

7.1.19 Handover of the care of urology patients at FGH takes place each morning from the RMO on duty overnight to the consultant based there or to foundation doctors if it is the weekend. There is no handover to the consultant on call following the ward round at FGH, though they might be required to assist during the day (if the consultant based there has other duties) or overnight. On weekends patients at FGH who require urgent treatment are transferred to RLI and all urology patients remaining at FGH should have a treatment plan in place, though it was reported that a handover of those patients to the consultant on call for the weekend did not take place.

7.1.20 At RLI urology patients are handed over each morning and evening between the consultant on-call and foundation doctors shared with general surgery.

7.1.21 Handovers between consultants on-call on Friday mornings and Sunday evenings were reported to often be provided over the telephone or by email, but rarely to take place in person. A number of interviewees commented that handovers between consultants on-call often lacked detail and that disputes between consultants had arisen regarding the content of handovers when delivered by telephone and not recorded.

Staffing levels

7.1.22 Many of those interviewed expressed the view that more support was needed from senior training grade doctors. It was reported that there had previously been a dedicated urology senior training grade post attached to the service, but that funding for this had been removed because the post had been deemed to incorporate too great a general surgery component.

7.1.23 Interviewees reported that the lack of senior training grade support at FGH meant that the consultant on-call had to travel frequently between RLI and FGH, often for minor procedures, such as catheterisation and exploration of testes. One interviewee reported that he was frequently required to make the c.50 mile journey between the sites twice in the space of a day and that on one occasion he had been required to travel back and forth three times in one day.

7.1.24 Interviewees recognised that it would take time to recruit additional senior training grade support for the service. Many expressed the view that in the interim more support should be provided by the general surgical team at FGH. Those interviewees were confident that the trainee doctors in the general surgery team would be capable of providing the care that would be required of them safely with only minimal additional training. However, many were sceptical that the general surgery department would be willing to assist the urology team in this way.

7.1.25 Some interviewees also suggested that advanced nurse practitioners (ANPs) in the service could take on greater responsibilities to alleviate some of the pressure on clinicians. It was proposed that additional ANPs with sufficient training and experience could competently manage catheters and investigate suspected cases of testicular torsion[2].

Centralisation of services

7.1.26 A minority of interviewees expressed the view that acute urology care at the Trust should be centralised to RLI. It was the opinion of one interviewee that all acute and elective in-patient care should take place at RLI with the other sites offering day-case care only.

7.1.27 Those interviewees in favour of centralising the service recognised that this could cause inconvenience to patients in some areas, but expressed the view that the current configuration of the service, across three disparate sites with no senior training grade support, was not conducive to patient safety or to the health and wellbeing of staff. It was therefore the view among this group that centralisation of the service was the best option in the circumstances.

7.1.28 A larger group of interviewees opposed centralisation of the service. Most of that group were of the view that a cross-bay service should continue to be delivered at FGH and RLI with acute care provided at each site. One interviewee expressed the view that the two sites should function separately, as discrete urological units.

7.1.29 Those opposed to centralisation of the service at RLI expressed concern over the potential impact of such a change on the population of Barrow-in-Furness. There was said to be greater levels of economic deprivation and poorer health in the area than was the case for the population of Lancaster. Interviewees were concerned that many patients in the area and their relatives did not have the resources to travel such a distance. Some were concerned that patients would take longer to seek help for urological symptoms if the service was based at RLI and that their conditions would worsen as a result.

[2] Testicular torsion occurs when the spermatic cord (from which the testicle is suspended) twists, cutting off the testicle's blood supply.

Urology bed capacity

7.1.30 The review team heard that there was insufficient bed capacity for urology patients in the Trust. It was reported that there was no dedicated urology ward at any of the hospitals in which the urology service is delivered. Urology patients at FGH were reported to be accommodated on wards 4 or 5 and this arrangement was said to work well. However, interviewees reported that the lack of beds for urology patients at RLI presented difficulties.

7.1.31 Interviewees reported that urology patients at RLI were spread out across a number of wards and were often moved from one ward to another during their stay, making them difficult to find and to monitor. The review team heard that urology patients were often accommodated on wards where staff lacked the knowledge and experience to provide the specialist care they required, e.g. post-operative TURP patients.

The overall standard of emergency and elective care provided, including the surgical outcomes of the service

Performance and outcome data

7.2.1 The review team was provided with a copy of the report on urology performance data presented to the urology business meeting on 8 January 2016.

7.2.2 The report stated that the average wait for new out-patient appointments was 4.5 weeks. It also documented that the service had met the 92% completed target for referral to treatment time (non-admitted) on 20/08/2015, and had been achieving this ever since. However, performance against the admitted element was noted to have remained below target and to have become worse over time.

7.2.3 With regards cancer waiting time performance, the proportion of patients first seen within 14 days of receipt of an urgent suspected cancer referral from a GP was 98.11%.

7.2.4 98.67% of patients with cancer were treated within the urology service within 31 days of the decision to treat.

7.2.5 The proportion of patients treated within 62 days of receipt of an urgent suspected cancer referral was 92.73%.

7.2.6 The review team was also provided with mortality data for the urology service across the Trust and by individual hospital, all of which was within an expected range.

7.2.7 Readmission rates for urology patients at RLI, FGH and WGH were also provided.

7.2.8 The review team also had sight of data on emergency readmissions within 28 days of discharge for 2014-15 by clinician. The overall readmission rate for the period was

16.83%. The rates for most the consultants and SAS grade doctors delivering the service at the time of the review visit were recorded to range from 11.06%-15.35%. However, the rate for one of the consultants was recorded to be significantly higher, at 38.49%. It is difficult to ascertain these figures without breaking down the case-mix and the proportion of planned readmissions possibly included.

Interventional radiology support

7.2.9 The review team heard that a shortage of interventional radiology support available to the Trust was having a negative impact on the quality of care provided and that this was a problem in the wider region.

7.2.10 It was reported that the shortage of interventional radiologists working at the Trust meant that urology surgeons had to ring around neighbouring Trusts to seek assistance. The review team heard that at times the nearest available interventional radiology support was at Manchester Royal Infirmary, meaning that very unwell patients would require transfer there by air ambulance.

7.2.11 A number of interviewees reported that the lack of interventional radiology support available to the service forced urology surgeons to undertake retrograde stenting[3] for patients with obstructed kidneys, when a percutaneous nephrostomy[4] might be a safer and more effective treatment.

Continuity of care

7.2.12 The review team heard that, although ostensibly urology patients had a named consultant, in practice patients were 'pooled' so that they would see and be managed by whichever consultant or associate specialist was available in clinic appointments or for surgical treatment.

7.2.13 The benefits of this system were reported to be reduced waiting time for patients and a more equal distribution of work between clinicians, including the associate specialists whose work often involved covering the clinical commitments of the consultant on call.

7.2.14 However, interviewees raised a number of concerns regarding the way in which the system worked in practice and the impact it had on patient care.

7.2.15 A number of interviewees reported that delays in the delivery of patient care occurred because there was no consultant ownership in each case. It was reported that in some cases follow up appointments might not be scheduled and that this

[3] A procedure whereby a catheter is inserted that has two "J-shaped" (curled) ends, where one is anchored in the renal pelvis and the other inside the bladder, in order to free the passage of urine from the kidney to the bladder.

[4] An interventional procedure whereby a catheter is inserted through the skin of the back and into the kidney to relieve a build-up of urine in the kidney. Urine then drains urine directly from one or both kidneys into a collecting bag outside of the body which can be emptied.

could be missed because there was no one clinician with oversight of the care provided to each patient.

7.2.16 The review team also heard of instances of patients remaining on the ward without being treated while successive consultants came on duty. Some interviewees expressed the view that this was because certain consultants in the team had a tendency to put off undertaking clinical work, in the knowledge that it would become the responsibility of a colleague in due course.

7.2.17 Some interviewees reported that delays in treatment could occur because of the difficulty of accessing the emergency theatre in order to treat urology patients. It was suggested that the poor quality of handovers between consultants meant that successive opportunities to treat a patient might be missed without the consultant on duty realising the extent of the delay that had already occurred at the point at which they took charge of the patient's care.

7.2.18 Some interviewees reported that patients' treatment plans could be changed a number of times within one episode of care, because consultants in the team did not agree with one another's management decisions. The review team heard from some interviewees that some consultants in the team did not document their reasons when changing plans or when making decisions that might be considered out of the ordinary, making it difficult for the next surgeon responsible for the patient to understand previous events.

7.2.19 Many interviewees told the review team that patients were dissatisfied with the 'pooling' system. It was reported that patients frequently complained both formally and informally that they had to repeat their symptoms and history to numerous clinicians, and that they received inconsistent messages regarding their treatment and care needs. Copies of complaints of this nature were provided to the review team.

7.2.20 The review team heard that efforts were made to arrange for patients to see the consultant who had provided treatment in follow-up appointments if the patient or the consultant specifically requested this. However, it was reported that if clinic slots were not available in the timeframe in which the patient was due to be seen, the patient would be seen by someone else in the team instead.

<u>Significant clinical incidents</u>

7.2.21 The review team received information about two significant clinical incidents which had occurred in the urology service in the year preceding the review visit.

7.2.22 The first incident involved a [redacted]

[redacted]

7.2.23 [redacted]

7.2.24 [redacted]

7.2.25 [redacted]

7.2.26 [redacted]

7.2.27 [redacted]

7.2.28 [redacted]

[redacted]

7.2.29 The review team had sight of a number of statements produced by the consultant urologists involved in this case which disagree on a number of points, including the standard of documentation of decisions in the patient's notes, and who among the group was primarily responsible for the delays in care.

7.2.30 Recommendations arising from the Trust's investigation into the incident included that communication and handovers in the urology team should be improved, that wider uses of [redacted] screening tool should be promoted and that the incident should be shared with the endoscopy team and junior doctors to clarify the difference in procedures and emphasise the ramifications of booking the wrong test.

7.2.31 The review team heard that subsequent to this incident a requirement had been introduced for any decision to delay treatment to be documented and that reasons for the decision must be provided.

7.2.32 However, a number of interviewees expressed the view that delays of this kind were still likely to occur due to ongoing problems in the way in which the service was delivered. Specifically, interviewees reported that communication and handovers between surgeons continued to be poor, which increased the risk that the care needs of patients could be overlooked.

The effectiveness of patient care pathways including the timeliness of interventions in emergency care

Outpatient clinics

7.3.1 The review team heard that the consultant on call is responsible for reviewing all new referrals into the service and determining whether the patient should be seen in a 'one-stop' outpatient clinic, where investigations can be undertaken on the day, or in a clinic without resource for investigations to be undertaken. It was reported that most patients did require investigations and so were seen in the one-stop clinic in order that they did not need to attend multiple appointments.

7.3.2 It was reported that up to 22 patients could be seen in the course of a one-stop clinic if it was delivered by four members of staff (consultants, associate specialists and nurse practitioners) or 18 patients if the clinic was delivered by three members of staff.

7.3.3 A number of interviewees reported that some consultants in the team were consistently late to clinics, causing them to overrun.

7.3.4 The review team heard that additional clinics were being held on weekends to clear a backlog of patients awaiting follow-up appointments.

Theatre capacity for emergency urology procedures

7.3.5 The review team heard from a number of interviewees that the urology team often

found it difficult to access emergency lists for their patients. It was reported that urology patients added to emergency lists were frequently not brought in to theatre until the early hours of the morning, because lists were dominated by the Trauma and Orthopaedics and General Surgery teams and other smaller specialties were also competing for space. Anaesthetists were reported to be responsible for clinical prioritisation of lists.

7.3.6 A smaller number of interviewees reported that it was not particularly difficult to access the emergency list for urology patients, providing the surgeon went to speak with theatre staff directly.

7.3.7 The review team heard that the Trust had implemented a 'golden hour' system, in which a slot in the emergency list was always dedicated to one of the smaller specialties. Interviewees reported that the system did not work in practice, however, because trauma and emergency general surgery procedures frequently ran over into the agreed time slot, and this was not addressed at a management level.

7.3.8 A number of interviewees cited the competition for emergency theatre capacity as a factor in delays to patients requiring stent changes, insertion or removal,

Inconsistencies in the management of urological conditions

7.3.9 The review team heard that there had been a significant level of disagreement among the consultant team over the management of patients with obstructed kidneys[8]. Some consultants in the team were reported to manage those patients more conservatively than did their colleagues, opting to wait until the patient's condition improved before operating. Others were strongly of the view that obstructed kidneys should be treated as medical emergencies and that patients should undergo surgery at the earliest opportunity.

7.3.10 Inconsistencies in the way in which ureteroscopies were performed were also raised. An example was provided of a patient being left with a solitary kidney with no stent.

Administrative support

7.4.1 The urology surgical service is supported by three full time and six part time medical secretaries. Administrative staff are based across the different sites at which the service is delivered.

7.4.2 The review team heard that the secretaries used digital dictation and that clinic letters were produced in good time. It was reported that letters could be sent out on the day of request if highlighted by a consultant as urgent.

7.4.3 The medical secretaries were reported to be a well-functioning team, committed to

[8] An obstructed kidney continues to produce urine and the build up of urine within the kidney increases pressure within the kidney

providing a high quality service to patients.

7.4.4 A team consisting of three full time waiting list coordinators is responsible for managing the urology waiting list. The team is based at FGH.

7.4.5 The waiting list team was reported to be very helpful and responsive to the needs of the clinicians delivering the service.

7.4.6 The review team heard that clinicians completed an electronic form, stating whether a patient needed to be seen urgently, within two weeks, or within the routine waiting time. At the time of the review visit patients marked as routine were reported to be waiting around 22 weeks on average.

7.4.7 Most patients were reported to be pooled on the system, rather than being listed under a particular consultant, though the review team heard that occasionally a clinician would specify that a patient was to be seen either by themselves or by a particular colleague.

7.4.8 Although waiting times for patients undergoing major procedures were reported to be within acceptable limits, those requiring some more minor procedures were said to frequently wait longer than would be desirable. In particular, a number of patients requiring stent changes or removal or waiting to undergo a flexible cystoscopy were said to be experiencing long delays. One interviewee reported that around 150 flexible cystoscopies were overdue at the time of the review visit (roughly enough to fill 15 clinics at the rate at which the procedure was reported to be undertaken within the service).

7.4.9 These delays were reported to be caused in part by changes to the prioritisation of waiting lists as more urgent cases were added and routine procedures were moved down the list. It was reported that clinicians could expedite treatment in writing, or if a patient's condition worsened while they were on the list they could see their GP or attend the ED in order to be re-prioritised.

7.4.10 The review team heard that other than the decision to classify whether a patient should be seen urgently, within 2 weeks, or routinely, decisions regarding the prioritisation of the urology list were mainly the responsibility of the waiting list officers, who were not medically qualified. Waiting list coordinators were reported to be uncomfortable making such decisions at times and to lack detailed information upon which to base decisions.

7.4.11 Some interviewees expressed the view that waiting list coordinators' level of responsibility and the information available to them when prioritising lists were not appropriate and could lead to poor decisions, such as adding patients newly diagnosed with cancer to weekend lists which were not supported by a cancer nurse specialist.

Systems of audit and governance within the Urology service and the Trust

7.5.1 The review team heard that a Divisional Governance and Assurance Group met monthly. In addition, a monthly business meeting for the urology department is held. Urology audit meetings take place weekly.

Incident reporting

7.5.2 Interviewees reported that the use of incident reporting systems by staff had much increased over recent years following increased focus on this by Trust managers.

7.5.3 The review team was provided with a list of incidents recorded in relation to the urology department in 2014-15, graded accorded to harm. It was reported that all incidents resulting in moderate or severe harm were formally investigated. Examples of completed Root Cause Analysis reports were provided.

7.5.4 Interviewees raised some concerns over the effectiveness of incident reporting systems. The review team heard that it was often difficult to determine whether the consultant listed as responsible in each case was actually involved in the delivery of care, because patients were pooled.

7.5.5 One interviewee described not always being made aware of incidents in which they were named close to the time when they were raised. This was said to result in the interviewee being asked to comment on two incidents as part of their appraisal which were previously unknown to them.

7.5.6 A small number of interviewees expressed the view that incident reporting systems were used unfairly by some members of staff in the urology team. See paragraphs 7.6.3-4 for further discussion of this issue.

Audit

7.5.7 [redacted]

7.5.8 The review team heard that an annual meeting is held to agree the forward audit plan for the department. The audits to be undertaken that year are agreed and responsibility for their completion allocated. Junior doctors in the department are encouraged to take on at least one audit, in line with their interests and development needs.

7.5.9 It was reported that in 2015 sixteen audits were completed. A sample of the audit reports produced was provided to the review team. These were reported to be presented and discussed during the weekly audit meeting.

Morbidity and mortality (M&M) review

7.5.10 Urology M&M review was said to take place as part of the monthly urology audit

meeting.

7.5.11 The review team heard that the processes supporting M&M review in the service had been thought by many to be insufficiently robust, but that some improvements had been made, primarily as a result of the efforts of a trust grade doctor (recently promoted to become a specialty doctor at the time of the review visit).

7.5.12 It was reported that all mortalities in the service were reviewed at the meeting. With regards morbidity review, the review team heard that the trust grade doctor preparing the meeting circulated a list of cases involving morbidity to the team, inviting them to add any cases to the list, so that they could highlight particular cases for discussion, but that suggestions were often not forthcoming. It was therefore reported that the trust grade doctor usually selected the morbidity cases for discussion, based on the severity of the case and the likelihood of learning for the team arising out of its particular circumstances.

7.5.13 Some interviewees reported that cases taking place at FGH may be missed in the selection for M&M review, because the information may not be as readily available to the trust grade doctor preparing the meeting. It was suggested that the inclusion of cases from FGH might be overly reliant on the efforts of the individual members of staff to share relevant information in preparation for the meeting. Others reported that systems for information sharing between the sites had improved and were more confident that there was little chance of cases being missed.

7.5.14 The review team was provided with a sample of case presentation slides used in the M&M review section of an audit meeting in August 2015. Cases presentations were structured using the Situation, Background, Assessment and Recommendation (SBAR) model. It was reported that cases were presented to the group by core trainee doctors.

7.5.15 The review team heard from a number of interviewees that no record was made of M&M review discussions. The Trust was not able to produce any record of agreed actions or learning points arising from M&M reviews when requested by the review team. However, one interviewee reported that, although no detailed record of the discussion was produced, brief action plans were documented and were shared on a drive accessible to attendees after the meeting. That interviewee expressed the view that a more detailed record could not be maintained without additional administrative support for this purpose.

7.5.16 Interviewees told the review team that there was also no system in place to monitor trends in the issues arising through M&M review in order to prevent repeated instances of poor care.

7.5.17 Interviewees reported that M&M discussions were mostly conducted in a civil manner, but that occasionally disputes between individuals could become heated. This was said to be caused by a perception among certain attendees that the basis

upon which cases were selected for review was not fair and that failings in the cases of some consultants were more likely to be highlighted than those of others.

MDT meetings

7.5.18 The review team heard that a weekly urology cancer network MDT meeting is held on Fridays from 14:00-15:00 at Royal Preston Hospital, followed by a urology service cancer MDT at RLI from 15:00-17:00, or whenever the list for discussion was completed. Both meetings are conducted via videolink so that staff across different sites can participate.

7.5.19 It was reported that, where disagreements over treatment plans arose at the service level MDT that could not be resolved, the case would be discussed at the wider network MDT.

7.5.20 The service level MDT meeting is chaired by the MDT lead, one of the consultant urologists in the team. Administrative support is provided by an MDT coordinator.

7.5.21 Interviewees reported that the average number of cases discussed was 15-20 per week, but that this could be much higher at times. The difficulties of preparing thoroughly for the discussion of all patients on the list and of maintaining concentration throughout lengthy meetings were raised by some.

7.5.22 The review team heard from some interviewees that frequently patients with non-cancerous urological conditions were inappropriately added to the list for discussion, causing the meeting to last longer than it might have otherwise.

7.5.23 Outcomes of MDT discussions were reported to be recorded by the MDT coordinator, with notes being projected on to a screen visible to attendees whilst being typed. Some interviewees reported that these were not always entirely clear when later reviewed. Possible reasons for this put forward by interviewees were that there was a high turnover in the coordinator role, meaning that the note-taker might be unfamiliar with the content of the discussion and the rushed nature of some meetings leading to inaccuracies.

7.5.24 Interviewees expressed a range of views as to the quality of discussion at MDT meetings. Some reported that tensions between the urology consultants impacted negatively on the atmosphere of the meeting and meant that discussions of treatment options were not as open and constructive as they might be. Others disagreed and said that, although the poor relationships among the consultant team were apparent in the meeting, discussion remained constructive and professional.

7.5.25 Some interviewees reported that management plans agreed at the MDT meeting were not always followed by consultants in the team. It was reported that in some instances those cases were then not brought back to the meeting for further discussion and learning and that there appeared to be no action taken by managers

in respect of this poor practice.

Appraisals

7.5.26 A bespoke software package is used for the administration of appraisals in the Trust. Organisation–wide performance on appraisal is reported to the Trust Board through the Workforce Committee.

7.5.27 Clinicians were reported to be advised of any incidents or complaints in which they are named prior to their appraisal meeting for comment. The review team heard that automated appraisal reminders were sent to clinicians and that training was available to assist them in accessing relevant performance data prior to their appraisal meeting. The Trust also produces an appraisal and revalidation newsletter for staff.

7.5.28 The review team had sight of the most recent appraisal reports for [redacted] in the team.

Communication and team working

7.6.1 T[redacted]

7.6.2 This was reported to have resulted in instances of poor behaviour and open conflict in meetings. A number of interviewees reported that consultants in the team frequently sent out emails detailing disputes with colleagues and copied in many other members of staff who were not involved in the matter. Many of the recipients of these emails reported feeling very uncomfortable to be involved in this way. Examples of emails of this nature were provided to the review team.

7.6.3 Some interviewees reported that a driving factor in the breakdown of relationships was the frequent disputes among the team over patient care and particularly over the management of urgent cases and the timeliness of care delivery. It was reported that consultants in the team had raised concerns about the safety of the care provided by their colleagues through the Trust's incident reporting systems and that this had caused much bad feeling within the team.

7.6.4 Some interviewees expressed the view that the concerns raised were entirely appropriate. However, one interviewee reported the view that unfounded incidents were raised maliciously by some consultants in relation to the care provided by their colleagues. Others reported that the incidents raised were not without foundation, but that different thresholds were applied to some consultants in the team as to what constituted an incident sufficiently serious to warrant reporting. Specifically, it

was alleged by some interviewees that incidents were more likely to be raised in relation to the care provided by black and minority ethnic (BME) consultants than that provided by their colleagues of white British descent.

7.6.5 More widely, the review team heard from some interviewees the view that the white British consultants in the team received preferential treatment in terms of the distribution of work and managerial roles across the team.

7.6.6 A number of interviewees told the review team that they had in the past been accused by consultants in the team of racism. Some felt that the accusation had been made to deflect attention when genuine clinical concerns were raised.

7.6.7 A number of interviewees reported the view that, although the poor relationships within the consultant team had not resulted in patients being directly harmed, the lack of effective communication between consultants had caused delays in care and prevented progress within the department. The review team heard from a number of interviewees that consultants would seek assistance from their colleagues if needed. However, one interviewee reported that this was not always the case and that disagreements over how to manage patient care had resulted in consultants refusing to assist one another.

7.6.8 The review team heard that senior managers at the Trust were well aware of the long standing interpersonal difficulties within the consultant urology team. In 2014 the Trust commissioned an occupational psychology service to undertake a review of the way in which the service level urology cancer MDT meeting was functioning and produce a development programme to bring about improvements. The review involved structured interviews with individual members of staff, and group workshops.

7.6.9 The report produced following this intervention noted that MDT meetings were negatively impacted by conflict and clashes of personalities among the consultant group. It was noted that attendees were not working as a team and that there was a lack of trust and respect between colleagues. The tendency of some staff to use emails to air disputes was highlighted. A code of conduct for MDT meetings was produced and agreed by attendees of the MDT meeting as part of the process.

7.6.10 The report recorded that some improvements in relationships within the team and behaviour at meetings had been made by the end of the intervention. However, interviewees told the review team that its long term impact had been limited and that many of the problems that were identified had persisted.

8. Conclusions

The following conclusions are reached on the basis of the documentation reviewed (as set out in section 6 above) and the interviews held with staff at the Trust (as described in section 5 above).

Service configuration

8.1.1 The review team recognised the challenges of providing a high quality urology service across a wide geographical area with varied demographic characteristics.

8.1.2 However, the review team considered that centralising acute urology care to just one site would be likely to cause significant disadvantage to some patients. It was therefore of the view that there may be merit in reconfiguring the urology service to offer emergency and elective inpatient care across two sites in the future, namely Furness General Hospital (FGH) and Royal Lancaster Infirmary (RLI).

The delivery of elective care

8.1.3 The review team was of the view that providing inpatient care across three separate sites was inefficient and likely to be unsustainable.

8.1.4 The reviewers were particularly concerned about the safety of the current arrangement of delivering inpatient care at Westmorland General Hospital (WGH), due to the limited resources available there to manage post-operative complications. The reviewers were not satisfied that the practice of listing only lower risk patients for surgery at WGH provided adequate safeguards, particularly in light of the concerning report from one interviewee that roughly one patient per month was transferred by ambulance to Royal Lancaster infirmary (RLI) from WGH to be returned to theatre after undergoing a TURP.

Emergency care at FGH

8.1.5 The review team considered that the current arrangements for the provision of emergency care for inpatients at the weekend at FGH were potentially unsafe, in light of the lack of consultant cover and of senior training grade doctors on site. Although the number of emergency referrals average one per day at FGH, the arrangements for senior cover for these patients is not clear.

8.1.6 Weekday emergency provision, supported by a consultant and an Associate Specialist, is satisfactory.

8.1.7 The review team recognised the likely difficulty of recruiting senior training grade doctors to provide adequate cover of both RLI and FGH every day. The reviewers therefore concluded that changes to the way in which emergency care is delivered at

weekends were required.

8.1.8 The reviewers considered sensible the suggestion that in the short term a greater level of support could be provided for minor urological procedures and investigations by junior doctors in the general surgery team and potentially also from additional advanced nurse practitioners (ANPs). This would reduce the level of unnecessary travel between sites for the urology consultant on-call and also relieve the burden of the current consultant at FGH. These arrangements would be contingent on the provision of adequate training to junior doctors and nurses so that the Trust could be assured that they were competent to provide the support required.

Communication between consultants regarding patient care

8.1.9 The review team was of the view that the considerable efforts of consultants and associate specialists in the urology team to provide 7 day a week on call cover across a wide geographical area are commendable.

8.1.10 However, the reviewers considered that the quality of handovers between consultants in the urology service was a cause for concern and had the potential to undermine the benefits of the on-call system. It is clear that poor communication regarding patient care between staff can be a major contributory factor to subsequent error and harm to patients.

Urology bed capacity

8.1.11 The reviewers were concerned by reports of urology patients at RLI being spread out across a number of wards, such that staff at times experienced difficulty finding them. The reviewers considered that the placement of urology patients on wards where staff lacked the knowledge and experience to provide the specialist care they required constituted an avoidable risk to patient safety. It is well established that post-operative TURP patients managed on non-urology wards have higher morbidity and mortality.

The overall standard of emergency and elective care provided, including the surgical outcomes of the service

Performance and outcomes of the service

8.2.1 Cancer performance and waiting times for the service were good.

8.2.2 Outcome data for the service provided to the review team was limited, making an overall assessment of the standard of surgical outcomes difficult. As mentioned in paragraph 7.2.8 the readmission data provided to the review team suggested one particular surgeon has a higher readmission rate than their colleagues, but the cause of this could not be ascertained on the basis of the limited information provided.

Interventional radiology support

8.2.3 The review team was concerned to hear that limited availability of interventional radiology support available to the service had forced urology surgeons to undertake retrograde stenting via cystoscopy under general anaesthetic for patients requiring relief of ureteric obstruction, when a percutaneous nephrostomy would be a safer and possibly more effective treatment. The reviewers considered this to be a clear patient safety risk.

Continuity of care

8.2.4 The review team was of the view that the care provided to patients in the urology service lacked continuity and that this had clearly impacted negatively on patient experience.

8.2.5 The reviewers were concerned by reports that the system of 'pooling' patients rather than one consultant maintaining oversight of their patients' care had led to delays and oversights in the delivery of the service. This is particularly concerning given the reportedly poor quality of handovers taking place between consultants and the lack of a cohesive approach to patient management among the surgical team.

8.2.6 However, the review team recognise the potential benefits of pooling waiting lists where appropriate, including reduced patient waiting times and a better balance of workload across the consultant team.

8.2.7 The review team concluded that changes are needed to the way in which pooled waiting lists are managed in order to ensure that the service is both efficiently delivered and suited to patients' individual needs.

Significant clinical incidents

8.2.8 The reviewers considered that the Trust had conducted appropriate investigations of the two significant clinical incidents which had occurred in the urology service in the year preceding the review visit (see paragraphs 7.2.21-32). Sensible learning points and action plans were set out in the root cause analysis reported into each case.

8.2.9 [redacted]

8.2.10 The reviewers considered that a repetition of the case [redacted] was le

likely to reoccur in light of the actions taken subsequently. The reviewers thought it particularly important that FY1 and FY2 doctors should not be discharging patients without them being seen by a more senior clinician.

8.2.11 However, the reviewers were very concerned that a consultant urologist in the team failed to identify [redacted].

The effectiveness of patient care pathways including the timeliness of interventions in emergency care

Outpatient clinics

8.3.1 The review team considered that the provision of 'one-stop' clinics, where investigations can be undertaken on the day, was an example of good practice. The clinics provide convenient service to patients and are a means to utilise the resources of the service effectively.

8.3.2 However, the review team was concerned to hear that there were empty slots in clinics held at smaller hospital sites in the Trust at a time when patients were experiencing delays in the provision of investigations and treatment for minor urological conditions. These clinics could be better managed to maximise efficiency.

8.3.3 The reviewers were also concerned by reports that certain consultants in the team were consistently late to clinics and that this did not appear to have been effectively addressed by service managers.

Theatre capacity for emergency urology procedures

8.3.4 It was clear that the majority of staff had experienced difficulty in gaining access to emergency lists for urology patients, though some felt that this was more difficult to achieve than others.

8.3.5 The review team considered that some degree of competition between specialties for emergency theatre space is perhaps inevitable, but was of the view that this should not be happening as consistently as was reported.

Inconsistencies in the management of urological conditions

8.3.6 The reviewers were of the view that inconsistencies in the management of both ureteroscopies and patients with obstructed kidneys within the service constituted a risk to patient safety and should be addressed as a priority by establishing a unified policy for the department.

Administrative support

8.4.1 The review team considered that the urology service was supported by a well organised and adequately staffed administrative infrastructure.

8.4.2 The review team was impressed by the enthusiasm of the waiting list coordinators interviewed and the way in which they managed the listing process. However, the reviewers were concerned by the degree of responsibility held by waiting list coordinators in ensuring that surgical lists were populated according to clinical need.

Systems of audit and governance within the Urology service and the Trust

Incident reporting

8.5.1 The review team considered that the efforts of the Trust to promote the use of incident reporting systems across the organisation should be commended.

8.5.2 Processes for incident reporting, recording and investigation appeared in the main to be clear and well understood by staff. Greater clarity was needed, however, over the identification of the responsible clinician in each incident and the timing with which incident reports were highlighted to the staff involved.

8.5.3 The reviewers considered it good practice to discuss significant incidents at the monthly audit meeting, though the failure to comprehensively document the outcomes of these discussions undermined the value of this exercise to an extent.

8.5.4 It was clear that the way in which incident reporting systems were used by some members of staff in the urology service was an area of contention, though the reviewers did not consider this to be indicative of any fault in the systems in place.

Audit

8.5.5 The process in place for agreeing an annual plan of audits to be undertaken and the allocation of responsibility for each audit appeared to be clear.

Morbidity and mortality (M&M) review

8.5.6 Despite reported recent improvements in this area, thanks to the efforts of an individual member of staff, the review team had a number of concerns in relation to the way in which M&M review is undertaken in the service.

8.5.7 The reviewers considered that the lack of agreed objective criteria for the selection

of cases to be discussed at the meeting fuelled disputes between members of the team about the fairness of the process, to the detriment of the atmosphere at the meetings and their effectiveness.

8.5.8 The review team was also of the view that the system in place to ensure that cases from both RLI and FGH are captured and reviewed is unreliable and appeared to be overly reliant on the efforts of the individual members of staff to share relevant information in preparation for the meeting.

8.5.9 The lack of a detailed record of agreed actions or learning points arising from M&M review was a cause for concern. Although one interviewee reported that brief action plans were documented and shared on a drive accessible to attendees, the reviewers noted that other members of staff interviewed were unaware of them.

8.5.10 The reviewers were also concerned to hear that there are no systems in place to support the identification of trends in M&M data in order to prevent repeated instances of poor care.

MDT meetings

8.5.11 The review team considered that the discussion of cases at the urology cancer MDT meeting that were not appropriate for that forum (i.e. not cancer cases) constituted a poor use of staff time.

8.5.12 The review team also considered that MDT outcomes and the allocation of actions appeared to lack clarity and that this increased the risk of errors being made and could result in staff having to spend time clarifying decisions.

8.5.13 The reviewers were concerned by reports of management plans that were agreed at the MDT meeting not being followed by the responsible consultant. While there is sometimes a clinical basis to alter a plan after the MDT meeting, this should not be frequent. Moreover, when this does occur it is valuable to bring the case back to the meeting to discuss the alternative decisions reached and their justification.

Communication and team working

8.6.1 The review team was of the view that the very poor relationships between some of the consultants within the urology department were not conducive to a well-functioning service and had the potential to impact negatively on patient care.

8.6.2 The review team was particularly concerned to hear reports of consultants refusing to assist one another and frequently sending out emails detailing disputes with colleagues, copying in many other members of staff who were not involved in the matter. The review team was of the view that this clearly had the potential to impact negatively upon the quality of the service as well as on satisfaction levels of staff.

8.6.3 Disagreements over patient care were clearly a factor in the breakdown in relationships in the team and wider issues of perceived unfairness and discrimination on racial grounds within the team have prevented their resolution.

8.6.4 The review team noted that managers of the service were aware of these issues and had attempted to resolve them through an exercise undertaken by an occupational psychology service in 2014. However, this intervention appeared to have limited long term impact on working relationships within the team.

9. Recommendations

The following recommendations are for the Trust to consider.

Safety measures

1. The Trust should review the outcomes of urology surgery being undertaken at Westmorland General Hospital (WGH) in order to assess the safety of inpatient care delivered at the site. The review should include an assessment of the number of patients requiring transfer to another hospital as a result of post-operative complications and the adequacy of medical cover out of hours.

2. The Trust should consider the reviewers' comments about the limited availability of interventional radiology support available to the service and the potential risk posed to patients by undertaking retrograde stenting under general anaesthetic for patients who are often seriously ill with urosepsis. Clear local and regional protocols for interventional radiology support are needed to provide a good quality service to this vulnerable group of patients.

3. The review team was concerned to hear that limited availability of interventional radiology support available to the service had forced urology surgeons to undertake retrograde stenting for patients requiring relief of ureteric obstruction, when a percutaneous nephrostomy would be a safer and possibly more effective treatment. The reviewers considered this to be a clear patient safety risk.

4. The Trust should introduce a clearer protocol for the management of stents. It may be of benefit to participate in the stent registry[9] operated by the British Association of Urological Surgeons (BAUS) which provides automatic email reminders when stents are nearing, or have reached, a user defined 'end-of-life', as well as a function to track all ureteric stents electronically so that forgotten or lost stents should be prevented. This will also ensure that this routine procedure is not repeatedly delayed, such that patients' conditions worsen to an unsafe degree.

5. The Trust should introduce a clear protocol for the management of ureteroscopies, especially in the case of a solitary functioning kidney and ensure that this is adhered to by all surgeons in the service. The protocol must require that, following any ureteroscopic therapeutic procedure in patients with a solitary kidney, a ureteric stent is inserted.

[9] http://www.baus.org.uk/professionals/sections/endourology/stent_registry.aspx

6. A clear protocol for the management of obstructed and infected kidneys in the service should be developed and implemented, taking into account the lack of interventional radiology support available to the service. Obstructed kidneys should be treated as an emergency and a policy should be introduced to ensure that patients with the condition get priority on emergency theatre lists. If a patient is not considered suitable for retrograde stenting they should be offered radiological intervention either locally or at a nearby hospital. If that is unavailable there may be situations where open drainage of the kidney becomes necessary. The pathways should be clearly understood by all consultants.

7. A list of urology patients must be updated electronically and verbal consultant to consultant handover of any patients who are sick or awaiting a procedure must take place. For the latter there should be a clear plan made by the on-duty consultant before handover. The Trust should consider including protected time in surgeons' job plans for handover.

Service configuration and staffing

8. The Trust should consider reconfiguring the urology service so that inpatient care is delivered at Furness General Hospital (FGH) and Royal Lancaster Infirmary (RLI) only, where appropriate resources are available to manage post-operative complications.

9. The Trust should continue to offer an acute urology service at both RLI and FGH from Monday to Friday, but should consider providing emergency care over the weekend at RLI only to make the best use of resources available and ensure that patients have access to consultant urological review.

10. The Trust should initiate the recruitment of senior training grade doctors to support the urology service. If this is not thought feasible, additional consultant posts may be required, to be based at FGH.

11. In order to reduce the level of unnecessary travel between sites for the urology consultant on-call, the Trust should also consider recruiting additional advanced nurse practitioners (ANPs) and arranging for junior doctors in general surgery to provide care for urology inpatients at FGH. This would include undertaking minor urological investigations and procedures.

12. Any ANP or junior doctor in general surgery responsible for urology patients as described in recommendation 11 must complete appropriate training so that the Trust can be assured that they are competent to provide the support required.

13. The Trust should ensure that urology inpatients at RLI are accommodated only on wards where staff have sufficient knowledge and experience to provide the specialist

care required.

Continuity of care

14. All urology patients should have a named consultant with oversight of their treatment throughout an episode of care. The surgeons listing the patient should indicate whether or not that specific patient is suitable for pooling. Patients should be made aware at an early stage that their surgery might not be performed by the surgeon who has listed them and should be given an opportunity to opt to remain under the care of their named consultant.

Service delivery

15. The Trust should review the way in which outpatient clinic lists at smaller sites are managed to ensure an effective uses of resources.

16. The Trust should review the process by which smaller specialties can access emergency theatre lists to ensure that emergency surgery is appropriately clinically prioritised and that there is sufficient capacity to meet demand for emergency surgery.

17. Waiting list coordinators must be provided with greater support from clinicians to ensure that surgical lists are populated according to clinical need rather than targets.

Morbidity and Mortality review

18. The service should agree a set of criteria by which cases are identified for discussion at M&M meetings. Objective and locally agreed criteria across the service will help remove the possibility of bias which may occur when the selection of cases lies in the discretion of an individual.

    To facilitate the process of case identification and ensure that no cases worthy of discussion are missed, the service should ensure that a single log of surgical patients is kept for all sites at which the service is delivered. The log should be generated automatically by linking to an existing electronic patient records system, or if this is not possible, a suitable individual should be assigned with the responsibility of maintaining an electronic list of all patients seen by the service.

19. A formal record of the outcomes of discussions held as part of M&M review in the service should be maintained. The record should present a summary of the discussion held and the consensus view reached rather than attribute specific points to individuals. Actions agreed by the team should also be formally recorded as part of this process and reviewed at subsequent meetings.

Any changes made to systems and practices as a result of issues identified through the M&M process should also be recorded to allow for the effect of these changes to be monitored.

20. The Trust should implement a system to monitor trends in the cases brought to the audit meeting for M&M review to prevent repeated instances of poor care over time.

MDT meetings

21. The Trust should review the process by which cases are listed for discussion at the service level urology cancer MDT meeting to ensure that only those appropriate for this forum are listed so as to ensure staff time is being well utilised.

22. The Trust should introduce a process to monitor whether treatment plans agreed at MDT meetings are ultimately followed. Instances of treatment plans not being followed because of a decision made by the responsible consultant, rather than by the patient, should be discussed at the next MDT meeting to foster transparency and share learning among the group.

23. Records of the MDT recommendations should also be reviewed for accuracy by the attendees of the meeting before being added to patients' files. This process will be assisted by the notes being projected on to a screen visible to attendees whilst being typed during the meeting.

Staff management

24. Managers of the service should discuss with the surgical team the quality of their relationships, their behaviour towards one another and the implications of these problems for the quality of the service. Standards of behaviour and professionalism must be agreed within the team and adhered to, regardless of the quality of consultants' personal relationships Additional external support may be required to facilitate the group's ability to work as a team. Participation in this exercise must be mandatory for all consultants in the team.

25. The Trust must take action in respect of each future instance of individual members of staff in the urology team using email communication inappropriately, in line with its policy for acceptable use of electronic communication.

26. The Trust should take appropriate action when consultants are consistently arrive late to undertake clinical commitments.

Responsibilities of the Trust in relation to these recommendations

This report has been prepared by The Royal College of Surgeons of England and the British Association of Urological Surgeons under the IRM for submission to University Hospitals of Morecambe Bay NHS Foundation Trust. It is an advisory document and it is for the Trust concerned to consider any conclusions and recommendations reached and to determine subsequent action. It is also the responsibility of the Trust to review the content of this report and in the light of these contents take any action to protect patient safety that is considers appropriate.

Further contact from the Royal College of Surgeons

Where recommendations are made that relate to patient safety issues, the Royal College of Surgeons will follow up this report with the Trust to ask them to confirm that the Trust has addressed these recommendations. The College's Lead Reviewer may be available to support this process.